



INSURANCE & SAVINGS
OMBUDSMAN

Annual Report 2015

Celebrating 20 years

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

Contact us now.

Phone: 0800 888 202

The Insurance & Savings Ombudsman Scheme

For 20 years, the ISO Scheme has been providing an independent, impartial and free dispute resolution service for consumers.

We resolve complaints and respond to enquiries about:

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

Since the ISO Scheme was established in 1995, it has responded to 48,951 complaint enquiries and investigated 5,496 complaints.

Negotiation, conciliation and mediation are used to reach an agreed resolution. If the ISO Scheme is required to make a decision it is binding on a Participant but not on a consumer.

4,326 Participants

The ISO Scheme currently has 4,326 Participants, which provide financial services throughout New Zealand. We can only formally investigate a complaint if it involves a Participant of our scheme.

ANZOA

The Ombudsman, Karen Stevens, is a member of the Australian and New Zealand Ombudsman Association (ANZOA). Established in 2003, ANZOA is a professional association and the peak body for Ombudsmen in Australia and New Zealand. ANZOA members are individual Ombudsmen working in not-for-profit, industry-based, parliamentary and other statutory offices. ANZOA members observe the benchmarks for industry based Customer Dispute Resolution (CDR Benchmarks): independence, accessibility, fairness, accountability, efficiency and effectiveness.

See: www.anzoa.com.au

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ISO Scheme 20 years

62 Participants
176 Complaints
515 Complaint enquiries

1995



ISO Scheme established as an industry based dispute resolution scheme for the insurance industry. Commission and Board are 2 tier governance bodies.

Terry Weir appointed Insurance & Savings Ombudsman.

Dr Mervyn Probine CB, FRSNZ, Chair.

97



Independent public review.

98



Karen Stevens appointed Insurance & Savings Ombudsman.

51 Participants
252 Complaints
2,359 Complaint enquiries

2000



Beverley Wakem DNZM CBE, Chair.

ISO is a founding member of the Australian and New Zealand Ombudsman Association (ANZOA).

Independent public review.

03



50 Participants
178 Complaints
1,900 Complaint enquiries
\$660K paid to consumers

2005



Alison Timms, Chair.

ISO Scheme is a founding member of the International Network of Financial Services Ombudsman Schemes.

07



08



Independent public review.

09



Paula Rebstock CNZM, Chair.

47 Participants
277 Complaints
1,984 Complaint enquiries
\$1.8M paid to consumers

2010



ISO Scheme becomes an approved dispute resolution scheme under the Financial Service Providers (Registration and Dispute Resolution) Act 2008 (FSP Act).

Expansion to include all financial service providers.

13



Independent public review.

4,326 Participants
254 Complaints
3,057 Complaint enquiries
\$2.6M paid to consumers

2015



Commission becomes a single governance body.

ISO Scheme becomes the **Insurance & Financial Services Ombudsman Scheme** on 1 November 2015 to reflect our expanded membership.



Paula Rebstock

ISO Scheme Commission Chair

This year the ISO Scheme celebrates 20 years of providing a high quality dispute resolution service for insurance and financial services.

Our particular strength is the wealth of knowledge gained from 20 years of resolving complaints in the financial sector.

This year we consulted on changes to our Terms of Reference and Constitution, to align our rules with updated legislation, and to further implement recommendations from our independent review. An important change was the move to a unitary governance structure, with the disestablishment of the Industry Board. We appreciated the valuable and encouraging feedback we received throughout the consultation process.

Becoming the “Insurance & Financial Services Ombudsman Scheme Inc.” on 1 November 2015 is another significant change, which more accurately reflects our expanded membership.

We acknowledge the professional relationships we have established with Participants over 20 years in business and, in particular, the original insurance Participants, while maintaining the ISO Scheme’s independence at an operational level. The ISO Scheme’s ability to resolve complaints fairly and independently is crucially important to consumers of financial services in New Zealand.

Paula Rebstock,
ISO Scheme Commission Chair

The ISO Scheme’s ability to resolve complaints fairly and independently is crucially important to consumers of financial services in New Zealand.



Karen Stevens

Insurance & Savings Ombudsman

The celebration of 20 years is a milestone in the life of any business, even more so when that business is an industry based consumer dispute resolution scheme.

The ISO Scheme was set up as a joint initiative between the insurance industry for its customers and the then Minister of Consumer Affairs.

There have been many changes over the 20 years: the move from a voluntary industry scheme to the statutory requirement for approval by the Minister; the change in the governance structure; the expansion of services and number of Participants; the people; the fluctuating numbers of complaints and complaint enquiries; and the increasing complexity of work.

What have not changed are the core principles which guide the ISO Scheme as a dispute resolution scheme: accessibility, independence, fairness, accountability, efficiency and effectiveness.

What have not changed are the core principles which guide the ISO Scheme as a dispute resolution scheme: accessibility, independence, fairness, accountability, efficiency and effectiveness. This year, complaints have decreased in number, but increased in complexity. We have had to be more flexible in our approach to resolving complaints, working on managing expectations and agreeing outcomes to achieve fair and reasonable resolutions.

Good communication is key. We draw on our experience to provide:

- Participants with the knowledge and means to avoid behaviour that can lead to customer complaints; and
- Consumers with knowledge to better understand products and financial services, so they can make more informed choices.

Karen Stevens,
Insurance & Savings Ombudsman

Complaint Summary 2015

The ISO Scheme dealt with 254 investigated complaints, and responded to 3,057 complaint enquiries.

Although complaint numbers are down, the range of complaints was significantly more complex this year, with less complex complaints being resolved before the ISO Scheme was required to carry out a full investigation. Contributing factors to this trend include: changes in industry practice based on complaint experience; complaints being resolved earlier by financial service providers' internal complaints processes; and the ISO Scheme's information and education role helping to resolve issues early and prevent future complaints.

3,057
complaints
enquiries

763 in writing
2,293 by
telephone
1 "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	2014/2015	2013/2014
Complaints carried over from previous year and completed	58	58
Complaints received for investigation	253	300
Complaints under investigation	311	358
Complaints completed during the year	254	300
Complaints for investigation but incomplete at year end	57	58

Received By Sector	2014/2015		2013/2014	
Credit Contracts	5	(2%)	5	(2%)
Financial Adviser	5	(2%)	5	(2%)
Fire and General	132	(52%)	188	(62%)
Health Life and Disability	104	(41%)	92	(31%)
Investment and Savings			1	(0%)
Not regulated financial service – investigation authorised	5	(2%)	6	(2%)
Superannuation	2	(1%)	3	(1%)
Total	253		300	

Outcomes	2014/2015		2013/2014	
Complaints Upheld	3	(1%)	30	(10%)
Complaints Partly Upheld	10	(4%)	11	(4%)
Complaints Settled *	56	(22%)	60	(20%)
Complaints Withdrawn	3	(1%)	3	(1%)
Complaints Not Upheld	182	(72%)	196	(65%)
Total	254		300	

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

In the year ended 30 June 2015, \$2,613,410 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 2014/2015 financial year, we received 753 complaint enquiries outside jurisdiction. Of these, 187 were written complaint enquiries and 566 were telephone complaint enquiries.

The most significant group of complaint enquiries outside jurisdiction related to enquiries where the financial service provider was not a Participant (42%), third party insurance claims (33%), and 20% being commercial/underwriting decisions.

Timeliness

The average time to close the 254 complaints was 88.89 days (down from 91.28 last year), from the date we received the Participant's file through to closure.

Systemic Issues and Breaches

We queried practices with 2 Participants, however, no systemic issues were identified.

Since the ISO Scheme was established in 1995, it has responded to 48,951 complaint enquiries and investigated 5,496 complaints.

Since 2010, more than 1,570 Canterbury earthquake complaint enquiries and over 140 complaints have been dealt with by the ISO Scheme.

Getting our message into the community

We want consumers to understand their options, make informed choices and avoid future issues. Providing information and sharing knowledge is an important role for the ISO Scheme, because preventing complaints is as important as resolving complaints.

In 2014/2015

3,057
complaint enquiries

we dealt with 2,293 telephone, 763 written and 1 'in person' complaint enquiries.

40 speeches,
presentations
& webinars

were delivered nationwide.

47,473
website visits

This is a monthly average of 3,956.
www.iombudsman.org.nz

7,297 calls

were received on our freephone number:
0800 888 202

1,500 info sheets
& brochures

were distributed to consumer groups nationwide.

30 media interviews

were provided by the Insurance & Savings Ombudsman on topics including: non-disclosure in insurance; floods; Canterbury earthquakes; jewellery insurance; travel, health and motor vehicle insurance; and financial advice complaints.

4
website video clips

were created for consumers, community organisations and Participants to explain our service and the complaints process, and to encourage contact.

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.

96.0% Agree

2.0% Disagree
2.0% Don't know

The ISO Scheme's forms were easy to understand.

89.8% Agree

6.1% Disagree
4.1% Don't know

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

91.9% Agree

2.0% Disagree
6.1% Don't know

The ISO Scheme kept you well informed about progress.

87.8% Agree

12.2% Disagree
0% Don't know

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

87.3% Agree

10.6% Disagree
2.1% Don't know

The ISO Scheme's service is easy to use.

93.6% Agree

4.3% Disagree
2.1% Don't know

Informing customers about complaints processes

Financial Service Providers are required to have a complaints process and to publicise it to their customers. ISO Scheme Participants must inform their customers about the ISO Scheme. 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.



“Sovereign values the ISO Scheme’s increased effort to communicate and discuss their approach during the decision making process. In a recent consultation on changes to its Terms of Reference and Constitution, the ISO Scheme provided Participants with real depth of opportunity to put forward their views, ensuring a meaningful hearing and consideration of consumer and Participant needs.”

Daimhin Warner

Customer Governance & Privacy Manager, Sovereign

Membership

The ISO Scheme's 4,300+ Participants include providers of insurance, investments, loans and credit, superannuation, financial advice and foreign exchange.

As at 30 June 2015, ISO Scheme Participants consisted of: 3,465 individuals, including nominated representatives of QFEs; 790 adviser businesses and other financial service providers; 62 insurance companies; and 9 superannuation schemes.

We provide added value to our Participants, in a variety of different ways:

- a monthly e-newsletter for Participants, **launched in November 2014**
- Participant-only web area and online resources, **launched in April 2015**
- webinar training focused on lessons learnt from complaints, data and trends
- face-to-face training on complaint handling and specific issues
- case studies on our website from 2000 to date.

Continuing professional development opportunities provide Participants with the help they need to prevent disputes from arising, and to resolve any that do arise. There were **557 Participants** who attended our **10 webinars**, which are run in collaboration with the **Institute of Financial Advisers** (IFA). In addition, we have partnered with **Professional IQ College** to provide training to **IBANZ** members, with **8 webinars** for more than **150 attendees**.

This year we co-hosted a series of successful workshops on managing customer interaction, facilitated by Dr Grant Lester, Forensic Psychiatrist, from Melbourne with more than 270 attendees. We also ran an industry discussion forum in Auckland for Participants as part of our 20th anniversary celebrations.

The ISO Scheme membership team look forward to working with all current Participants, and those who will join us this year. We welcome your contact.

“ *On-going professional development is important, and the ISO Scheme has provided a number of excellent webinars again this year. As we are ‘frequent flyers’ at webinars, the membership team sought feedback about the value this was adding, and offered customised training to our QFE advisers. This is certainly an example of proactive engagement from the ISO Scheme.”*

Brent Ballantyne,
General Manager Client Contact,
Partners Life Limited

“ *Karen Stevens and Virginia Douglas presented with enthusiasm and humour at adviser training clinics we ran around the country. Feedback was overwhelmingly positive and advisers came away with a good understanding of what the ISO Scheme does, and how important it is to manage customer expectations.”*

Bob Frost
Head of Quality Advice Network,
AMP

Contact

0800 888 202 or

membership@iombudsman.org.nz



“ Being independent, the ISO scheme case manager explained points of view from both sides, unbiased.”

“ Very grateful for ISO efficiency, communication and impartial opinion.”

“ On every occasion we felt that our complaint was handled in a reasonable time with all due care.”

“ I was kept well informed of the process and have great respect for the conclusion regardless of the result as the process was extremely thorough and the objective well set out regardless of each party’s opinion.”

“ I didn’t get the result I wanted but I am happy with the process.”

Case Studies

1. House insurance – Canterbury Earthquake
2. Motor Vehicle Insurance – duty of reasonable care
3. Financial adviser – fees
4. Superannuation – responsibilities to members
5. Trauma Insurance – policy terms
6. Credit contract – liability for unauthorised transactions
7. Non-disclosure - 3 case studies

House insurance – Canterbury Earthquake

The ISO Scheme is taking a more active approach to helping Participants and their customers resolve issues and settle Canterbury Earthquake claims. Our mediation, negotiation and facilitation experience helps to resolve issues and finalise claims.

Following the earthquakes, Mr and Mrs Thompson* made claims to their insurer for the damage to their house. Subsequently, the house was red-zoned by the Canterbury Earthquake Recovery Authority (CERA) and, as a result, Mr and Mrs Thompson wished to build a new home on another site.

During its investigation and assessment of the damage, the insurer established that the house was underinsured by 21 m². However, when Mr Thompson met with the insurer, it agreed to waive the underinsurance and also committed to making an allowance of \$25,000 for enhanced foundations.

The insurer initially agreed to Mr and Mrs Thompson's claim being settled by way of a rebuild within its Works Programme and a builder was engaged to undertake the work. A scope of works was provided, which indicated a rebuild rate of \$1,745 per m², but Mr Thompson did not believe that this was adequate to reinstate his house.

The builder subsequently declined to work with Mr Thompson, on the basis that he did not consider there would be a viable working relationship. Mr Thompson indicated he did not consider the builder capable of building to the required specifications.

The insurer allocated the rebuild to another builder, so that the house rebuild could still be completed as part of its Works Programme. As a condition of entering the programme, Mr and Mrs Thompson were asked to sign a Customer Authorisation Letter. Mr Thompson disputed several aspects of the letter and, despite the insurer amending the letter, it was never signed.

Due to the history of the claim, Mr Thompson's refusal to sign the letter and the inability of the parties to agree to a way forward, the insurer believed it would not be possible to progress the claim within its Works Programme. Therefore, the insurer elected to settle Mr and Mrs Thompson's claim by making a full and final cash settlement, in accordance with the policy terms.

The insurer offered to cash settle the claim at a rebuild rate of \$2,100 per m², based on advice from the second builder. As part of the settlement offer, the insurer agreed to waive the underinsurance of 21 m² (valued at \$44,940) and to include an allowance of \$25,000 for enhanced foundations. The insurer believed the rebuild rate of \$2,100 per m² was generous and sufficient to meet its policy obligations.

Mr Thompson believed the insurer's revised offer was inadequate and sought settlement based on \$2,500 per m². However, Mr Thompson did not provide any evidence to support his claim.

The case manager's role in assisting the parties to settle the complaint

The case manager encouraged Mr and Mrs Thompson to obtain evidence to support their request for an increased build rate. Despite approaching a number of builders, Mr and Mrs Thompson were unable to provide any compelling evidence to satisfy the insurer that it should consider a rebuild rate higher than \$2,100 per m².

While investigating the complaint, the case manager was made aware that the rebuild rate of \$2,100 per m² offered by the insurer included the enhanced foundation allowance of \$25,000. The case manager did not believe this correctly reflected what was advised to Mr and Mrs Thompson at the outset, namely that the foundation cost should be in addition to the rebuild rate of \$2,100 per m², or any subsequent rebuild rate that was determined. After some discussion with the insurer, it agreed with the case manager.

Despite this increased offer from the insurer, Mr Thompson still did not accept that the rebuild rate of \$2,100 per m² was adequate. However, the insurer advised the case manager it was equally adamant that it was adequate. Because both parties were firmly entrenched in their positions, the case manager believed the best way forward was for him to attend a meeting with the parties to facilitate a resolution.

At the meeting, the case manager indicated that it would be difficult to uphold Mr and Mrs Thompson's complaint, because they could not provide any compelling evidence to show that the insurer's offer was inadequate.

Mr Thompson then indicated he was prepared to settle at a rebuild rate of \$2,300 per m², plus out of scope items, foundation allowance and temporary accommodation allowance, less EQC payments and the policy excess. The insurer then agreed to increase its rebuild rate to \$2,150 per m². As a result, the amount in dispute was \$34,710.

Following the meeting, the insurer had a further discussion with Mr Thompson and settlement was agreed on a rebuild rate of \$2,200 per m². Mr and Mrs Thompson signed the insurer's discharge in full and final settlement of the claim.

Complaint settled

Motor Vehicle Insurance – duty of reasonable care

The ISO Scheme considers every case on its facts. As well as focusing on resolving complaints and making decisions, we aim to improve consumer awareness of contract terms and their obligations through our consumer publications and community work.

In June 2014, Barry* made a claim to his insurer, because Helen* had borrowed his vehicle and had picked up a hitchhiker. Helen drove to a friend's house and went inside, leaving the hitchhiker in the vehicle with the engine running. The hitchhiker then drove away in the vehicle.

In July 2014, Barry advised the insurer that the vehicle had been found by the police, who had used road spikes to stop the vehicle, causing significant damage.

When the insurer spoke to Helen to confirm the circumstances of the claim, Helen said she had been alone in the vehicle, and she gave various different versions of what had happened. Eventually she admitted, when directly asked by the insurer, that Barry had provided the correct information to the insurer.

The insurer declined the claim on the basis that Helen had failed to take reasonable care to ensure the safety and security of the vehicle, and she had provided false and misleading information in support of the claim. The insurer said Barry's claims history would not be affected as Helen had provided the incorrect information, and the insurer also said it would have declined the claim even if Helen had been honest.

Barry believed the insurer's decision was incorrect, because he had provided the correct information when he made the claim. Also he said Helen had not been reckless, only naïve and too trusting when she left the hitchhiker in the vehicle.

The case manager's assessment

The policy specified "the reasonable care conditions", in which it excluded cover for loss or damage "caused by, arising from or involving" Barry's or "any driver's failure to take all reasonable steps to ensure the safety and security" of the vehicle. The policy also required that Barry or "any driver must take reasonable care, at all times, to avoid circumstances that could result in a claim".

To decline a claim under this policy condition, an insurer must prove the conduct was reckless, grossly careless, or grossly negligent. Proof of mere negligence or carelessness is not sufficient. Insurance, by its nature, protects against negligence and mere inadvertence.

The New Zealand courts consider what a “reasonable person” would have done in the circumstances of each particular case. It is therefore recognised that an insured person has breached their duty of reasonable care if they disregarded, or failed to recognise, a significant risk that would have been obvious to a reasonable person.

The case manager considered legal precedent about reasonable care conditions and noted that surrounding circumstances in each case must be considered.

Helen left a stranger in the vehicle with the keys in the ignition and the engine running. She took no precautions to ensure that the hitchhiker could not drive away. While Barry believed this was merely too trusting, the case manager considered the legal test and believed that Helen was reckless, grossly careless, or grossly negligent, therefore, breached the reasonable care conditions.

Barry had also argued that the damage caused by the police was not a result of Helen’s actions. However, the policy stated that there was no cover for loss or damage “*caused by, arising from or involving*” the failure to take reasonable care.

The term “*arising from*” means there needs to be a causal connection, but it does not have to be direct. Therefore, after the vehicle was stolen, the subsequent damage caused by the road spikes had arisen from the initial failure to take reasonable care, and was therefore within the exclusion. The insurer was entitled to decline the claim.

Complaint not upheld

Financial adviser – fees

The ISO Scheme considers complaints about all financial services. We apply our experience and expertise to resolve all complaints. We also work with our Participants to share the lessons learnt from complaints to benefit the industry and consumers.

In August 2013, Mr Collins* met with his financial adviser (“the first meeting”) to discuss a loan for a house. Mr Collins had already arranged a loan with a bank but he wanted to see whether the financial adviser could arrange a loan with a lower interest rate.

The financial adviser gave Mr Collins documents at the first meeting, including: a form acknowledging Mr Collins had received specified documents; an agreement with the financial adviser allowing the financial adviser to proceed with the loan approval (“the agreement”); an authorisation allowing the financial adviser to deal with the bank to obtain a loan approval; an agreement with the financial adviser setting out the fees that would apply; and the financial adviser’s disclosure statement (together referred to as “the documents”).

At the end of the meeting, Mr Collins took away the documents to consider and sign and to have his wife sign. Two to 3 days later, Mr Collins returned the signed documents to the financial adviser’s office. Shortly afterwards, the financial adviser requested pre-approval of \$220,000 to purchase the house from the bank. The following day, the loan application was approved by the bank (“the loan approval”).

In late August 2013, Mr Collins had another meeting with the financial adviser, at which he discussed the loan approval, together with the bank’s loan conditions (“the loan conditions”). At that meeting, Mr Collins signed a confirmation that stated he wished to “*proceed with [his] goal*”.

At a later date, Mr Collins provided the financial adviser with the first loan condition, but he did not provide the second loan condition. When the financial adviser called, Mrs Collins said Mr Collins did not wish to proceed with the loan.

In October 2013, Mr Collins met with the financial adviser and confirmed he did not want to proceed with the loan. The financial adviser asked Mr Collins to pay a fee of \$1,540 for arranging the loan that the financial adviser believed was owing under the agreement (“the brokerage fee”).

There was some dispute about what happened after that, however, Mr Collins paid the financial adviser \$500 (“the fee”) in cash and signed a receipt that stated it was a mutual settlement of the payment of the brokerage fee.

Mr Collins complained that he did not believe he was required to pay the fee, because he did not ask the financial adviser to obtain a loan, or loan approval, for him. Instead, he believed he made an informal enquiry to see what interest rate the financial adviser would be able to obtain for him, in order to compare it with the loan he had already arranged.

The case manager's assessment

There were differing views between the parties about what the verbal arrangements were between Mr and Mrs Collins regarding fees.

The case manager reviewed the documents and believed the agreement clearly stated that fees would apply in a situation where a loan had been applied for and approved, but the applicant did not proceed with it. 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.

Based on this, the case manager believed that Mr and Mrs Collins entered into an arrangement with the financial adviser that included terms, whereby, if the financial adviser arranged the final approval for a loan and Mr and Mrs Collins did not draw the loan down, they would pay a fee related to the brokerage the financial adviser would have received, had the loan, in fact, been drawn down. The documents Mr and Mrs Collins signed specifically authorised the financial adviser to apply for a loan on their behalf.

The case manager believed that by taking the documents home, then returning them signed 2 to 3 days later, Mr Collins had the opportunity to read and understand the documents, or request further clarification from the financial adviser, if he did not understand what they covered or authorised.

The case manager believed that the financial adviser was entitled to charge them the brokerage fee.

The receipt Mr Collins 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)"*. Even though Mr Collins did not believe this agreement was reached by *"mutual settlement"*, the receipt he signed and the fact that he left the meeting to withdraw the fee, then returned and paid it to the financial adviser in cash, did not support Mr Collins's stated position. In all the circumstances, the receipt appeared to record Mr Collins's agreement with the financial adviser i.e. to pay the amount of \$500 as a discounted settlement of the brokerage fee.

Complaint not upheld

Superannuation – responsibilities to members

All providers must carry out their services with reasonable care and skill. However, there will be limitations on what providers can do, so it is important for them to discuss the limitations of their role with their customers from the beginning.

In May 2009, Elaine* transferred her UK Pension to B Ltd* in New Zealand, which was a Qualifying Recognised Overseas Pension Scheme ("QROPS"). In 2013, Elaine withdrew 20% of the funds held by B Ltd, in accordance with the rules of the scheme. In 2014, Elaine requested a full withdrawal from the scheme, as she had been a member of the scheme for 5 years, which was the minimum length of time Elaine was required to remain in the scheme.

On 9 June 2014, B Ltd advised Elaine that the funds would be paid by 15 June 2014. On 12 June 2014, after receiving a notification of a tax penalty for the 20% withdrawal from Her Majesty's Revenue and Customs ("HMRC"), Elaine emailed B Ltd, stating that she would be *"grateful to know"* what the *"HMRC impact"* of the full withdrawal would be.

On 13 June 2014, the full withdrawal payment was made to Elaine's bank account. Later that day, B Ltd advised Elaine that it would reply to her enquiry within the next few business days. B Ltd then notified HMRC that it had made the full withdrawal payment on 19 June 2014.

B Ltd did not reply to Elaine again. Elaine did not contact B Ltd until 2 July 2014, to advise that she had learned she was going to be taxed 55% on the full withdrawal by HMRC.

Elaine believed that B Ltd had failed to provide proper advice to her about her ability to make withdrawals from the scheme; that it had failed to warn her that her UK tax residency might have been reset when she went back to the UK; and, by failing to respond to her email of 12 June 2014, it had failed to prevent the full withdrawal payment being made to her.

The case manager's assessment

Section 28 of the Consumer Guarantees Act 1993 provides a guarantee that *"services supplied to a consumer"* will be *"carried out with reasonable care and skill"*. If there is a failure under section 28, section 32 of the CGA allows for damages for any *"reasonably foreseeable loss"* resulting from that failure.

According to UK tax law, Elaine was subject to a penalty of 55% on a withdrawal, if Elaine had been a UK tax resident at any point in the preceding 5 tax years. Elaine had been in the UK from November 2012 until September 2013 while she arranged for the sale of her house in the UK. Elaine said she had to stay there for longer than planned, because she had suffered an injury and could not return to NZ.

The case manager considered the following “services” provided by B Ltd:

i. Payment of benefits under the scheme

Elaine believed that B Ltd should have warned her about any possible HMRC tax penalties and whether she was able to make the 2 withdrawals from the scheme, under UK tax law.

The case manager did not believe B Ltd was obliged to provide Elaine with any advice, other than the rules for withdrawing the money. Because B Ltd had made the 2 benefit payments in accordance with the rules of the scheme and had acted on Elaine’s instructions appropriately and in a timely manner, the case manager believed B Ltd had not failed to provide this service with reasonable care and skill.

ii. Advice

Elaine noted that she had emailed B Ltd a number of times while she was in the UK, which meant B Ltd had an obligation to warn her to check her UK tax residency status.

As the scheme documents were clear that a member must obtain independent tax advice prior to making withdrawals, the case manager did not believe that B Ltd was required to provide Elaine with UK tax residency information. Accordingly, B Ltd had not failed to provide a service with reasonable care and skill.

iii. Response to emails

Elaine believed that, by failing to respond to her emails of 12 June 2014 and 2 July 2014, B Ltd was largely responsible for the 55% HMRC tax penalty incurred by her.

B Ltd acknowledged that its lack of response to Elaine was poor customer service. Therefore, the case manager considered whether this customer service failure had led to a loss that was “reasonably foreseeable as liable to result from the failure”.

Elaine had not specifically asked B Ltd to stop the full withdrawal payment to her; she had simply asked for information about the “HMRC impact”. Elaine did not immediately contact B Ltd when she discovered the payment had been made to her. If the payment had been reversed, prior to the notification being sent to HMRC, it seemed likely that Elaine would not have incurred the tax charge.

The case manager was unable to find that the failure in customer service had led to a loss that was “reasonably foreseeable as liable to result” from that failure.

Complaint not upheld

Trauma Insurance – policy terms

As an experienced, independent third party, the ISO Scheme can review a claim and facilitate a resolution for a previously unresolvable issue. Our inquisitorial process sometimes involves seeking independent experts’ opinions.

John* had 2 trauma policies, one was a standalone policy and the other was “accelerated”, which meant that, if the benefit was paid, his life insurance reduced by this amount. After having a heart attack, John made claims to his insurer. The insurer declined the claims, because the policies required an elevation of cardiac enzymes above normal, which they did not believe John had.

The case manager’s assessment

Evidence showed John experienced a huge rise in his hs-Troponin-T levels. The issue was whether hs-Troponin-T was a “cardiac enzyme”, as John claimed it was. The insurer argued that hs-Troponin-T is a protein, not an enzyme. Both John and the insurer provided a lot of medical information to support their respective positions. The ISO Scheme obtained an independent opinion from a Cardiologist.

The term “cardiac enzymes” has different meanings in different contexts. The independent Cardiologist said “biochemical purists” would say that Troponins are proteins and do not function as enzymes. However, the insurer’s Cardiologist and the independent Cardiologist agreed that this view changed from 1997, when Troponins began to be used to diagnose heart attacks and the meaning of cardiac enzymes changed to include Troponins.

The insurer agreed to pay the claims after discussing the opinions with the case manager.

Complaint settled

Credit contract – liability for unauthorised transactions

Where an agreed outcome cannot be achieved, the ISO Scheme will provide an independent assessment of a complaint. Case managers focus on explaining the decision to the customer to give them a better understanding of why a decision was reached.

Sharee* held a credit card with a lender. In November 2014, Sharee complained that 35 unauthorised transactions were made in New Zealand with her credit card over a 1 month period, while she was overseas.

Sharee first advised that she had cut up the card before she went overseas, however, she later stated that she had cut up the card when she returned home, after she discovered the unauthorised transactions.

Sharee complained to the police, who confirmed she had been overseas during the time stated and that the use of the credit card was fraudulent. However, because there was a delay before Sharee made the police complaint, there was no CCTV footage available to identify who had used the card, and the police were unable to investigate further.

The lender investigated and found that 32 of the 35 unauthorised transactions were made with the card itself, and were a combination of either PIN number entry or contactless PayWave payments. The remaining 3 transactions were made online, using the CVV number located on the back of the card. The lender believed that Sharee had failed to protect her card from unauthorised use and failed to protect her PIN number from disclosure, which was a breach of the conditions of use. Therefore, Sharee was liable for the unauthorised transactions.

The case manager's assessment

The conditions of use stated that Sharee would be liable for any unauthorised transactions, if she had acted negligently or failed to safeguard the card, or had disclosed the PIN number or allowed someone else to use the card, or if she selected an unsuitable PIN number.

Sharee believed that the lender had mistakenly added the transactions from another account to her account. However, the lender advised that the transactions required the specific card linked to the account and it was not possible to misapply purchases from another account. The lender also advised that it was not possible for the credit card to have been subject to skimming fraud, because

the chip in the actual card was required for the PayWave purchases, and the CVV number located on the back of the card was required for the online purchases. Neither the chip nor the CVV numbers are able to be copied in skimming operations.

Because the actual card had to have been used for the unauthorised transactions, it seemed likely that the credit card was left in New Zealand while Sharee was overseas, and whoever used the credit card had to have had access to Sharee's house to obtain and replace the credit card.

It also seemed likely that Sharee either selected an unsuitable PIN number that someone who knew her was able to guess, or which had been previously disclosed, because the PIN was used in the majority of the transactions, following one initial incorrect attempt to use the PIN at the beginning of the period. As this was a breach of the conditions of use, Sharee was liable for the unauthorised transactions.

However, the lender did agree to reverse all interest charges for the unauthorised transactions, and make the remaining balance on the card interest-free for a further 6 months. The case manager believed this was a fair and reasonable resolution of the complaint.

Complaint not upheld

Non-disclosure - different responses

Over the last 20 years, customers' non-disclosure of material information has been a persistent issue in complaints to the ISO Scheme.

Non-disclosure continues to be a key reason for insurers declining to consider claims and/ or avoiding policies. Insurers' responses to non-disclosure vary: some opt to exercise their legal right to avoid the policy in its entirety; and others adopt a more flexible response, based on what they would have done had the information been disclosed at inception.

While legislation is highly desirable, the ISO Scheme works within the current legal framework for non-disclosure, making decisions that are fair and reasonable in all the circumstances. We aim to improve consumers' understanding of their duty of disclosure and the consequences of failing to disclose material information.

Life insurance

Mrs Smith* died and her son made a claim to her life insurer. The insurer said Mrs Smith had not told it about her diabetes, stress, high cholesterol, high blood pressure and asthma and she had not accurately recorded her weight.

Two independent underwriters confirmed that Mrs Smith's diabetes and high cholesterol were material information.

The insurer offered Mrs Smith's son a reduced payment (to take into account the premiums Mrs Smith would have paid, if the insurer had known her full medical history), plus a goodwill payment of \$10,000. The insurer was not legally obliged to make this offer and the case manager believed this was a fair and reasonable resolution of the complaint.

Trauma insurance

Ms Hill* had a heart attack and made a claim under her trauma policy. The insurer avoided the policy and declined to consider the claim, on the basis that Ms Hill had failed to correctly disclose her level of alcohol consumption when she arranged the policy. The insurer avoided all of the benefits under the policy (including income protection and premium cover), leaving only the life cover in place and it retained the premiums.

During her treatment in hospital for her heart attack, Ms Hill was referred for drug and alcohol assessment. The hospital records contained a note stating Ms Hill consumed more than 7 bottles of wine per week (1 bottle every week night, and 2 bottles each day on the weekend), that Ms Hill's family was concerned she was drinking too much and Ms Hill would like to learn to moderate her consumption.

Ms Hill said the hospital records were not accurate, because they implied she had been drinking heavily for the past 5-7 years, when she had only had periods of heavy drinking, particularly at the time of the Canterbury earthquakes in September 2010 and February 2011.

When Ms Hill completed the insurance application, she said she often drank alcohol and had 2 standard drinks daily. The case manager believed the questions only asked Ms Hill her standard consumption and, therefore, the insurer had limited the scope of its enquiries to exclude other matters, such as historical drinking outside of her current standard consumption. However, the hospital records indicated that Ms Hill's consumption at that time was substantially more than 2 glasses a day.

The case manager also noted that Ms Hill answered the alcohol question in May 2011, about 3 months after the most damaging and significant of the Canterbury earthquakes. Therefore, even if Ms Hill's statements were accepted, the case manager believed that, at the time Ms Hill completed the application, her relatively current, standard consumption of alcohol, would have been higher than she disclosed to the insurer.

Two senior independent underwriters confirmed this level of alcohol consumption was material. The insurer was legally entitled to avoid the policy benefits for trauma, income protection and premium cover, and retain all of the premiums.

Life and loan protection insurance

Ms Green* made a claim to her insurer. She ceased working, because she was suffering from rapid heart rate, hot flushes, headaches, blood pressure issues, sweating, weight gain, fatigue and back pain.

The insurer found that, when she arranged the policy, Ms Green had not told it about a number of blood tests and resulting B12 injections. The insurer avoided the loan protection cover, which meant the claim could not be considered.

On the application, Ms Green was asked whether she had had any medical test or examination in the previous 5 years (disregarding minor ailments such as colds and flu). Ms Green said she had regular medical checks for her job in child care.

In the 5 years prior to arranging the insurance, Ms Green had a number of doctor's consultations and had at least 7 blood tests. The result was that Ms Green was given multiple B12 injections for a number of years.

The case manager did not believe this was a minor ailment such as a cold or flu and these medical examinations were not regular medicals for her job. Because Ms Green did not disclose the material information about her consultations, tests and results on her application, the insurer was legally entitled to avoid the loan protection cover and decline to pay the claim.

** Names have been changed to preserve anonymity*

Full case studies are available on our website
www.iombudsman.org.nz

Financials

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Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2015

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.

Address

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

IRD Number

063–250–759

Incorporation Number

2541616

Incorporation Date

29 October 2010

Chartered Accountant

Grant Thornton New Zealand Limited

Auditors

BDO Limited
Wellington

Bankers

ANZ Bank Limited
Wellington

Statement of Profit or Loss

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2015

Income	Notes	2015	2014
Revenue			
Complaint Fees		249,001	237,000
Interest Received		68,883	65,212
Levies – Existing Participants		977,495	955,471
Levies – New Participants		885,081	862,953
Levies – Other		80,000	80,000
Sundry Income		–	1,334
Workshop Income		30,725	8,251
Total Revenue		2,291,187	2,210,223
Total Income		2,291,187	2,210,223
Gross Profit		2,291,187	2,210,223
Operating Expenses			
Administration		213,818	234,326
Audit		8,629	5,600
Commissioners Expenses		121,029	111,060
Depreciation		33,297	42,494
Occupancy		168,298	165,284
Professionals & Consultancy		39,377	85,710
Promotion		24,612	17,073
Staff Costs		1,523,530	1,454,496
Total Operating Expenses		2,132,594	2,116,046
Net Profit		158,592	94,177
Surplus Allocated to Reserves			
Allocation of Surplus to Scheme Review Reserve	14	40,008	–
Total Surplus Allocated to Reserves		40,008	0
Surplus Allocated to Retained Earnings			
Total Surplus Allocated to Retained Earnings		118,584	94,177

Statement of Movements in Total Funds

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2015

Funds	Notes	2015	2014
Opening Balance		1,053,232	959,055
Plus Movement for the Year			
Current Year Earnings After Allocation to Reserve		118,584	94,177
Other Increases			
Reserve - Scheme Review	14	40,008	–
Total Other Increases		40,008	0
Total Plus Movement for the Year		158,592	94,177
Total Funds		1,211,825	1,053,232

Balance Sheet

Insurance & Savings Ombudsman Scheme Inc.

As at 30 June 2015

Assets	Notes	30 June 2015	30 June 2014
Current Assets			
Accounts Receivable		2,503	3,508
Accrued Income		–	27
Cash and Bank	10	1,287,991	1,176,544
GST Receivable		20,226	(724)
Petty Cash		23	1
Prepayments		11,346	20,006
Income Tax	12	8,923	18,462
Work in Progress - CRM		38,187	–
Total Current Assets		1,369,202	1,217,827
Non-Current Assets			
Property, Plant and Equipment	11	67,232	31,951
Total Non-Current Assets		67,232	31,951
Total Assets		1,436,435	1,249,778
Liabilities			
Current Liabilities			
Accounts Payable		212,879	181,437
Income Invoiced in Advance		11,731	15,108
Total Current Liabilities		224,610	196,545
Total Liabilities		224,610	196,545
Net Assets			
Total		1,211,825	1,053,232
Equity			
Retained Earnings		1,171,817	1,053,232
Reserves	14	40,008	–
Total Equity		1,211,825	1,053,232

Signed by:



Insurance & Savings Ombudsman

Date:

28 August 2015



ISO Scheme Commission Chair

Date:

28 August 2015

Notes to the financial statements

Insurance & Savings Ombudsman Scheme Inc.

For the year ended 30 June 2015

1. Statement of Accounting Policies

The financial statements are for ISO Scheme as a separate legal entity.

ISO Scheme is an incorporated society under the Incorporated Societies Act 1908.

Basis of Preparation

These 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 policies have been identified.

Differential Reporting

The ISO Scheme 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 ISO Scheme has taken advantage of all differential reporting concessions.

2. Changes in Accounting Policies

There have been no changes in accounting policies. Policies have been applied on a consistent basis with those of the previous reporting period.

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

All amounts are stated exclusive of goods and services tax (GST) except for accounts payable and accounts receivable which are stated inclusive of GST.

8. Revenue

Levies comprise amounts received and receivable from Participants in the ISO Scheme and are recognised on an accrual basis.

9. Comparatives

Complaint fees have been reported as a separate item in the Statement of Financial Performance in order to provide additional understandability for the users. These were previously included in Levies - Existing Participants. The comparative figures have been restated to conform to the current year's presentation.

10. Cash and Bank	2015	2014
ANZ Call Account	155,670	88,148
ANZ Cheque Account	14,450	9,845
ANZ Serious Saver – 29	1,117,810	1,078,550
ASB Account	60	–
Total Cash and Bank	1,287,991	1,176,544

11. Fixed Assets

Office and Equipment

Office & Computer Equipment: At Cost	415,844	347,264
Office & Computer Equipment: Accumulated Depreciation	(357,915)	(325,796)
Total Office and Equipment	57,929	21,468

Furniture & Fittings

Furniture & Fittings: At Cost	17,707	17,707
Furniture & Fittings: Accumulated Depreciation	(8,403)	(7,224)
Total Furniture and Fittings	9,303	10,482
Total Fixed Assets	67,232	31,951

12. Income Tax Expense

Net Profit (Loss) per Financial Statements	158,592	94,177
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Additions to Taxable Profit

Non Deductible Expenditure	2,129,150	2,112,787
Total Additions to Taxable Profit	2,129,150	2,112,787

Deductions from Taxable Profit

Non Deductible income	2,222,304	2,145,011
Losses Brought Forward	403,317	465,270
Total Deductions from Taxable Profit	2,625,621	2,610,281

Total Assessable/(Deficit)

Total Deficit	(337,877)	(403,316)
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Tax Effect

Deduct

RWT Paid	(27,427)	(18,462)
Total Deduct	(27,427)	(18,462)

Add Back

Refund Received	18,504	–
Total Add Back	18,504	0
Income Tax Payable (Refund Due)	(8,923)	(18,462)

Income tax losses available to be carried forward total \$337,877 (Last year: \$403,316). 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	2015	2014
Current	61,319	147,165
Non-Current	–	61,319
Total Operating Lease	61,319	208,484

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.

14. Reserves	2015	2014
Reserves	40,008	–
Total	40,008	0

15. Audit

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

16. Contingent Liabilities

There are no contingent liabilities at balance date (2014:\$nil)

17. Capital Commitments

There are no capital commitments at balance date (2014:\$nil)

18. Subsequent Events

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

19. Related Parties

The following Commission Members of the ISO Scheme hold positions of responsibility at the listed entities. The ISO Scheme also received Levy Income from these entities.

- Dave Kibblewhite, Chief Financial, Investment and Risk Officer of Farmers Mutual Group
- Victoria Werohia, Chief Risk Officer, Suncorp Life New Zealand
- Martin Stokes is the Chief Executive Officer of Medical Assurance Society NZ Limited (Resigned 12 November 2014) - Nigel Tate is a Director of Nigel Tate Financial Planning (Resigned 12 November 2014)

20. Employees' Remuneration

There are four employees who earn over \$100,000 (2014: Two employees)



Independent Auditor's Report

To the Members of the Insurance & Savings Ombudsman Scheme Incorporated

Report on the Financial Statements

We have audited the financial statements of Insurance & Savings Ombudsman Scheme Incorporated on pages 19 to 23, which comprise the balance sheet as at 30 June 2015, and the statement of profit or loss and statement of changes in total funds 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 auditor's 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 made by the Commission, 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, Insurance & Savings Ombudsman Scheme Incorporated.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Insurance & Savings Ombudsman Scheme Incorporated as at 30 June 2015, and its financial performance for the year then ended in accordance with New Zealand Financial Reporting Standards.

BDO Wellington
28 August 2015
Wellington
New Zealand

“Excellent communication, procedure and information from the case manager.”

“We were kept very well informed the whole way through. We felt whatever decision was reached it would be very fair and unbiased.”

“Disappointed by the result - but no complaints with the service.”

“I believe that the service had industry knowledge and experience and used it to their complete disposal.”

“The case manager was marvellous. I was tired and stressed from the communications [with the company]. To have someone in between to see a fresh perspective was what was needed.”



INSURANCE & FINANCIAL SERVICES
OMBUDSMAN

The IFSO Scheme Inc.

On 1 November 2015, the Insurance & Savings Ombudsman Scheme will become the Insurance & Financial Services Ombudsman Scheme (IFSO Scheme) to reflect our growing range of financial service provider Participants.

Website: www.ifso.nz

Information email: info@ifso.nz

Freephone: 0800 888 202

“

Becoming the 'Insurance & Financial Services Ombudsman Scheme' is significant. As our membership continues to expand, we must look to the future.”

Paula Rebstock
ISO Scheme
Commission Chair