

# Looking for help with financial complaints?

THE INSURANCE & SAVINGS OMBUDSMAN

IS AN INDEPENDENT SERVICE FOR RESOLVING  
FINANCIAL SERVICE DISPUTES, WHICH IS FREE  
TO CONSUMERS.



**“CASE  
MANAGER  
EXTREMELY  
HELPFUL.  
AS A BROKER  
RATHER THAN  
THE CLAIMANT  
I WAS VERY  
PLEASED TO  
BE TREATED  
AS WELL  
AS I WAS BY  
THE CASE  
MANAGER.”**

*“Our case manager  
was brilliant,  
extremely helpful  
and informative.  
We were aware  
of the timings and  
progress being  
made with our  
complaint and  
kept up to date.”*

**“I FELT REGAR  
THE OUTCOM  
TREATED WIT  
AND AS A HU**

*“The ISO is a fantastic service,  
however, I hope for all concerned  
I do not ever have to use its services  
again. I have learned a lot about my  
responsibilities as a consumer.”*

*“VERY COMPASSIONATE  
AND UNDERSTANDING  
IN A STRESSFUL TIME  
OF MY HUSBAND’S  
ILLNESS.”*



**“WE WERE VERY IMPRESSED WITH THE ISO AND THE SERVICE RECEIVED.”**

**“The ISO is a great service to have to help consumers as it avoids going to court.”**

**“THERE WAS A PERIOD OF ‘MEDIATION’ ON HOW TO SETTLE THE PAYMENT GIVEN BOTH SETS OF EVIDENCE. IT FELT AS IF THE ISO WAS IN BOTH CAMPS – MANY THANKS FOR YOUR HELP.”**

**“DLESS OF  
E I WAS BEING  
H RESPECT  
MAN BEING.”**

**“Excellent communication – both written and oral – went extra distance, made a huge difference through a very stressful time.”**

**2010 CONTENTS**

|    |  |
|----|--|
| 02 | Paula Rebstock, Chairperson                  |
| 04 | Karen Stevens, Insurance & Savings Ombudsman |
| 07 | Complaints Summary                           |
| 08 | Jurisdiction                                 |
| 09 | How we got our message into the community    |
| 10 | How do people rate us?                       |
| 12 | Complaints Checklist                         |
| 12 | Case Studies                                 |
| 26 | Financial Statements                         |
| 32 | Audit Report                                 |
| 33 | Scheme Participants                          |

# Paula Rebstock, Chairperson

The last 12 months have witnessed the most significant changes in recent history to New Zealand's financial market regulation.

The last 12 months have witnessed the most significant changes in recent history to New Zealand's financial market regulation.

The impact of these changes on the Insurance & Savings Ombudsman ("ISO") Scheme has also been profound. Most significantly, the ISO Scheme has become an approved dispute resolution scheme under Part 3 of the Financial Service Providers (Registration and Dispute Resolution) Act 2008 ("the Act"). In addition, with the support of the Board, the Commission and Scheme Participants, the ISO Scheme has been opened to new Participants.

Therefore, the focus of the ISO Commission over the past year has been on the necessary changes to the ISO Scheme's Rules and Terms of Reference required to allow the expansion of Scheme membership to additional financial service providers and to ensure the ISO complies with section 63 of the Act, which sets out what rules must be provided for in a dispute resolution scheme. In addition, the Commission established the appropriate levy basis going forward, considered organisational design matters and provided oversight of the Scheme's expansion plan.

The membership of the Ombudsman Commission has remained unchanged during the year, which has supported the effective transition to the new regulatory environment. I am grateful to my colleagues on the Commission, as well as the Board and Scheme Participants for their commitment to ensuring the ongoing relevance of the ISO Scheme as we move forward. Currently, the Commission and Board are undertaking a joint governance review in order to consider how to ensure representation of both new and existing Participants and the appropriate independent processes for future amendments to the Scheme's Rules and Terms of Reference, which is to be completed by 31 December 2010.



As the Commission has prepared for the new regulatory regime, the Ombudsman and her staff have experienced a further significant increase in the number and complexity of complaints received. This workload, alongside the Scheme expansion plan, has underscored the value of having an experienced ISO whose integrity, professionalism and expertise is highly regarded.

The ISO Scheme has established its credibility as a dispute resolution scheme which is independent of Participants, fair in its decision-making, accessible to consumers, accountable to stakeholders, and effective and efficient in its complaints handling operation. In its 15 years of operation, the ISO Scheme has dealt with more than 35,000 complaints enquiries, investigated over 4,100 complaints and has assisted its Participants to improve business practices through complaints handling. From the outset, the ISO Scheme willingly adopted the principles which are now set out in section 52(2) of the Act and are the standards of best practice promoted by the Australian and New Zealand Ombudsman Association ("ANZOA") – a peak professional association of which the ISO was a founding member.

Looking forward, the new regulatory regime for financial service providers will be fully implemented over the next 12 months. Higher standards of business practice are essential to achieving public confidence in all financial markets. The ISO Scheme is well positioned to play a leadership role in ensuring that our Participants and their customers continue to have access to the highest quality dispute resolution services.

**Paula Rebstock**

Chairperson, Insurance & Savings Ombudsman Commission (CNZM)

# Karen Stevens, Insurance & Savings Ombudsman

Regulation has been introduced in the financial sector to promote confidence in the financial markets and to improve consumers' access to redress and dispute resolution.

The year in review has been a year spent looking forward: to the implementation of new legislation in the financial sector, the expansion of the ISO Scheme and increasing opportunities for dispute resolution in a regulated environment.

Regulation has been introduced in the financial sector to promote confidence in the financial markets and to improve consumers' access to redress and dispute resolution. All financial service providers must be registered. Registration of organisations is required by 1 December 2010 and individuals by 1 April 2011 and, as a prerequisite to registration, all financial service providers must belong to an approved dispute resolution scheme.

To become an approved dispute resolution scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008 ("the Act"), changes were required to the ISO Scheme's Rules and Terms of Reference. They needed to reflect that the ISO Scheme will be operating within a regulated environment and, in particular, to comply with section 63 of the Act, which sets out what the rules of an approved dispute resolution scheme "*must provide for*". The Minister of Consumer Affairs granted approval to the ISO Scheme on 19 May 2010.

Changes to the ISO Scheme's Rules and Terms of Reference were also required to allow the ISO Scheme to expand the provision of its dispute resolution services beyond the insurance and savings industries to other financial service providers, including: finance companies, trustee corporations, financial advisers and brokers.

The ISO Scheme is pivotal in the provision of dispute resolution services, giving financial service providers an independent and credible scheme which can use the name "Ombudsman". It is one of only two industry schemes in New Zealand which have been allowed to do so by the Chief Parliamentary Ombudsman under the Ombudsmen Act 1975.



The ISO Scheme was set up in 1995 as a voluntary initiative by the insurance and savings industries to provide a free complaints resolution service for their customers. ISO Scheme Participants have embraced change in the last year, recognising that expansion will ensure more consumers have access to a well established and highly regarded dispute resolution scheme.

Technology is an important consideration in our plans to expand the ISO Scheme's dispute resolution service, both from the perspective of consumers and new Participants. More consumers are accessing information online, with over 84,000 sessions recorded on our website this year. At the same time, work has been undertaken to upgrade the current ISOCS database system, building a complementary registration website for new Participants to make joining the ISO Scheme simple – online in one easy transaction.

The ISO Scheme's jurisdiction allows complaints involving amounts of up to \$200,000 to be made to the ISO. However, the ISO can only consider a complaint when it has been through the Participant's internal dispute resolution process and has reached "deadlock". The complaint fee of \$1,000 is only charged if the complaint is accepted as being within the ISO's jurisdiction, for resolution by negotiation, conciliation, informal mediation, or investigation and decision.

It is vital that all Participants in the ISO Scheme understand the importance of early dispute resolution. If complaints are handled well, both internally and externally, customer relationships and business practices have been shown to improve. For that reason, we have spent time preparing a complaints handling manual to give Participants the ability to deal effectively with their customers' complaints themselves. Workshops with an expert are also planned for Participants to learn how to resolve complaints, without the ISO's involvement, supported by online complaints handling training.

From our perspective, it is all about giving our Participants the tools to deal effectively with complaints in the knowledge that the external process is available, if resolution is not possible through the internal dispute resolution process.

This year, we have had a further significant increase in the number of complaints received. This has continued the upward trend of the last few years and is probably indicative of consumers facing harsher economic conditions, with greater scrutiny of claims by Participants. We have seen a marked increase in the number of cases in the fire and general insurance sector, particularly in travel, with fraud and pre-existing health conditions being common reasons for declining claims across all of the sectors.

From our Complainant surveys, we understand there has been an increase in the amount of information provided by Participants about their own internal dispute resolution processes and about the ISO Scheme's external process this year, which may also have contributed to an increase in the number of complaints. This is very positive from a complaints handling perspective and Participants are to be commended for improved communication about both the internal and external dispute resolution processes.

This has been a very exciting time for everyone involved with the ISO Scheme. It has been a time of change and anticipated growth. I appreciate the support we have received from the ISO Commission, and from the ISO Board led by Martin Stokes. I would like to thank Paula Rebstock, the new Chairperson of the ISO Commission, whose experience with regulation and compliance cannot be underestimated and will continue to be invaluable in the year ahead. I also would like to thank my staff who are very good at what they do and, in particular, Lionel Hinton, who has successfully navigated a way for us through computer enhancements and moving registration dates to ensure we are well prepared for expansion in the coming financial year.



**Karen Stevens**

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



# Complaints Summary



There were 1,985 complaint enquiries (861 in writing), 284 complaints received for investigation and 277 complaints resolved in the 2009/2010 financial year, as set out in the tables below. There were 43 complaints resolved, as a result of involvement of the ISO Office, before a formal investigation was undertaken.

| STATUS   | 2009/10    |     | 2008/09    |     |
|--|------------|-----|------------|-----|
| Complaints carried over from previous year and completed | 64         |     | 42         |     |
| Complaints received for investigation                    | 284        |     | 242        |     |
| Complaints under investigation                           | 348        |     | 284        |     |
| Complaints completed during the year                     | 277        |     | 220        |     |
| Complaints for investigation but incomplete at year end  | 71         |     | 64         |     |
|  |            |     |            |     |
| RECEIVED BY SECTOR                                       | 2009/10    |     | 2008/09    |     |
| Fire and General   | 194        | 68% | 142        | 59% |
| Health   | 37         | 13% | 39         | 16% |
| Life and Savings   | 53         | 19% | 61         | 25% |
| <b>TOTAL</b>   | <b>284</b> |     | <b>242</b> |     |
|  |            |     |            |     |
| OUTCOMES   | 2009/10    |     | 2008/09    |     |
| Complaints upheld  | 38         | 14% | 33         | 15% |
| Complaints partly upheld                                 | 7          | 3%  | 10         | 5%  |
| Complaints settled                                       | 45         | 16% | 23         | 10% |
| Complaints withdrawn                                     | –          | –   | 2          | 1%  |
| Complaints not upheld                                    | 187        | 67% | 152        | 69% |
| <b>TOTAL</b>   | <b>277</b> |     | <b>220</b> |     |

A **COMPLAINT ENQUIRY** can be made by telephone or in writing and can relate to any aspect of a complaint, before it has been through the Participant's internal complaints process.

A **COMPLAINT** has gone through a Participant's internal complaints process 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 Participant has not treated the consumer's complaint fairly, reasonably and in accordance with the contract. The resolution is partly or totally in favour of the consumer.

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

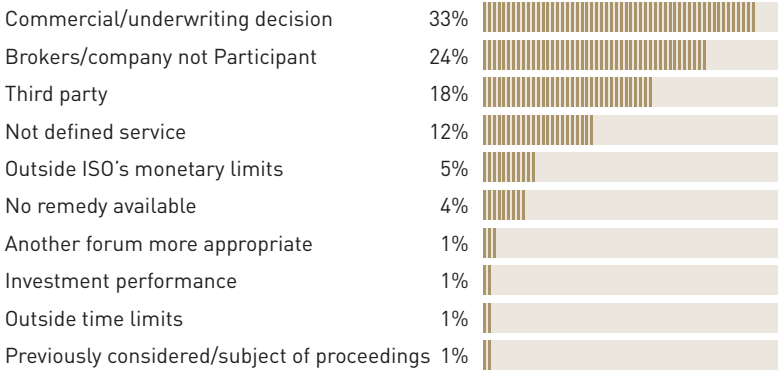
A complaint is **NOT UPHELD**, when the ISO finds that the Participant has treated the consumer's complaint fairly, reasonably and in accordance with the contract. However, sometimes the Participant has made/will make an ex-gratia payment, acceptable to the consumer.

In the year ended 30 June 2010, more than \$1,800,000 was paid by the Participants to consumers who had their complaints considered by the ISO (not including weekly disability benefit payments under income protection, superannuation or life policies).

JURISDICTION

In the 2009/2010 financial year, we received written enquiries about 143 disputes outside jurisdiction which required consideration and a written response. We also received 191 telephone enquiries about disputes outside the ISO's jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO'S JURISDICTION



TIMELINESS

The average time to close the 277 complaints investigated in the year ended 30 June 2010 was 96 days from receiving the company's file and accepting the complaint for investigation.

ISO'S EXPERIENCE OF PROVIDING DISPUTE RESOLUTION SERVICES IN THE FINANCIAL SECTOR:

Since the ISO Scheme was established in 1995, it has handled more than 35,000 enquiries and investigated 4,177 complaints.

# How we got our message into the Community

## IN 2009/2010:

**SPEECHES AND PRESENTATIONS:** We provided complaints handling training for Participants and spoke at a total of 21 seminars and conferences, to members of ICNZ, ANZIIF, IBANZ, SIFA and FINSIA. In April 2010, the ISO gave 2 presentations at the ANZOA conference on change in the financial sector and fair and reasonable decision-making.

**CONSUMER OUTREACH:** We co-hosted, with the Banking Ombudsman and Electricity and Gas Complaints Commissioner, 3 sessions around New Zealand for consumer advisers, including Citizens Advice Bureaux, Community Law Centres, Budget Advisers and other community groups.

**0800 NUMBER:** We received 3,157 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 84,100 website sessions on our website: [www.iombudsman.org.nz](http://www.iombudsman.org.nz), an increase of 52% on the previous year.

**COMPLAINT ENQUIRIES:** We dealt with 1,123 telephone and 861 written complaint enquiries from consumers.

**MEDIA ENQUIRIES:** We handled 21 requests for information from the media.

**SUBMISSIONS:** We made 8 submissions relating to the Financial Service Providers (Registration and Dispute Resolution) Act 2008 and Financial Advisers Act 2008.

**“The ISO kept me informed every step of the way through the process. I would like to thank [the Case Manager] for all his efforts in resolving my matter.”**

*“Having scanned the ISO website I felt comfortable with ISO procedures and was kept well informed of progress.”*

**“Excellent communication – both written and oral – went extra distance, made a huge difference through a very stressful time.”**

# How do people Rate us?



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

|            |       |                        |
|------------|-------|------------------------|
| Agree      | 86.8% | <div><div></div></div> |
| Disagree   | 9.6%  | <div><div></div></div> |
| Don't know | 3.6%  | <div><div></div></div> |

## THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME

|            |       |                        |
|------------|-------|------------------------|
| Agree      | 74.7% | <div><div></div></div> |
| Disagree   | 16.9% | <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      | 90.4% | <div><div></div></div> |
| Disagree   | 8.4%  | <div><div></div></div> |
| Don't know | 1.2%  | <div><div></div></div> |

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

|            |       |                        |
|------------|-------|------------------------|
| Agree      | 77.1% | <div><div></div></div> |
| Disagree   | 19.3% | <div><div></div></div> |
| Don't know | 3.6%  | <div><div></div></div> |

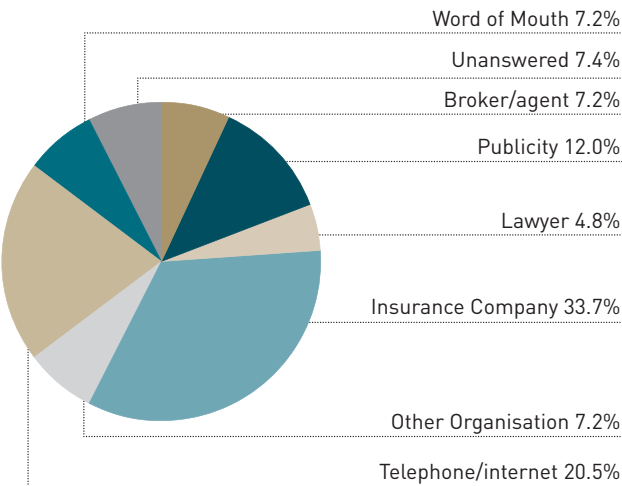
## THE ISO'S SERVICE IS EASY TO USE

|            |       |                        |
|------------|-------|------------------------|
| Agree      | 88.0% | <div><div></div></div> |
| Disagree   | 7.2%  | <div><div></div></div> |
| Don't know | 4.8%  | <div><div></div></div> |

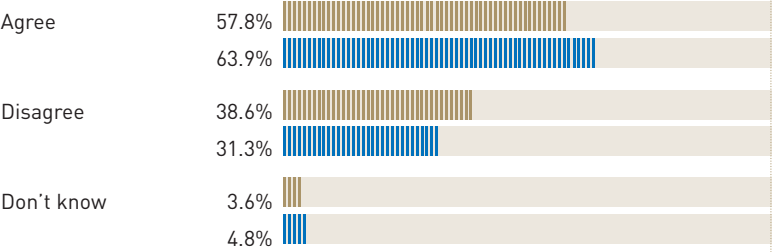
## THE CASE MANAGER WAS HELPFUL AND EASY TO SPEAK TO ON THE TELEPHONE

|            |       |                        |
|------------|-------|------------------------|
| Agree      | 90.4% | <div><div></div></div> |
| Disagree   | 7.2%  | <div><div></div></div> |
| Don't know | 2.4%  | <div><div></div></div> |

HOW DID YOU FIND OUT ABOUT THE ISO?



INFORMATION PROVIDED BY PARTICIPANTS



■ You received enough information from your insurance or savings company about its own internal complaints procedure.

■ You received enough information from your insurance or savings company about the ISO Scheme.

**“I was pleasantly surprised how soon the matter was resolved.”**

**“We found it very helpful to have phone calls from our case manager, as it gave the process a more personal feeling.”**

# Complaints Checklist

|  |     |
|--|-----|
| 1. Do you have a dispute with your financial services provider?  | Yes |
| 2. Have you been through the internal dispute resolution process?  | Yes |
| 3. Have you had a letter saying you have reached "deadlock"?   | Yes |
| 4. Do you know about the ISO's external dispute resolution process that is free to use and aims to resolve your dispute? | Yes |

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

# Case studies

- |    |   |
|----|---|
| 13 | 1: House Insurance: Scope of cover, Exclusion – House   |
| 16 | 2: Travel Insurance: Scope of cover, Service issues, Suitability of policy, Restricted cover, Ex-gratia payment, Exclusion – Travel |
| 19 | 3: Life Insurance: Death Claim, Interest  |
| 22 | 4: Loan Protection Insurance: Exclusion – Redundancy, Scope of cover  |
| 23 | 5: Disability Insurance: Interpretation – Medical evidence, Interpretation – Specific policy provisions, Scope of cover             |
| 24 | 6: Disability Insurance: Burden of proof, Interpretation – Medical evidence, Interpretation – Specific policy provisions            |



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

# 1

## HOUSE INSURANCE

### Scope of cover, Exclusion – House

#### Background

In November 2007, C arranged for her house to be relocated. C arranged transit insurance for the house with the house moving company (“the house movers”) and house insurance at the former situation and the new situation with P, through her broker.

During December 2007, the house movers divided the house and relocated 3 of the 4 house sections to the new situation and, in January 2008, relocated and attached the 4th house section (an upper storey).

During the period from December 2007, when the 3rd section had been relocated, and early January 2008, when the 4th section was relocated, rain caused water damage to the uncompleted house (“the damage”). C made a claim under the transit cover. The house movers’ insurer declined to pay for the damage, because the 3 sections of the house had been relocated onto the piles at the new situation.

In March 2009, C made a claim to P for water damage, to the house. P appointed a loss adjuster to inspect the damage and provide a report. On the basis of the loss adjuster’s report, P declined the claim, because when the damage occurred, the sections of the house were not suitable for normal residential use or occupation; the sections of the house were not fully built and the roofing materials and exterior cladding had been removed from the house.

In September 2009, C disputed the declinature, because she believed that cover attached when the house was relocated onto piles. P reviewed the claim and maintained declinature.

#### Assessment

The policy provided cover for “sudden **accidental loss to the house**”. In the policy, “**accidental**” was defined as “unexpected and unintended by **you**” and “**loss**” was defined as “physical loss or physical damage”. The policy, however, excluded “[a]ny part of the **house** which [wa]s not fully built and suitable for normal residential use or occupation” and “[l]oss which [wa]s caused by ... water entering the **house** because any of the [following had] been removed: roofing materials; exterior cladding; door or window”.

When making a claim under an insurance policy, the initial onus is on the insured to establish that he/she has suffered a loss, which is covered by the policy. This is known as a prima facie claim.

If the prima facie claim is established, then the insurer is entitled to raise an objection to meeting the claim. However, if the insurer wishes to rely on an exclusion in the policy, the onus is on it to establish the application of the exclusion.

In this case, the prima facie claim was established by virtue of the damage to the house and P relied on the exclusions to decline the claim. The Case Manager considered whether P was entitled to rely on these exclusions.

- **Was the house “fully built and suitable for normal residential use or occupation”?**

The house was in a fully built state at the former situation. The house movers divided the house into 4 sections for relocation to the new situation. At the time the damage occurred, 3 sections had been relocated to the new situation and the 4th section (an upper storey) was still at the old situation and stored offsite. Therefore, the Case Manager believed the house was not “fully rebuilt” at the new situation.

The ceiling of the rooms below the missing upper storey was exposed to the elements and had not been covered by tarpaulins. C intended the 3 sections comprising the lower storey were to be used as living quarters and the upper storey as an office. At the time of the damage, C was living in a separate cottage on the property at the new situation. With the lack of a roof covering, the Case Manager believed the house was not “suitable for normal residential use or occupation”.

- **Had water “enter[ed] the house because roofing materials [and] exterior cladding” were removed?**

At the time of the damage, the 4th section had not been relocated and reattached to the house at the new situation. The rooms below the missing upper storey were only protected from the elements by the ceiling and it was through this exposed area that water had entered the house. Therefore, the Case Manager believed the water had entered the house because the roofing materials and the exterior cladding of the upper storey had been removed.

In summary, the policy did not provide cover for damage to “[a]ny part of the **house** which [wa]s not fully built and suitable for normal residential use or occupation” and “[l]oss which [wa]s caused by ... water entering the **house** because ... roofing materials ... [and] exterior cladding [had been removed]”. The Case Manager believed that P had reasonably and correctly applied the exclusions of the policy to decline the claim.

- **Other issues**

In her submission to the ISO, C referred to the respective roles of the house movers, the broker and P and commented that “[n]o one w[ould] put their hand up and say they w[ould] help”. The ISO’s jurisdiction was limited to considering C’s complaint about the claim against P. Therefore, consideration had not been given to any complaint C might have had against the house movers or the broker.

**Result** *Complaint not upheld*



**“I am very grateful for what the ISO did for me, I think you are very helpful and fair people and I certainly could not have achieved a fair outcome by myself. I would like to thank everyone concerned very much and express my heartfelt thanks.”**

***“THE ISO WAS A LAST RESORT. I ONLY WANTED A FAIR HEARING AND THE ISO GOT ME THAT.”***

***“It was made entirely clear that the ISO was not an advocate for us and that its job was to independently and fairly review the case.”***

## 2

## TRAVEL INSURANCE

Scope of cover, Service issues,  
Suitability of policy, Restricted cover,  
Ex-gratia payment, Exclusion – Travel

## Background

In April 2009, C arranged travel bookings through a travel agency (“the agency”), for his visit to France to follow the Tour de France. The travel bookings included the hire of a vehicle suitable for carrying the bike C would be taking.

On 30 June 2009, the day before travel commenced, C visited the agency and arranged travel insurance for the bike. The consultant telephoned P’s travel insurance team (“the travel team”) before proceeding with the transaction, as this was the first time she had been asked to insure a bike. The travel team confirmed cover was in order and advised there would be an additional charge to cover the bike for \$8,150. The consultant arranged for the policy documents to be emailed, because C was leaving on his trip the next morning.

On 26 July 2009, C emailed the consultant that the bike had been stolen during an overnight stop at a rest area. C indicated the bike had been chained to a fence while C and his partner slept in the vehicle. On 27 July 2009, P emailed C that the policy did not provide cover for the loss of the bike, because cover was only available if it had been stolen from “*locked accommodation premises*”. On his return home, C made a number of representations to P, expressing his disappointment at the limited cover provided, as that was contrary to the information he had been given by the agency.

Following its further deliberations, P indicated it could also decline the claim, because of an exclusion in the policy, relating to personal baggage being “*left unattended ... in a public place*” (“the left unattended exclusion”) and a breach of the policy condition that C take “*all reasonable steps to prevent loss*” (“the reasonable care condition”).

## Assessment

C had established a prima facie claim under the policy, because the bike was stolen. In order to decline the claim based on a policy exclusion, P had the onus of proving the exclusion applied.

- the left unattended exclusion

The Case Manager addressed the issue of whether P could rely on the left unattended exclusion and the reasonable care condition and concluded that P could not do so, because a bike chained to a fence adjacent to where its owner was sleeping was not “*left unattended*”; and, in any event, a specified



high value item was not regarded as personal baggage under the policy so the application of the left unattended exclusion was debatable.

Although the steps C took to secure the bike might not have been adequate, in accordance with the legal test, C was not grossly careless, grossly negligent, or reckless.

- **the theft exclusion**

The Case Manager then addressed the theft exclusion and noted that the policy clearly provided cover for loss only when it resulted from “*burglary from locked accommodation premises*” (“the theft exclusion”). Given the bike was chained to a fence in a roadside rest area, the Case Manager believed P could rely on the theft exclusion to decline the claim.

- **scope of cover**

However, C’s complaint was primarily about being misled about the scope of cover provided. C told the Case Manager that:

- the agency was aware of his intention to follow the Tour de France and it would involve, at times, leaving the bike chained and locked and he would sometimes sleep overnight in the vehicle;
- he had discussed insurance on the bike with the agency during the months prior to arranging cover. He had only wanted to insure the bike but was told he could only do so by taking travel cover and listing the bike as a specified item;
- he was never given any indication of any limitations on the cover and was led to believe the bike was covered for “*any loss*”;
- the delay in arranging the cover was due to an oversight; and
- he had not had a chance to study the policy before he left and had very limited access to his emails during his time in France.

The Case Manager discussed the arranging of the insurance with the consultant and was surprised that she was not aware of any limitations on the scope of cover provided for the bike. Given the agency routinely arranged travel insurance for clients, the Case Manager was surprised that, although P provided the agency with access to an online training package for travel insurance, there was no obligation for staff to undertake such training.



The Case Manager then considered the role of the travel team, given the insurance was for a high value bike. The consultant told the travel team she had no previous experience with insuring a bike, she sought clarification about the proposed cover and alerted the travel team to the fact it was too late to issue C with a paper copy of the policy. The Case Manager found it was surprising the travel team made no attempt to ensure C was alerted to the fact that the cover provided was subject to a number of limitations.

In making any decision, the ISO is required to do so by reference to what is, in his/her opinion, fair and reasonable in all the circumstances, in accordance with paragraph 5.7 of the ISO's Terms of Reference. The ISO may consider the following factors:

- "9... (d) the degree to which the Participant was in control of the systems and procedures which are the subject of the complaint; and*
- (e) any other matter the ISO considers relevant."*

The Case Manager accepted that an insurer is not usually required to draw a policyholder's attention to a restrictive term or condition, when such a term or condition is part of the standard policy. The Case Manager also acknowledged that some other travel insurers have restrictive clauses relating to bikes and other sporting equipment, so the theft exclusion was not inconsistent with insurance industry practice. However, given *"the degree to which the Participant was in control of the systems and procedures which [were] the subject of the complaint"*, the Case Manager believed P should have alerted C to the limited cover being provided.

The Case Manager also believed P had an obligation to ensure that the people selling its travel insurance, at least understand the fundamental elements of a travel insurance policy and are able to alert policyholders to relevant limitations.

Following the Case Manager's representations to P, it acknowledged the transaction could have been handled better. P offered a "without prejudice and without admission of liability" payment of 50% of the bike's sum insured and this was accepted by C.

**Result** *Complaint settled*

## 3

## LIFE INSURANCE

## Death Claim, Interest

## Background

In June 2002, a life insurance policy was arranged with P and, in August 2003, the life insured died.

From August 2003, there were delays in providing the information P required to enable it to consider the claim made by relatives of the life insured, who were acting on behalf of the Estate. The claim was not accepted until May 2008. Solicitors were subsequently instructed to act on behalf of the Estate.

In April 2009, the Estate's solicitor sent P the information it required to pay the claim. When the claim was settled, P paid the sum insured, but did not include any interest.

The Estate's solicitor queried the non-payment of interest on the basis that, in accordance with the provisions of section 41A of the Life Insurance Act 1908 ("the Act"), the payment of interest was mandatory from the 91st day after the date of the life insured's death.

P responded with the payment of interest of \$10,209.40 from October 2008, when the solicitor first advised P he was representing the Estate, to the settlement date. The amount was challenged by the Estate's solicitor, who referred to the mandatory requirements of section 41A of the Act.

Although P subsequently offered to pay additional interest (initially of \$51,878.42 – based on a rate of 5% and, later of \$77,409.60 – on the basis of P's actual earnings over the period), it defended the claim for interest on the bases of a breach of the duty of good faith, breach of contract, negligence and unjust enrichment. In making its final offer of additional interest of \$77,409.60, P advised the Estate's solicitor it did not believe it was required to pay interest in accordance with section 41A of the Act, "*in circumstances where [the Estate was] seeking to be unjustly enriched as a result of its own unreasonable and inexcusable delay in providing [P] with the evidence necessary for it to process and approve the claim*".

When considering P's final offer of additional interest of \$77,409.60, the Estate's solicitor queried whether P would pay interest on the unpaid interest. P offered to pay interest on the unpaid interest at the rate of 4% for a specified period. The offer was not accepted and the matter was referred to the ISO.



## Assessment

- **Payment of interest in accordance with section 41A of the Act**

To obtain information on industry practice in the situation, the Case Manager provided 6 companies with an outline of the facts and asked what their practice would have been in relation to the payment of interest. Two companies indicated they would have paid interest in accordance with the Act – irrespective of the cause of the delay. Three companies indicated their position could be affected by the reason for the delay. The sixth company indicated it would not have paid any interest, because its policy wording required all proofs to be provided before the provisions of the Act applied. (The ISO disagreed with this approach and the matter was pursued separately with the company concerned and resolved satisfactorily.)

Having regard to the provisions of paragraph 5.7 of the ISO's Terms of Reference ("TOR") and, in particular, the manner in which C had been dealt with by P and the degree to which P was in control of the systems and procedures which were the subject of the complaint, the Case Manager believed P could have provided a better level of support to the Estate.

Although there were significant delays on the Estate's part in providing information to P, the Case Manager believed P had also contributed to the delay and provided P with a number of examples of his reasons for coming to this view.

Notwithstanding P's arguments of defending a claim for interest on the basis of the duty of good faith and unjust enrichment, the Case Manager believed the payment of interest from the 91st day after the date of the insured's death under section 41A of the Act was mandatory. Consequently, any arguments about a set-off or a counter claim would be after the fact and any decision which accepted those arguments would not be fair and reasonable. For that reason, the Case Manager concluded that interest was payable as provided under section 41A of the Act, with no deductions for set-off.

- **Interest on unpaid interest**

The provisions of section 41A of the Act do not extend to paying interest on interest which is unpaid and, as the Case Manager understood it, there is no statutory requirement for payment of interest in this situation. Consequently, the Case Manager considered whether P should be required to make an additional payment under the provisions of paragraph 6.6 of the ISO's TOR which provide as follows:

*"If either an Assessment ... or a Recommendation ... partly or wholly upholds a complaint ... the ISO may also require the Participant to pay [a] monetary amount, not exceeding \$1,000, as is in the opinion of the ISO appropriate to reimburse or compensate the Complainant for any incidental expenses incurred by the Complainant in making and pursuing the complaint and for any loss arising from any delay in settling the claim. This discretion is only to be exercised in cases where special inconvenience and extra expense has been incurred."*

The Case Manager considered this from 2 perspectives:

- First was the question of whether *"incidental expenses [were] incurred"*. Although the costs were not known, it was evident the Estate had incurred additional legal costs in pursuing the claim for interest and in making and pursuing the complaint.
- Second was the question of whether *"any loss [arose] from ... delay in settling the claim"*. If the required interest had been paid when the claim was settled, the Estate would have had the opportunity to invest the additional amount. Based on calculations made by the Case Manager, applying the 4% interest rate which P had offered to pay and the *"Use-of-money interest"* rate which is used by Inland Revenue where tax has been overpaid, either of those bases would have produced interest on the unpaid interest which was in excess of the \$1,000 maximum payment which the ISO can require a Participant to pay in cases where special inconvenience and extra expense have been incurred.

The Case Manager concluded that, in accordance with paragraph 6.6 of the TOR, P should pay an additional \$1,000 to the Estate.

**Result** *Complaint upheld*

## 4

## LOAN PROTECTION INSURANCE

## Exclusion – Redundancy, Scope of cover

## Background

In 2007, C arranged loan repayment insurance with P.

In April 2009, C made a claim to P for *“Involuntary Unemployment of a self-employed person due to business factors beyond [her] reasonable control”*.

P declined the claim, because C’s *“employment end[ed] at the end of a specific contract period”* and the policy stated it would *“not pay [for] an event or circumstance ... [if C was] employed seasonally or for a specific task or period, and [her] employment cease[d] at the end of that season, task or period”*.

## Assessment

C was self-employed. However, because she was a *“self-employed contractor”*, in terms of the policy, *“Involuntary Unemployment mean[t] loss of employment prior to the expiry date of the contract as a result of being made redundant by your employer, where the loss of employment [wa]s not of a voluntary nature”* (Case Manager’s emphasis).

C advised that she ceased work on 28 November 2008, because her contract ended and she had been unable to secure further contract work.

Unfortunately, because C worked to the end of her last contract and was not made redundant, she did not qualify for an *“Involuntary Unemployment Benefit”* and P was entitled to decline the claim.

**Result** *Complaint not upheld*



**“The final report was very supportive of us and explained all the details clearly. I am in no doubt that this scheme works independently from the industry. thank you for the great service you provide and hopefully I will not be in a position to require your service again!”**

## 5

## DISABILITY INSURANCE

## Interpretation – Medical evidence, Interpretation – Specific policy provisions, Scope of cover

### Background

In 1992, C arranged life insurance with total and permanent disability and critical illness benefits, with P.

In January 2009, C made a claim to P, because he suffered a heart attack in December 2008. P declined the claim, because it did not believe C's heart attack had been diagnosed, based on "*new electrocardiographic changes*" ("new ECG changes"), as required by the policy.

C believed he had "*had new ECG changes*" and, therefore, met the policy definition of a "*heart attack*".

### Assessment

The policy was the basis of the contractual relationship between C and P. The policy did not simply state P was liable for a claim, if C had a heart attack. The policy set out precise criteria, which had to be present for P to consider C's heart attack a "*heart attack*" in terms of the policy. For P to be liable for the claim, the diagnosis of C's heart attack had to be based on the following (as required by the policy definition):

1. "*a history of typical chest pain*"; and
2. "*new electrocardiographic changes*"; and
3. "*elevation of cardiac enzymes*".

C's hospital discharge summary stated he "[p]resented ... with '*chest heaviness*'" and was diagnosed as suffering from a "*NSTEMI*". As such, C's heart attack was diagnosed, based on "*a history of typical chest pain*".

A Cardiologist examined C's ECG recordings and advised that "*none of them show[ed] changes characteristic of myocardial infarction (or myocardial ischaemia)*". As such, C's heart attack was not diagnosed based on new ECG changes.

C's cardiac enzymes were not tested for elevation. However, in a letter to C, P said he had had "*an elevation in Troponin (cardiac enzyme substitute)*". As such, P accepted the rise in Troponin I that C experienced as equivalent to an "*elevation of cardiac enzymes*" and considered that C's heart attack was diagnosed based on this elevation.

The medical evidence did not show any new ECG changes. Therefore, C's heart attack did not qualify as a "*heart attack*" as defined in the policy and C was not eligible for the heart attack benefit.

**Result** *Complaint not upheld*

## 6

## DISABILITY INSURANCE

## Burden of proof, Interpretation – Medical evidence, Interpretation – Specific policy provisions

### Background

In 2003, C arranged critical illness insurance with P.

In April 2008, C made a claim to P because he had suffered a heart attack.

P declined the claim, because although C had suffered from a heart attack, it did not believe he met the policy definition of a “Heart attack”. It advised that based on his Troponin T levels, he had had “an insufficient rise in his cardiac enzymes”.

### Assessment

- **The policy**

In terms of the policy, for P to be liable for the claim, C’s heart attack had to meet the criteria in the policy definition, based on the following:

1. “clinical features” consistent with a heart attack;
2. “confirmatory new electrocardiogram (ECG) changes” consistent with a heart attack; and
3. “diagnostic elevation of cardiac enzyme CK-MB” consistent with a heart attack; or
4. “evidence that the event produced a permanent reduction in the Cardiac Ejection Fraction to 50% or less”.

C’s hospital discharge stated he had “intermittent chest pain” and was diagnosed with a “Non-ST elevation MI”. As such, C had “clinical features” consistent with a heart attack.

C’s ECG showed a “T-wave inversion”, which P accepted as “confirmatory new electrocardiogram (ECG) changes” consistent with a heart attack.

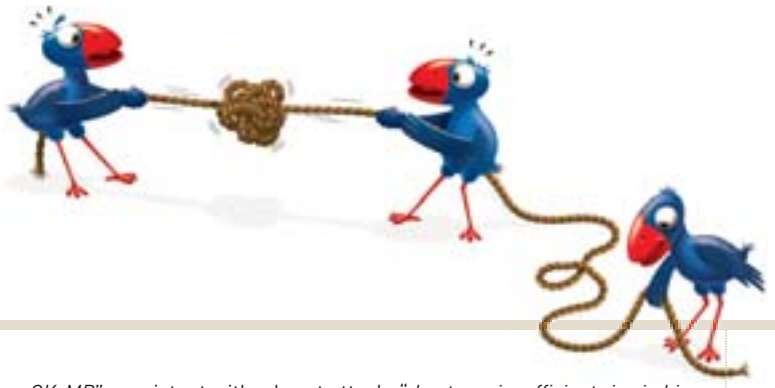
C’s “cardiac enzyme CK-MB” was not tested for elevation (in New Zealand, these tests have largely been superseded by measurements of the cardiac markers Troponin T (“TnT”) and Troponin I (“TnI”)).

C’s “ejection fraction was 74%”.

C’s heart attack could not be measured against the third element required by the policy for a “Heart attack”, because his “cardiac enzyme CK-MB” was not measured when he had his heart attack. Moreover, C’s heart attack did not meet the alternative requirement that the “Cardiac Ejection Fraction” be permanently reduced to 50% or less. Therefore, C did not meet the definition of a “Heart attack” under the policy.

- **P’s declinature**

P declined the claim, because C did not have an elevation of TnT to above 0.6 ug/L. It said that he did not meet the criteria of a “diagnostic elevation of cardiac



enzyme CK-MB" consistent with a heart attack, "due to an insufficient rise in his cardiac enzymes".

Because P declined the claim on this basis, to determine whether C's heart attack met the policy definition for a "Heart attack", the Case Manager believed it needed to be established what level of TnT equated to a "[d]iagnostic elevation of cardiac enzyme CK-MB" consistent with a heart attack.

- **The research**

The Case Manager reviewed the available medical research on cardiac enzymes and TnT and, in particular, any comparative studies carried out.

This proved to be a difficult process to undertake, as there has been little or no medical research done to date that specifically addresses this matter. Advice from specialists was that "Troponin levels are not directly comparable to previously used enzymatic markers including Creatine Kinase (CK) and its cardiospecific MB fraction (CKMB)".

An independent cardiologist advised, "it is difficult to define a precise threshold of Troponin T levels where a rise in CKMB might not be expected to be detected but my view would be that this would be around 0.1 mcg/L".

The Case Manager also found a document from the Diagnostic Medlab, New Zealand, which referred to a TnT level of 0.1 ug/L as being comparable to the "Old M.I. Threshold [by comparing with CKMB cut off]".

- **The medical information**

The highest recorded TnT level was 0.19 ug/L.

- **The analysis**

The Case Manager did not believe there was any way to determine a TnT value that absolutely and definitively equated to a "diagnostic elevation of cardiac enzyme CK-MB". However, because of the way P declined the claim, it was important to find an approximate TnT value, based on the best information available.

According to the information from the Diagnostic Medlab and supported by the statements made by the cardiologist, a TnT reading of 0.1 ug/L would equate approximately to the "Old M.I. Threshold [by comparing with CKMB cut off]".

The Case Manager believed, therefore, that for the purposes of this Assessment, a TnT level of 0.1 ug/L or above should be considered to equate to a "diagnostic elevation of cardiac enzyme CK-MB." Therefore, because C had a TnT reading of 0.19 ug/L he met the policy definition of a "Heart attack", given P's reliance on TnT levels in its consideration of his cardiac enzyme levels and application of the policy wording to the claim.

**Result** Complaint upheld

# Financial Statements

INSURANCE & SAVINGS OMBUDSMAN COMMISSION  
FOR THE YEAR ENDED 30 JUNE 2010

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|    |                                    |
|----|------------------------------------|
| 26 | Directory                          |
| 27 | Statement of Financial Performance |
| 27 | Statement of Movements in Equity   |
| 28 | Statement of Financial Position    |
| 29 | Notes to the Financial Statements  |
| 32 | Audit Report                       |

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# Directory

## For the year ended 30 June 2010

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### 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, Datacraft House, 99-105 Customhouse Quay, Wellington

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|             |  |
|-------------|--|
| BANKERS     | The National Bank of New Zealand Ltd, Wellington |
| ACCOUNTANTS | BDO Wellington Limited, Wellington               |
| AUDITORS    | Grant Thornton, Wellington                       |

**STATEMENT OF FINANCIAL PERFORMANCE:** For the year ended 30 June 2010

|  | Note | 2010             | 2009             |
|--|------|------------------|------------------|
| <b>Income</b>  |      |                  |                  |
| Levies   |      | 1,291,000        | 1,110,000        |
| Casebook Sales   |      | 1,478            | 1,187            |
| Conference   |      | 151              | 36,668           |
| Interest Received  |      | 42,205           | 54,447           |
| Sundry Income  |      | 1,246            | 450              |
| Profit on Sale of Fixed Assets   |      | 53               | 173              |
| <b>Total Income</b>  |      | <b>1,336,133</b> | <b>1,202,925</b> |
| <b>Less : Expenditure</b>  |      |                  |                  |
| Administration Costs   |      | 162,900          | 152,035          |
| Audit Fees   |      | 4,500            | 5,535            |
| Commissioners' Fees & Expenses   |      | 63,711           | 34,000           |
| Conference   |      | –                | 25,513           |
| Depreciation – Office Equipment  |      | 33,002           | 29,890           |
| Depreciation – Furniture & Fittings  |      | 109              | 237              |
| Professionals & Consultancy  |      | 47,476           | 47,196           |
| Occupancy  |      | 12,181           | 11,912           |
| Promotion  |      | 5,425            | 13,700           |
| Rent   |      | 104,142          | 97,683           |
| Salaries   |      | 838,797          | 724,590          |
| Staff Costs  |      | 27,118           | 9,873            |
| <b>Total Operating Expenditure</b>   |      | <b>1,299,361</b> | <b>1,152,164</b> |
| <b>Net Surplus (Deficit) Before Tax</b>  |      | <b>36,772</b>    | <b>50,761</b>    |
| Tax Expense  | 4    | 5,615            | 6,614            |
| <b>Net Surplus (Deficit) After Tax</b>   |      | <b>31,157</b>    | <b>44,147</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 2010

|                                 | Note | 2010           | 2009           |
|---------------------------------|------|----------------|----------------|
| Balance at Beginning of Year    |      | 431,508        | 387,361        |
| Net Surplus (Deficit) After Tax |      | 31,157         | 44,147         |
| <b>Balance at End of Year</b>   |      | <b>462,665</b> | <b>431,508</b> |

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

**STATEMENT OF FINANCIAL POSITION:** As at 30 June 2010

|                                     | Note | 2010           | 2009    |
|-------------------------------------|------|----------------|---------|
| <b>Equity</b>                       |      |                |         |
| Accumulated Funds Account           |      | 462,665        | 431,508 |
| <b>Total Equity</b>                 |      | <b>462,665</b> | 431,508 |
| <b>Represented By :</b>             |      |                |         |
| <b>Current Assets</b>               |      |                |         |
| Accrued Income                      |      | 4,571          | 678     |
| Prepayments                         |      | 7,643          | 8,041   |
| Cash & Bank                         |      | 218,867        | 183,345 |
| National Bank of N.Z. Term Deposits |      | 307,305        | 250,000 |
| Income Tax Refund                   |      | –              | 4,479   |
| G.S.T. Refund                       |      | 13,167         | 7,475   |
| <b>Total Current Assets</b>         |      | <b>551,553</b> | 454,018 |
| <b>Fixed Assets</b>                 | 2    | <b>55,432</b>  | 60,959  |
| <b>Total Assets</b>                 |      | <b>606,985</b> | 514,977 |
| <b>Current Liabilities</b>          |      |                |         |
| Accounts Payable                    |      | 140,573        | 83,469  |
| Income Tax Payable                  | 4    | 3,747          | –       |
| <b>Total Current Liabilities</b>    |      | <b>144,320</b> | 83,469  |
| <b>Total Liabilities</b>            |      | <b>144,320</b> | 83,469  |
| <b>Net Assets</b>                   |      | <b>462,665</b> | 431,508 |

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

Chairperson:  Date: 17.08.10

Ombudsman:  Date: 17.08.10

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 2010**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     | 18.6–60.0% |
| 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.

**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 – 2010</b> |                  |                |                 |
| Office Equipment                    | 150,709          | 98,110         | 52,599          |
| Furniture & Fittings                | 7,679            | 4,846          | 2,833           |
|                                     | <b>\$158,388</b> | <b>102,956</b> | <b>\$55,432</b> |
| <b>Plant &amp; Equipment – 2009</b> |                  |                |                 |
| Office Equipment                    | 123,125          | 65,108         | 58,017          |
| Furniture & Fittings                | 7,679            | 4,737          | 2,942           |
|                                     | <b>\$130,804</b> | <b>69,845</b>  | <b>\$60,959</b> |

## NOTE 3 – OPERATING LEASE COMMITMENTS

| Analysis    | 2010          | 2009          |
|-------------|---------------|---------------|
| Current     | 89,003        | 56,984        |
| Non-Current | –             | –             |
|             | <b>89,003</b> | <b>56,984</b> |

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 2011. 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                                 | 2010          | 2009           |
|--|---------------|----------------|
| Book Profit/(Loss) Before Tax                      | 36,772        | 50,761         |
| Adjustment for Non-Taxable Income and Expenses     | 3,166         | 573            |
| Losses Utilised                                    | –             | (15,649)       |
| Holiday Pay Timing Difference                      | 15,409        | –              |
| <b>Taxable Profit/(Loss)</b>                       | <b>55,347</b> | <b>35,685</b>  |
| Tax @ Marginal Rates                               | 11,315        | 6,614          |
| Prior period tax adjustment                        | (5,700)       | –              |
| Tax Expense  | 5,615         | 6,614          |
| Opening Balance                                    | (4,479)       | (14,734)       |
| RWT Paid   | (7,568)       | (11,093)       |
| Refund Received                                    | 10,179        | 14,734         |
| <b>Tax Payable/(Refundable) as at 30 June 2010</b> | <b>3,747</b>  | <b>(4,479)</b> |

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 (2009: \$Nil).

As at balance date, the Insurance & Savings Ombudsman had the following contingent liability: An ISO Scheme Review will be undertaken during the 2013 year. As part of the prudent financial management the Commission has designated \$60,000 of its accumulated funds for the ISO Scheme review (2009: \$40,000).

## 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 (2009: \$Nil).

## NOTE 7 – 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 statements on pages 27 to 31. The financial statements provide information about the past financial performance of the Insurance & Savings Ombudsman Commission and its financial position as at 30 June 2010. This information is stated in accordance with the accounting policies set out on page 29.

### COMMISSION'S RESPONSIBILITIES

The Commission is responsible for the preparation of the financial statements that fairly reflects the financial position of the Insurance & Savings Ombudsman Commission as at 30 June 2010 and the financial performance for the year ended on that date.

### AUDITORS' RESPONSIBILITIES

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

### BASIS OF OPINION

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

- the significant estimates and judgements made by the Commission in the preparation of the financial statements; and
- whether the accounting policies used are appropriate to the entity'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 statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

Other than in our capacity as auditors, we have no relationship with or interests in the Insurance & Savings Ombudsman Commission.

### UNQUALIFIED OPINION

In our opinion the financial statements on pages 27 to 31 fairly reflect the financial position of the Insurance & Savings Ombudsman Commission as at 30 June 2010 and the financial performance for the year ended on that date.

Our audit was completed on 17 August 2010 and our unqualified opinion is expressed as at that date.

Grant Thornton New Zealand Audit Partnership  
Wellington, New Zealand  
18 August 2010

## SCHEME PARTICIPANTS: as at 30 June 2010

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

• Denotes subsidiary or associated company or business division

“It has restored my faith in the industry. I honestly would have questioned my career as a broker if the complaint wasn't upheld.”

“***I WOULDN'T  
HESITATE TO USE  
THEIR SERVICES  
AGAIN REGARDLESS  
OF THE OUTCOME.***”

“NEVER FOR A MOMENT I THOUGHT THAT ISO DECISIONS AND RULINGS ARE THIS STRONG AND (ALMOST) BINDING AND POWERFUL. TRULY AN INDEPENDENT BODY. GREAT SERVICE.”

“I appreciate the careful consideration given to my claim and as a former lawyer and judge I do have some knowledge of these matters.”

“EXCELLENT RESPONSE AND ADVICE WHENEVER CONTACTED. ALWAYS MADE EFFORTS TO UNDERSTAND MY CONCERNS.”

“The ISO kept me informed every step of the way through the process. I would like to thank (the Case Manager) for all his efforts in resolving my matter. Many thanks.”



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