



INSURANCE & SAVINGS
OMBUDSMAN

Annual Report 2014

The Insurance & Savings Ombudsman Scheme Inc. is independent, impartial and free for consumers. We resolve complaints about insurance and financial services.



The Insurance & Savings Ombudsman Scheme

The ISO Scheme is independent, impartial and free for consumers.

The ISO Scheme was established in 1995. Since then, we have responded to thousands of complaints about:

- Insurance: including house, vehicle, contents, health, life and travel insurance
- Superannuation, investments and securities
- Loans and credit
- Financial advice and broking services
- Foreign exchange and money transfer services

Complaints are resolved by agreement (through negotiation, conciliation or mediation), or the ISO Scheme may make a decision. An ISO Scheme decision will be binding on a Participant, but not on a consumer.

4,386 Participants

The ISO Scheme currently has 4,386 Participants, which provide financial services throughout New Zealand. We can only formally investigate a complaint if it involves a Participant of our scheme.

Annual Report 2014

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From the Chair

The ISO Scheme had a successful year providing a high quality dispute resolution service for our 4,386 Participants and their customers. The Commission's role is to ensure that the service provided by the ISO Scheme remains at the highest possible level.

Karen Stevens and her team of Case Managers apply their extensive industry and legal knowledge to resolve complaints across an increasingly broad subject range. Superannuation, investments, loans and credit, financial advice and foreign exchange are among the issues the ISO Scheme deals with on a daily basis. But the greatest proportion of complaints still relate to insurance.

It is fair to say the insurance industry has been under scrutiny in recent years, largely due to the Canterbury experience. However, it is widely agreed that the scale of damage from the Canterbury earthquakes, and the resulting pressure on the insurance industry, is unprecedented. There are still unresolved insurance claims in Canterbury, and the ISO Scheme's Canterbury Earthquake Response Team provides assistance where it can. More than 1,450 earthquake-related complaint enquiries and over 120 formal complaints have been dealt with so far.

In spite of complexities and delays, immense progress has been made in Canterbury, and many insurers have introduced flexible initiatives to get through the remaining claims. In particular,

Southern Response has made the positive move to give the ISO Scheme open ended jurisdiction. The ISO Scheme can become involved at any stage for claims of any value, greatly increasing accessibility to free dispute resolution for Southern Response customers.

More than 1,450 earthquake-related complaint enquiries and over 120 complaints have been dealt with so far.



Paula Rebstock,
ISO Scheme Commission Chair

On accessibility in the broader sense, it is essential, from a Commission perspective, that consumers can access and understand ISO Scheme information. Proactive opportunities are sought to give consumers information via speaking engagements, community forums, information channels, and the media. Upfront information helps consumers make informed choices and avoid future issues.

For the financial services sector, a well informed and well run dispute resolution scheme provides a critical layer of protection. While consumers have access to justice, the industry has an essential indicator of business practice so improvements can be made. Businesses that learn from past complaints, and make improvements as a result, will have a competitive advantage.

The ISO Scheme Participant base has expanded to the current 4,386 financial service providers. We expect and welcome further growth, because the ISO Scheme is sufficiently flexible to respond swiftly to change.

We expect and welcome further growth, because the ISO Scheme is sufficiently flexible to respond swiftly to change.

I want to thank my fellow Commissioners for their insightful governance. I acknowledge the valuable contribution of outgoing Commission Members, Roger Moses and Chris Black. I also warmly welcome our new Commission Member, Denese Bates QC.

Finally, I would like to thank the ISO Karen Stevens for her leadership, Deputy Ombudsman Louise Peters and all ISO Scheme staff for their commitment.

Paula Rebstock,
ISO Scheme Commission Chair

From the Insurance & Savings Ombudsman

The ISO Scheme offers consumers a fair, independent and free service. Complaints resolution is our core business and with 19 years' experience, we are leaders in the field. The ISO Scheme resolved the largest number of complaints since 1998, with 3,215 complaint enquiries and 300 complaint investigations.

An increasing focus for us is on providing our Participants and their customers with information to make informed choices and prevent complaints from arising. When consumers contact us with a complaint enquiry, we are often able to sort out the issues there and then, with a potential complaint stopped in its tracks.

One Christchurch resident's earthquake settlement increased by nearly \$200,000 by getting us involved to help reach resolution before a formal complaint was made.

For Participants, a complaint can be time consuming, costly and difficult to resolve, so learning how to better manage customers' expectations and deliver a better service can improve their business. Most complaints can be avoided with clear processes and good client communication. We provide training and information for our Participants so they can learn from past complaints and better serve their customers.

Our dispute resolution process is the heart of the ISO Scheme. We provide an independent, impartial and fair process with the aim of reaching an agreed outcome. Sometimes, an agreement cannot be reached, or we cannot uphold a complaint in a consumer's favour. However, the parties can trust our process to deliver a fair and reasonable

decision. The responses from our Complaint Questionnaires remain very positive about our service, with over 95% of the Complainants who responded saying our service was easy to use.

The ISO Scheme is not a consumer advocate; however, we work with community organisations, including: Citizens Advice Bureau, Community Law, Family Budgeting and, more recently, the Residential Advisory Service in Christchurch. Neither are we part of the financial services industry, but we value relationships with industry groups and associations which share the same members, including: ICNZ, HFANZ, FSC, ANZIIF, IFA, IBANZ and PAA.

Complaints resolution is our core business and with 19 years' experience, we are leaders in the field.



Karen Stevens,
Insurance & Savings Ombudsman

We balance our stakeholder relationships in the same way as we balance our approach to the parties involved in any dispute resolution; we have no vested interest in the outcome of any complaint. The balance of interests is critical to achieving a fair outcome.

We provide training and information for our Participants so they can learn from past complaints and better serve their customers.

Independence is a cornerstone of what we do and one of the guiding principles in the legislation, together with fairness, accessibility, accountability, effectiveness and efficiency. In 2013, the ISO Scheme had its fourth independent public review focussed on “Accessibility” which followed similar reviews in 1998, 2003 and 2008.

We are now actioning the Reviewer’s recommendations to raise the ISO Scheme’s public profile, and to become more accessible. We are in the middle of a major website redevelopment and engaging more regularly with media.

Consumer education is an important part of our role. To stimulate growth in financial markets, consumers need information to make informed choices. Consumers can make better financial decisions when they know about the financial products and the related legal obligations.

Equally, our website information and complaints data is valuable for business practice improvement among our Participants. This ultimately has a flow-on effect for their customers and for the New Zealand economy generally.

The ISO Scheme is well placed for the future. While our core role is resolving complaints, the ISO Scheme will continue to work on improving business practices across the financial sector. Ultimately, improved business practice will instil New Zealand consumers with greater confidence to invest in the financial sector.

None of the work this year would have been possible without the support and guidance of Paula Rebstock and Members of the Commission, and the efforts of staff led by my very able deputy, Louise Peters – my personal thanks to all of them.

Karen Stevens,
Insurance & Savings Ombudsman

Complaint Summary 2014

The ISO Scheme received and resolved the largest number of complaints since 1998, with 3,215 complaint enquiries and 300 complaint investigations.

3,215
complaints
enquiries

810 in writing
2,400 by
telephone
5 “walk-in”

Complaint Enquiries are any questions or issues brought to the ISO Scheme.

Complaints have been accepted by the ISO Scheme for investigation and resolution, by agreement where possible (through negotiation, conciliation, mediation) or by decision.

Status	2013/2014	2012/2013
Complaints carried over from previous year and completed	58	63
Complaints received for investigation	300	274
Complaints under investigation	358	337
Complaints completed during the year	300	279
Complaints for investigation but incomplete at year end	58	58

Received By Sector	2013/2014		2012/2013	
Credit Contracts	5	(2%)	2	(1%)
Financial Adviser	5	(2%)	8	(3%)
Fire and General	188	(62%)	167	(61%)
Health Life and Disability	92	(31%)	86	(31%)
Investment and Savings	1	(0%)	1	(0.5%)
Request for services outside scope	6	(2%)	1	(0.5%)
Superannuation	3	(1%)	9	(3%)
Total	300		274	

Outcomes	2013/2014		2012/2013	
Complaints Upheld	30	(10%)	16	(6%)
Complaints Partly Upheld	11	(4%)	3	(1%)
Complaints Settled *	60	(20%)	55	(20%)
Complaints Withdrawn	3	(1%)	2	(0%)
Complaints Not Upheld	196	(65%)	203	(73%)
Total	300		279	

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

In the year ended 30 June 2014, \$1,942,414 was paid by Participants to consumers who had their complaints considered by the ISO Scheme.

(This does not include weekly disability benefit payments under income protection, superannuation or life policies).

Jurisdiction

In the 2013/2014 financial year, 709 of our complaint enquiries were outside jurisdiction. Of these, 296 were written complaint enquiries and 413 were telephone complaint enquiries.

The most significant group of complaint enquiries outside jurisdiction, related to third party insurance claims (36%). Of these, 28% were commercial/underwriting decisions and, for 30%, the financial services provider was not a Participant.

Timeliness

The average time to close the 300 complaints was 91.28 days (down from 94.85 last year), from the date we received the Participants file through to closure.

Systemic Issues and Breaches

We raised a potential systemic issue with a Participant about the way a policy excess was being applied. The Participant reviewed its procedures and agreed to amend the way the excess was applied to all future claims. It also contacted customers who had been required to pay the excess and provided refunds.

Since the ISO Scheme was established in 1995, it has responded to 45,894 complaint enquiries and investigated 5,182 complaints.

How we get our message into the community

With the right knowledge, consumers can understand their options, and make more informed choices. Proactive opportunities are sought to present information, as preventing complaints is as important as resolving complaints.

In 2013/2014

3,215
complaint enquiries

We dealt with 2,400 telephone, 810 written and 5 'in person' complaint enquiries.

29 speeches
& presentations

were delivered nationwide.

43,309
website visits

This is a monthly average of 3,609.
www.iombudsman.org.nz

7,627 calls

were received on our freephone number:
0800 888 202

1,000 info sheets
& brochures

were distributed to consumer groups nationwide.

44 media interviews

The Insurance & Savings Ombudsman provided media interviews on a range of consumer topics. Our media releases covered issues such as floods and cyclones; sum insured house insurance; KiwiSaver withdrawals; contents, travel, health and vehicle insurance; and financial advice complaints.

Website Redevelopment

We initiated a website redesign to make it easier for people to understand and access the ISO Scheme, and to find what they are looking for.

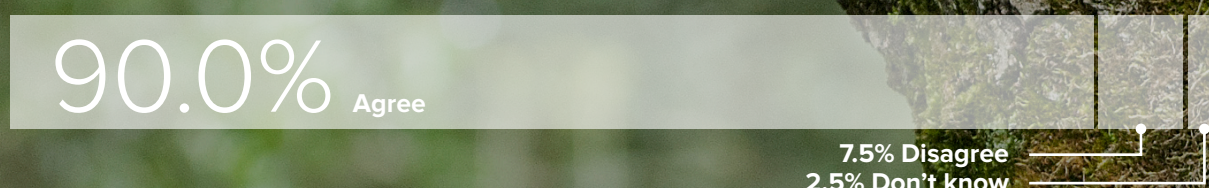
Community Outreach

Consumer outreach is an important part of our work. Activities we have been involved in this year include: working with CERA's Residential Advisory Service in Christchurch; presentations to the NZ Police Welfare Division, Christchurch; discussions with industry groups such as Workplace Savings; and presentations to community groups, such as Cancer, Palmerston North Community Group and Probus.

How do people rate us?

Questionnaires are sent to all those who have had complaints formally investigated. Their responses provide valuable feedback.

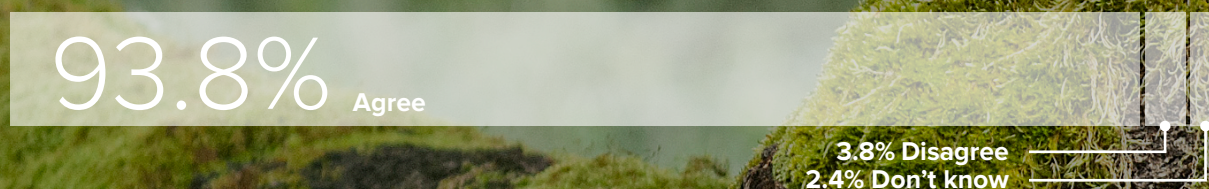
When you first contacted us, the ISO staff member gave you a clear explanation about the ISO Scheme's process.



The ISO Scheme's forms were easy to understand.



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



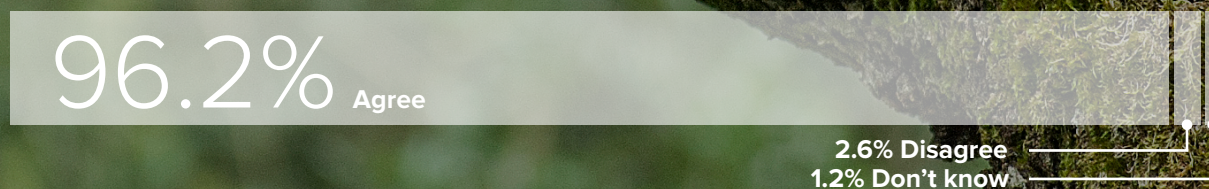
The ISO Scheme kept you well informed about progress.



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



The ISO Scheme's service is easy to use.

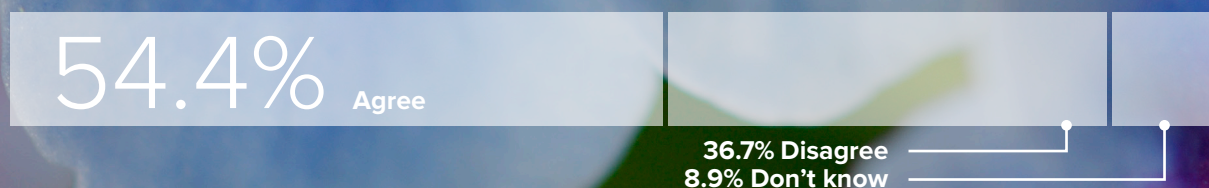


Informing customers about complaints processes

Financial Services Providers are required to have a complaints process, and to publicise this to their customers. ISO Scheme Participants must inform their customers that they are an ISO Scheme member. Including this information on websites and other material promotes good business practice.

Questionnaires are sent to all those who have had complaints formally investigated. Their responses provide valuable feedback.

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 chose the ISO Scheme because it was an established body with a depth of knowledge and capacity in dealing with financial service complaints and consumers.”

Rebecca Thomas
Chief Executive Officer, Mint Asset Management

Membership

ISO Scheme membership has rapidly expanded from 47 in 2010 to our current 4,386 Participants. This includes providers of insurance, investments, loans and credit, superannuation, financial advice and foreign exchange.

As at 30 June 2014, ISO Scheme Participants consisted of: 3,619 individuals, including nominated representatives of Qualifying Financial Entities (QFEs); 698 adviser businesses and other financial service providers; 60 insurance and savings companies; and 9 superannuation schemes.

As our Participant base continues to grow, the priority is to consistently provide support, guidance and professional development opportunities. Preventing complaints is as important as resolving complaints. Therefore ISO Scheme training focuses on how to avoid issues and improve business practices.

Complaints data and information is shared with our Participants via:

- Case Studies on our website
- Our Participant-only website
- Our bi-monthly Participant newsletter 'Assessment'
- Free on-line training about complaint handling
- ISO Webinar training focusing on lessons learnt from complaints
- Face-to-face training on complaint handling and specific issues

ISO Webinars are available for Participants in collaboration with the Institute of Financial Advisers (IFA). **We were delighted with the response this year, with 837 people attending 11 ISO Webinars.** As well as providing useful tips and information, this professional development contributes to Code Structured CPD credits.

Training details, resources and information are available from the Participant website, which is accessible via login from the main ISO Scheme website.

While many Participants will never have a complaint formally investigated, belonging to an established dispute resolution service helps protect the industry and customers.

The ISO Scheme membership team, Penelope England and Felicity Bunny, look forward to supporting all current and future Participants.

“ *In my dealings with the membership team I have found them to be professional, proactive and above all, deliver a quality service. They are a pleasure to deal with.* ”

Bryce Marsden,

Chief Operating Officer, Milford Asset Management Limited

Contact

0800 888 202 or

membership@iombudsman.org.nz



Case Studies

1. House insurance – Canterbury Earthquake
2. Financial Adviser – extent of liability
3. Credit Contracts – contract interpretation
4. Travel Insurance – pre-existing condition
5. Health Insurance – exclusion
6. Health, Life and Disability – non-disclosure

1. House insurance – Canterbury Earthquake

Mr and Mrs Smith's* home was damaged in the Canterbury earthquakes. It was in the Red Zone and assessed as a rebuild.

The insurer, ABC*, costed the rebuild at \$390,311, but the Smith's Quantity Surveyor, Bill*, costed the rebuild at \$638,414. On the basis of Bill's report the Smiths challenged ABC's rebuild costings. ABC revised its rebuild costings to \$409,319.

The ISO Scheme Case Manager aimed to resolve the complaint through mediation to reach an agreed outcome.

The Smiths were under significant financial pressure. Their bank would not agree to assign the mortgage, as required to complete the CERA Red Zone offer, without the insurance claim being resolved. CERA advised the Smiths they were in default under the agreement to buy their land, and CERA reserved the right to charge penalty interest or issue a settlement notice. The Smiths took out a bridging loan to purchase a new house, as they could not live in the property. Their mortgage lender was threatening to foreclose on that mortgage. The Smiths faced bankruptcy.

On 16 September 2013, after attempting to resolve the severe financial pressure on the Smiths by agreement with ABC, the Case Manager issued an interim decision requiring ABC to pay a lump sum directly to the Smiths equal to the costs for which it had acknowledged liability.

The Case Manager reviewed Bill's rebuild estimate and identified items that were out of scope under the policy and ABC's Quantity Surveyor identified the items that he thought were out of scope or unreasonable.

On 27 September 2013, the Case Manager facilitated a meeting between ABC, the Smiths and Bill to discuss the differences between ABC's and Bill's rebuild estimates. Many of the differences between the two rebuild costings were resolved at the meeting.

Discussions between ABC, the Smiths and Bill continued. ABC revised its costings and, on 20 December 2013, ABC provided the Smiths with a final rebuild costing of \$446,369. On 21 January 2014, the Smiths agreed to settle the complaint on the basis of the final costing.

Complaint settled

2. Financial Adviser – extent of liability

Charlie* met with P* to discuss a loan for a house. Charlie had already arranged a loan with a bank, but he heard P's radio advertisement, and wanted to see whether P could arrange a loan with a lower interest rate. At the meeting, Charlie discussed whether he could get loan approval.

P gave Charlie various documents, including: an agreement allowing P to proceed with loan approval; an authorisation allowing P to deal with the bank to obtain loan approval; and an agreement with P setting out the fees that would apply.

Charlie took the documents to consider and sign with his wife, Denise*. A few days later, Charlie returned the signed documents to P, and P sent a proposal to the bank, requesting pre-approval of \$220,000 to purchase the house.

The bank sent P confirmation that Charlie and Denise's home loan application had been approved.

Charlie then had another meeting with P to discuss the loan approval, together with the bank's loan conditions. P also calculated whether Charlie could repay the loan within 10 years. At that meeting, Charlie signed a confirmation that stated he wished to "*proceed with [his] goal*".

Two months later Charlie met with P and said he did not want to proceed with the loan. P asked Charlie to pay a fee of \$1,540 for arranging the loan ("the brokerage fee").

Charlie paid P \$500 in cash and signed a receipt that stated it was a mutual settlement of the payment of the brokerage fee. Charlie said he did not believe he was required to pay the fee, because he did not ask P to obtain a loan, or loan approval, for him. Instead, he believed he made an informal enquiry to see what interest rate P would be able to obtain for him, in order to compare it with the loan he had already arranged.

Was P entitled to charge Charlie a fee for arranging the loan?

Whether P was entitled to charge Charlie a fee for arranging the loan depended on the arrangement Charlie and P had in place. There were differing views between the parties about those arrangements.

The documents clearly stated that fees would apply where a loan had been applied for and approved. The agreement also specified the point at which the brokerage fee became payable and that point was when a final approval letter for the loan had been arranged.

The Case Manager believed Charlie entered into an arrangement with P that included terms, whereby, if P arranged the final approval for a loan and Charlie did not draw the loan down, Charlie would pay a fee related to the brokerage P would have received, had the loan been drawn down.

Charlie said he contacted P to find out about interest rates, and he was not aware that P was going to apply for a loan on his behalf.

However, the documents Charlie and his wife signed specifically authorised P to apply for a loan on their behalf. While Charlie said the documents were not explained to him, he was given the documents to take home, sign and return. The Case Manager believed that Charlie had the opportunity to read and understand the documents, or request further clarification from P.

In the absence of any other evidence, the Case Manager had to rely on the documents. When Charlie signed the documents, he authorised P to apply for a loan on his behalf; P acted on that authorisation. On that basis, the Case Manager believed that P was entitled to charge Charlie a brokerage fee for arranging a loan and that, based on the arrangement Charlie and P had in place, the fee it could charge was 0.7% of \$220,000 or \$1,540.

Did the receipt record the arrangement Charlie came to with P for paying the fee?

Charlie also complained about paying the fee, on the basis that it was not “mutually agree[d]” or justified. The Case Manager believed the agreement allowed P to charge Charlie a brokerage fee of \$1,540. However, Charlie paid P \$500.

As the oral evidence about how the fee arrangement came about was contradictory, the Case Manager had to rely on the documents provided.

The receipt Charlie signed in October 2013 recorded the payment of the fee as an “... amount received towards payment of fee for arranging your home loan ... in terms of mutual agreement dated 23.08.13 (Discounted from \$1540 to \$500 as per mutual settlement)”. In all the circumstances, the receipt appeared to record Charlie’s agreement with P i.e. to pay the amount of \$500 as a discounted settlement of the brokerage fee.

Complaint not upheld

3. Credit Contracts – contract interpretation

ABC Limited* provided Linda* with a personal loan of \$3,000. Linda’s mother’s vehicle was provided as security for the loan.

Three months later the vehicle was involved in an accident and was a “total loss”. The insurer indicated that it would pay the insurance money to ABC Limited.

ABC Limited offered to apply \$2,000 to the loan, rather than the full settlement amount. Linda’s mother did not want any of the insurance money paid to ABC Limited, because she believed it was not her loan. ABC Limited then offered to vary the contract, release the security over the vehicle without payment and continue with the loan unsecured. Linda and her mother refused to sign the contract variation. They argued that Linda’s mother was a guarantor under the contract, not a co-borrower and, therefore, Linda’s mother should be entitled to the insurance money.

Linda’s mother signed the contract as a co-borrower and, therefore, she was a co-borrower under the contract. However, even if she had been a

guarantor rather than a co-borrower, in accordance with the terms of the contract, ABC Limited would have still been entitled to the insurance money.

The Case Manager explained to Linda and her mother that ABC Limited’s offer to vary the contract (which meant Linda’s mother could keep the insurance money and Linda could continue with the loan unsecured) was very reasonable.

Complaint not upheld

4. Travel Insurance – pre-existing condition

When Conrad* was hospitalised with an infection in his artificial hip joint and was unable to travel, he made an insurance claim for his prepaid travel costs. Conrad’s insurer declined the claim, on the basis that his artificial hip joint was not a “*controlled*” condition covered by the policy, because it related to a pre-existing condition, and claims arising from pre-existing conditions were not covered.

The policy automatically provided cover for a list of conditions (including joint replacements), provided they met the policy’s definition of “*controlled*”. To be “*controlled*”, the joint replacement (among other criteria) must not have been “*medically related to a Pre-Existing Condition*”. The policy stated that if the joint replacement was not a controlled condition, it would be a pre-existing condition (and, therefore, claims “*arising directly or indirectly*” from it would be excluded).

Given the broad nature of the policy’s definition of “*Pre-Existing Condition*”, the Case Manager had concerns that most (if not all) hip joint replacements would be medically related to a pre-existing condition. Therefore, it was confusing for customers to include (hip) joint replacements in a list of conditions automatically covered by the policy.

The insurer agreed that the wording of the policy needed to be changed. Both parties agreed to a resolution where the insurer paid Conrad’s prepaid travel costs on an *ex-gratia* basis.

Complaint settled

5. Health Insurance – exclusion

A gastrointestinal and hepatobiliary surgeon recommended Bob* have gastric bypass surgery to either resolve or improve Bob's diabetes. The surgeon wrote to Bob's health insurer to seek coverage for the surgery. The surgeon advised that the surgery may bring about some weight loss, but was being performed specifically to "*ameliorate or improve [Bob's] type 2 diabetes and metabolic status*". The claim was declined on the basis of a policy exclusion for "*Treatment for weight reduction (including surgery, whether recommended or not)*".

After having the surgery, Bob made a complaint. The Case Manager was satisfied that Bob had established a *prima facie* claim, as the policy provided cover for "*general surgery*". Therefore the insurer was obliged to prove that the exclusion applied.

Although gastric bypass surgery is often undertaken to achieve weight loss, in this case the surgery was recommended to treat Bob's diabetes. It was not "*treatment for weight reduction*".

The surgeon confirmed that gastric bypass surgery has been shown to eliminate or substantially improve patients' diabetes regardless of any weight loss. He further stated "*we and many other groups around the world have recognised and published that type 2 diabetes can resolve, and frequently does resolve, within one week of gastric bypass surgery, long before any major impact on weight. This ... is no longer contested, or contestable.*"

Within days of the surgery, the glucose levels in Bob's blood had substantially reduced, he had reduced his medication by two-thirds, and his diabetes was under control.

The Case Manager was satisfied that the surgery was not "*treatment for weight reduction*", particularly in light of the surgeon's comments that the impact on diabetes was not dependent on any weight loss. The insurer could not prove the application of the exclusion.

Complaint upheld

6. Health, Life and Disability – non-disclosure

Mary* went to her bank and, with the help of a bank employee, completed an application for life, critical illness, temporary disability and redundancy covers.

Four years later when Mary was diagnosed with breast cancer, she made a critical illness claim to the insurer XYZ*. The claim was declined and the policy avoided by XYZ, on the basis that Mary had failed to advise she had consulted her doctor about, and received treatment for, anaemia.

Non-disclosure

The policy application asked if she had "... ever had ... any blood disease or disorder, raised cholesterol, anaemia, haemophilia or leukaemia". Mary's answer was recorded as "No".

Medical evidence showed that Mary had a history of anaemia during 2005 – 2008 caused by heavy menstrual bleeding. The question was whether that was material information she should have disclosed.

An insured has a common law duty of good faith to disclose any information, within his/her actual knowledge, which may be material to a prudent insurer. A fact is material if it would influence the mind of a prudent insurer in deciding whether or not to accept an insurance application and on what terms. Whether a particular fact is material depends upon the circumstances of the case. However, an insured person can only disclose the information about which she knows.

Knowledge

Mary was born in Tonga and stated in her complaint that she did not understand English well. Mary's lawyer, who acted as her representative in the ISO Scheme complaint, stated she did not believe Mary would "have understood any of the medical terms in the application" and that Mary "... didn't even understand the concept" of anaemia.

Mary's doctor said Mary would not necessarily have recognised what she had as being anaemia. He also said when Mary was diagnosed with breast cancer, the oncology department organised an interpreter for the discussion about chemotherapy.

XYZ checked with the bank employee, who said he was confident Mary understood all questions asked when completing the application. XYZ also checked with another bank employee who helped Mary with earlier personal loan applications and reported she believed that, in the main, Mary had a reasonable grasp of English but did occasionally require a more detailed and careful explanation around some points.

Taking all of the available evidence into account, the Case Manager did not believe that Mary “knew” she had previously had anaemia. Even if she did, the Case Manager did not believe Mary had sufficient English to be able to identify its medical name on the application form. Consistent evidence showed Mary had difficulty understanding English, especially technical terms.

The Case Manager did not believe that Mary failed to disclose material information, or that XYZ could avoid the policy on the grounds of non-disclosure.

Fair and reasonable

Decisions made by the ISO Scheme must be fair and reasonable in all the circumstances, taking into consideration certain factors. In this case the most relevant factors were:

1. the educational, cultural and personal circumstances of Mary; and
2. the degree to which XYZ was in control of the systems and procedures which were the subject of the complaint.

Mary ceased formal education at about intermediate school level in Tonga. Mary did not approach the bank to purchase the policy. This was relevant because, where a person is sold a policy they have not actively set out to purchase it. They are likely to be more reliant on the seller, and the seller cannot rely on the purchaser having made their own enquiries, or having a general understanding of the policy or their obligations.

The bank controlled the sales process, including the fact that the bank employee completed the application for Mary. Had Mary been given a blank form, it would have become obvious whether she

understood English well enough to understand and answer the technical questions. Accordingly, the sales process, together with the bank’s procedure to complete the form on Mary’s behalf, significantly contributed to the result in this case.

In all the circumstances, and based on the information set out above, the Case Manager did not believe it was fair or reasonable for XYZ to rely on Mary’s non-disclosure to decline the claim and avoid the policy.

Complaint upheld

** Names have been changed to preserve anonymity.*

“ The service was excellent – our case manager and others were always helpful, professional and clear in their communications. Importantly they were also empathetic to our situation which we were grateful for. We really appreciate the help (and understanding) we received. Thank you.”

**“ Thank you
very much for
a wonderful
piece of
negotiation.
We are very
grateful.”**

**“ I was
delighted
with the open,
transparent,
friendly
approach.
It helped
enormously.”**

“ The ISO scheme is
very good as it saves
people’s money and
time to go through
legal procedures.”

“ Disappointed with
outcome but satisfied
that all areas were
covered fairly.”

“ I appreciate having
an independent
service to investigate
a complaint impartially
and free of charge.”

“ Thanks ISO Service.
My complaint was not
upheld but oh well ...
I have learnt my lesson.”

“ To people like myself
without the expertise
and funds for lawyers
it is good to know that
this service is available.”

Financials

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Directory

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2014

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 Limited
Wellington

8. Bankers

ANZ Bank Limited
Wellington

Statement of Financial Performance

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2014

Income	30 June 2014	30 June 2013
Revenue		
Financial Advisor Complaint Fees	2,000	8,000
Interest Received	65,213	56,961
Levies – Existing Participants	1,190,472	1,207,500
Levies – New Participants	942,953	928,142
Sundry Income	1,335	309
Workshop Income	8,251	4,667
Total Revenue	2,210,223	2,205,579
Total Income	2,210,223	2,205,579
Gross Profit	2,210,223	2,205,579
Less Operating Expenses		
Administration	234,326	208,664
Audit	5,600	6,000
Commissioners Expenses	111,061	97,815
Depreciation	42,494	70,126
Occupancy	165,285	163,181
Professionals & Consultancy	85,710	68,602
Promotion	17,074	8,335
Staff Costs	1,454,496	1,195,650
Total Operating Expenses	2,116,046	1,818,372
Net Profit	94,177	387,206

Statement of Movements in Total Funds

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2014

Funds	30 June 2014	30 June 2013
Opening Balance	959,055	571,849
Plus Movement for the Year		
Current Year Earnings	94,177	387,206
Total Movement for the Year	94,177	387,206
Total Funds	1,053,232	959,055

Statement of Financial Position

Insurance & Savings Ombudsman Scheme Inc.

As at 30 June 2014

Assets	30 June 2014	30 June 2013
Current Assets		
Accounts Receivable	3,509	1,324
Accrued Income	28	8,153
Cash and Bank Balances ¹	1,176,545	330,783
Current Investments	–	712,036
Petty Cash	1	73
Prepayments	20,006	14,253
Taxation ²	18,463	6,534
Total Current Assets	1,218,552	1,073,157
Fixed Assets		
Fixed Assets as per Schedule ³	31,951	61,735
Total Fixed Assets	31,951	61,735
Total Assets	1,250,503	1,134,892
Liabilities		
Current Liabilities		
Accounts Payable	171,619	177,485
Credit Cards	9,818	16,194
GST	724	(17,842)
Income Invoiced in Advance	15,108	–
Total Current Liabilities	197,270	175,837
Total Liabilities	197,270	175,837
Net Assets	1,053,232	959,055
Equity		
Accumulated Funds	1,053,232	959,055
Total Equity	1,053,232	959,055

Notes: 1. Refer to Note 9, 2. Refer to Note 12, 3. Refer to Note 10

Signed by:

Insurance & Savings Ombudsman

Date:

9 September 2014

ISO Scheme Commission Chair

Date:

9 September 2014

Notes to the financial statements

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2014

1. Statement of 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.

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

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 Profit and Loss Statement.

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. Revenue

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

9. Cash and Bank

	June 2014	June 2013
Petty Cash	1	73
ANZ – Cheque	9,846	3,845
ANZ – Call	88,148	314,645
ANZ – Serious Saver – 29	1,078,551	–
Total	1,176,546	318,563

10. Fixed Assets

	June 2014	June 2013
Office & Computer Equipment		
Office & Computer Equipment – At Cost	347,265	335,575
Office & Computer Equipment – Accumulated Depreciation	(325,796)	(284,397)
Total	21,469	51,178
Furniture & Fittings		
Furniture & Fittings – At Cost	17,707	16,687
Furniture & Fittings – Accumulated Depreciation	(7,225)	(6,130)
Total	10,482	10,557
Total Fixed Assets	31,951	61,735

11. Investments

	June 2014	June 2013
Current		
ANZ Term Deposit – 1014	–	509,154
ANZ Term Deposit – 1016	–	202,882
Total Current	–	712,036
Total Investments	–	712,036

12. Taxation

	June 2014	June 2013
Net surplus / (deficit) per financial statements	94,177	387,206
Add back		
Non-deductible expenditure	2,112,787	1,815,525
Deduct		
Non-assessable income	2,145,038	2,148,618
Losses carried forward	465,270	519,384
Total assessable surplus/(deficit)	(403,344)	(465,271)
Tax effect	–	–
Add back		
Other income	–	–
Tax credits foregone	–	–
Deduct		
Resident withholding tax paid	18,463	6,534
Terminal tax due / (refund due)	(18,463)	(6,534)

Income tax losses available to be carried forward total \$403,344 (Last year: \$465,270)

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.

13. Operating Lease Commitments

	June 2014	June 2013
Current Portion	147,165	147,165
Non-Current Portion	61,319	208,484
Total	208,484	355,649

The Existing operating lease expense expires on 30 November 2021. The lease has two right 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.

14. Audit

These financial statements have been subject to audit, please refer to Auditor's Report.

15. Contingent Liabilities

At balance date contingent liabilities have been estimated at \$nil (2013: \$nil).

16. Capital Commitments

Capital commitments at balance date are \$nil (2013: \$nil).

17. Subsequent Events

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

18. Related Parties

The following Commission Members of the Insurance and Savings Ombudsman Scheme Inc hold positions of responsibility at the listed entities. The Scheme also received Levies Income from these entities:

- Martin Stokes is the Chief Executive Officer of Medical Assurance Society NZ Limited.
- Nigel Tate is a Director of Nigel Tate Financial Planning.
- Chris Black is the Chief Executive of Farmers Mutual Group.

19. Employees Remuneration

There are two employees who earn over \$100,000 per year.



Independent Auditor's Report

To the Members of the Insurance & Savings Ombudsman Scheme Incorporated

For the year ended 30 June 2014

Report on the Financial Statements

We have audited the financial statements of the Insurance & Savings Ombudsman Scheme Incorporated on pages 19 to 23, which comprise the statement of financial position as at 30 June 2014, and the statement of changes in equity, and statement of comprehensive income (single statement approach), 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 Incorporated. 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 Responsibility for the Financial Statements

The Members of the Commission 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 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.

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

Opinion

In our opinion, the financial statements on pages 19 to 23, present fairly, in all material respects, the financial position of the Insurance & Savings Ombudsman Scheme Incorporated as at 30 June 2014, and its financial performance for the year then ended in accordance with generally accepted accounting practice in New Zealand.

BDO Wellington

9 September 2014

Wellington

New Zealand





INSURANCE & SAVINGS
OMBUDSMAN

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

PO Box 10-845, Wellington 6143, New Zealand

Phone 04 499 7612 **Fax** 04 499 7614 **Freephone** 0800 888 202

Website www.iombudsman.org.nz **Email** info@iombudsman.org.nz