

Building on experience



The Insurance
& Savings
Ombudsman
Scheme
is an
independent
and impartial
service for
resolving
financial
service
complaints,
which is free
to consumers.

The ISO Scheme may be able to help you

The Insurance & Savings Ombudsman Scheme Inc. ("ISO Scheme") provides a free, independent service which can consider complaints about your financial service provider.

HOW THE ISO SCHEME CAN HELP

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

The ISO Scheme can look at a complaint if you have received a letter of "*deadlock*" from your financial service provider. A letter of "*deadlock*" means you have come to the end of your financial service provider's internal dispute resolution process and the complaint has not been resolved.

The ISO Scheme can help you to resolve your complaint by agreement, or it may make a decision. The decision may be in your favour, or in the financial service provider's favour. The ISO Scheme's decision is binding on the financial service provider, but not on you. If you are unhappy with ISO Scheme's decision, you can take your complaint to court.

COMPLAINTS THE ISO SCHEME CAN HELP YOU WITH INCLUDE:

- ✓ amounts in dispute up to \$200,000 or \$1,000 per week for a product that provides regular payments
- ✓ breaches of contract, statutory obligations, industry codes
- ✓ credit contracts (loans), mortgages
- ✓ financial advice and broking services
- ✓ financial guarantees
- ✓ fire and general, health and life insurance
- ✓ foreign exchange and money transfer services
- ✓ superannuation and securities.

COMPLAINTS THE ISO SCHEME CANNOT HELP YOU WITH:

- ✗ awards of damages
- ✗ financial service providers' commercial decisions
- ✗ third party or uninsured losses.

The ISO Scheme considers complaints within its jurisdiction and in accordance with its Terms of Reference. You can get a copy of the Terms of Reference from our website, www.iombudsman.org.nz

The ISO Scheme's decisions are always independent and impartial.

Constitution Changes

from March 2012

SOME OF THE MAIN CHANGES IN THE NEW CONSTITUTION INCLUDE THE FOLLOWING:

- Membership of the Board is increased, to include 2 new representatives for financial service providers.
- Membership of the Commission is increased, to include 2 new representatives – one financial services industry and one consumer representative.
- The Commission sets fees and levies in future.
- On winding-up of the ISO Scheme, Participants would not be required to make up any shortfall and any remaining property would be transferred to similar organisation(s), indicative of a not-for-profit organisation.

SOME OF THE MAIN CHANGES IN THE NEW TERMS OF REFERENCE INCLUDE THE FOLLOWING:

- The new definition of “*Complainant*” includes those who could be affected by a broader range of financial services.
- The new definition of “*Small Business*” is the same as in section 63(c) of the FSP Act.
- The dispute resolution process, as described, reflects the actual process the ISO Scheme uses.
- The ISO Scheme does not have to look at complaints lacking in substance.
- The ISO Scheme may look at matters outside jurisdiction if everyone agrees.
- The ISO Scheme makes decisions in jurisdictional disputes.
- New information can be introduced by parties to support their case with the ISO Scheme, provided this information was not previously available.
- Interest may be awarded from the date of loss.
- The remedy for special inconvenience has increased from \$1,000 to \$3,000.
- The Test Case procedure has been simplified and made more accessible.
- The ISO Scheme may report breaches to the Financial Markets Authority, as set out in the FSP Act.

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Paula Rebstock, Chairperson, ISO Commission

During the previous 12 months, the Commission, in consultation with the Board and Participants, undertook a review of the ISO Scheme's governing documents to ensure the ISO Scheme meets the standards expected of approved dispute resolution schemes, while continuing to meet the requirements of its original Participants and new members.

As a consequence of the review and following extensive consultation, the Commission recommended to the Board and Participants significant changes to the ISO Scheme's Terms of Reference and Rules.

The changes to the ISO Scheme Rules (now the Constitution) have expanded the role of the Commission, by establishing a unitary governance structure whereby the Commission, rather than the Board, is responsible for changing the ISO Scheme's Terms of Reference and Constitution. The key driver for this change in the structure of the ISO Scheme was to fully meet the principle of independence required of approved schemes.

In addition, changes in the ISO Scheme's governing documents were made to ensure the rules were relevant to all financial service providers, including the original insurance and savings Participants. The Constitution ensures that new members are represented in the governance arrangements, while continuing to ensure the ISO Scheme remains responsive to its traditional membership.

On 8 February 2012, the then Minister of Consumer Affairs, the Honourable Chris Tremain, approved the new Constitution, Terms of Reference and Participation Agreement in accordance with section 66 of the Financial Service Providers (Registration and Dispute Resolution) Act 2008. In granting approval to the ISO Scheme, the Minister commented that the *"change means that the governance of the Scheme now fully meets the principle of independence"*. The Minister also noted that the *"... changes to the Scheme documents modernise and simplify the legal structure and documents governing the Scheme, and ensure that the Scheme operates with accepted good practice in external disputes resolution"*.

The Commission remains indebted to the ISO, Karen Stevens, whose integrity, professionalism and expertise is widely acknowledged by Participants and their customers. In addition, the ISO, who is also the Chief Executive Officer, demonstrated



commensurate change management skills over the past year. Despite the uncertainty facing the ISO Scheme as it was expanded to new membership and dealt with the aftermath of the Christchurch earthquakes, management proved to be adept at planning, budgeting and meeting all key service performance measures.

As Chair of the Commission, I would like to acknowledge the collective leadership provided by Commission Members and the Board who jointly reviewed and transformed the ISO Scheme to ensure it is well positioned to meet future challenges and opportunities. The Chairman of the Board, Martin Stokes, who is also a Member of the Commission, was particularly instrumental in leading the industry throughout the consultation and decision making process. Finally, the Board and Commission were ably assisted by Navigator Company Pty Ltd, who assisted with the governance review of the ISO Scheme.

The Commission is confident that the ISO Scheme now has a governance structure which will enable it to continue to strongly contribute to public confidence in our financial markets. We are determined to ensure the ISO Scheme fully meets the public's expectations that Christchurch earthquake related disputes falling within our jurisdiction are resolved through exemplary standards of service. We are equally committed to providing the customers of our Participants with free access to the highest quality dispute resolution services and to maintaining a service based on 17 years' experience for Participants.

Paula Rebstock

Chairperson, Insurance & Savings Ombudsman Commission CNZM

Karen Stevens, Insurance & Savings Ombudsman

For the last 17 years, the ISO Scheme has been building on its experience to provide a comprehensive dispute resolution service for the customers of its Participants; in that time, we have dealt with nearly 40,000 complaints enquiries and over 4,600 complaints investigations.

Understanding dispute resolution in the financial sector has meant we were able to deal with the 2,833 complaints enquiries and 242 complaints received this year, while reducing the time to close complaints investigations to an average of about 75 days.

The 17 years' experience handling fire and general insurance complaints has been invaluable since the devastating earthquakes in Canterbury in September 2010 and February 2011. Understanding the specific insurance sector which has been so impacted by earthquake claims has helped us to assist our insurance Participants' customers – letting the people of Christchurch know that they are being listened to and their complaints heard. Access to an independent and free disputes resolution process is essential – particularly for vulnerable consumers dealing with natural disaster on such a huge scale.

To date, we have dealt with over 600 earthquake complaints enquiries and received 33 earthquake complaints for investigation. We have found that a focus on early resolution inevitably provides the best outcome and, to assist consumers with that, we have created a dedicated page on our website with information, answers to frequently asked questions and case studies. Given that all complaints have to reach “deadlock” in the internal dispute resolution process of the insurance Participant before they can be referred to us, we are aware that there are likely to be many more complaints about the earthquakes referred to the ISO Scheme in the years to come.

We continue to liaise with the ICNZ, Office of the Ombudsmen, Christchurch City Council, CERA and EQC to find workable solutions to address such an enormous challenge for the New Zealand insurance industry and all New Zealanders.

The 17 years' dispute resolution experience has also enabled the ISO Scheme to respond to the needs of new financial sector members over the last year. We now have over 2,500 Participants in the ISO Scheme. As part of assisting our new members with complaints handling training and to ensure best practice in their internal dispute resolution processes, we developed training sessions to suit a variety of different needs. The very clear message given was that the early resolution of complaints is cost-effective, good



for business, and can strengthen customer relationships. We are spending considerable time fielding questions from our Participants about complaints and complaints handling processes – helping them to help themselves and their customers.

It is also important from a much broader perspective for the ISO Scheme to benchmark its own dispute resolution processes internationally and, for that reason, I have continued my involvement with the Australian and New Zealand Ombudsman Association (“ANZOA”) as an Executive Committee Member and with the International Network of Financial Services Ombudsman Schemes (“INFO Network”), more recently as an INFO Network Committee member.

The ISO Scheme has built its reputation on its processes, experience and people. Those currently involved in its governance have been instrumental in changing the ISO Scheme to respond appropriately to the times. I would like to thank Paula Rebstock for her guidance and for her very able leadership of the Commission. I would like to thank the Commission Members, the Industry Board and our Board Chairman Martin Stokes who steered the governance consultation process on behalf of the industry.

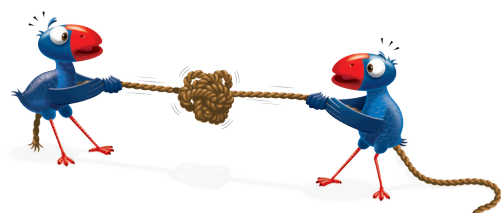
My thanks also to my staff, particularly those who have shown such commitment to resolving disputes, the membership team who seem to make things easier for everyone, and the management team who ensure we provide the best possible dispute resolution service to Participants.

As we look forward to the coming year, a robust dispute resolution process, good governance and dedicated people will stand the ISO Scheme in good stead to handle complaints across the financial sector and, in particular, those arising out of the Canterbury earthquakes.

Karen Stevens

Insurance & Savings Ombudsman LLM LLB BA MCIArb AAMINZ FNZIM ASB LTCL

Complaints Summary



There were 2,833 complaint enquiries, 713 in writing (including 457 emails), 2,114 by telephone and 6 “walk-in”. (An increase of 74% on the previous year’s figure of 1,625.)

STATUS	2011/2012		2010/2011	
Complaints carried over from previous year and completed	40		71	
Complaints received for investigation	242		250	
Complaints under investigation	282		321	
Complaints completed during the year	219		281	
Complaints for investigation but incomplete at year end	63		40	
RECEIVED BY SECTOR	2011/2012		2010/2011	
Financial Adviser			1	
Fire and General	181	75%	153	61%
Health	26	11%	44	18%
Life and Savings	33	14%	52	21%
Other Financial Service Providers	2			
TOTAL	242		250	
OUTCOMES	2011/2012		2010/2011	
Complaints upheld	4	2%	28	10%
Complaints partly upheld	3	1%	4	1%
Complaints settled	50	23%	75	27%
Complaints withdrawn	–	–	2	1%
Complaints not upheld	162	74%	172	61%
TOTAL	219		281	

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 Scheme, after “deadlock” has been reached and jurisdiction established.

A complaint is **PARTLY UPHELD** or **UPHELD**, when the ISO Scheme 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 Scheme.

A complaint is **NOT UPHOLD**, when the ISO Scheme 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 2012, almost \$984,508.28 was paid by the Participants to consumers who had their complaints considered by the ISO Scheme (not including weekly disability benefit payments under income protection, superannuation or life policies).

JURISDICTION

In the 2011/2012 financial year, we received 431 complaint enquiries outside jurisdiction. We received 116 written complaint enquiries, which required consideration and a written response, and 315 telephone complaint enquiries which were outside the ISO Scheme's jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO SCHEME'S JURISDICTION

Brokers/company not Participant	38.5%	<div></div>
Commercial/underwriting decision	32%	<div></div>
Third party	19%	<div></div>
Outside ISO's monetary limits	2.3%	<div></div>
Not defined service	1.9%	<div></div>
Previously considered/subject of proceedings	1.4%	<div></div>
Time barred	1.4%	<div></div>
No remedy available	1.2%	<div></div>
Another forum more appropriate	1.2%	<div></div>
Outside time limits	0.9%	<div></div>
Investment performance	0.2%	<div></div>

TIMELINESS

The average time to close the 219 complaints investigated in the year ended 30 June 2012, was 75 days from receiving the Participant's file and accepting the complaint for investigation.

SYSTEMIC ISSUES AND BREACHES

No systemic issues arising from complaints or any material or persistent breaches by Participants were identified 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 39,554 complaints enquiries and investigated more than 4,669 complaints.

How we got our message into the Community

IN 2011/2012:

SPEECHES AND PRESENTATIONS: We spoke at a total of 50 seminars and conferences.

We provided training for our Participants. Complaints handling workshops were run in 8 locations throughout New Zealand, with 7 half-day workshops and 4 hour long workshops, attended by 176 people.

In addition, in conjunction with the IFA, we offered Participants and IFA members 3 (45 minute) webinars, with more than 350 individuals participating.

Given the significance of the Canterbury earthquakes, we have not only had specific meetings in Christchurch, but we have also taken part in 12 community presentations.

CONSUMER OUTREACH: We took part in 3 Ministry of Consumer Affairs Consumer Rights Days in Waitakere, Auckland and Christchurch, where there was a particular emphasis on earthquake issues affecting Canterbury residents.

0800 NUMBER: We received 7,254 inward calls on our freephone number 0800 888 202, which provides callers with options of talking to an experienced Case Manager about their enquiry or directly to membership for Participants. We also offer a special information service for those affected by the Canterbury earthquakes.

WEBSITE SESSIONS: During the year we had a total of 39,165 website visits (monthly average 3,264) and a total of 28,206 unique visitors to our website. www.iombudsman.org.nz. We have developed a dedicated webpage and FAQs for those affected by the Canterbury earthquakes.

Complaint enquiries: We dealt with 2,114 telephone, 713 written and 6 "in person" complaint enquiries from consumers, a total of 2,833 complaint enquiries.

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

We have also contributed case studies and other commentary to industry publications.

“The ISO case manager explained any delays clearly and reassuringly.”

Membership



We engage with our Participants through training webinars, our bi-monthly *Assessment* newsletter and the regular provision of case studies through *Good Returns*. Participants regularly respond to articles and provide feedback which forms the basis of ongoing topics. This contact is a vital indicator of the effectiveness of our performance and keeps us well informed of issues in the financial sector.

The membership team is constantly striving to improve its internal processes, ensuring our response to enquiries is timely, the online registration procedure is easy to access, and is backed up by support from the membership team where needed. In 2011, we surveyed our original Participants to find out how the ISO Scheme had performed as an External Dispute Resolution ("EDR") Scheme:

- 100% agreed the ISO Scheme's service was easy to access and understand.
- 90% agreed they were kept up-to-date with ISO Scheme news and events.
- 100% agreed the ISO Scheme was independent of the industry and their customers.
- 83% agreed the searchable case studies on the ISO Scheme's website were valuable.
- 100% agreed they understood the ISO Scheme's complaints handling process.
- 89% agreed that the reasons for the ISO Scheme's decision were clearly explained.
- 94% agreed that using the ISO Scheme was a better alternative than going to court.

At 30 June 2012, the ISO Scheme had about 2,500 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 scheme's website at www.iombudsman.org.nz, or the Financial Service Providers Register at www.business.govt.nz/fsp.

**"Thank you for the opportunity to link in.
A very good economic way of me gaining
my Professional Development Hours."**

**"LOVED WEBINAR... ITS SO MUCH
EASIER THAN ATTENDING A SEMINAR...
BACK TO WORK QUICKLY."**



How do people Rate us?

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

Agree	88.6%	<div></div>
Disagree	9.1%	<div></div>
Don't know	2.3%	<div></div>

THE ISO SCHEME RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME

Agree	77.3%	<div></div>
Disagree	13.6%	<div></div>
Don't know	9.1%	<div></div>

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

Agree	95.5%	<div></div>
Disagree	4.5%	<div></div>
Don't know	0.0%	<div></div>

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

Agree	79.5%	<div></div>
Disagree	18.2%	<div></div>
Don't know	2.3%	<div></div>

THE ISO SCHEME'S SERVICE IS EASY TO USE

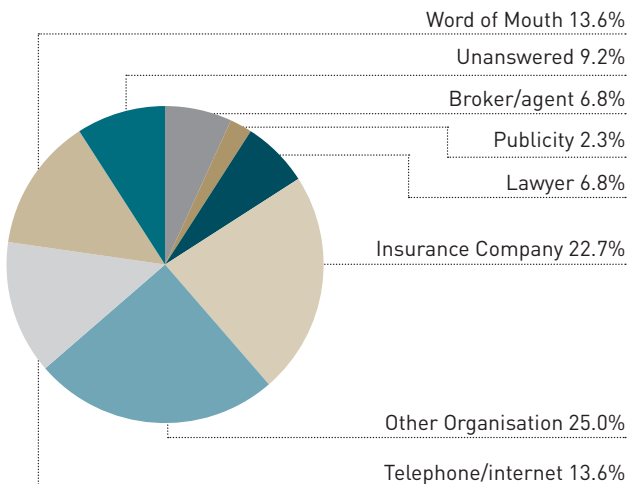
Agree	93.2%	<div></div>
Disagree	4.5%	<div></div>
Don't know	2.3%	<div></div>

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

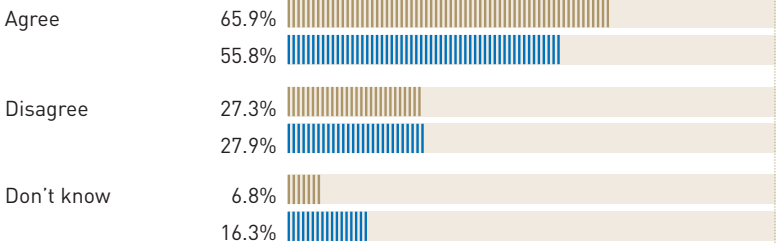
Agree	97.7%	<div></div>
Disagree	2.3%	<div></div>
Don't know	0.0%	<div></div>

“Your ISO case manager kept us well informed about progress on our complaint.”

HOW DID YOU FIND OUT ABOUT THE ISO SCHEME?



INFORMATION PROVIDED BY PARTICIPANTS



- You received enough information from your financial service provider about its own internal complaints procedure.
- You received enough information from your financial service provider about the ISO Scheme.

“WE WERE VERY IMPRESSED WITH THE CLARITY OF INFORMATION WE RECEIVED AND THE COMMUNICATION, THANKS.”

Case studies

- 13 1: Life Insurance: Non-disclosure – Life insurance, Duty of disclosure – limitations, Evidential issues
- 14 2: Income Protection: Partial disablement
- 15 3: Fire and General: Material Damage
- 16 4: Superannuation: Reimbursement of costs, Service issues, Ability to claim
- 17 5: Fire and General: Quantum, Interpretation – Specific policy provisions, Earthquake, Damage – House, Delay
- 19 6: Travel Insurance: Expert/Specialist opinion, Pre-existing condition, Causation, Evidential issues
- 20 7: Fire and General: Non-disclosure – Other, Burden of proof, Whether 'on notice', Evidential issues

“Very good overall experience dealing with case manager.”

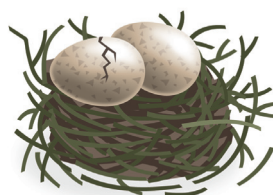
“Outstanding service. Professional. Although not the desired result was never led up garden path. Good to know you guys exist. Keep up good work.”

“Entirely satisfied with the service you provided. End result most satisfactory thanks to your intervention.”

IN THE CASE STUDIES,

C = CONSUMER

P = PARTICIPANT.



1

LIFE INSURANCE

Non-disclosure – Life insurance, Duty of disclosure – limitations, Evidential issues

Background

On 16 March 2011, C completed an application for a life insurance policy with P. On 1 April 2011, P wrote to C offering him revised terms and, on 11 April 2011, C agreed to those revised terms. On 15 April 2011, C was admitted to the Intensive Care Unit of a hospital after the bulldozer he was driving rolled.

On 20 April 2011, the policy commenced. On 5 May 2011, C died in hospital from a cardiac arrest, resulting from the injuries he sustained on 15 April 2011. On 1 June 2011, C's lawyer notified P of C's death and initiated the claim process under the policy.

P avoided the policy from commencement and declined to consider the claim, on the basis that C did not disclose he had had an abnormal liver function test result in 2008.

Assessment

The information provided when an insurance application is completed becomes the basis of the policy, which is a legal contract. Information is material and must be disclosed, if it would influence the mind of a prudent insurer in deciding whether or not to accept an application and, if so, on what terms.

The policy provided that P could avoid the policy from commencement, if C failed to disclose material information on the application. P said C failed to disclose raised liver function test results in 2008 and, had it been aware of those results, P would have deferred cover. The issue to determine was whether C had sufficient knowledge of the tests to be able to disclose them on the application.

The Case Manager contacted C's doctor who said she would have discussed the results with him, but would have indicated it was not serious and, as it was a slight change, it would need to be checked again. C's doctor said she would have sent C for further tests, or have repeated the tests, if the results continued to be raised.

On the basis of the medical evidence obtained from C's doctor, it was not clear whether C would have understood he had had an abnormal liver function test in 2008. Following the Case Manager's discussions with P, it reviewed its decision in regard to the claim and agreed to meet the claim.

Result *Complaint settled*

2

INCOME PROTECTION

Partial disablement

Background

In September 1998, C arranged income protection insurance with P. In October 2010, C injured his wrist. In December 2010, C underwent surgery to his wrist and ceased working in his occupation as an Osteopath. C made a claim to P under the policy.

P accepted the claim and paid C the Total Disability benefit under the policy until May 2011. From May 2011 to 22 June 2011, because C returned to work, P paid C the Partial Disability ("PD") benefit.

From 22 June 2011, P declined to pay C any further benefits under the policy, because it believed there was no independent evidence that C was prevented by the injury from earning a weekly rate equal to the average weekly earnings prior to the injury, as required by the policy.

C believed he was entitled to on-going PD benefit payments, because he suffered continuing incapacity from the injury and his income was reduced.

Assessment

Under the policy, C was entitled to the PD benefit if he had proven he was *"prevented by [the injury] from earning a weekly rate equal to the average weekly earnings prior to [the injury]"*.

In June 2011, C's specialist completed a progress report for P, in which he said C's *"symptoms/function [would] continue to improve over the next six months"*. On the same day, the specialist wrote to C's doctor and said C would *"be able to return to full time duties over the next few weeks."*

There was independent medical evidence to indicate C had some on-going impairment to his wrist. However, the impact this impairment had on C's ability to earn *"a weekly rate equal to the average weekly earnings prior to [the injury]"* was not clear.

The Case Manager discussed the difficulties with the medical evidence and the policy wording with P. Following these discussions, P agreed to offer C an *ex-gratia* payment of \$10,000 in full and final settlement of the claim and C accepted P's offer.

Result *Complaint settled*

3

FIRE AND GENERAL

Material Damage

Background

C operated a laundromat and held a material damage policy with P. While C was cleaning a customer's wedding dress, it was damaged beyond repair. C's customer took C to the Disputes Tribunal to recover the replacement cost of the dress. The Disputes Tribunal ruled that C was liable to pay the customer the full replacement value. C made a claim to P for the replacement value of the dress.

P declined the claim, initially on the basis that customers' goods were not covered by the policy. However, due to the low value of the claim, P accepted that the dress was covered by the policy, but believed it was only liable to settle the claim on an indemnity basis. C believed he was entitled to the replacement value of the dress.

Assessment

The policy provided cover for *"insured property"*; however, this was not defined in the policy. The policy stated that the schedule formed part of the policy. The schedule listed the property insured and the type of insurance, as *"Machinery and Plant & Contents – RV"*.

The policy defined *"contents"* as including *"property owned by another person or entity, and left in your care, custody or control for cleaning, servicing or repair."* The wedding dress was property owned by another person, left in C's care, custody or control for cleaning and, therefore, the dress was *"contents"* covered by the policy.

The policy stated that, where an item of property was shown in the schedule *"as insured for reinstatement"*, P would *"indemnify [the insured] by reinstatement of that insured property"*. In the event that the property was destroyed (as it was in this case), the policy defined *"reinstatement"* as *"replacement by an equivalent building or equivalent plant as appropriate"*.

While this did not specifically refer to contents, the Case Manager believed the reference to *"as appropriate"* meant P would replace the property in question, whether it was building, or plant, or contents (as shown on the schedule).

However, the *"Reinstatement cover"* provided by the policy was subject to a list of conditions. The conditions included the provision that reinstatement would not apply *"if [the insured did] not reinstate the property."* If the insured did not reinstate the property, the policy stated that P was entitled to settle the claim *"on the same basis as if reinstatement cover had not applied"*. C did not *"reinstate the property"*, because the dress belonged to the customer and the customer did not want C to replace the dress. In accordance with the Disputes Tribunal's ruling, C paid the customer the full replacement value.

However, in terms of P’s liability, the reason C did not reinstate the property was irrelevant. In accordance with the terms of the policy, because C had not replaced the dress, P was entitled to “*settle [the claim] on the same basis as if reinstatement cover had not applied to the property.*” This meant P could choose whether to pay the cost of the repairs, or replace the property with property of similar condition, or pay the market value of the property.

The policy defined “*market value*” as “*the new replacement cost of an item, less a fair allowance for depreciation based on age, use and condition.*” P believed the market value of a used wedding dress would be less than 50% of the replacement cost. On this basis, P offered C \$1,500.

Having regard to P’s obligations under the policy, the Case Manager believed this payment was reasonable and P was not legally liable to pay C the replacement/ reinstatement cost of the dress. The Case Manager recommended C accept P’s offer.

Result *Complaint not upheld*

4

SUPERANNUATION
Reimbursement of costs, Service issues, Ability to claim

Background

In July 2007, C joined a Kiwisaver scheme and completed a direct debit authority for monthly contributions of \$100. In July 2008, C put his Kiwisaver contributions on hold. In March 2009, C advised P to reactivate the direct debit and resume his Kiwisaver contributions. P advised C’s bank to reactivate the direct debit.

In April 2011, C made a claim to P when he discovered his Kiwisaver contributions had not been deducted from his bank account since he reactivated the direct debit. C believed this was P’s fault and asked it to reimburse him the value of what his contributions would have been, together with the loss of investment and any applicable tax credits.

C’s bank advised P that the reason that C’s bank account had not been debited was because C cancelled the direct debit in July 2008. P declined to pay C the value of his contributions; however, it said, if C paid the contribution of \$2,500, it would reimburse C for the loss of investment and arrange for his Kiwisaver account to be credited with the applicable tax credits.

Assessment

The Case Manager explained to C that, even if P was at fault (or partially at fault) in respect of the reactivation of the direct debit, the ISO Scheme could only compensate C for direct financial loss, caused by acts or omissions of P. C had not suffered any financial loss and, in the circumstances, P’s offer was reasonable.

Result *Complaint not upheld*

5

FIRE AND GENERAL**Quantum, Interpretation – Specific policy provisions,
Earthquake, Damage – House, Delay****Background**

C's house was insured with P. On 4 September 2010, the house, which incorporated an attached triple garage/workshop, was badly damaged by earthquake. Further damage was sustained in subsequent earthquakes. C made a claim to the Earthquake Commission ("EQC"), and to P in respect of the damage to the house.

The cost of repairing the damage exceeded the EQC's maximum liability and, in March 2011, P's appointed project manager visited the property and conducted a detailed repair/rebuild analysis. The analysis indicated that the house would be economic to repair. However, because of the land issues in the area, the house was eventually zoned as "Red Zone" in August 2011.

While the house interior looked sound, the concrete floor slab in the house and adjoining garage was split, but not dislocated, in a number of places. This damage also caused the floor level to move or subside inconsistently along its length. Most of the repair cost was focused on the need to support, level and repair the concrete floor slab of the house and garage.

P's project manager originally identified a repair methodology which involved extensive use of underground injection grout filling material to support the floor slab and the creation of new underground support foundation piles. With the floors re-levelled, carpet and tiles re-laid and no cracking in the foundation visible, the repair would have ensured there was no possible aesthetic dissatisfaction. The assessed repair cost amounted to \$223,858 and this amount was offered to C as a settlement.

C disagreed with P's proposed repair methodology and assessed repair cost, and did not believe P was complying with the replacement policy entitlement. In particular, he did not agree that, in terms of the policy, repair of the concrete floor slab was permissible and would return the floor to its pre-damage condition.

P arranged for 2 subsequent assessments of the damage, which were carried out in November and December 2011. Each assessment by P's project manager confirmed that the house was repairable, confirmed the proposed repair methodology and the originally assessed cost of repairs. P's offer to settle for the assessed repair cost of \$223,858 (including EQC payments and excesses) was rejected by C.

Assessment

The house was in the Red Zone, where repairs could not actually be carried out, because the land could not be used again. P did not insure the land and, therefore, its assessment was based on the cost of repairing the damage to the house. P’s repair estimate was based on what it would have cost to repair the house, but for the fact that the land could not be used again.

The Case Manager fully considered all of the documentation available and held numerous discussions with both P and C, in respect of some aspects of the damage and the proposed repair methodology. The Case Manager believed several questions about the repair had to be addressed, especially the theoretical nature of the repair in the Red Zone, as well as the methodology, costs and compliance with the terms of the policy in relation to C’s entitlement.

C advised the Case Manager that he believed some areas of damage and the significance of this had not been fully investigated and considered by P’s project manager. He continued to stress that the house should not be considered repairable and, in particular, the concrete floor simply had to be replaced rather than repaired. He believed this would significantly add to the cost, to the extent that it would no longer be regarded as economic to repair.

The Case Manager provided P with the opportunity to critically review the repair option methodology, with particular emphasis on delivering a repair outcome in accordance with the policy terms. The Case Manager met with P, P’s project manager and C to discuss a number of issues, guiding the review process, partly to gain a greater insight and detailed understanding of the proposed repair methodology. This resulted in confirmation of the repair methodology, costs and compliance with replacement policy terms for the main part of the house, but that this repair methodology and cost was not appropriate for the garage structure.

As a result, the garage structure was reassessed and re-costed on P’s instruction to its project manager as a rebuild, including foundation requirements. The increased cost for this overall repair methodology complied with C’s policy entitlement and was acceptable to P. The Case Manager’s involvement and guidance assisted C to understand the proposed repair methodology and limits on entitlement under the terms of the replacement policy.

The combination of repair and partial rebuild methodology resulted in an agreed resolution between P and C. The changes resulted in P’s increased offer of \$397,115 (including EQC payments and excesses), which was accepted by C in full and final settlement of the claim.

Result *Complaint settled*

6

TRAVEL INSURANCE**Expert/Specialist opinion, Pre-existing condition, Causation, Evidential issues****Background**

In November 2011, C arranged travel insurance with P, for a trip to India, from December 2011 to January 2012.

While in India, C sought treatment for “cloudy vision” from a general practitioner. C was diagnosed as suffering from optic neurosis and treated with intravenous methylprednisolone. However, C later developed severe thrombophlebitis and cellulitis at the injection site and was admitted to Bombay Hospital. C underwent surgery to treat the thrombophlebitis and cellulitis and later made a claim to P for the surgery and associated treatment costs.

P declined the claim on the basis that it was indirectly linked to a pre-existing condition – the optic neurosis.

Assessment

On returning to New Zealand, C visited his doctor, who suggested C may be suffering from optic atrophy and referred him to an ophthalmologist. In both consultations, C reported having symptoms of poor vision in low light, since childhood. The ophthalmologist diagnosed C as suffering from retinitis pigmentosa and cataracts.

P relied on the doctor’s statement that C was suffering from optic atrophy which, it believed, could be linked to optic neurosis, to decline the claim as indirectly related to a pre-existing condition and, therefore, excluded by the policy.

However, the Case Manager believed that the initial diagnosis of optic atrophy by the doctor had been replaced by the ophthalmologist’s diagnosis of retinitis pigmentosa. P could not show that the retinitis pigmentosa was linked to the optic neuritis. Therefore, after further discussion with the Case Manager, P agreed to accept the claim.

Result *Complaint settled*



7

FIRE AND GENERAL

Non-disclosure – Other, Burden of proof, Whether ‘on notice’, Evidential issues

Background

In March 2007, C arranged insurance on a rental property through a bank, with P. The house was covered for the full replacement value.

In February 2011, a significant earthquake struck Canterbury, resulting in a total loss to the house. C made a claim to P for the loss.

P believed C failed to disclose that the house was built in the 1920s, rather than the 1930s. Therefore, P believed it was entitled to avoid the policy and decline to consider the claim. However, instead, P offered to settle the claim on the basis of a payment for “*the present day value*” of the house, which is what C would have been entitled to, had P known the house was built in the 1920s.

Assessment

An applicant for insurance has a common law duty to disclose to an insurer all information, which a prudent insurer would consider material. If the applicant fails to provide material information, the insurer is able to avoid the policy, even if the non-disclosure was unintentional. The current law does not distinguish between innocent and deliberate non-disclosure.

C arranged the refinancing and insurance of her house through the bank. C believed that, as part of this, she had been asked by the bank to provide a valuation of the house, which stated the house was built in the 1920s. The bank denied that it was provided with this valuation, as it had no record of having received it. However, C was able to provide documentation to show that the bank did have the valuation before the policy’s inception. In addition, 2 policy quotations were generated by the bank: one for a 1920s house and the other for a 1930s house.

The Case Manager was concerned that the bank, as P’s agent, was on notice that the house was built in the 1920s, rather than 1930s. 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 additional *ex-gratia* payment of \$45,480.65. C agreed to accept this amount in full and final settlement of the claim.

Result *Complaint settled*



Financial Statements

INSURANCE & SAVINGS OMBUDSMAN SCHEME INC
FOR THE YEAR ENDED 30 JUNE 2012

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For the year ended 30 June 2012

NATURE OF BUSINESS

The Scheme's principal powers and duties are:

- (a) to resolve Complaints arising out of the provision of financial services by a Participant in a way that is accessible, independent, fair, accountable, efficient and effective; and
- (b) to promote and publicise the Scheme to consumers and small businesses and to encourage and provide advice to Participants on the development and maintenance of good complaint-handling practices.

BUSINESS LOCATION

Level 11, Classic House, 15-17 Murphy Street, Thorndon, Wellington

BANKERS	The National Bank of NZ Limited, Wellington
CHARTERED ACCOUNTANTS	BDO Wellington Limited, Wellington
AUDITORS	Grant Thornton, Wellington

STATEMENT OF FINANCIAL PERFORMANCE: For the year ended 30 June 2012

	Note	2012	2011
Revenue			
Levies – Original Participants		1,186,000	1,008,000
Levies – New Participants		780,037	633,196
Financial Adviser Complaint Fees		3,355	3,000
Workshop Income		4,089	43,950
Carpark Rental Income		1,600	–
Interest Received		47,406	42,600
Sundry Income		7,835	5,322
Profit on Sale of Fixed Assets		–	637
Total Revenue		2,030,322	1,736,705
Less			
Administration		208,540	227,581
Audit Fees		5,500	5,505
Commissioners' Fees		74,417	78,556
Depreciation – Office Equipment		59,511	57,558
Depreciation – Furniture & Fittings		308	68
Professionals & Consultancy		179,757	90,358
Occupancy		36,736	16,481
Promotion		33,194	27,676
Rent		166,585	119,550
Salaries		1,132,659	1,050,028
Staff Costs		59,496	26,888
Total Expenses		1,956,702	1,700,249
Net Surplus before Taxation		73,620	36,456
Provision for Income Tax	5	–	–
Net Surplus after Taxation		\$73,620	\$36,456
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 2012

	2012	2011
Net Surplus for the Year	73,620	35,566
Total Surplus for the Year	73,620	35,566
Funds at the Beginning of the Year	498,230	462,664
Funds at the End of the Year	\$571,849	\$498,230
This statement should be read in conjunction with the Notes To The Financial Statements.		

STATEMENT OF FINANCIAL POSITION: As at 30 June 2012

	Note	2012	2011
Current Assets			
Accrued Income		3,418	654
Prepayments		14,301	15,098
Accounts Receivable		4,338	27,099
Cash and Bank	3	144,503	146,372
Term Deposits	4	451,526	330,598
GST Refund Due		16,554	8,966
Taxation	5	7,811	8,611
Total Current Assets		642,450	537,400
Current Liabilities			
Accounts Payable		174,964	128,519
Credit Cards		15,085	–
Income Invoiced in Advance		350	950
Total Current Liabilities		190,399	129,469
Working Capital		452,051	407,931
Non Current Assets			
Property, Plant & Equipment	6	119,798	90,299
Total Non Current Assets		119,798	90,299
Net Assets		571,849	498,230
Represented by:			
Equity			
Accumulated Funds	7	571,849	498,230
Total Equity		\$571,849	\$498,230

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

Chairperson

ISO Commission:



Date: 20.08.12

Ombudsman:



Date: 20.08.12

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 2012

NOTE 1 – STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY

The financial statements presented here are for the entity Insurance & Savings Ombudsman Scheme Inc.

REPORTING BASIS

The financial statements have been prepared in accordance with Generally Accepted Accounting Practice ("GAAP") as defined in the Financial Reporting Act 1993.

DIFFERENTIAL REPORTING

The Insurance & Savings Ombudsman Scheme Inc is a qualifying entity within the New Zealand Institute of Chartered Accountants Differential Reporting Framework. The entity is not publicly accountable, the owners and governing body are separate, and satisfies the relevant size criteria. The Insurance & Savings Ombudsman Scheme Inc has taken advantage of all differential reporting concessions.

MEASUREMENT BASE

The Measurement Base adopted is historical cost.

ACCOUNTS RECEIVABLE

Accounts Receivable are stated at expected realisable value.

FIXED ASSETS

Fixed Assets are included at cost less accumulated Depreciation.

The cost of the 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 is provided at the maximum rates allowed by the Inland Revenue Department. Fixed assets are depreciated using the straight-line method at the following rates:

Office & Computer Equipment	17.5% – 60.0% CP
Furniture & Fittings	0.00% – 10.5% CP

INVESTMENTS

Investments are stated at cost.

TAXATION

Provision is made for taxation after taking full advantage of all deductions and concessions permitted using the taxes payable method.

GOODS AND SERVICES TAX

The financial statements have been prepared on a GST exclusive basis, with the exception of Accounts Receivable and Accounts Payable balances which are stated on a GST inclusive basis.

LEVY INCOME

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

EMPLOYEE ENTITLEMENTS

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

CHANGES IN ACCOUNTING POLICIES

There have been no changes in accounting policies. All policies have been applied on bases consistent with those used in previous years.

NOTE 2 – NATURE OF BUSINESS

The nature of the Insurance & Savings Ombudsman Scheme Inc business has not changed during the year under review.

NOTE 3 – CASH AND BANK

	2012	2011
Petty Cash	85	200
National Bank of NZ – Cheque	3,364	1,054
National Bank of NZ – Call	141,053	145,119
Total Cash and Bank	\$144,503	\$146,372

NOTE 4 – TERM DEPOSITS

	2012	2011
National Bank Term Deposit – 1005	–	330,598
National Bank Term Deposit – 1010	201,526	–
National Bank Term Deposit – 1011	200,000	–
National Bank Term Deposit – 1012	50,000	–
Total Term Deposits	\$451,526	\$330,598

NOTE 5 – TAXATION

	2012	2011
Net Surplus/(Deficit) before Taxation	73,620	36,456
Adjustment for Non Taxable Income & Expenses	441	1,955
Holiday Pay Timing Adjustment	7,706	(12,419)
Permanent Adjustment	(73,620)	(586,781)
Tax Losses Brought Forward	(560,789)	–
Taxable Income/(Loss)	(\$552,643)	(\$560,789)
Opening Balance	(8,611)	3,747
RWT Paid	(7,811)	(8,611)
Terminal Tax Paid	–	(4,979)
Refund Received	8,611	–
Interest	–	342
Prior period tax adjustment	–	890
Transfer to/from another tax type	–	0
Taxation Payable/(Refundable)	(\$7,811)	(\$8,611)

Tax losses amounting to \$552,643 (2011:\$560,789) 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 6 – FIXED ASSETS

	2012	2011
Office & Computer Equipment		
At cost	325,758	242,342
Less Accumulated Depreciation	215,179	155,668
	110,579	86,674
Furniture & Fittings		
At cost	14,441	8,539
Less Accumulated Depreciation	5,222	4,914
	9,219	3,625
Total Property, Plant & Equipment	\$119,798	\$90,299

NOTE 7 – ACCUMULATED FUNDS

	2012	2011
Accumulated Funds/(Accumulated Losses)		
Balance Brought Forward	498,230	462,664
Net Surplus/(Deficit) for the Year	73,620	35,566
Available for appropriation	571,849	498,230
Closing Balance	\$571,849	\$498,230

Included in Accumulated Funds is \$55,000 which is for the Insurance & Savings Ombudsman Scheme Inc Review which will be undertaken in 2013. The total allocation for this fee review is \$100,000 of which \$45,000 has been accrued as at 30 June 2012.

	2012	2011
Scheme Review Provision	55,000	80,000
Other Retained Earnings	516,849	418,230
Total Retained Earnings	\$571,849	\$498,230

NOTE 8 – RELATED PARTIES

	2012	2011
Paula Rebstock (Chairperson) ACC	3,679	2,909
Total	\$3,679	\$2,909

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

NOTE 9 – LEASE COMMITMENTS

	2012	2011
Current	147,165	174,928
Non Current	355,649	502,814
Total Lease Commitments	\$502,814	\$677,741

The existing operating lease expires on 30 November 2021. The lease has two rights of renewal of three years each. The first renewal date for the lease is 30 November 2015.

NOTE 10 – CAPITAL COMMITMENTS

At balance date, the Insurance & Savings Ombudsman Scheme Inc had no capital commitments. (2011:Nil).

NOTE 11 – CONTINGENT LIABILITIES

The Insurance & Savings Ombudsman Scheme Inc Review will be undertaken during the 2013 year. The total allocation for this fee review is \$100,000 of which \$45,000 has been accrued as at 30 June 2012.

NOTE 12 – ADOPTION OF INTERNATIONAL FINANCIAL REPORTING STANDARDS

In December 2002, the New Zealand Government announced that New Zealand International Financial Reporting Standards ("NZ IFRS") will apply to all New Zealand reporting entities for the period 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 Scheme Inc 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).



INDEPENDENT AUDITOR'S REPORT


**TO THE MEMBERS OF INSURANCE & SAVINGS OMBUDSMAN SCHEME INC
REPORT ON THE FINANCIAL STATEMENTS**

We have audited the financial statements of the Insurance & Savings Ombudsman Scheme Inc on pages 22 to 27, which comprise the statement of financial position as at 30 June 2012 and the statement of financial performance, statement of changes in equity for the year ended 30 June 2012, and a summary of significant accounting policies and other explanatory information.

COMMISSION MEMBERS' RESPONSIBILITIES

The Commission 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 Commission 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 of financial statements that present fairly the matters to which they relate 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 the Insurance & Savings Ombudsman Scheme Inc.

OPINION

In our opinion, the financial statements on pages 22 to 27 present fairly, in all material respects, the financial position of the Insurance & Savings Ombudsman Scheme Inc as at 30 June 2012, 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
20 August 2012

Professional Associations and Relationships

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

The ISO Scheme is a founding member and Karen Stevens is on the Committee of the International Network of Financial Services Ombudsman Schemes ("INFO Network") www.networkfso.org. All INFO Network members operate as independent out-of-court dispute resolution mechanisms in the financial sector. Established in 2007, with the aim of working together to develop members' expertise in dispute resolution, the INFO Network currently extends to 50 member schemes from 33 countries.



Many of our Participants belong to the following professional bodies:

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

“We are extremely grateful for the opportunity to have our case reviewed independently and are more than satisfied with the service.”

“ISO WAS EXTREMELY HELPFUL AT ALL LEVELS.”

“THIS IS A FANTASTIC SERVICE TO ENABLE RESOLUTION OF DISPUTES. IT PROVIDES THE MUCH NEEDED BRIDGE OF COMMUNICATION BETWEEN THE TWO PARTIES INSTEAD OF HAVING TO GO THROUGH AN EXPENSIVE COURT PROCESS.”

“I APPRECIATE THE INDEPENDENT REVIEW AND EXPLANATION.”



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