

# The key to complaints handling is... early resolution.

THE INSURANCE & SAVINGS OMBUDSMAN SCHEME INC  
IS AN INDEPENDENT AND IMPARTIAL SERVICE  
FOR RESOLVING FINANCIAL SERVICE DISPUTES,  
WHICH IS FREE TO CONSUMERS.



# How the ISO can help

The ISO Scheme Inc resolves disputes between consumers and their financial service providers which are Participants of the ISO Scheme.

The ISO can look at disputes if a consumer has received a letter of “*deadlock*” from their provider, which means they have come to the end of the provider’s internal dispute resolution process and the dispute has not been resolved.

The ISO can help to resolve a dispute by agreement or, if an outcome cannot be agreed, may make a decision. The decision may be in the consumer’s favour, or in the Participant’s favour. The ISO’s decisions are always independent and impartial and are binding on Participants, but not on consumers.

## DISPUTES THE ISO CAN HELP WITH:

- ✓ claims (and disputes about part of a claim) up to \$200,000
- ✓ the cover provided by and the amount payable under a contract
- ✓ small business claims
- ✓ breaches of contract, statutory obligations, industry codes
- ✓ fire and general, health and life insurance, superannuation and any advice given about the products
- ✓ credit contracts, trustee related issues, mortgages

## DISPUTES THE ISO CANNOT HELP WITH:

- ✗ awards of damages
- ✗ third party or uninsured losses
- ✗ commercial decisions

“I found the ISO service very easy and professional to use and there was a real want to get a full understanding of my situation.”



# Is your financial service provider a Participant of the ISO Scheme?

The ISO can only consider complaints against financial service providers which are Participants of the ISO Scheme. Visit [www.iombudsman.org.nz](http://www.iombudsman.org.nz) to find out.

## ASK THE PARTICIPANT TO REVIEW ITS DECISION

Before the ISO can consider any complaint, the matter must have been through the Participant's internal complaints procedure.

## IF THE MATTER IS STILL UNRESOLVED

If you are not happy with the Participant's decision about your complaint, we may be able to help.

Before the ISO can consider a complaint, the Participant must provide you with a letter of "deadlock". This letter will state that you have exhausted the Participant's internal complaints procedure and a complaint can be made to the ISO.

## CONTACT US

When you have received the letter of "deadlock" from the Participant, you must send it to the ISO Office **within 2 months** of the date in the letter. If you do not do so, the ISO cannot investigate your complaint, unless the Participant agrees.

## DO I NEED A LAWYER?

No. We provide a free disputes resolution service for customers of participating financial service providers, so it is not necessary to use a lawyer. If you do want to use a lawyer, please note that the ISO is unable to make the Participant pay your legal expenses, even if your complaint is upheld.

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# Paula Rebstock, Chairperson, ISO Commission

The last 12 months have witnessed the most significant expansion of the ISO Scheme since its inception.

As a consequence of changes in the regulatory regime, and with the support of the Board, Commission and Scheme Participants, the ISO Scheme has opened its membership to a significant group of financial service providers.

At the same time, many of the Scheme's original Participants and their customers have been focused on responding to the aftermath of the Canterbury earthquake disasters.

Therefore, the focus of the Commission over the past year has been on ensuring the Scheme has the capacity to handle effectively, in a timely and respectful manner, any disputes that arise out of the Canterbury earthquakes, while also providing the quality service all other Participants and their customers expect from the Scheme.

In addition, a key focus of the Commission has been the successful expansion of the Scheme. At the end of the financial year, the membership totalled over 1,400 Participants. It is particularly pleasing that we have achieved our growth and revenue targets and this has allowed the Commission to lock in an overall reduction in levies for the second year running. It also ensures we can continue to offer highly competitive services to new Participants.

The challenges and opportunities of the past year have underscored the value of having an experienced ISO whose integrity, professionalism and expertise is widely recognised by Participants and their customers. As Chair of the Commission, I would also like to acknowledge the collective leadership provided by Commission Members which has underpinned the successful expansion of the Scheme. In addition, I would like to thank the outgoing Commission Members, Dr Ian McPherson, Dr Claire Dale and Sam Huggard, for their skillful guidance of the ISO Scheme over many years.



In its 16 years' of operation, the ISO Scheme has dealt with more than 36,700 complaints enquiries, has investigated over 4,400 complaints and has assisted its Participants to improve business practices through complaints handling. The ISO Scheme has established its credibility as an approved 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.

Looking forward, the Commission, in consultation with the Board and Participants, is undertaking a review of the Scheme's governing documents to ensure they continue to meet the requirements of our original Participants, while also being responsive to new Participants. We anticipate consulting on any recommended changes by September this year.

The Commission is confident that the ISO Scheme is well positioned to continue to strongly contribute to public confidence in our financial markets. We are committed to ensuring that customers of our Participants have free access to the highest quality dispute resolution services, while also maintaining a competitive price for Participants.

**Paula Rebstock**

Chairperson, Insurance & Savings Ombudsman Commission CNZM

# Karen Stevens, Insurance & Savings Ombudsman

Change can be challenging – this year we experienced positive change coming from the expansion of the ISO Scheme; we then saw catastrophic changes to Canterbury brought about by the earthquakes.

Both of these events will have a significant impact on the ISO Scheme and each will pose challenges for us in the years to come.

Expansion occurred against a background of financial sector reform, aimed at rebuilding consumer confidence in New Zealand's markets with improved regulation. In March 2011, it was timely for the Retirement Commissioner to carry out an independent review of the ISO Scheme's performance. Included in the review was the comment that the *"brief monitoring report... focused on how well the ISO Scheme has been serving the consumers of insurance and savings products in recent years. Despite the financial turmoil of recent years and the resulting loss of trust and confidence in the finance sector the overall picture with respect to dispute resolution services is very positive"*.

It is also very positive that, as an approved dispute resolution scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008, the ISO Scheme continues to comply with the principles of accessibility, independence, fairness, accountability, efficiency and effectiveness.

Since 1995, we have provided a free dispute resolution service to customers of insurance and savings Participants. From 1 July 2010, as a result of the new legislation, we expanded that service through an online registration system to include financial advisers, financial adviser businesses, finance companies, brokers, QFEs, credit contract providers, trustees, trustee corporations and other financial service providers. As at 30 June 2011, we had grown our core membership from about 50 insurers to over 1,400 Participants.

Most of our new Participants joined the ISO Scheme prior to the registration deadline on 1 December 2010, with financial advisers being required to join before 1 April 2011.



For many of them, it is the first contact that they have ever had with a dispute resolution service. While we understand there can be fear of the unknown, we want to engage with our Participants as valued stakeholders in the ISO Scheme, treating all of them equally with fairness and impartiality.

Complaints handling is a new concept for many of our new Participants, so we have developed a “*how to*” manual and have staff available to assist with any issues Participants may have about the internal and external disputes resolution processes. Louise Peters and Virginia Douglas are managing our financial services response and will build on the existing team, as required, to meet demand.

In November 2010, we brought out Nina Harding, an expert in dispute resolution, from Australia to provide 5 training workshops on complaints handling in the main centres. We received tremendous feedback from Participants who took the opportunity to take part and we are pleased Nina’s on-line complaints handling training is available to Participants at a discounted rate.

On 19 February 2011, I attended an earthquake recovery briefing in Christchurch and, only 3 days later, the 22 February earthquake overshadowed everything that had gone before – Canterbury had been changed dramatically and most New Zealanders’ lives were touched. Insurance has become pivotal to the recovery of Canterbury and will continue to be a primary consideration going forward.

It is inevitable, with so many claims arising out of the September and February earthquakes, that disputes will arise. However, possibly because of EQC’s involvement in residential claims to the first \$100,000 for property damage and \$20,000 for contents, we have only received 140 complaints enquiries and 4 complaints for investigation since September, which are included as case studies in this Annual Report.

We cannot predict the number of complaints or when we are likely to receive them, but we can prepare for the types of issues likely to arise. We have established an earthquake response unit, led by Iain Opray, with the expertise to deal with both domestic and small business issues. After 16 years' experience in handling insurance complaints, we have built up a body of knowledge and expertise which stands alone in New Zealand and should see us in good stead for the future.

Good communication with all stakeholders is the key to avoiding disputes and the ISO Scheme is doing as much as possible to facilitate that communication, particularly between our Participants and their customers. With free access to redress, consumers should have greater confidence to invest in the financial services sector.

While there was a decrease in the number of complaints received this year, more emphasis was placed on early intervention and reaching agreed outcomes between the parties to disputes. Overall, we have had a very positive response from Participants and consumers to settlement negotiations, where the parties agree a resolution without the need for the ISO to impose a decision. This is important looking forward to an increasing number of financial services complaints and insurance disputes arising out of the earthquakes.

We could not have managed the expansion process this year without the careful and strategic leadership of Paula Rebstock as Chairperson of the ISO Commission and the support received from Martin Stokes as Chairman of the ISO Board. The day-to-day operation of the ISO Scheme depends upon the staff and their resolution of the complaints received and I thank them all, noting that Keith Ryan and Bronwyn Thurston will be missed.

The ISO Scheme cannot operate in a vacuum, without the support and co-operation of its Participants. We look forward to working with our new Participants and to the continued support and co-operation of our insurance and savings Participants in the challenging times ahead.



**Karen Stevens**

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





# Complaints Summary



There were 1,625 complaint enquiries (800 in writing), 250 complaints received for investigation and 281 complaints resolved in the 2010/2011 financial year, as set out in the tables below. There were 39 complaints resolved, as a result of involvement of the ISO Office at the complaint enquiry stage.

STATUS	2010/2011	2009/2010
Complaints carried over from previous year and completed	71	64
Complaints received for investigation	250	284
Complaints under investigation	321	348
Complaints completed during the year	281	277
Complaints for investigation but incomplete at year end	40	71

RECEIVED BY SECTOR	2010/2011	2009/2010
Financial Adviser	1	–
Fire and General	153 61%	194 68%
Health	44 18%	37 13%
Life and Savings	52 21%	53 19%
<b>TOTAL</b>	<b>250</b>	<b>284</b>

OUTCOMES	2010/2011	2009/2010
Complaints upheld	28 10%	38 14%
Complaints partly upheld	4 1%	7 3%
Complaints settled	75 27%	45 16%
Complaints withdrawn	2 1%	–
Complaints not upheld	172 61%	187 67%
<b>TOTAL</b>	<b>281</b>	<b>277</b>

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

A **COMPLAINT** has gone through a Participant'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 Participant has not treated the consumer's complaint fairly, reasonably and in accordance with the contractual terms. 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 imposed by the ISO.

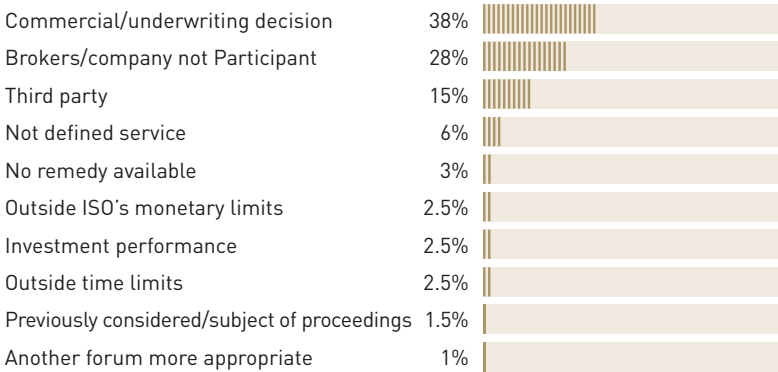
A complaint is **NOT UPHELD**, when the ISO finds that the Participant has treated the consumer’s complaint fairly, reasonably and in accordance with the contractual terms. However, sometimes the Participant has made/will make an *ex-gratia* payment, acceptable to the consumer.

In the year ended 30 June 2011, almost \$1,500,000 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 2010/2011 financial year, we received 127 written enquiries about 201 disputes outside jurisdiction, which required consideration and a written response. We also received 73 telephone enquiries and one walk-in enquiry about disputes outside the ISO’s jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO’S JURISDICTION



TIMELINESS

The average time to close the 281 complaints investigated in the year ended 30 June 2011, was 89 days from receiving the company’s file and accepting the complaint for investigation.

SYSTEMIC ISSUES AND BREACHES

There were no systemic issues arising from complaints or any material or persistent breaches by Participants this year.

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 36,700 complaints enquiries and investigated more than 4,400 complaints.

# How we got our message into the Community

## IN 2010/2011:

**SPEECHES AND PRESENTATIONS:** We provided complaints handling training for Participants and spoke at a total of 40 seminars and conferences, including to members of ANZIIF, IBANZ, ICNZ, IFA and LADUCA.

We brought out Nina Harding, an expert in dispute resolution, from Australia to provide 5 training workshops on complaints handling in the main centres.

**CONSUMER OUTREACH:** We took part in 4 Ministry of Consumer Affairs Consumer Rights Days in Napier, South Auckland, West Auckland and Whangarei. We also presented at 2 Consumer outreach days in Hutt City and Tauranga, together with joining the ANZOA stand at “*Fielddays 2011*” in Hamilton.

**0800 NUMBER:** We received 4,682 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:** For the beginning of the year, we averaged about 7,188 website sessions per month and then the reporting system changed. For the 7 months covered by the new reporting system, we had 23,359 website visits, and a total of 16,175 unique visitors to our website [www.iombudsman.org.nz](http://www.iombudsman.org.nz).

**COMPLAINT ENQUIRIES:** We dealt with 821 telephone and 800 written complaint enquiries from consumers.

**MEDIA ENQUIRIES:** We handled 22 requests for information from the media, particularly in relation to the changes to financial sector dispute resolution and to the Canterbury earthquakes.

**“I know that the ISO Scheme is independent of the Insurance & Savings Industry, but acknowledge that the relationship between the two must be a good working relationship.”**

**“The ability to take complaints to an independent Scheme is very beneficial to the general public.”**

# How do people Rate us?



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

Agree	93.7%	<div><div></div></div>
Disagree	6.3%	<div><div></div></div>
Don't know	0.0%	<div><div></div></div>

## THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME

Agree	87.5%	<div><div></div></div>
Disagree	11.2%	<div><div></div></div>
Don't know	1.3%	<div><div></div></div>

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

Agree	95%	<div><div></div></div>
Disagree	3.8%	<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	84.8%	<div><div></div></div>
Disagree	10.1%	<div><div></div></div>
Don't know	5.1%	<div><div></div></div>

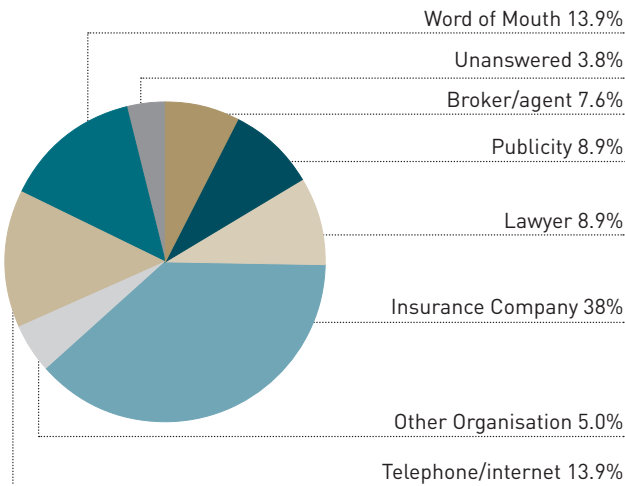
## THE ISO'S SERVICE IS EASY TO USE

Agree	97.5%	<div><div></div></div>
Disagree	1.2%	<div><div></div></div>
Don't know	1.3%	<div><div></div></div>

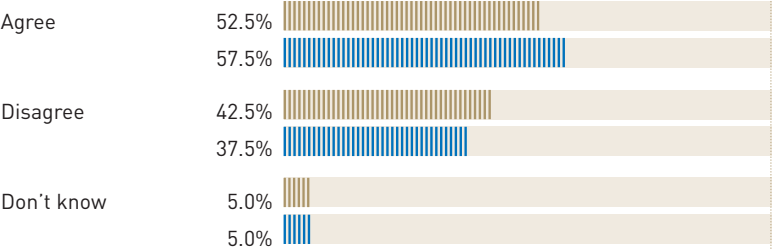
## THE CASE MANAGER WAS HELPFUL AND EASY TO SPEAK TO ON THE TELEPHONE

Agree	97.5%	<div><div></div></div>
Disagree	1.2%	<div><div></div></div>
Don't know	1.3%	<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.

**“The Case Manager was very helpful in all aspects of the process from the time the complaint was received through to the very end. We were well informed on every aspect of the process.”**

# Case studies

- 
- |    |   |
|----|---|
| 13 | 1: Health Insurance: Scope of cover, Interpretation - Medical evidence, Non-disclosure - Pre-existing conditions, Pre-existing condition, Exclusion - Health  |
| 13 | 2: House Insurance: Damage - House, Earthquake, Extent of liability, Method of repair, Method of settlement, Quotation  |
| 15 | 3: House Insurance: Damage - House, Earthquake, Loss of rent, Scope of cover  |
| 16 | 4: Business Interruption (small business): Business equipment, Completion of proposal/application, Damage - Commercial Property, Business interruption, Earthquake, Ability to claim, Insured event |
| 17 | 5: Travel Insurance: Scope of cover, Fair and reasonable, Interpretation - Specific words/expressions, Exclusion - Travel   |
| 18 | 6: Transfer of Funds: Adviser/Agent/Representative, Service issues, Transfer of schemes/plans/funds, Interest   |
| 20 | 7: Life and Disability Insurance: Personal accident/Disability  |
- 

“I felt very supported by the ISO and enjoyed my contact with the office.”

“THE COMPLAINT WAS RESOLVED WITHIN A TIMEFRAME WHICH I FELT WAS REASONABLE GIVEN THE COMPLEXITY OF IT.”

“*I knew it was never going to be a ‘quick fix’ so was happy with the process.*”



IN THE CASE STUDIES,

**C** = CONSUMER

**P** = PARTICIPANT.

# 1

## HEALTH INSURANCE

**Scope of cover, Interpretation - Medical evidence, Non-disclosure - Pre-existing conditions, Pre-existing condition, Exclusion - Health**

### Background

In October 2009, C arranged health insurance with P.

In July 2010, C contacted P requesting prior approval for surgical treatment of a deviated septum. P requested further information.

P declined the claim, because it believed C had not disclosed information material to the policy when he arranged the cover. P advised it was legally entitled to avoid C's cover, but offered to add an exclusion to the policy instead.

### Assessment

The Case Manager obtained further information from C's doctor, indicating C may not have been aware of the information that was not disclosed on the application. However, C's condition was a pre-existing condition in terms of the policy.

The Case Manager discussed the new information with P, which offered to settle the complaint by removing the exclusion from the policy and paying 50% of C's surgery costs. C accepted the settlement offer.

**Result** *Complaint settled*

# 2

## HOUSE INSURANCE

**Damage - House, Earthquake, Extent of liability, Method of repair, Method of settlement, Quotation**

### Background

C's house was insured with P.

On 4 September 2010, the paved driveway at the house was damaged by earthquake. C made a claim to P in respect of the damage. Before P's assessor viewed the damage, C arranged for a contractor to view the damage and a repair estimate of \$3,550 was provided.

P arranged for its initial inspection of the damage to determine the validity of the claim and establish a repair cost estimate. This took place in late October 2010 and the claim was accepted with a repair estimate of \$1,365.

C advised P that, because of anticipated delays in having the repairs carried out,

he would accept \$1,500 in full and final settlement of the claim. However, P did not take up C's offer.

In November 2010, P engaged a paving contractor to inspect the driveway and advise on repair options and provide a cost estimate. An estimate of \$13,052 was provided to replace the driveway, but this did not focus on the actual area of damage. Based on the higher cost of repair and his belief that further damage had occurred to the driveway due to erosion, C advised P that he was withdrawing his offer to accept \$1,500 in full and final settlement.

In December 2010, a subsequent quote, based on the actual area of damage, as determined from P's initial assessment and on a "like for like" basis, was provided for \$2,101. During December 2010, P arranged for a further assessment of the damage. This was the result of C's complaint to P about the settlement process; P's refusal to undertake remedial work on the driveway within C's required timeframe and; a dispute about the magnitude of loss.

P's assessor concluded that there was a question mark over whether the damage was, in fact, related to the earthquake. However, he recommended that, because the claim had been accepted, a cash settlement should be made to C, based on the quote for \$2,101.

C rejected P's assessment of the area of damage and the settlement offer. In late December 2010, C referred the matter as a complaint to the ISO.

## Assessment

P's file was not provided to the ISO until March 2011, on account of the difficulties presented by the further earthquake on 22 February 2011.

When the Case Manager reviewed the documentation provided by P and C, he discovered that, in December 2010, C obtained a quotation for \$10,200 from a paving company, which P had not seen. The Case Manager obtained C's agreement to provide P with a copy of this quotation and advised C that he would liaise with P to find a workable solution to the dispute, within the terms of the policy.

The Case Manager was concerned that the driveway might have sustained further damage in the February earthquake and, therefore, believed that an updated inspection and appraisal of the damage was necessary.

The Case Manager discussed the situation with P, which agreed that, if the driveway had sustained further damage, P would have to give C's claim further consideration.

In late March 2011, P advised the Case Manager that the driveway had been re-inspected and a meeting held with C. P had agreed to meet on site with C's





preferred contractor, to determine the extent of the damage which could be attributed to the earthquakes; what needed to be done to repair the driveway; what portion of costs could be attributed to earthquake and; to arrive at a workable solution for settlement.

P's assessor agreed with C's preferred contractor that approximately 40% of the driveway required repair and a revised estimate of \$5,091 was provided for this. The assessor discussed the repair process and the revised quote with C who agreed to what was proposed and repairs were authorised.

**Result** *Complaint settled*

## 3

### HOUSE INSURANCE

#### Damage - House, Earthquake, Loss of rent, Scope of cover

##### Background

In September 2006, C insured her rental house with P.

In August 2010, C's tenants moved out of the house. C carried out some refurbishment work on the house with the intention of placing it on the market for sale. If the house did not sell, C intended to re-tenant the house.

In September 2010, the house was damaged by earthquake and rendered uninhabitable. Therefore, C was unable to sell or rent the house. C made a claim to the Earthquake Commission ("EQC") which, following inspection, confirmed the house should be condemned.

C made a claim to P for the damage, notwithstanding EQC's involvement. C also made a claim for loss of rent, which P declined.

##### Assessment

For a claim under the loss of rent benefit, the policy required that, when the damage occurred, "[the] house is let, lent, leased, rented or tenanted" (Case Manager's emphasis).

Tenancy of the house ceased in mid-August 2010 and P declined the claim because, when the damage occurred in September 2010, the house was vacant and in the process of being prepared for sale. Therefore, as there was no tenant in the house, no tenancy agreement in force and C was not receiving any rent, there could not be a claim for loss of rent.

In all the circumstances, the Case Manager believed P was entitled to decline the claim.

**Result** *Complaint not upheld*

## 4

**BUSINESS INTERRUPTION (SMALL BUSINESS)**

**Business equipment, Completion of proposal/application, Damage - Commercial Property, Business interruption, Earthquake, Ability to claim, Insured event**

**Background**

In early February 2011, C entered into discussions with P about transferring his business insurances from his existing insurer and updating the cover. C authorised his Practice Manager ("C's manager") to liaise with P's staff adviser regarding the cover required and to obtain quotes. C wished to include business interruption cover in the updated package.

On 15 February 2011, C signed P's proposal form agreeing to the new cover. The proposal indicated that cover with P was to commence on 1 March 2011, at which time cover with his existing insurer would lapse.

On 22 February 2011, the building where C's business was located sustained earthquake damage ("the earthquake") and, as a result, C had to relocate his business. C indicated that loss of business and profit had resulted.

Because C's existing insurance did not include cover for business interruption, C wished to make a claim to P for the loss. However, P advised C that, because the earthquake occurred before the cover was due to commence, he did not have grounds to make a claim to P.

**Assessment**

C's main concern was that he was not adequately advised by P's adviser of the 1 March 2011 start date for the cover with P. He raised the issue of P's adviser's responsibility to him in relation to explaining the policy and that the adviser had no authority to make decisions directly with C's manager.

From the documentation presented to the Case Manager, it appeared that C's manager was actively involved in the discussions and negotiations of arranging cover with P. The Case Manager was not aware of what was actually discussed, or the authority given to C's manager in this regard. However, the Case Manager believed P's adviser was clearly of the opinion that C's manager had the necessary authority to the point where C signed the proposal.

In regard to the starting date for cover with P, the Case Manager advised C it was very clear from the proposal that P did not assume cover until 1 March 2011. While the discussions arranging the transfer and updating of cover from P's existing insurer involved C's manager and P's staff adviser, C had clearly signed the proposal accepting the terms and conditions and agreeing to a 1 March 2011 start date.



The Case Manager noted that, on the morning of 22 February 2011, C's manager communicated with C's broker, requesting cancellation of C's existing insurance arrangements from 1 March 2011. This coincided with the start date for the policy with P.

C also raised the issue that, because his business was insured with P from 1 March 2011, loss of profit from that date should be covered by P.

The Case Manager explained that it was the date of the earthquake (22 February 2011) which dictated whether the policy with P provided cover. Unfortunately, because the earthquake occurred before cover commenced with P on 1 March 2011, any loss of profit related to the earthquake was not covered by P's policy. This applied to ongoing loss of profit from 1 March 2011, which was related to the earthquake. However, P would, subject to the terms and conditions of the policy, provide cover for loss or damage arising from a new insured event occurring on, or after, 1 March 2011.

The Case Manager had to rely on the documentation provided and this clearly pointed to the intention being to commence cover with P on 1 March 2011, with C's existing insurance arrangements ceasing on that date, as indicated by C's manager's communication with the broker on the morning of 22 February 2011.

Having regard to all the circumstances, the Case Manager believed P was entitled to decline to consider the claim.

**Result** *Complaint not upheld*

## 5

### TRAVEL INSURANCE

#### Scope of cover, Fair and reasonable, Interpretation – Specific words/expressions, Exclusion – Travel

##### Background

In May 2010, C arranged travel insurance for an overseas trip through Mumbai, India, to Southeast Asia, with P. In June 2010, C arrived in Cambodia and while C was walking in Phnom Penh, she was approached by 2 Cambodian women and C arranged to meet them the following day.

C was met by one of the Cambodian women and taken to a small apartment, where there were a group of people. C was invited to dinner, after which one of the Cambodians ("J") asked C if she would like to learn to play Black Jack. J and C practised until a man ("L") arrived. J suggested that C practise against L. J gave C US\$200 to bet with. Unknown to C, J kept a tally of the betting. At the end of a few games, J told C that she owed L US\$62,000. J and L

demanding C take cash advances from Western Union and ATMs over a period of hours and managed to obtain US\$15,860. C was taken to her accommodation with a warning to get more money; she arranged different accommodation and flights to New Zealand for the next day.

C made a claim to P for the return flight, the money taken by the Cambodians, the flights missed, other expenses as a result of curtailing the trip, and an unrelated medical expense, in the sum of about \$24,500.

P declined the claim, based on the policy exclusion that C had “*intentionally and recklessly plac[ed] herself in circumstances... which pose[d] a risk to [her] personal safety...*”. P also declined the claim for the money given to J and L, because C’s circumstances did not meet the definition of “*Kidnapping*” in the policy and, therefore, was outside the scope of cover. However, \$2,371.53 was paid to C by P on an *ex-gratia* basis, to cover the return flight, the maximum cash amount allowed by the policy of \$925 and an unrelated medical expense.

### Assessment

The Case Manager discussed the circumstances of the claim and the application of the policy with P. After considering all the information, P offered to settle the claim on the basis of an *ex-gratia* payment of \$11,000. C agreed to accept this amount in full and final settlement of the claim.

**Result** *Complaint settled*

## 6

### TRANSFER OF FUNDS

#### Adviser/Agent/Representative, Service issues, Transfer of schemes/plans/funds, Interest

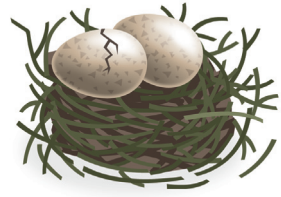
#### Background

On 8 November 2010, through his financial adviser, C authorised P to transfer pension funds from the United Kingdom (“UK”) to New Zealand, for immediate transfer to C’s bank account in Jersey.

On 24 November 2010, following advice about the funds to be transferred from the UK fund, P issued instructions to the UK fund to transfer the funds to P’s bank account in New Zealand “*by CHEQUE in £-STERLING*”.

On 8 December 2010, the UK fund mailed the cheque. There was bad weather in the UK at that time and the mail was delayed.

On 21 December 2010, when the cheque had not arrived in New Zealand, C’s financial adviser asked P to arrange with the UK fund to send the funds by telegraphic transfer (“TT”).



On 23 December 2010, the TT was effected. On the same day, the cheque arrived in New Zealand by post and was cancelled. The funds were deposited into a bank holding account that night.

P's office was closed between 24 December 2010 and 4 January 2011 (inclusive) for the Christmas holiday period and, on 5 January 2011, the funds were immediately transferred to C's bank account in Jersey.

C's complaint was that the funds transfer should not have been made by cheque, that other parties had benefitted from the delay in transferring the funds, and that he had missed out on investment opportunities in the interim.

### Assessment

When C signed the forms to effect the transfer of his funds from the UK to New Zealand, he had been provided with information which advised that the transfer could take "2-4 months". His financial adviser told the Case Manager that he advised his clients "a transfer from A to B would take around 6 weeks". The transfer of C's funds took 6 weeks from the time instructions were issued to the UK fund, so the time taken was not considered unreasonable.

C objected to P's preferred method of transfer which was by cheque, stating it was "archaic". However, the ISO has no jurisdiction to consider "commercial decisions relating to [P's] business" and no ability to find P's practice "archaic" or otherwise. The Case Manager found there was no failure of P to disclose its preferred method of transfer, either to C or his adviser.

P had also notified C and his adviser on numerous occasions that its offices would be closed over the Christmas period. The closure would not have become an issue had the cheque been despatched in good time from the UK and the bad weather had not delayed postal services.

C's claim, that he had lost income through loss of investment opportunities during the period of transfer, was considered to be speculative and not a proper basis upon which to consider a claim for 10% interest to be paid by P.

In addition, C's claim that P's fee was unjustified and the bank fee should be refunded was not valid. All fees had been disclosed before the transfer took place and P had met all of its contractual obligations to C.

**Result** *Complaint not upheld*

# 7

## LIFE AND DISABILITY INSURANCE

### Personal accident/Disability

#### Background

In 2007, C's financial adviser advised C to replace his existing income protection policy with a new policy. C agreed and this cover was provided by P.

On 24 December 2009, C injured his shoulder. He totally ceased work until he visited his doctor on 11 January 2010.

On 11 January 2010, C visited his doctor, who noted C was unable to move his shoulder above horizontal and could not put any weight on it. C's doctor did not certify he was unable to work. From 11 January 2010, C resumed working in his business as a mechanic. C said he was unable to perform the manual duties of his job, he reduced his working hours from 45 to 20 hours per week and only did administration duties.

On 20 August 2010, C underwent surgery to repair his shoulder. C's doctor certified he was unable to work at all for 42 days following the surgery. After 42 days, C resumed working in his business doing administration duties for 20 hours per week. In November 2010, C made a claim to P for a disability benefit under the policy.

P declined the claim because, based on a disablement date of 20 August 2010, C did not meet the policy requirements for a Total Disability ("TD") benefit.

#### Assessment

The approach of the ISO to complaints concerning disability claims is similar to that taken by the courts. In particular, in investigating a complaint, the ISO considers whether, in view of all the information, the insurer's decision was reasonable and made in good faith.

The courts will only replace an insurer's decision on the claim, if it is found that the insurer's decision was not reasonable, on the information before it at the time, or the insurer did not act in good faith. The Case Manager considered whether P's decision that C was not entitled to a benefit from 24 December 2009 to 20 August 2010, was reasonable.

To establish a prima facie claim for the TD benefit, C had to provide P with evidence from a "Registered Medical Practitioner" establishing that he was "so seriously incapacitated by... injury that [he was]... [u]nable to follow the occupation or carry on the business [he was] involved in before the disablement date for more than 10 hours per week". C needed to show that he was "totally disabled... for a continuous period of at least the waiting period", which was 13 weeks.



When C visited his doctor in January 2010, the doctor did not certify that C was unable to work and he did not comment on C's ability to work.

Therefore, on the available medical evidence at the time, P's decision that C was not entitled to a benefit from 24 December 2009 to 20 August 2010, was reasonable. In the event that medical evidence was available, the Case Manager considered whether C would have been entitled to a benefit (TD or PD) from 24 December 2009 to 20 August 2010.

The Case Manager considered C's financial information. Because C had taken drawings from his business, rather than a taxable income, C's pre-disability income (as defined by the policy) was zero, which meant any TD benefit payment was zero. For the same reason, C was not entitled to any PD benefit payment.

The Case Manager also considered whether P's decision that C was not entitled to a benefit following his surgery, was reasonable. P accepted that C was TD for 42 days following 20 August 2010. However, C was not entitled to the TD benefit, because the TD did not exceed the wait period of 13 weeks. Even if C had continued to be TD or PD after the 42 days, because his pre-disability income was zero, C was not entitled to a benefit.

The Case Manager believed P had correctly and reasonably applied the terms and conditions of the policy to the claim.

**Result** *Complaint not upheld*

***“When I first submitted a claim to the ISO I understood that you could only help with the claim being declined and couldn't clear my name. So I was delighted that a settlement was reached that did clear my name so thank you very much.”***

# Financial Statements

INSURANCE & SAVINGS OMBUDSMAN SCHEME INC  
FOR THE YEAR ENDED 30 JUNE 2011

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# Directory

## For the year ended 30 June 2011

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### NATURE OF BUSINESS

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

- (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.
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### BUSINESS LOCATION

7th Floor, Dimension Data 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 New Zealand Audit Partnership, Wellington





**STATEMENT OF FINANCIAL POSITION:** As at 30 June 2011

	Note	2011	2010
<b>Equity</b>			
Accumulated Funds Account		498,231	462,665
<b>Total Equity</b>		<b>498,231</b>	462,665
<b>Represented By :</b>			
<b>Current Assets</b>			
Accrued Income		655	4,571
Prepayments		15,099	7,643
Accounts Receivable		27,100	–
Cash & Bank		146,372	218,867
National Bank of N.Z. Term Deposits		330,598	307,305
Income Tax Refund	4	8,611	–
G.S.T. Refund		8,966	13,167
<b>Total Current Assets</b>		<b>537,401</b>	551,553
<b>Fixed Assets</b>	2	<b>90,299</b>	55,432
<b>Total Assets</b>		<b>627,700</b>	606,985
<b>Current Liabilities</b>			
Accounts Payable		128,519	140,573
Income Tax Payable	4	–	3,747
Income Received in Advance		950	–
<b>Total Current Liabilities</b>		<b>129,469</b>	144,320
<b>Total Liabilities</b>		<b>129,469</b>	144,320
<b>Net Assets</b>		<b>498,231</b>	462,665

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

Chairperson:  Date: 24.08.11

Ombudsman:  Date: 24.08.11

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 2011**NOTE 1 – STATEMENT OF ACCOUNTING POLICIES****ENTITY REPORTING & STATUTORY BASIS**

The Financial Statements presented here are for the Insurance & Savings Ombudsman Scheme Incorporated.

During the year the entity became an Incorporated Society and changed its name from Insurance & Savings Ombudsman Commission to Insurance & Savings Ombudsman Scheme Incorporated (ISO Scheme).

The Financial Statements are prepared in accordance with Generally Accepted Accounting Practice (GAAP) as defined in the Financial Reporting Act 1993.

**DIFFERENTIAL REPORTING**

The ISO Scheme is a qualifying entity within the New Zealand Institute of Chartered Accountants differential reporting framework. The ISO Scheme 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 ISO Scheme, and are recognised on an accrual basis. During the year, the ISO Scheme was approved as a dispute resolution scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008. New participant levies represent amounts received from financial service providers who are now required to join an approved scheme.

**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.

## NOTE 1 – STATEMENT OF ACCOUNTING POLICIES *(continued)*

**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 polices 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	242,342	155,668	86,674
Furniture & Fittings	8,539	4,914	3,625
	<b>\$250,881</b>	<b>160,582</b>	<b>\$90,299</b>
<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>

## NOTE 3 – OPERATING LEASE COMMITMENTS

Analysis	2011	2010
Current	174,928	89,003
Non-Current	502,814	–
	<b>677,742</b>	<b>89,003</b>

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

The existing operating lease expires on 20 April 2012. The ISO Scheme has committed to a new operating lease from 1 December 2011 for new premises.

**NOTE 4 – TAXABLE INCOME RECONCILIATION**

<b>Income Adjustments</b>	<b>2011</b>	<b>2010</b>
Book Profit/(Loss) Before Tax	36,456	36,772
Adjustment for Non-Taxable Income and Expenses	1,955	3,166
Holiday Pay Timing Difference	3,612	15,409
Permanent Adjustment	(586,781)	–
<b>Taxable Profit/(Loss)</b>	<b>(544,758)</b>	<b>55,347</b>
Tax @ 30% (2010: Marginal Rates)	–	11,315
Prior period tax adjustment	890	(5,700)
Tax Expense	890	5,615
Opening Balance	3,747	(4,479)
RWT Paid	(8,611)	(7,568)
Terminal Tax Paid	(4,979)	–
Refund Received	–	10,179
Interest	342	–
<b>Tax Payable/(Refundable) as at 30 June 2011</b>	<b>(8,611)</b>	<b>3,747</b>

Tax losses amounting to \$544,758 (2010:\$NIL) are to be carried forward to future income years. The availability of tax losses is subject to the requirements of the Income Tax Act 2007 continuing to be met. The potential future income tax benefit has not been recorded in the accounts.

**NOTE 5 – CONTINGENT LIABILITIES & COMMITMENTS**

As at balance date the ISO Scheme had no capital commitments (2010: \$Nil).

As at balance date, the ISO Scheme 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 \$80,000 of its accumulated funds for the ISO Scheme Review (2010: \$60,000).

**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 (2010: \$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 ISO Scheme 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 INSURANCE & SAVINGS OMBUDSMAN SCHEME INC REPORT ON THE FINANCIAL STATEMENTS

We have audited the financial statements of Insurance & Savings Ombudsman Scheme Inc on pages 23 to 27, which comprise the statement of financial position as at 30 June 2011, and the statement of financial performance, statement of changes in equity for the year then ended, and a summary of significant accounting policies and other explanatory information.

### COMMITTEE MEMBERS' RESPONSIBILITIES

The committee members are responsible for the preparation of financial statements in accordance with generally accepted accounting practice in New Zealand and for such internal control as the committee members determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

### AUDITOR'S RESPONSIBILITIES

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control.

An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates, as well as evaluating the presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Other than in our capacity as auditor we have no relationship with, or interests in Insurance & Savings Ombudsman Scheme Inc.

### OPINION

In our opinion, the financial statements on pages 23 to 27 present fairly, in all material respects, the financial position of Insurance & Savings Ombudsman Scheme Inc as at 30 June 2011, and its financial performance, for the year then ended in accordance with generally accepted accounting practice in New Zealand.

Grant Thornton New Zealand Audit Partnership  
Wellington, New Zealand  
24 August 2011

# Professional Relationships

## ASSOCIATIONS

ISO, Karen Stevens, is a founding member of the Australian and New Zealand Ombudsman Association ("ANZOA") [www.anzoa.com.au](http://www.anzoa.com.au) Established in 2003, ANZOA is the peak body in Australia and New Zealand, with members from not-for-profit, industry-based and statutory external dispute resolution offices.

The ISO Scheme Inc is a founding member of the International Network of Financial Services Ombudsman Schemes ("INFO Network") [www.networkfso.org](http://www.networkfso.org) All INFO Network members operate as independent out-of-court dispute resolution mechanisms in the financial sector. Set up in 2007, with the aim of working together to develop members' expertise in dispute resolution, the INFO Network currently extends to 31 countries.

## PARTICIPANTS & PROFESSIONAL BODIES

At 30 June 2011, the ISO Scheme had over 1,400 Participants, including: insurance and savings organisations, financial advisers, financial adviser businesses, finance companies, brokers, QFES, credit contract providers, trustees, trustee corporations and other financial service providers.

To find a Participant, search the ISO's website [www.iombudsman.org.nz](http://www.iombudsman.org.nz) or the Financial Service Providers Register [www.business.govt.nz](http://www.business.govt.nz)

Many of our Participants belong to the following professional bodies:

- Australian and New Zealand Institute of Insurance and Finance (ANZIIF) [www.theinstitute.com.au](http://www.theinstitute.com.au)
- Financial Services Federation Inc. (FSF) [www.fsf.org.nz](http://www.fsf.org.nz)
- Health Funds Association of New Zealand Inc. (HFANZ) [www.healthfunds.org.nz](http://www.healthfunds.org.nz)
- Institute of Financial Advisers (IFA) [www.ifa.org.nz](http://www.ifa.org.nz)
- Insurance Brokers Association of New Zealand Inc. (IBANZ) [www.ibanz.co.nz](http://www.ibanz.co.nz)
- Insurance Council of New Zealand Inc. (ICNZ) [www.icnz.org.nz](http://www.icnz.org.nz)
- Investment Savings and Insurance Association Inc. (ISI) [www.isi.org.nz](http://www.isi.org.nz)
- Life Brokers Association (LBA) [www.lba.org.nz](http://www.lba.org.nz)
- Professional Advisers Association (PAA) [www.paa.co.nz](http://www.paa.co.nz)

“I WAS ALWAYS KEPT IN THE LOOP WITH HOW MY CLAIM WAS PROGRESSING AND FEEL THAT IT WAS HANDLED IN AN EFFICIENT AND PROFESSIONAL MANNER, GAINING A FULL AND FAIR PICTURE OF MY CLAIM.”

“***I FOUND THE ISO EXTREMELY EASY TO TALK WITH AND UNDERSTAND. WAS KEPT FULLY INFORMED.***”

“All of the communication I have had was clear and concise keeping me up to date with any progress or points of clarification.”



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