

2013 Annual Report

INSURANCE
& SAVINGS
OMBUDSMAN

I·S·O

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



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Disputes res

The Insurance & Savings Ombudsman Scheme Inc. (“ISO Scheme”) provides a free, independent service which can consider complaints about financial service providers.



The ISO Scheme can look at a complaint when consumers have received a notice of “*deadlock*” from their financial service provider. A notice of “*deadlock*” means the complaint has not been resolved and the end of the financial service provider’s internal dispute resolution process.

The ISO Scheme can help to resolve complaints by agreement (through negotiation, conciliation or mediation), or it may make a decision. The decision may be in a consumer’s favour, or in the financial service provider’s favour. The ISO Scheme’s decision is binding on the financial service provider, but not on consumers. If consumers are unhappy with ISO Scheme’s decision, they can take their complaint to court.

“Very helpful in getting closure, very helpful, great communication.”

“Was good having someone that could understand me and who I could understand over the phone.”

olved

“A very good service. I had confidence in the procedure even though my complaint was not upheld.”

“Delighted with the efficiency and manner in which my claim was handled and delighted with the outcome.”

“We were overseas during most of the time but our complaint was still handled in a business-like manner.”

Paula Rebstock,
Chairperson

Successful e

The previous 12 months has seen the successful expansion of the ISO Scheme, with membership growth exceeding Commission expectations. During this period the Commission has focused on ensuring that our Participants and their customers continue to receive the highest quality dispute resolution services.

Given the changes in the ISO Scheme, it was timely in April to June 2013 for our 5 yearly independent review to be undertaken by Cameronralph Navigator, with a particular focus on accessibility – one of the six Principles specified in the Financial Service Providers (Registration and Dispute Resolution) Act 2008. The Commission was pleased that the independent review found the ISO Scheme to be a competent, well-run EDR scheme that meets the six principles of accessibility, independence, fairness, accountability, efficiency and effectiveness.

It also found that the ISO Scheme:

- Exhibits the same sensible, careful approach to complaints resolution that had been found in the previous 2008 review;
- Had largely implemented the recommendations of the 2008 Review;
- Had broadened its skills and capacity to address complaints in its new areas of responsibility; and
- Meets the key practice areas under Accessibility.

“It has a substantial and rapidly growing Participant base, is trusted by consumers and is in a strong financial and organisational position.”

xpansion

The Review went on to recommend a subtle shift in balance and emphasis to a more proactive, ‘front foot’ style of operation that would strengthen and underscore our leadership in financial sector EDR, through:

- Continuing to strengthen the ISO Scheme’s capacity and skill mix;
- Continuing to professionalise procedures and systems;
- Continuing the outward shift in focus of the Ombudsman’s role and taking a more proactive leadership role in the community; and
- Further improving the accessibility of the ISO Scheme to consumers and ensuring that Participants are meeting their obligations to make consumers aware of the ISO Scheme.

Having come through a period of considerable change, the ISO Scheme is well placed for the future. It has a substantial and rapidly growing Participant base, is trusted by consumers and is in a strong financial and organisational position. The ISO, Karen Stevens, has provided proven leadership over more than a decade. She is also now well supported by a Deputy Ombudsman, Louise Peters, Participant Liaison Manager, Penelope England, and a full complement of experienced case managers.



“Having come through a period of considerable change, the ISO Scheme is well placed for the future.”

I am grateful to my fellow Commissioners for their insightful governance of the Scheme. They share with me a firm commitment to our Participants and consumers that we will continue to provide the highest quality dispute resolution service, which is of critical importance to a well-functioning financial market.

Paula Rebstock

Chairperson, Insurance & Savings Ombudsman Commission
CNZM

Karen Stevens,
Insurance & Savings Ombudsman

Fair process

It has been another very successful year for the ISO Scheme: a year of growth and consolidation. We have grown the membership again this year to over 3,000 Participants, who provide financial services to potentially more than 1 million consumers.

Our complaint numbers increased significantly, with over 3,100 complaints enquiries handled and 279 complaints investigated and resolved by negotiation, conciliation or decision.

The ISO Scheme provides access to dispute resolution for a great many New Zealand consumers. For that reason, our 5 yearly independent review focused on “Accessibility”.

“We have grown the membership again this year to over 3,000 Participants.”

We wanted to find out whether consumers know about the ISO Scheme and the free and independent service we provide, so we surveyed various community groups who refer people to us. Over 90% of the Citizens Advice Bureau surveyed were aware of the ISO Scheme and 95% use information provided by us to assist consumers. We also survey all Complainants who use the ISO Scheme; of those who responded, 95% agreed that the ISO Scheme has an easy service to use and 90% said decisions were explained clearly, while only 50% of them got the actual outcome they wanted or agreed to. This result underlines that customers want a fair process and will be satisfied with a fair process, even if they cannot get exactly what they want in terms of outcome.

At the same time, we wanted to find out whether our Participants, particularly our new Participants, offer their customers an internal complaints process and, if not, whether they need help from us to set one up. Over 90% of Participants surveyed said they have an internal complaints process and inform their customers that the ISO Scheme is available to provide them with a free dispute resolution process, primarily through disclosure statements or on their websites.

We will be working with our Participants to increase this. For those who need support and assistance, we offer complaints handling training and training on specific areas (e.g. non-disclosure) through regular webinars and at conferences and seminars. Currently, about 80% of Participants said they use the ISO Scheme's website as a resource for themselves and their customers.

From 1 July 2013, a new dedicated Participant website will make it easier for our Participants to access all of the information they need to help their customers. Another new initiative for the coming year is offering each Participant a free complaint. Knowing they will not have to pay the first complaint fee should encourage Participants to refer customers with complaints to the ISO Scheme's fair and independent dispute resolution process. This is a positive step for consumers.

In addition to expertise in complaints handling, strong governance from committed industry and consumer representatives is essential for the continued success of the ISO Scheme. Thanks to Paula Rebstock, our fabulous chairperson, the ISO Commission Members and Board; the fantastic staff, including my deputy, Louise Peters, and our significant "go-to" person for Participants, Penelope England.



“We have expertise acquired over 18 years – handling over 42,000 complaints enquiries and investigating nearly 5,000 complaints.”

The advantage of being a customer of a Participant in the ISO Scheme is knowing we have the expertise acquired over 18 years – handling over 42,000 complaints enquiries and investigating nearly 5,000 complaints – to independently resolve complaints, preserve relationships and ensure fair financial services.

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

Complaints

Complaint enquiries

A complaint enquiry has not usually been through the Participant’s internal complaints process when it is referred to the ISO Scheme. There were 3,125 complaint enquiries (an increase of 10.3% on the previous year’s figure of 2,833), 769 in writing (including 537 emails), 2,352 by telephone and 4 “walk-ins”.

Complaints

A complaint has been through the Participant’s internal complaints process and has been accepted by the ISO Scheme for investigation and resolution, by agreement where possible (through negotiation, conciliation, mediation) or by decision.

Status	2012/2013		2011/2012	
Complaints carried over from previous year and completed	63		40	
Complaints received for investigation	274		242	
Complaints under investigation	337		282	
Complaints completed during the year	279		219	
Complaints for investigation but incomplete at year end	58		63	

Received by sector	2012/2013		2011/2012	
Credit Contracts	2	1%	0	
Financial Adviser	8	3%	1	0.5%
Fire and General	167	61%	181	75%
Health Life and Disability	86	31%	55	23%
Investment and Savings	1	0.5%		
Not regulated financial service – investigation authorised	1	0.5%	1	0.5%
Superannuation	9	3%	4	1%
TOTAL	274		242	

“My complaint was certainly dealt with without bias and I thank the staff member concerned for their thoroughness and pleasantness.”



Outcomes	2012/2013		2011/2012	
Complaints Upheld	16	6%	4	2%
Complaints Partly Upheld	3	1%	3	1%
Complaints Settled*	55	20%	50	23%
Complaints Withdrawn	2		0	
Complaints Not Upheld	203	73%	162	74%
TOTAL	279		219	

** Complaint settlements were achieved through negotiation, conciliation and mediation.*

In the year ended 30 June 2013, almost \$1,430,179 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 2012/2013 financial year, we received 423 complaint enquiries outside jurisdiction. We received 105 written complaint enquiries, which required consideration and a written response, and 315 telephone complaint enquiries which were outside the ISO Scheme’s jurisdiction.

The most significant group of complaint enquiries outside jurisdiction related to commercial/underwriting decisions (34%), with 27% where the financial service provider was not a Participant and 26% related to third party insurance claims.

Timeliness

The average time to close the 279 complaints investigated in the year ended 30 June 2013, was 95 days from receiving the Participant’s file and accepting the complaint for investigation.

Systemic issues and breaches

We raised a potential systemic issue about the way policy exclusions were being applied with a Participant. The Participant reviewed its procedures and agreed to amend the way exclusions were applied to policies and also to limit those exclusions it had already added to policies.

The ISO Scheme’s experience of providing dispute resolution services in the financial sector

Since the ISO Scheme was established in 1995, it has handled more than 42,679 complaint enquiries and investigated more than 4,943 complaints.



How we get our message into the community

In 2012/2013

Speeches and Presentations:

We spoke at a total of 35 seminars and conferences.

Consumer Outreach:

Consumer outreach is an important part of our work, particularly education for consumers about financial services. We have been involved in many activities this year, including: the annual conference of Citizens Advice Bureau; working with CERA's Residential Advisory Service in Christchurch to provide assistance as needed; Ministry of Consumer Affairs Consumer Rights Days; presentations to the Canterbury District Health Board with the Office of the Ombudsmen and the Human Rights Commission; presentations to community groups, like Rotary. In addition, throughout the year we have distributed over 1,000 brochures and fact sheets to consumer groups nationwide.

0800 Number:

We received 6,869 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.

Website sessions:

During the year we had a total of 42,535 website visits (monthly average 3,544) and a total of 28,222 unique visitors to our website **www.iombudsman.org.nz**. We have developed a dedicated web page and FAQs for those affected by the Canterbury earthquakes.

Complaint Enquiries:

We dealt with 2,352 telephone, 769 written and 4 "in person" complaint enquiries from consumers, a total of 3,125 complaint enquiries.

Media Enquiries:

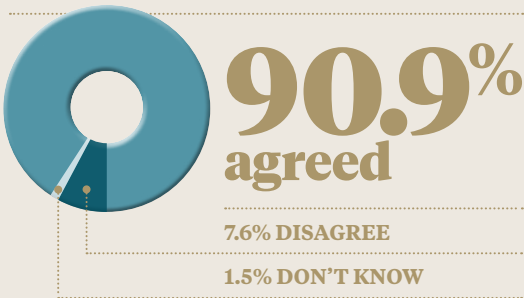
On 33 occasions, we provided information to media on topical issues, including: funeral plans, sum insured, Canterbury earthquakes, life, travel and health insurance. We have also contributed case studies and other commentary to *Good Returns*, *Asset Magazine*, *IBANZ* and *Covernote*.

"I have absolutely no complaints. I have been treated very professionally and compassionately by the Case Manager."

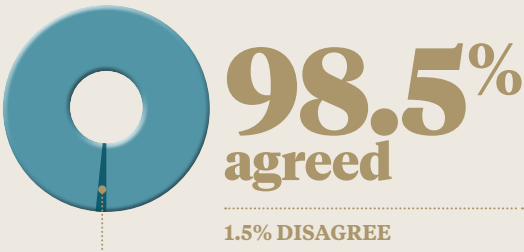
How do people rate us?



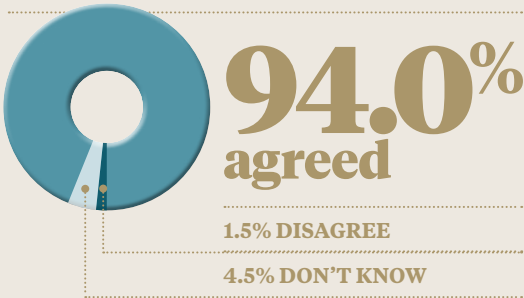
When you first contacted us, the ISO staff member gave you a clear explanation about the ISO Scheme's process



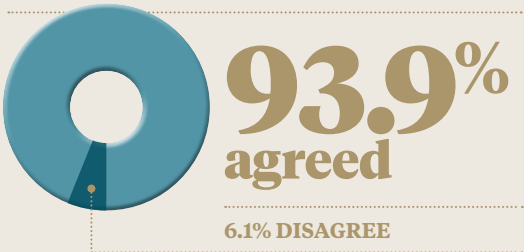
The ISO Scheme's forms were easy to understand



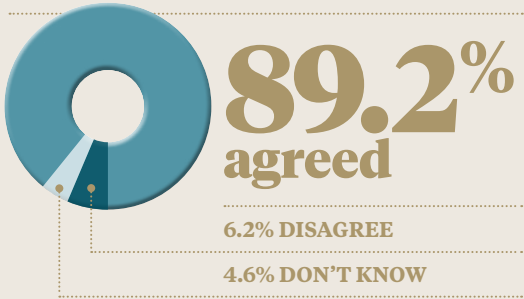
The Case Manager was helpful and easy to speak to on the telephone



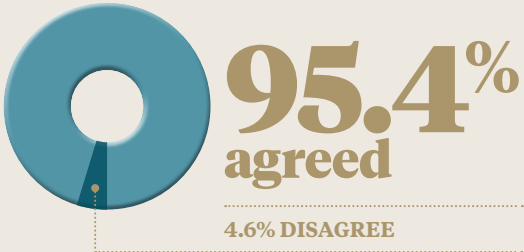
The ISO Scheme kept you well informed about progress



The reasons for the decision made about your complaint were explained clearly



The ISO Scheme's service is easy to use



“We have not had the need to address any complaints or issues with the ISO but find all other information most useful and the ISO as one vehicle to fulfil compliance and regulation requirements.”

Key support for participants

The core focus of 2012 has been sustaining and growing our Participant numbers, as well as further development of our key support resources for Participants of the ISO Scheme.

As at 30 June 2013, membership of the ISO Scheme was comprised of: 2,359 individuals, including nominated representatives of Qualifying Financial Entities (QFEs); 583 adviser businesses and other financial service providers; 18 insurance and savings companies; 7 superannuation schemes; and 38 insurers which were original Participants prior to the implementation of the new financial sector legislation in 2010.

In collaboration with the Institute of Financial Advisers (IFA), we continue to provide training webinars to our Participants; this is a professional development opportunity that allows attendees to gain CPD points, with 504 people attending the 7 ISO Webinars.

We have a regular programme of Participant communications, including the bi-monthly *Assessment* newsletter and the ISO Scheme Case Studies. We also launched a new quarterly consumer newsletter called *Consumer Focus* for Participants to give to their customers. The first issue explains the change of house insurance to “Sum Insured” cover.

The Participant Resource Page was redeveloped into a Participant only website, where all relevant membership resources are easily accessible. This website is located on the main ISO Scheme website and can be accessed using a unique Participant number.

We continue to foster key industry and regulator relationships. We maintain regular communication with industry bodies and financial adviser networks; this keeps us well informed of emerging issues in the financial sector. The feedback we receive, positive or negative, also forms the basis of many of our communications with our membership.

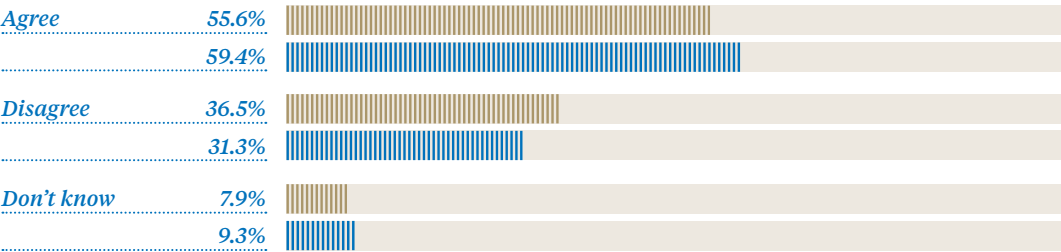
We are pleased that so many of our current Participants are choosing to recommend the ISO Scheme when talking to their networks of adviser colleagues; these recommendations are a positive acknowledgement of the work that the membership team is doing to add value to membership for all of our Participants.

While the coming year will certainly come with some challenges, the membership team is very positive and looks forward to supporting our Participants through any challenges that might arise.



“I have fortunately not had any complaints and am impressed with the ISO communication and case studies.”

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.



“I have found the ISO incredibly thorough and they seem to follow a “solomons sword” approach in finding an equitable solution in each complaint. They propose solutions rather than demand solutions, and anyone who works with ISO and is flexible will find the ISO process very fair, while it remains neutral.”

13	1 Financial Adviser
13	2 Fire & General
15	3 Fire & General: Sum Insured
16	4 Travel Insurance
16	5 Life
17	6 Superannuation

Case studies

“ISO is a wonderful service for individuals to receive a fair and balanced decision in cases of dispute, often with large corporations.”

“Thank you for all your time and effort put in on our behalf.”

“Fully satisfied by ISO Scheme’s service. Keep up the good work.”



1

Financial Adviser

Background

In June 2011, Sue and Dave had discussions with a mortgage broker about building a house. They decided to proceed and signed an authorisation form which incorporated the mortgage broker's disclosure statement ("the disclosure statement"). The disclosure statement included a term that "... a lender may apply a remuneration claw back from the adviser when the loan is not retained for a minimum period (normally 2 years)". The provision also stated that the mortgage broker could invoice the client directly if a "... commission reimbursement..." was applied by the loan provider.

In July 2011, Sue and Dave purchased a section and were advanced \$54,000 using a loan arranged through the mortgage broker ("the first loan"). In October 2011, Sue and Dave signed a "LOAN AGREEMENT" for a consolidated loan for the construction of a house, which included the amount owing under the first loan ("the second loan").

On 22 June 2012, Sue and Dave repaid the second loan in full and, on 25 June 2012, the mortgage broker sent Sue and Dave an invoice for \$2,018.39, for the amount the lender had clawed back from him ("the clawback amount"), because the loan had been repaid early.

Assessment

The complaint made by Sue and Dave was that the mortgage broker "...failed to disclose if there was a clawback fee to be charged what percentage or details relating to the clawback would be...".

The Case Manager believed that the clause in the disclosure statement constituted a contractual term between the mortgage broker, Sue and Dave. However, following discussions between the parties, the mortgage broker offered to settle the complaint on the basis of payment from Sue and Dave of \$1,000. Sue and Dave agreed to pay that amount in full and final settlement of the complaint.

Result Complaint settled

2

Fire & General

Background

Bill's house was insured with an insurance company. 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. Bill made a claim to the Earthquake Commission ("EQC") and to his insurer in respect of the damage to the house.

The cost of repairing the damage exceeded the EQC maximum liability and in March 2011, the insurer'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 had 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.

The insurer'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 Bill as a settlement.

Bill disagreed with the insurer's proposed repair methodology, assessed repair cost and did not believe the company 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 not return the floor to its pre-damage condition.

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

Assessment

The house was in the Red Zone, where repairs could not actually be carried out, because the land could not be used again. The insurer did not insure the land and, therefore, its assessment was based on the cost of repairing the damage to the house. The insurer'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 the insurer and Bill, in respect of some aspects of the damage and the proposed repair methodology. The Case Manager believed several pertinent questions about the repair had to be addressed, especially the theoretical nature of the repair in the Red Zone together with the methodology, costs and compliance with the terms of the policy in relation to Bill's entitlement.

Bill advised the Case Manager that he believed some areas of damage and the significance of this had not been fully investigated and considered by the insurer'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 the insurer 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 the insurer, their project manager and Bill 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 the insurer's instruction to its project manager as a rebuild, including foundation requirements. The increased cost for this overall repair methodology complied with Bill's policy entitlement and was acceptable to the insurer. The Case Manager's involvement and guidance assisted Bill 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 the insurer and Bill. The changes resulted in the insurer's increased offer of \$397,115 (including EQC payments and excesses), which was accepted by Bill in full and final settlement of the claim.

Result Complaint settled

3

Fire & General – Sum Insured

Background

Alison arranged insurance on her house for a sum insured of \$967,000 (GST excl), specified on the policy schedule.

In October 2011, the house was totally destroyed in an arson attack and Alison made a claim to her insurer. The estimated cost to reinstate the house was \$1,595,050 (GST incl), meaning that Alison was significantly underinsured.

Alison claimed that the professional fees should be paid in addition to the sum insured specified on the policy schedule. She believed that the policy wording was ambiguous and, therefore, should be interpreted in her favour.

The insurer did not believe professional fees and demolition costs were payable in addition to the sum insured. It claimed they were included in the sum insured of \$967,000 (GST excl).

Assessment

The policy contained a provision, setting out how a claim would be settled. It stated “*where a sum insured is specified on the schedule, this is the maximum amount [the insurer] will pay*”. However, the policy also included a number of additional benefits. The preamble to the additional benefits stated “[the insurer] *will also cover or pay for*”. One of the additional benefits was cover for professional fees and demolition costs.

The insurer believed that the settlement provisions use of “*maximum*” indicated that the professional fees and demolition costs were not payable in addition to the sum insured. In support of its position, the insurer stated that the intention of having a sum insured as the basis of the cover is to provide certainty and a clear monetary limit on the risk.

Alison argued that the fee benefit was payable in addition to the sum insured, because of the wording preceding the list of additional benefits in the policy. She also noted that the context in which “*the maximum amount*” appeared in the settlement provision was in relation to materials and techniques used to rebuild the house.

It has been held by the courts that insurance policies are to be interpreted according to the principles of construction applicable to commercial contracts generally. Therefore, when construing a contract, regard must be given to, among other things, the natural and ordinary meaning of the words, the intention of the parties, the contract as a whole and the context in which the words appear. The more reasonable construction will be preferred and, in the last resort, if the contract is ambiguous, the policy is to be construed *contra proferentem* against the party who wrote the contract.

Because the decision about the interpretation of this wording would have a significant impact on both parties, the ISO Scheme decided it was fair and reasonable in all the circumstances to instruct independent counsel to provide an expert legal opinion.

After taking into account the factual matrix, including that when Alison arranged the policy she obtained a reinstatement estimate of \$967,000 which included demolition costs, counsel advised he did not consider the professional fees and demolition costs were payable in addition to the sum insured.

The ISO Scheme’s counsel believed there is some doubt in the industry about whether professional fees and demolition costs fall within the scope of any policy’s operative covering clause; i.e. cover for reinstating a house. Therefore, the words “*also cover or pay*” were in the policy to extend the scope of the cover, rather than increase the quantum, in this particular context. He believed that this interpretation gave full effect to the wording and that to treat fees and demolition costs as extras undermined the express statement about the maximum payable for accidental damage to the house.

Consequently, relying on the independent legal advice obtained, the Case Manager believed that the insurer was entitled to limit its liability under the claim to the sum insured specified on the policy.

Result Complaint not upheld

4

Travel Insurance

Background

In May 2012, Jane and Bruce arranged insurance for a trip to the Cook Islands, in August 2012.

In August 2012, while on the trip, Bruce suffered a fatal heart attack (myocardial infarction). Jane made a claim to the insurer for the cost of returning Bruce's body to New Zealand and associated costs.

The insurer declined the claim, on the basis that Bruce's myocardial infarction was related to a "Pre-Existing Condition" and, therefore, excluded by the policy.

Assessment

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

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

The policy provided a pre-existing condition exclusion for loss directly or indirectly arising from conditions, symptoms or circumstances of which an insured was aware.

The insurer obtained a doctor's opinion which stated Bruce's myocardial infarction was indirectly related to: his peripheral vascular disease, his cardio risk assessment, and/or a previous hospital admission for chest pain. Therefore, the insurer relied on the exclusion to decline the claim.

However, Jane provided a doctor's opinion which disagreed with this assessment.

As there were differing medical views, the Case Manager obtained an expert medical opinion from a cardiologist. The cardiologist's opinion was that, on the balance of probabilities, the myocardial infarction was not indirectly related to Bruce's peripheral vascular disease, his cardio risk assessment, or a previous hospital admission for chest pain.

After receiving the specialist's opinion, the insurer agreed to meet the claim.

Result Complaint settled

5

Life

Background

In March 1991, Tim's father completed an enrolment form and applied for a "\$50,000 PLAN" (which he believed was a life insurance policy), through a bank (now administered by an insurer). The bank accepted the enrolment form and agreed to provide cover and sent Tim's father a policy schedule, a schedule of benefits and a copy of the policy wording.

In January 2009, Tim's father died from "Acute Chronic Heart Failure Secondary to Dilated Cardiomyopathy... [and] Pancytopenia". Tim's father's estate made a claim to the insurer under the policy.

The insurer declined to pay the estate the Accidental Death benefit of \$50,000 under the policy, because Tim's father died from natural causes. They agreed to pay the estate the "DEATH BY ANY CAUSE" benefit of \$500. Tim's father's estate did not accept the payment of \$500.

The estate argued that Tim's father signed up for a \$50,000 life insurance policy and, therefore, his estate should be paid \$50,000.

Assessment

The policy schedule stated that the details of the benefits were shown in the schedule of benefits. The schedule of benefits stated that the "ACCIDENTAL DEATH" benefit of \$50,000 was payable if the insured died as a result of an "Accident" and, when an insured died "by any [other] cause", the amount payable was \$500.

As Tim's father died from natural causes, the insurer was not liable to pay Tim's estate \$50,000 under the policy.

From Tim's father's will, it was clear that he had believed the insurer would pay his estate \$50,000 when he died. The Case Manager considered whether this misunderstanding was due to any action, or inaction, on the insurer's part.

The enrolment form indicated Tim’s father signed up for a “\$50,000 PLAN”. The bank sent Tim’s father a schedule of benefits, which clearly explained the benefits provided by the policy. The policy document also advised Tim’s father that he could return the policy within 14 days for a full refund, if he was not satisfied with the cover provided.

On this basis, the Case Manager believed the insurer had correctly applied the terms of the policy to the claim and there was no evidence that Tim’s father’s misunderstanding of the policy was due to any action, or inaction, by the insurer.

Result Complaint not upheld

6

Superannuation

Background

George became a member of a KiwiSaver Scheme (“the Scheme”) in 2009. By virtue of the KiwiSaver Scheme Rules in the KiwiSaver Act 2006, his membership was deemed to have begun on 15 March 2009 when his first contribution was received by Inland Revenue.

In September 2011, George telephoned the Scheme to check whether he would be eligible for a first home withdrawal (“FHW”). The Scheme told George, among other things, that he would not be eligible to make a FHW until he had been a member of the Scheme for 3 years (“the telephone call”).

In September 2011, shortly after the September telephone call, George signed an “AGREEMENT FOR SALE AND PURCHASE OF REAL ESTATE” to purchase his first house (“the house”). As he was not eligible for a FHW at that time, he arranged to take a loan from his parents for the amount of \$5,875 (“the sum”), until such time as he became eligible for the FHW.

On 14 March 2012, George telephoned the Scheme and told it he had purchased a house and wished to make a FHW. The Scheme told George he was not eligible for a FHW, as he had already purchased the house.

George believed that he was not provided with correct and complete information in the telephone call and claimed the sum from the Scheme (“the complaint”).

Assessment

The Case Manager reviewed the documentation provided to George by the Scheme, including the Investment Statement, and also listened to the telephone call. She believed there were some deficiencies in the information provided to George, in that it was not clear from either the Investment Statement or the telephone call that the FHW would not be available to George in March 2012, if he had already purchased his first home. However, she was also of the view that George failed to inform the Scheme he was about to purchase his first home. The Case Manager believed that, had George told the Scheme that, they would have informed him he would not be eligible for FHW in March 2012.

Following discussions between the parties, the Scheme offered to settle the complaint on the basis of an *ex-gratia* payment of \$2,000 to George in full and final settlement of the complaint.

Result Complaint settled



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Financials

Directory

Insurance & Savings Ombudsman Scheme Inc
For the year ended 30 June 2013

1. 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.

2. Business location

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

3. IRD Number

063-250-759

4. Incorporation Number

2541616

5. Date of Incorporation

29 October 2010

6. Accountants

Grant Thornton New Zealand Limited

7. Auditors

BDO Wellington

8. Bankers

ANZ Bank Limited
Wellington

Statement of Financial Performance
Insurance & Savings Ombudsman Scheme Inc
For the 12 months ended 30 June 2013

	30 June 2013	30 June 2012
Income		
Revenue		
Financial Advisor Complaint Fees	8,000	3,355
Interest Received	56,961	47,406
Levies – Existing Participants	1,207,500	1,186,000
Levies – New Participants	928,142	780,037
Rental Income – Carpark	–	1,600
Sundry Income	309	7,835
Workshop Income	4,667	4,089
Total Revenue	2,205,579	2,030,322
Total Income	2,205,579	2,030,322
Gross Profit	2,205,579	2,030,322
Less Operating Expenses		
Administration	208,664	203,464
Audit	6,000	5,500
Commissioners Expenses	97,815	79,493
Depreciation	70,126	59,819
Occupancy	163,181	203,321
Professionals & Consultancy	68,602	179,757
Promotion	8,335	33,194
Staff Costs	1,195,650	1,192,154
Total Operating Expenses	1,818,372	1,956,702
Net Profit	387,206	73,620

Statement of Movements in Total Funds
Insurance & Savings Ombudsman Scheme Inc
As at 30 June 2013

	30 June 2013	30 June 2012
Funds		
Opening Balance	571,849	504,444
Plus Movement for the Year		
Accumulated Funds	–	(6,214)
Current Year Earnings	387,206	73,620
Total Movement for the Year	387,206	67,406
Total Funds	959,055	571,849

Statement of Financial Position
Insurance & Savings Ombudsman Scheme Inc
As at 30 June 2013

	30 June 2013	30 June 2012
Assets		
Current Assets		
Accounts Receivable	1,324	4,338
Accrued Income	8,153	3,418
Cash and Bank Balances	330,857	144,503
Current Investments	712,036	451,526
GST	17,842	16,553
Prepayments	14,253	14,301
Taxation	6,534	7,811
Total Current Assets	1,090,999	642,450
Fixed Assets		
Fixed Assets as per Schedule	61,735	119,798
Total Fixed Assets	61,735	119,798
Total Assets	1,152,734	762,248
Liabilities		
Current Liabilities		
Accounts Payable	177,485	174,964
Credit Cards	16,194	15,085
Income Invoiced in Advance	–	350
Total Current Liabilities	193,679	190,399
Total Liabilities	193,679	190,399
Net Assets	959,055	571,849
Equity		
Accumulated Funds	959,055	571,849
Total Equity	959,055	571,849

Signed by:



Chairperson ISO Commission

Date: 23.08.13



Ombudsman

Date: 23.08.13

Notes to the Financial Statements

Insurance & Savings Ombudsman Scheme Inc

For the year ended 30 June 2013

1. Summary of Significant Accounting Policies

The financial statements are for the Insurance & Savings Ombudsman Scheme Inc as a separate legal entity.

The Insurance & Savings Ombudsman Scheme Inc is an incorporated society registered under the Incorporated Societies Act 1908.

Basis of Preparation and Statement of Compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand. They comply with New Zealand Financial Reporting Standards (FRS).

Measurement Base

The accounting principles recognised as appropriate for the measurement and reporting of earnings and financial position on an historical cost basis have been used, with the exception of certain items for which specific accounting policies have been identified.

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.

The following are the significant accounting policies which have been adopted in the preparation of the financial statements:

2. 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.

3. Accounts Receivable

Receivables are stated at their estimated realisable value. Bad debts are written off in the year in which they are identified.

4. Employee Entitlements

Employee entitlements to salaries and wages, annual leave, long service leave and other benefits are recognised when they accrue to employees.

5. Fixed Assets and Depreciation

All fixed assets are recorded at cost less accumulated depreciation.

Depreciation of the assets has been calculated at the maximum rates permitted by the Income Tax Act 2007.

The entity has the following asset classes:

Furniture & Fittings: At Cost. 0% – 17.5% Straight Line

Furniture & Fittings: At Cost. 16% – 20% Diminishing Value

Office & Computer Equipment: At Cost. 17.5% – 60% Straight Line

Notes to the Financial Statements *Continued*

6. Foreign Currency

Transactions denominated in foreign currencies are converted at the exchange rate current at the transaction date. Foreign currency receivables and payables are converted at exchange rates current at balance date. Foreign exchange gains or losses are included as income or expenses respectively in the Statement of Financial Performance.

7. Goods and Services Tax

These financial statements have been prepared on a GST exclusive basis with the exception of Accounts Receivable and Accounts Payable.

8. Levy Income

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

9. Comparatives

The comparative figures have been restated to conform to the current year’s presentation.

10. Cash and Bank

	June 2013	June 2012
Petty Cash	73	85
ANZ – Cheque	3,845	3,364
ANZ – Call	314,645	141,053
ANZ – Serious Saver	12,294	–
Total	330,857	144,503

11. Fixed Assets

Office & Computer Equipment

	June 2013	June 2012
Office & Computer Equipment – At Cost	335,575	325,758
Office & Computer Equipment – Accumulated Depreciation	(284,397)	(215,179)
Total	51,178	110,579

Furniture & Fittings

	June 2013	June 2012
Furniture & Fittings – At Cost	16,687	14,441
Furniture & Fittings – Accumulated Depreciation	(6,130)	(5,222)
Total	10,557	9,219
Total Fixed Assets	61,735	119,798

12. Investments

	June 2013	June 2012
Current		
ANZ NZ Term Deposit – 1014	509,154	–
ANZ Term Deposit – 1010	–	201,526
ANZ Term Deposit – 1011	–	200,000
ANZ Term Deposit – 1012	–	50,000
ANZ Term Deposit – 1016	202,882	–
Total Current	712,036	451,526
Total Investments	712,036	451,526

13. Taxation

	June 2013	June 2012
Net surplus / (deficit) per financial statements	387,206	73,620
Add back		
Non-deductible expenditure	1,815,525	1,954,332
Deduct		
Non-assessable income	2,148,618	1,982,916
Losses carried forward	552,643	560,789
Total assessable surplus/(deficit)	(498,530)	(515,754)
Tax effect	–	–
Add back		
Other items	–	–
Tax credits foregone	–	–
Deduct		
Resident withholding tax paid	6,534	7,811
Terminal tax due / (refund due)	(6,534)	(7,811)

Income tax losses available to be carried forward total \$498,530.05 (Last year: \$552,643).

The losses are subject to Inland Revenue Department confirmation.

Income Tax expense charged to the Profit and Loss statement recognises the current obligations for the period, calculated using the Taxes Payable method.

Notes to the Financial Statements *Continued*

14. Operating Lease Commitments

	June 2013	June 2012
Current Portion	147,165	147,165
Non-Current Portion	208,484	355,649
Total	355,649	202,814

The existing operating lease expense 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.

Operating leases are those which all the risks and benefits are substantially retained by the lessor. Lease payments are expensed in the periods the amounts are payable.

15. Audit

These financial statements have been subject to audit; please refer to Auditor’s Report.

16. Contingent Liabilities

At balance date contingent liabilities have been estimated at \$nil (2012: \$45,000).

17. Capital Commitments

Capital commitments at balance date are \$nil (2012: \$nil).

18. Subsequent Events

There have been no material events after balance date that require adjustment to or disclosure in the financial statements.



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 19 to 24, which comprise the statement of financial position as at 30 June 2013, and the statement of movements in equity, and statement of financial performance for the year then ended, and a summary of significant accounting policies and other explanatory information.

This report is made solely to the Members, as a body, in accordance with the Constitution of the Insurance & Savings Ombudsman Scheme Inc. Our audit has been undertaken so that we might state to the Members those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members, as a body, for our audit work, for this report, or for the opinions we have formed.

Commission Members' Responsibility for the Financial Statements

The Insurance & Savings Ombudsman Scheme Commission Members are responsible for the preparation and fair presentation of these 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 Responsibility

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 judgment, 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 overall 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.

In addition to audit services, our firm provided other services in the areas of taxation advice and business services. We have no other relationship with or interests in the Insurance & Savings Ombudsman Scheme Inc.

Opinion

In our opinion, the financial statements on pages 19 to 24, present fairly, in all material respects, the financial position of Insurance & Savings Ombudsman Scheme Inc as at 30 June 2013, and its financial performance for the year then ended in accordance with generally accepted accounting practice in New Zealand.

Other matters

The financial statements of Insurance & Savings Ombudsman Scheme Inc for the year ended 30 June 2012 were audited by another auditor who expressed an unmodified opinion on those statements on 21 August 2012.

BDO WELLINGTON
23 August 2013

50 Customhouse Quay
Wellington
New Zealand

"I find the staff at the ISO Office to be approachable, open to discussion/ ideas, and seem to strive for a win/win solution. Offering additional training via webinars is a great idea."

"I find the newsletter a great way of communication to keep us advisers up to date of current events."

"Staff that dealt with our membership were very helpful and easy to deal with."

"I have only gone into the website once, but always read your newsletters and have read the case studies which I thought were brilliant help."

"Easy to deal with and communications to date have been clear, concise and reasonable."



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