ANNUAL REPORT **2011**

OMBUDSMAN
FOR LONG-TERM INSURANCE

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FOREWORD BY THE CHAIRPERSON OF THE

OMBUDSMAN'S COUNCIL

In terms of section 10(1)(b) of the Financial Services Ombud Schemes Act, 37 of 2004, the Ombudsman's Council has the function to monitor the performance and independence of the Ombudsman. The Council has always had the same function in terms of its own Constitution, which predated the Act. For these purposes the Council as usual met twice in 2011, on 6 May and 28 October. At the meetings the Ombudsman duly reported on all relevant matters, including the office's statistics and accounting, as well as its consumer awareness initiatives, its outreach initiatives, its funding model, and its participation in the central helpline.

The past year has been an uneventful one thanks to the smooth operation of the Ombudsman's office. On reflection the Council was satisfied, as in previous years, that the Ombudsman and his office, in their usual competent manner, had fulfilled their mission, complied with their obligations, dealt with any matters raised by Council and, most importantly, that the Ombudsman had steadfastly maintained his independence. For that they are to be congratulated.

There was no change to the membership of the Council in 2011. During the year the Council had occasion to congratulate Judge Selby Baqwa, who has been an acting Judge since the beginning of 2011, on his permanent appointment.

On a personal note I would again like to take the opportunity to thank the members of the Council for their support and valued contributions during the year.

John Smalberger

Members of the Ombudsman's Council as at 31 December 2011

Judge John Smalberger
(Chairperson)

Formerly Judge of the Supreme Court of Appeal; formerly Chairperson of the Electoral Court.

Mr Ken Baldwin

Retired senior partner KPMG.

Judge Selby Baqwa

Formerly the Public Protector; formerly head of Enterprise Governance and Compliance, Nedbank Group; currently Judge of the High Court, Gauteng Division.

Mr Moses Moeletsi

CEO, National Regulator for Compulsory Specification, formerly Chairperson of the Short-term Insurance Ombudsman's Board.

Mr Desmond Smith

Chairperson of Reinsurance Group of America (South Africa); Chairman of Sanlam; director of companies.

Ms Mpho Thekiso

Head of the Debt Review Centre at FNB Shared Services; formerly Project Manager: Debt Counselling with the National Credit Regulator.

Judge Leona Theron

Judge of the Supreme Court of Appeal.

Mr Jonathan Dixon
(ex officio)

Deputy Executive Officer: Insurance, Financial Services Board, as such Deputy Registrar of Insurance.

Ms Dorea Ozrovech
(ex officio)

Manager: Client Relations, Sanlam Life; Chairperson of the Ombudsman's Committee.

Judge Brian Galgut
(ex officio)

Ombudsman.

FOREWORD BY THE CHAIRPERSON OF THE

OMBUDSMAN'S COMMITTEE

The year 2011 was again packed with many activities in the long-term insurance industry. Some involved the Ombudsman's office and the Ombudsman's Committee, such as the effect of the Treating Customers Fairly initiative of the Financial Services Board. This will have a substantial impact on complaints handling, and developments will be closely monitored.

The role of the Ombudsman's Committee, which meets twice per year, is to act as a liaison body between subscribing members and the Ombudsman's office. Subscribing members are invited to join the Committee in order that the various industry role players in the long-term insurance landscape are represented. Their companies share common trends, and need to understand the operations of the Ombudsman's office and its requirements and how to assist the Ombudsman in dealing with complaints in the most effective way. This information is fed into our internal complaints processes and normal activities in processes like claims assessment.

Although there was no increase in the number of complaints the Ombudsman's office received during 2011 it was able to finalise 5% more cases than in 2010 and it managed to close 78% of cases within six months. We noticed that complaints finalised wholly or partially in favour of the complainant decreased from 46% in 2010 to 40% in 2011. We believe that the Committee's continuous effort to ensure proper internal complaints resolution assisted in this. The Committee was also glad to once again see a decrease in the number of incompetent cases.

The Committee would once again like to thank the Ombudsman's office for its open-door relationship with the industry. The office continued with its informative workshops, visits to insurers and the publication of newsletters and other articles, all of which provided clarity, views and guidance on sometimes difficult technical matters.

A sub-committee of the Ombudsman's Committee, together with Jennifer Preiss of the Ombudsman's office, was tasked to investigate the possibility of publishing data on the complaints ratios of the subscribing members. This will be a focus area in 2012.

We continue to regard the Ombudsman's office as a very important guide in fair treatment of complainants and sound decision-making in a balanced and impartial manner.

It gives me great pleasure to thank Judge Galgut and his team on behalf of the long-term insurance industry for a job well done during 2011.

Dorea Ozrovech

Complaints received	Full cases finalised	Percentage of cases resolved wholly/partially in favour of complainants	Percentage of cases finalised within six months
9 195	**4 254**	**40%**	**78%**

KEY **FIGURES**

R2 100	**R104.25m**	**R488 963**	**R13.08m**
Cost per standard case	Recovered for complainants (lump sums)	Compensation granted	Total expenses for the year

FOREWORD BY THE

OMBUDSMAN

Comment on 2011 generally

During 2011 the office strove as always to fulfil its mission, which requires that by following informal, fair and cost-effective procedures we resolve complaints against subscribing members independently and objectively.

Readers will find statistics and other matters in this report that will hopefully be of interest to them. What emerged in particular are the following:

- The average W/P figure for all subscribing members, being the percentage of cases in which complaints were resolved wholly or partially in favour of the complainant, reduced from 46% in 2010 to 40% in 2011.
- Complaints about funeral policies made up 37% of the total number of complaints finalised by the office.
- The number of cases marked by the office as incompetent, which we do when subscribing members fail to respond to the office's queries timeously or sufficiently and where the insurer concerned is therefore charged double the fee, was down in 2011.

Final determinations

During 2011 there were three cases in which determinations were made against subscribing members, all three involving issues which were not clear cut.

In one the question was whether, on the particular medical history of the complainant, Clientèle Life was correct in its contention that the condition that gave rise to his hospitalisation was one that had resulted directly from a condition that had already existed at the inception of the policy.

In the second the complainant had been issued by Liberty Group with a policy offering *inter alia* income protection. The complainant became permanently disabled and as such entitled to the monthly benefit. The issue, which was one of interpretation, was whether the complainant, once in claim, was entitled to periodic increases in the monthly benefits that would otherwise have become payable, and the office made a determination in favour of the complainant. Although Liberty Group was given leave to appeal, the Appeal Tribunal, Mr Justice L S Melunsky, upheld the office's determination.

Summaries of these two cases were duly published, which is a requirement of the office's Rule 3.8 in the case of a determination against an insurer, and they are also available on the office's website at www.ombud.co.za.

In the third case, a complaint against Momentum, however, there was no publication. Rule 3.8 stipulates that there should be no such publication if it is likely to expose the identity of the complainant concerned, and on the facts that very possibility existed. A summary of the case is therefore also not included on our website.

A happy ending to a sad case

In my 2010 Annual Report I had occasion to deal (pages 16 – 17 thereof) with a sad case in which I could not uphold the policyholder's claim. The complainant had for many years owned and managed a successful business and almost from the start had maintained a life policy which included disability cover in the sum of about R1.1 million. In October 2007 he sustained brain damage in a collision as a result of which he was no longer able to run his business successfully and was sequestrated in June 2009. The insurer did not dispute that the complainant's brain damage rendered him disabled for the purposes of the policy and that the disability benefit was therefore payable. The sole issue was whether the R1.1 million disability benefit was payable to the complainant himself, or to the trustee in his insolvent estate for the benefit of his creditors.

In other areas of the law our legislation provides, when a person suffers a disability for which compensation from any source is due, that such compensation is protected from creditors so that the disabled person can rehabilitate himself without the burden falling upon the State. When it came to disability benefits under a long-term policy, however, section 63 of the Long-term Insurance Act, No. 52 of 1998, limits the protection to R50 000. I therefore had no choice but to rule that the insurer was correct in its submission that, save for R50 000, the disability benefit had to be paid to the trustee of the complainant's estate.

Immediately thereafter I addressed submissions to the SA Law Commission, the Financial Services Board and National Treasury, suggesting that consideration be given to amending section 63. The sad fact, however, was knowing that any amendments that might follow would not of course be made retrospective in effect, and would not therefore avail the complainant.

The sad case nevertheless had a happy ending. Within months it was made known that amending legislation would be introduced granting full protection to an insolvent policyholder for disability benefits. I conveyed this news to the complainant's representative. He told me that there were only two substantial creditors in the estate, both being banks, and I suggested that the banks be informed of the proposed change to the legislation. Soon thereafter I was informed that at the following meeting of creditors in the estate both banks agreed to waive 80% of their

claims for the benefit of the complainant (the remaining 20% to be retained to cover administration costs). The two banks are in the circumstances to be commended for their willingness to help easing the complainant's plight.

2011 INFO Conference

The International Network of Financial Services Ombudsman Schemes, called INFO, of which the office is a member, holds a conference in a different country each year. Together with my Deputy, Jennifer Preiss, I attended the 2011 annual conference held in Vancouver in September.

Appointment of Jennifer Preiss

It was announced at the Conference that Jennifer would become the Chairperson of INFO when the present incumbent vacates the position later in 2012. The honour is well deserved. Because INFO is of considerable size, by now having 48 members from 31 countries, and is still growing, the office is extremely proud.

Topics

As usual topics of common interest to ombudsmen were dealt with, including *inter alia* the need to balance an ombudsman's advocacy role with impartiality, multi-stakeholder management, serving vulnerable complainants (such as those suffering from dementia and other kinds of diminished capacity) and what can be expected in the regulatory sphere around the world.

The social media

The main focus, however, was on the social media revolution, its use by one billion people making it the fastest growing communication tool in history. Speaker experts in the field dealt with its substantial effect on business and some of the advantages available to ombudsman offices. They also warned of the inherent dangers and how unwise use of the social media has brought down prominent people and massive businesses.

Multi-stakeholder management

To judge by what speakers at the annual INFO conference said about multi-stakeholder management, confirmed by what the delegates had to say informally out of session, it is clear that the international trend is to make more contact, both face to face and telephonically, with both complainants and subscribing members. That they appear thereby to be more open-minded and receptive, and that disputes become more readily settled even where it seems unlikely, are matters that had in any event been the office's experience, so that during 2011 the adjudicating staff was encouraged to more often make such contact.

Quite apart from complainants and subscribing members, however, it has become apparent over the years that regular personal contact with all stakeholders is helpful in furthering the office's function. So it is that during 2011 we met with National Treasury, the Financial Services Board, the Commissioner appointed under the Consumer Protection Act, the Association of Savings and Investment in South Africa (ASISA), the Chairperson of the Parliamentary Standing Committee on Finance and the other financial ombudsman offices.

The global trend, not only in the financial field, is moving ever more in the direction of the establishment of ombudsman offices, something that is to some extent promoted by proper stakeholder contact. In the financial field the trend is evidenced by the fact that INFO membership is on the increase.

I reported last year that during 2010 the office had received a delegation from Tanzania, who needed assistance in establishing a financial ombudsman scheme in their country. In March 2011 the office received a delegation from the Saudi Monetary Agency, who needed the same assistance. The office was also visited by representatives of SARS, who were tasked with opening a dispute resolution office.

Regulatory review

At an Insurance Regulatory Seminar in October 2011 the FSB furnished an overview of the Regulatory reforms that will take place in the next three to four years. Those that are likely to impact on our work include:

- Treating customers fairly (see page 21)
- New Microinsurance legislation
- Binder Regulations under the Long-term Insurance Act
- Demarcation Regulations (demarcating insurance business from medical scheme business)
- Directives on group schemes
- A review of insurance laws
- Financial Services General Laws Amendment Bill

National Treasury has also launched a project to develop and implement a national consumer financial education strategy, which is in line with their policy statement "A safer financial sector to serve South Africa better".

Our office participates in these initiatives when invited to do so, and when we can make a meaningful contribution.

Tribute to staff

The success of the office, as I have said in the past, depends almost entirely on the ability and motivation of the whole office team, both those who deal with complaints as such, and the support staff. My staff members lived up to these measures in 2011. They thereby helped the office to fulfil its mission, and I owe them my whole-hearted thanks. I also owe a debt of gratitude especially to my Deputy, Jennifer Preiss, and my Finance and Operations Manager, Ian Middup, without whose presence and assistance the office would not operate as successfully as it does.

Publication of claims ratios

ASISA made a decision in 2011 that its risk insurance members should provide claims payout statistics on a standardised basis. The first reporting period will be early 2013 for 2012 on fully underwritten death benefits.

This step is to be welcomed and it is hoped that the reporting will be extended to all death and other risk benefits over time.

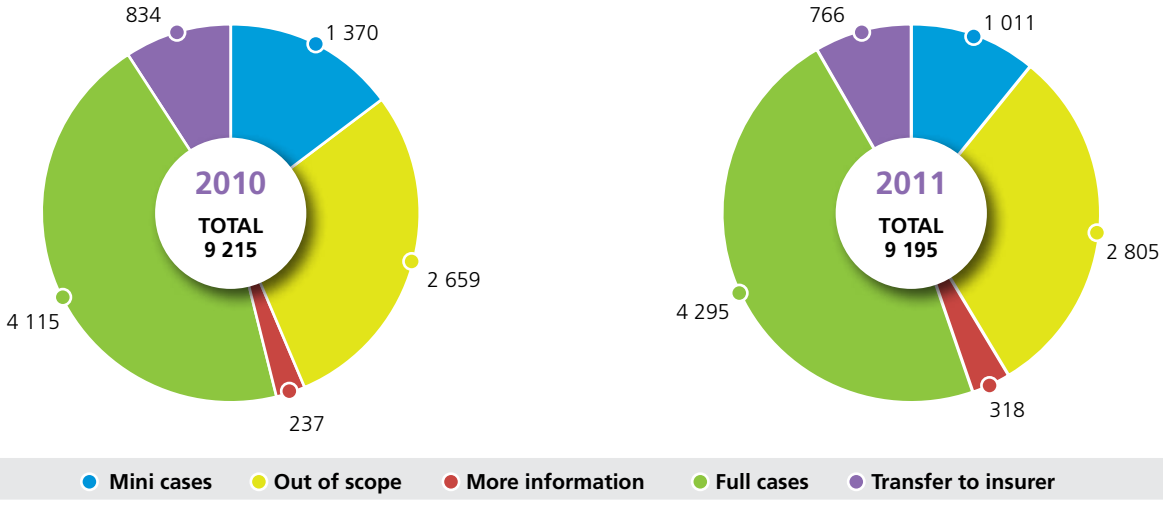
In our November 2009 Newsletter we stated –

> *"When buying a risk policy an insurer's claim philosophy is as important as the premium and the benefits to a prospective policyholder. In order to assess its approach to paying claims it would therefore be relevant to look at the insurer's claims ratio (i.e. the percentage of claims paid to claims submitted)."*

Brian Galgut

COMPLAINT
VOLUMES

Complaints and enquiries received



Complaints and enquiries received for 2011 totalled 9 195, similar to the 9 215 received in 2010. It was a year of two halves, with the volumes at the end of the first half being 9% up on the previous year, and then slowing in the second half. The break-down is as follows:

Full cases >> The 4 295 cases, or 47% of complaints, are those that are handled by the office's team of adjudicators and assessors.

Transfers to insurers >> Reflects those complaints which, by agreement with the office, are transferred to insurers who have appointed an internal arbitrator.

Mini cases >> A number of these complaints relate to simple enquiries that the insurer can readily handle at source, while the majority are cases where the office feels the insurer has not had an adequate opportunity to respond to the complainant.

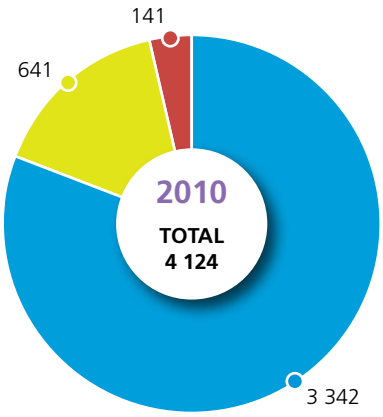
More information required >> The office accepts complaints in various forms, and often more information regarding the policy, insurer or complainant is needed.

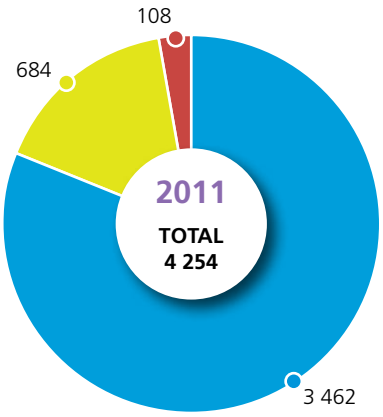
Out of scope >> In any given year approximately 30% of complaints or enquiries submitted are not for the office. These consist of:

- Complaints for other ombudsman offices.
- Complaints unconnected with life insurance.
- "Not taken up" – enquiries that have some connection to life insurance policies but need no action by the office.

It is worth noting that all ombudsman offices receive a substantial number of both written and telephone enquiries that do not fall within the jurisdiction of their offices. These complaints are always directed to their correct destination.

Cases finalised





Standard Complicated Incompetent

Finalised cases, which encompass only full cases, totalled 4 254 for the year, an increase of 3% on the 4 124 finalised during the previous year.

An analysis of cases finalised shows the following:

- Standard cases – 3 462 or 81% of the cases closed
- Complicated cases – 684 or 16% of the total, a slight increase on the 15% recorded last year.
- Incompetent cases of 108 make up the balance.

In 2011 the office introduced two further charging categories for the first time:

- The Complicated Plus Case, for cases that are particularly difficult or take an inordinate amount of senior staff input.
- The Basic Case, charged experimentally at a rate of about 75% of the standard case, and applicable to smaller insurers and smaller benefit policies.

CASES
FINALISED SUMMARY

NATURE OF COMPLAINT	LIFE				DISABILITY			
	2010	W/P*	2011	W/P*	2010	W/P*	2011	W/P*
Poor communications/ documents or information not supplied/poor service	925	54%	924	46%	9	33%	10	50%
Claims declined (policy terms or conditions not recognised or met)	1 736	47%	1 860	42%	240	42%	264	34%
Claims declined (non-disclosure)	55	25%	102	25%	34	24%	59	14%
Dissatisfaction with policy performance and maturity values	158	28%	166	18%	1	0%	0	0%
Dissatisfaction with surrender or paid-up values	201	25%	93	18%	0	0%	0	0%
Misselling	94	38%	65	40%	0	0%	0	0%
Lapsing	156	44%	183	45%	4	25%	3	0%
Miscellaneous	146	33%	142	20%	5	40%	7	14%
Total	**3 471**	**46%**	**3 535**	**40%**	**293**	**39%**	**343**	**30%**

** Resolved wholly or partially in favour of the complainant.*

The above table summarises three key aspects of complaints for the year:

- What the complaints were about (Nature of Complaint).
- The insurance benefit or product the complaint related to (Life, Health, Disability).
- Whether the complaint was resolved wholly or partially in favour of the complainant, the W/P, which has decreased to 40% from 46% in 2010.

This information assists the office with identifying trends for both the office and the individual subscribers.

A further analysis and comment on the above follows on pages 14 – 17.

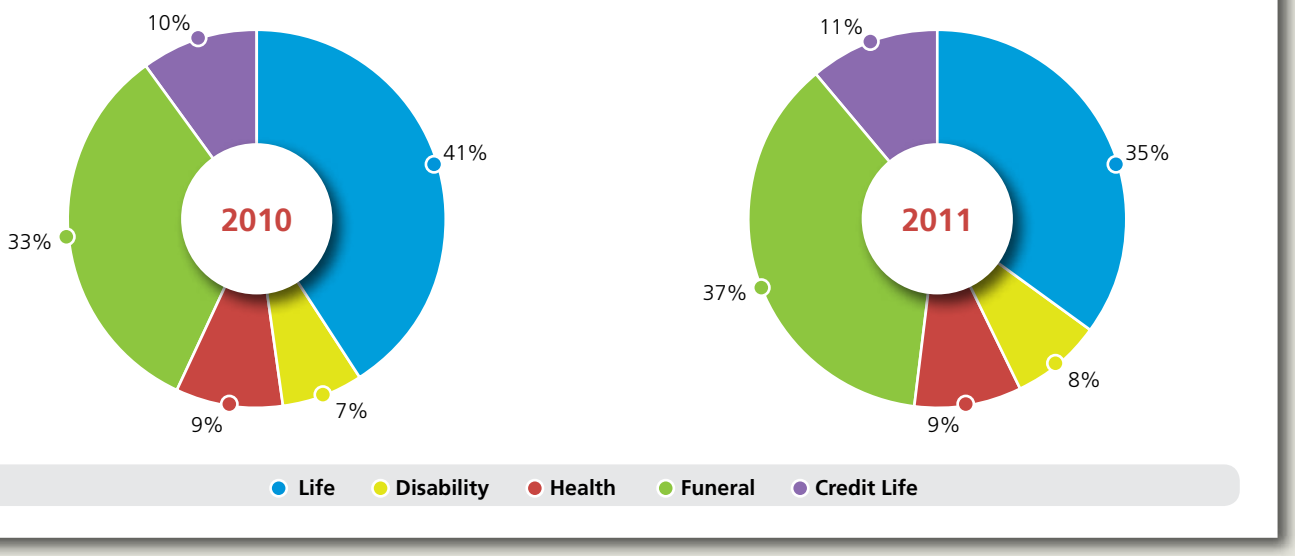
	HEALTH				TOTAL				% OF TOTAL	
	2010	W/P*	2011	W/P*	2010	W/P*	2011	W/P*	2010	2011
	31	68%	17	47%	965	55%	951	46%	23%	22%
	303	50%	336	43%	2 279	47%	2 460	41%	53%	58%
	16	25%	14	21%	105	25%	175	21%	3%	4%
	0	0%	0	0%	159	28%	166	18%	4%	4%
	0	0%	0	0%	201	25%	93	18%	5%	2%
	1	100%	1	0%	95	38%	66	41%	4%	2%
	3	67%	4	0%	163	44%	190	44%	4%	4%
	6	17%	3	0%	157	32%	153	20%	4%	4%
	360	**51%**	**375**	**41%**	**4 124**	**46%**	**4 254**	**40%**	**100%**	**100%**

The major category of complaints for 2011 was Claims Declined, as it has been for the last eight years. During 2011 this category was responsible for 58% of cases finalised, five percentage points more than previously. While this has been the largest growth area over the years it was given a further boost with the recent change to the Policyholder Protection Rules which now state that after a claim is declined the insurer must advise the policyholder that he has the right to lodge a complaint with this office.

The second largest category was that of Poor Communication/Poor Service, a category which has been steady over the past seven years at between 22% and 25% of complaints.

As recently as 2003 the above two categories were level at 26% of complaints each, but since then the Claims Declined complaints have increased substantially.

TYPES OF BENEFIT



In the above chart the categories contained in the summary table on page 12 have been expanded to separately identify funeral and credit life benefits.

The chart shows the year-on-year growth of Funeral complaints over the 2010/2011 period, to a point where in 2011 they comprised 37% of cases finalised.

The chart also shows that for the first time Funeral complaints have exceeded Life complaints.

Complaints concerning Health benefits have been on the increase in the last four years both in complaint volumes and as a percentage of the total (6% to 9% over the period).

Complaints involving Credit Life benefits make up 11% of the total but the volumes of these complaints and their relative percentages have declined since 2008 and 2009, a period which followed the credit granting spree leading up to the coming into effect of the National Credit Act of 2007 (NCA) and the substantial reining in of credit from 2008.

As we approach the five year anniversary of the NCA, with lower interest rates and credit providers more willing to lend, it will be interesting to monitor Credit Life complaints in the future.

The office also analyses Credit Life complaints by life, disability and retrenchment benefits. The proportions show a fairly consistent trend over the four-year period.

Productivity

A fraction fewer cases were closed than received during the year, resulting in a small increase in the work in progress to 1 550 cases. The productivity measure of the office (see accompanying table), reduced slightly.

The productivity of the office, measured by the number of cases finalised per adjudicator/assessor on average each week, fell by 1% in 2011, largely as a result of the higher number and complexity of Complicated cases.

	2010	**2011**
Opening work in progress	1 518	**1 509**
New full cases	4 115	**4 295**
Cases finalised	4 124	**4 254**
Closing work in progress	1 509	**1 550**
Productivity	7.2	**7.1**

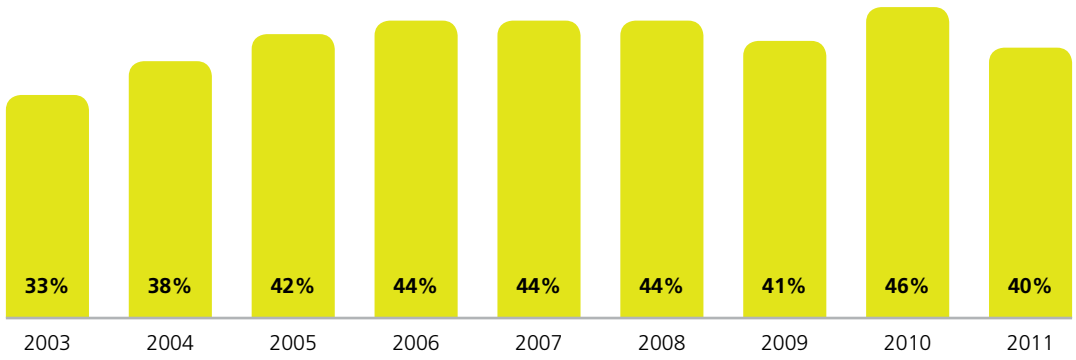
Case duration

It is worth noting that while the turnaround times have not substantially reduced, the cases themselves have higher "activity" levels than previously. The improved response time from insurers has tended to be balanced out by the higher level of persistence from some complainants, resulting in the adjudicating staff handling cases more often than in the past.

	2010	**2011**
0 – 30 days	15%	**11%**
31 – 60 days	20%	**19%**
61 – 90 days	17%	**17%**
91 – 180 days	27%	**31%**
181 – 365 days	16%	**17%**
Over 365 days	5%	**5%**

W/P RESOLVED WHOLLY OR PARTIALLY IN FAVOUR OF COMPLAINANTS

W/P trends from 2003 to 2011



The W/P figure represents the proportion of complaints finalised by the office that were resolved wholly or partially in favour of the complainant, and as can be seen the figure reduced from 46% in 2010 to 40% in 2011. The statistic is important for all ombudsman offices and can be contributed to by various factors, but it is often difficult to pinpoint why the figure goes up or down in any given year.

What sometimes happens is that one or two factors are obviously responsible for the increase or decrease. So it was that in 2009, when there was a reduction to 41% from the 44% in 2008, what the office could identify as having contributed in large measure was that it had suspended work on some 500 so-called cost cases awaiting a court judgment on whether certain costs were deductible from the investment value of savings policies.

No such obvious factor presented itself in 2011 and it is therefore too early to tell whether or not the anomalous 2011 figure will remain at 40% or will rise again.

COMPLAINTS RECEIVED PER PROVINCE

The office records the province from which each complaint or enquiry originates.

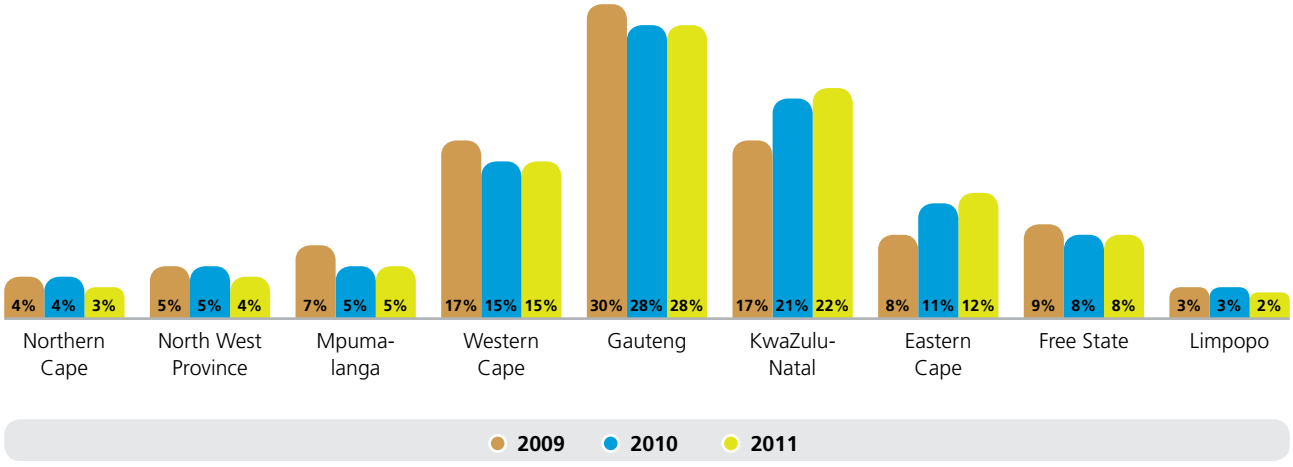
The following charts show the pattern over the past three years for:

- Percentage of total complaints received.
- Percentage of funeral complaints received.

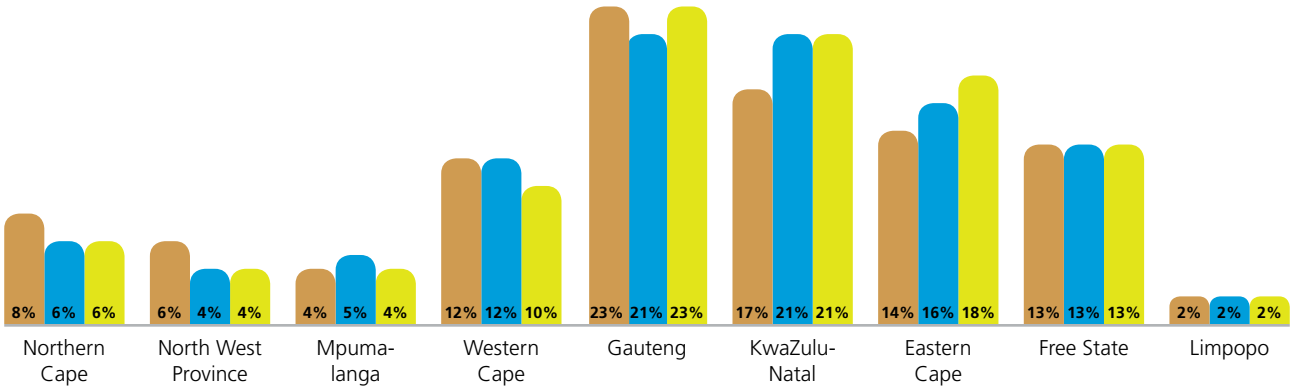
They specifically highlight that:

- The growth of total complaints in KwaZulu-Natal and the Eastern Cape appears to be directly attributable to the increase in funeral complaints in those areas.
- The Free State and the Eastern Cape have a higher percentage of funeral complaints compared to total complaints.

Complaints received per province: 2009 – 2011



Funeral complaints received per province: 2009 – 2011



MATTERS OF
INTEREST

Insurable interest

Wagering contracts have long been regarded as offending against public policy, the result being that while they are capable of being performed they are not legally enforceable. Risk policies are in essence wagering contracts, but provided a policyholder has an insurable interest in what is being insured the contract will not be regarded as being against public policy and will therefore be legally enforceable. So it is that in the work *LIFE INSURANCE IN SOUTH AFRICA* by Nienaber and Reynecke we are told that –

> *"The parties do not in express terms have to identify and insure an alleged interest. It suffices if the interest intended to be insured can, if challenged, be proved to be insurable. In short, it is enough if an ascertainable interest exists."*

In the case of indemnity insurance, which is what short-term insurance is all about, there is generally no difficulty in ascertaining whether an insurable interest exists – when you insure your home or motor car you have an insurable interest therein to the extent of the value thereof, which is patrimonial in nature.

In the case of life insurance, however, which is non-indemnity insurance, the authors say –

> *"But the fact is that while most of the recognised long-term insurance interests may have financial overtones they are essentially non-patrimonial in nature, such as the interest a spouse has in the other spouse's life or the interest a person has in an extended family member.*
>
> *The conclusion is that both the purpose and the basis of a true contract of insurance is the protection of a genuine insurable interest. For that very reason a contract of insurance, notwithstanding being a contract of chance, is considered to be in accordance with public policy. Should it be found that a purported contract of insurance is not intended to safeguard an insurable interest but is simply payable on the occurrence of an uncertain event, it will not be insurance proper but a wager."*

In the case of non-indemnity insurance the inquiry into whether an insurable interest exists sometimes raises difficult questions. Although the Roman Dutch Law has contributed, our insurance law was inherited from England, and with it the concept of insurable interest. It is not a static concept, and its meaning is liable to adjustments as public policy changes. There is no legislation that defines it and for many decades our courts, and those in the United Kingdom, have not sought to rule on the extent to which the concept has changed. The authors of the abovesaid work therefore say –

> *"At this stage it cannot be stated categorically that the outer boundaries of insurable interest have been charted. Further developments lie ahead. In case of doubt a court or tribunal will invariably lean in favour of finding, rather than rejecting, the existence of an insurable interest."*

Usually, however, whether an insurable interest exists in a given case is clear enough, the obvious cases being that one has an insurable interest in one's own life, and in the life of one's spouse, a member of one's family, one's putative spouse, one's "spouse" by virtue of a traditional marriage, one's cohabitant, any person against whom one may have a right of support, one's business partner, one's key employee and one's debtor.

It does not end there, however, but where the line is to be drawn remains unclear, especially in relationships between people who are not married, engaged to be married or living together. With the relaxation of

Example

One of the cases involving insurable interest that came before the office during 2011 was unusual because, while it is usually the insurer that takes the point that there had not been an insurable interest and does so at claim stage, in this case it was the policyholder who took the point, and she did so four years after she had taken out the policy.

The applicant for the policy, a woman in her fifties, sought cover on the life of a man in his sixties. In making the application she described him as her "*boyfriend*" and added that they were "*dating*". The insurer accepted the application and a policy was issued. Some four years later the complainant surrendered the policy, in doing so contending that there had never been an insurable interest and claiming repayment of the premiums. The circumstances described by her were that she and the life insured had not been engaged, had not intended to become married and had never lived together, and that she had never been supported by him. Because the office feels, as stated alongside, that an insurable interest may exist in such a relationship, it was vital to know what the full extent of their bond, their companionship and the emotional support had been. On such information as was provided in these regards the office was not satisfied, however, that the full extent of these features had been disclosed by the complainant, and because the onus was on her we were unable to hold that it had been proved by her on a balance of probabilities that there had not been an insurable interest. Her claim for repayment of the premiums could not therefore be upheld.

A complainant in a case involving the payment of a death benefit.

conservative attitudes over recent decades the office considers that the concept of insurable interest will be held to embrace such an informal relationship, provided the strength of the bond, the companionship and the measure of emotional support approximate sufficiently to those in the case of married and engaged couples.

There is another, entirely different aspect of insurable interest that raises serious questions. As the law stands it is only at the inception of a policy that an insurable interest is required to exist for the contract to be legally enforceable. What sometimes happens, however, is that at some later stage the insurable interest ceases to exist, for example where a business partner, whose life is insured by another partner, leaves the partnership. In those cases the policy remains legally enforceable as the law stands, and the policyholder retains full rights to the policy, one being the right to cede it.

In cases where the policyholder, or the cessionary in the case of a cession, still holds a policy after the insurable interest has come to an end, it sometimes happens that the life insured becomes concerned for his safety, often for good reason – for all he knows the policyholder or cessionary might have a greater interest in his death than his life. Even if his life is not in danger, however, a life insured may justifiably feel it is unacceptable that a person or company with whom he has no ongoing relationship should benefit from his death. From time to time the office receives complaints from such lives insured, but because the policy is valid there is nothing we can do.

Central helpline

It will be recalled that the service provider that has for some time run a call centre for the Financial Services Board and the FAIS Ombud, was engaged to provide a separate central helpline (0860OMBUDS) to be shared by:

- The Ombudsman for Long-term Insurance
- The Ombudsman for Short-term Insurance
- The Ombudsman for Banking Services
- The Credit Ombud
- The National Credit Regulator
- The Pension Funds Adjudicator

The helpline, a central contact point that transfers calls directly to the office the caller requires, opened on 2 January 2011. The number of calls destined for the office started slowly and did not increase dramatically, but we will continue to be party to the helpline because it is in the interests of consumers that we do so. The offices concerned had originally contributed equally to the monthly cost, but at the end of the year a more usage-based contribution was agreed to.

Treating customers fairly

Some time ago the Financial Services Board (FSB) set in motion its Treating Customers Fairly (TCF) drive, which is aimed at certain financial industries in South Africa, including long-term insurers. TCF legislation is expected to be in place within two years, and its purpose will be to achieve a culture change, in particular by financial industry players adopting a policy of fair treatment of consumers at the heart of their businesses.

Commentators in newspapers and financial magazines have for obvious reasons backed the TCF drive, and by way of example reference might be made to only two. In one, which appeared in the May 2011 edition of *Cover*, the editor said –

> *"While equity is a requirement in terms of the Ombud's determinations, increasing focus on consumer protection means insurers would do well to apply the principles of equity and fairness in their own claim settlement decisions. This should not only be done to limit the number of consumer complaints submitted to the office of the Ombud, but also to help build and endorse a positive image of the insurance industry."*

And in an article named "*Fear Factor*" in the 2 February 2012 edition of Finweek, Bruce Whitfield referred to –

> *"... the issue around the legalese that accompanies insurance contracts and ... the importance of fully understanding precisely what it is you are buying. The small print can devastate policyholders' expectations."*

What is of concern is the fact that policyholders are so often unaware of what exactly they are or are not covered for. Despite insurers entreating policyholders to read their policies upon receipt, it is well known that many do not do so. The fact that policyholders are therefore sometimes to blame for not knowing what exactly they are or are not covered for is a matter that insurers should nevertheless not ignore.

Also of concern are policies in which the cover is unclear.

Wording of health policies

The wording of these policies of necessity contains medical terms, but even if they are accurate and clear to doctors they will not necessarily be meaningful to the lay consumer. A policyholder might therefore be covered for a heart attack or cancer, but might find out at claim stage that because of the definition of the conditions his particular heart attack or cancer is not necessarily covered.

A greater problem arises where the medical terms are unclear or insufficient.

Example 1

In one case that came before the office a dread disease policy provided for different severity levels in cases of aneurysms, being "*a thoracic or abdominal*" aneurysm, an "*aorto-iliac*" aneurysm and an "*ileo-femoral*" aneurysm. In at least two respects these severity levels were inadequately worded. First, they did not provide expressly for an aneurysm that might occur in the aorta alone, or in any part of the iliac artery or the femoral artery alone. Secondly, what exactly was intended by the word "*abdominal*" in the first of these terms was not clear, because an aorto-iliac aneurysm (and possibly also an aneurysm in the iliac artery) could well fall within the abdomen. The matter is still under consideration by the office.

Example 2

Two other cases involved a clause in the dread disease policies issued by another insurer. The policy offered cover for what was called a "*benign brain tumour*", which was defined as "*a tumour of the brain characterised by uncontrolled growth of non-malignant cells ... but subject to two or more of the following:*

- *The tumour being non-removable or only partially removable by surgery.*
- *Signs of progression of the tumour being present.*
- *The tumour resulting in signs and symptoms of raised intra-cranial pressure.*"

In each the complainant developed a tumour which, when it is in or around the brain, is always a matter of concern. In each the tumour could only be partially removed. In both, however, the second and third requirements listed above were absent, so that the policyholders were not entitled to the dread disease benefit.

Misleading promotion

A feature relevant to product promotion that sometimes gives rise to complaints is where consumers are informed in advertising material that they are not required to undergo a medical examination when applying for cover, which without more would create the impression that this holds some meaningful advantage for them. One advantage would be that they will be spared the inconvenience and resultant delay of having to undergo the medical examination. The difficulty, however, is that consumers who already suffer from some existing medical condition before applying for the policy might deduce that they are being offered full cover despite that fact. In such cases the absence of a need for a medical examination might hold serious disadvantages. The reason is that where the insurer does not require a medical examination as a prerequisite to granting the policy, it will usually protect itself by inserting in it a pre-existing medical condition exclusion clause. The effect of such a clause will be that the policyholder will not be covered for any benefits in the event of a claim arising directly or indirectly from that condition, although for the benefit of the policyholder the clause might be worded so as to limit its application to a given period (say two years) after inception of the policy rather than for its full duration. Unless the policyholder is made aware of the existence and effect of such an exclusion clause, and is in any event aware of any medical condition that he may be suffering from at the time of his application, he or his beneficiaries might only find out at claim stage that the claim is not payable, and by then it might of course be too late.

In those cases where an insurer requires an applicant to undergo a medical examination, on the other hand, the application will usually be underwritten, and if the applicant is found to be suffering from some pre-existing medical condition, the policy that follows, if granted, may take account of it in two ways. First, the insurer may impose an increase in the premiums, where the policyholder will at least be covered; secondly, the insurer may insert an exclusion clause that specifically stipulates that the policyholder will not be covered for any claim that might arise directly or indirectly from the named pre-existing medical condition, where the policyholder will at least know where he stands.

The approach of the office

The approach that the office takes in resolving disputes is mainly determined by the individual facts of each case.

- Cases can be resolved fairly informally, getting both sides to agree at an early stage on a settlement.
- Often cases require investigation and further consideration, but the majority of these cases are also resolved after a provisional determination or a settlement.
- A further category, although minor, tend to be entrenched disputes and a final determination is made by the office to dispose of the case.

A complainant in a case involving the payment of a disability benefit.

TRENDS

Excessive claims on hospital plans in KwaZulu-Natal

During 2011 complaints in respect of hospital cash plans increased significantly and have continued into 2012. The complainants have all been medical aid patients from KwaZulu-Natal. The majority of the claims have been in respect of hospitalisation for Pelvic Inflammatory Disease (PID). The issue in dispute is the length of time the claimants claim for hospitalisation. They claim for six to ten days of hospitalisation for treatment of the condition, and they have all been treated by one of two gynaecologists in the same hospital group. Medical opinions we have received from independent practitioners indicate that it is unusual to be hospitalised for PID, as it is mostly treated on an outpatient basis. In the event of complications hospitalisation may be indicated, but would seldom be necessary for more than three days.

The office deals with each case on its merits but in most of these complaints we have upheld the insurer's right to limit the benefit to a reasonable period (usually three days). Based on the medical information submitted the office has not been convinced that the extended stay claimed for is warranted. The medical motivation submitted by the two gynaecologists has been unconvincing.

The office has been informed by one of the insurers concerned that the matter has been reported to the Health Professions Council of SA and that an enquiry will be instituted.

Funeral Policies

Complaints about funeral policies increased in 2011 (see page 14), which can possibly be ascribed to the growth in the sale of funeral policies but also to the increased awareness about the right to complain to the office.

The types of problems about funeral policies that were particularly troublesome in 2011 were:

Rate reviews

We received a number of complaints about rate reviews and the consequential premium increases. Complainants received notices of premium increases which were very high, in one case resulting in increases of 100%. These steep increases usually occur in group schemes after a review because of bad claims experience. We can seldom assist in setting the increase aside because the actuary determines that the scheme would not be viable unless the premiums are increased to that extent. The concerns are the fact that the increases are so steep that it suggests that the premiums were set too low in the first instance, and that the increase makes it difficult for members/policyholders to afford the cover.

Change of underwriter

There are certain funeral group schemes that change underwriters alarmingly frequently.

These changes can be to the disadvantage of scheme members because it creates uncertainty and confusion, and when members institute claims it can be difficult and time consuming for both the member and the office to determine which insurer is ultimately responsible for payment of a claim if the scheme or scheme administrator does not pay it.

It also creates an added risk that the scheme may be uninsured for the period between underwriters, which does happen in practice. This is of course problematic if unpaid claims arise during this period. All such instances are reported to the FSB as the scheme is then carrying on unlicensed insurance business.

Premiums exceeding policy benefit

In 2011 the office received a number of complaints where the total amount of premiums paid amounted to considerably more than the sum assured. Funeral policies generally have modest benefits so this is not unexpected. However, the problem becomes more acute when the premiums increase every year and the life insured is elderly. The dilemma for the complainant is that if he

should stop paying premiums the life insured is without cover as the policies only have risk cover with no paid-up value and no premium loan facility. At the same time the premiums may become unaffordable.

This problem is not unique to South Africa. The Insurance Mediator (ombudsman) in France wrote in his 2007 Annual Report that it is also a problem in France and suggested that insurers should cease asking for premiums as soon as the amount paid by the insured exceeds the amount of the sum assured, but in France not all insurers are prepared to follow the Insurance Mediator's recommendation.

In many cases the office has also not been successful in persuading insurers to accommodate complainants. It is an issue of concern and we are discussing it with the industry to try and find a solution.

Two examples demonstrate the problem

In one case the complainant was an 84 year old pensioner who had taken out a funeral policy in 1994, when she was 67, for a sum assured of R11 000. She had paid R20 400 in premiums over 17 years. The cover remained at R11 000 and she would have to continue paying premiums as there was no paid-up benefit.

In the other the complainant had in 2003 taken out cover on her sister's life under a group scheme arrangement for an amount of R7 500 and with a monthly premium of R165. The premium increased every year by 5% and by 2011 amounted to R221.09 but the sum insured remained at R7 500. The complainant wanted the sum insured to be increased to R15 000 as she had already paid more than R7 500 in premiums. The insurer pointed out that she would have had to double her premiums for that cover, and was also unwilling to make the policy paid-up.

A complainant in a case about payment of a funeral benefit on her grandmother's death.

Poor underwriting

The office experienced a percentage increase in non-disclosure cases for the first time since 2004. What concerns the office is the indication in some of the cases that underwriting standards might be slipping. The perception is that underwriters in some cases overlook very obvious issues which should have been investigated. The cases below reflect this.

Example 1

At application stage a policyholder had submitted a medical report which disclosed that he had suffered a motor vehicle accident. The subsequent pain questionnaire he was asked to complete reflected that as a result of the accident he had suffered lung collapse and a bruised liver, and was paralysed from the waist down.

The insurer made no further enquiries and issued a policy at standard rates providing life, capital disability, income disability and dread disease cover.

Example 2

An applicant for life cover had disclosed that she suffered from major depression and asthma and that she had received treatment for her conditions. In the mental health questionnaire she was asked to complete she also disclosed that she had attempted suicide by taking an overdose of medication. In a report by her medical practitioner it was stated that she had also received counseling and that her prognosis was good.

The insurer issued the policy at standard rates with no exclusions.

In discussions with employees at reinsurers our perception that there appear to be more instances of poor underwriting was confirmed. Whether policies are being accepted without the necessary investigation and on better than expected terms because of the competitive market, or because of less experienced underwriters or because of business decisions, it does raise concerns not least because it is only at claim stage that complaints about non-disclosure arrive at the office. If our perception is correct the impact of poor underwriting decisions will continue to be felt for many more years.

The training program ASISA introduced in 2011 for underwriters must be welcomed, as it will hopefully ensure that underwriting standards improve.

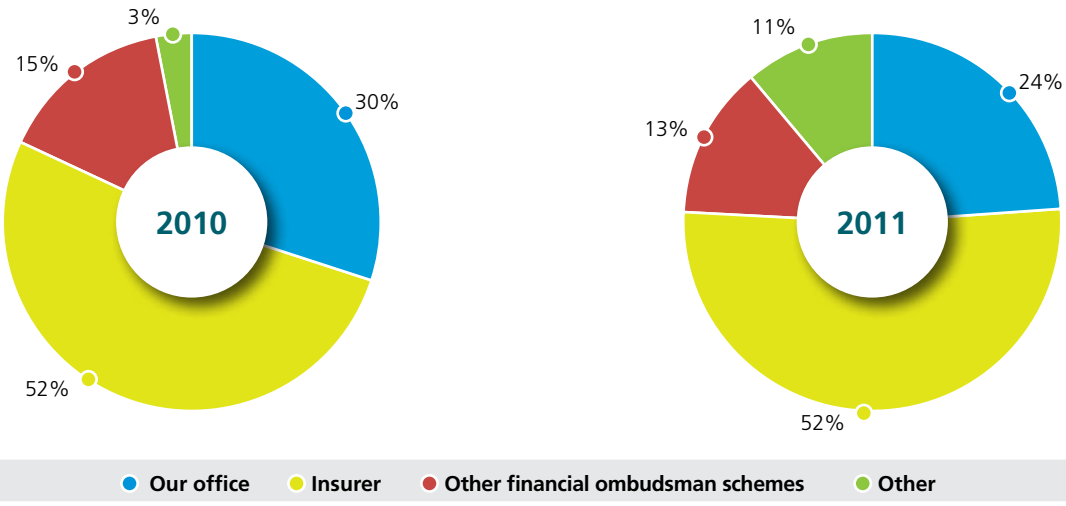
Credit Life – Retrenchment

Credit Life complaints comprised 11% of the closed cases in the office, and complaints about retrenchment benefits under these policies made up 23% of these cases.

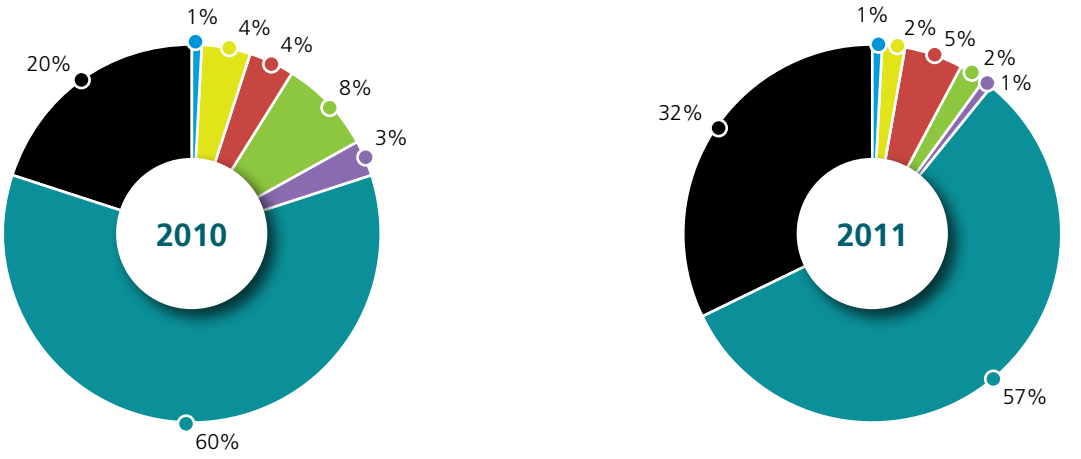
Many of the complaints demonstrate that policyholders do not understand the nature of retrenchment benefits in Credit Life policies. There is an expectation that the outstanding credit amount will be paid, but it is usually only four to six months instalments that are covered. The office also became aware of policies that only allow an advance against the policy to cover additional interest which becomes due in respect of each instalment deferred during four to six months of retrenchment cover. If it is only at claim stage that complainants become aware of this limited extent of their cover, they are understandably disappointed.

TELEPHONE CALLS

Telephone calls received 2010 vs 2011: Who the caller actually wanted



Telephone calls received 2010 vs 2011: How callers heard about the office



* Includes calls forwarded from the Directory Enquiries service.

APPENDICES

Appendix 1 **Subscribing members as at 31 December 2011**

1 Life Direct Insurance Limited
Absa Life Limited
Allied Insurance Co. Ltd
UBS Insurance Co. Ltd
Absa Insurance and Financial Advisers (Pty) Ltd
Acsis Ltd
African Unity
Allan Gray Life Ltd
Alexander Forbes Life Ltd
Assupol Life
AVBOB Mutual Assurance Society
Channel Life Ltd
PSG Anchor Life
Chartis Life SA Ltd (AIG Life)
Clientèle Life Assurance Co. Ltd
Discovery Life Ltd
Frank.Net
Guardrisk Life Ltd
Platinum Life
Hollard Life Assurance Co. Ltd
Crusader Life
Fedsure Credit Life
Investec
Covision Life Ltd
Investec Assurance Ltd
Investment Solutions Ltd
JDG Microlife LTD
KGA Life
Liberty Group Limited
Manufacturers Life
Prudential
Sun Life of Canada
Capital Alliance Life Ltd
AA Life
ACA Insurers Limited
Amalgamated General Assurance
Fedsure Life
IGI Life
Norwich Life
Saambou Credit Life
Standard General – pre-1999
Traduna
Rentmeester Assurance Ltd
Rondalia
Liberty Active Ltd
Lombard Life Ltd
Pinnafrica Life Ltd
McLife Assurance Co. Ltd
Medscheme Life Assurance Co. Ltd
Metropolitan Life Limited
Commercial Union
Homes Trust Life
Metropolitan Odyssey Ltd
Protea Life
Momentum Group Limited
African Eagle Life
Allianz Life
Anglo American Life
FNB Life
First Rand
Guarantee Life
Legal and General
Lifegro
Magnum Life
Rand Life
Sage Life
(National Mutual of Australasia)
(Ned Equity)
(Netherlands of 1845)
Shield Life
Southern Life
Yorkshire
Nedbank Financial Planning
Nedgroup Life Assurance Ltd.
NBS Life
BOE Life Ltd
Nestlife Assurance Corp. Ltd
New Era Life Insurance Co. Ltd
Old Mutual Life Assurance Co. (SA) Ltd
Colonial Mutual
Outsurance Insurance Co. Ltd
Professional Provident Society Ins Co. Ltd
Prosperity Life Co. Ltd
PSG Futurewealth Ltd
M Cubed Capital Limited
Time Life
Real People Assurance Company Ltd
Regent Life Assurance Co. Ltd
Relyant Life Assurance Co. Ltd
RMB Structured Life Ltd
Safrican Insurance Co. Ltd
Sanlam Life Insurance Ltd
Sanlam Sky (African Life Assurance Co. Ltd)
Permanent Life
Sentry Assurance
SA Home Loans Life Ltd
Union Life Ltd
Workers Life
Sekunjalo Investments Ltd

Appendix 2 **Members of the Ombudsman's Committee as at 31 December 2011**

Dorea Ozrovech (Chairperson)
Sanlam Life Insurance Limited

Chantal Meyer
Sanlam Sky Life Assurance Company Limited

Gail Walters
Hollard Life Assurance Company Limited

Anna Rosenberg
ASISA

Glenn Hickling
Discovery Life Limited

Russel Krawitz
Clientèle Life Assurance Company Limited

Brian Gibbon
Momentum Group Limited

Andrew Raichlin
Old Mutual Life Assurance Company (SA) Limited

Esrom Kgaphole
Assupol Life Limited

Deidre Wolmarans
Metropolitan Life Limited

Hazel Lerman
Liberty Group Limited

Audrey Rustin
Nedgroup Life Assurance Limited

Kurt Terblanche
1 Life Direct Insurance Limited

Appendix 3 **Staff as at 31 December 2011**

Management team
Mr Justice Brian Galgut
Jennifer Preiss
Ian Middup

Adjudicators/Assessors
Eddie de Beer
Heinrich Engelbrecht
Sue Myrdal
Nceba Sihlali
Nuku van Coller
Cikizwa Nkuhlu
Lisa Shrosbree
Deon Whittaker
Sharai Gaka
Diana Mills
Lorraine Allan
Kathy Heath
Ganine Bezuidenhoudt
Edith Field
Jenny Jenkins

Support staff
Clyde Hewitson
Rosemary Galolo
Charmaine Bruce
Jameelah Leo
Andrea Lennox
Marshalene Williams
Colleen Louw
Tamara Sonkqayi
Lisa Fincham
Angelo Swartz
Sithandwa Tolashe
Yolanda Augustine
Tania Thomas
Phindiwe Fana
Puleka Ngalo

Appendix 4 **Rules**

These Rules, effective from 1 January 1998 and last amended with effect from 9 July 2009, regulate the relationship between the Ombudsman for Long-term Insurance (the Ombudsman) and each member of the Long-term Insurance Industry (the Industry) who subscribes to the Ombudsman's scheme as well as between the Ombudsman and each complainant who lodges a complaint with the Ombudsman's office.

1 Mission

1.1 The mission of the Ombudsman is to receive and consider complaints against subscribing members and to resolve such complaints through mediation, conciliation, recommendation or determination.

1.2 The Ombudsman shall seek to ensure that:

1.2.1 he or she acts independently and objectively in resolving any complaint received and takes no instructions from anybody regarding the exercise of his or her authority;

1.2.2 he or she follows informal, fair and cost-effective procedures;

1.2.3 he or she keeps in balance the scale between complainants and subscribing members;

1.2.4 he or she accords due weight to considerations of equity;

1.2.5 he or she maintains confidentiality, in so far as it is feasible to do so and subject to Rules 3.8 and 7 below, in respect of every complaint received;

1.2.6 he or she co-operates with the Council established in terms of the Financial Services Ombud Schemes Act, 2004, in promoting public awareness of the existence, function and functioning of the Ombudsman and the Ombudsman's office and in informing potential complainants of available dispute resolution forums;

1.2.7 subscribing members act with fairness and with due regard to both the letter and the spirit of the contract between the parties and render an efficient service to those with whom they contract.

2 Jurisdiction

2.1 Subject to Rule 2.2, the Ombudsman shall receive and consider every complaint by a policyholder, a successor in title or a beneficiary, or by a life insured or premium payer, against a subscribing member concerning or arising from the marketing, conclusion, interpretation, administration, implementation or termination of any long-term insurance contract marketed or effected within the Republic of South Africa.

2.2 The Ombudsman shall not consider a complaint:

2.2.1 if such complaint is, or if it has been, the subject of legal proceedings instituted and not withdrawn, or if legal proceedings are contemplated to be instituted by the complainant against the subscribing member, during such time as the complaint remains under advisement by the Ombudsman; or

2.2.2 if it has previously been determined by the Ombudsman, unless new evidence likely to affect the outcome of a previous determination has thereafter become available; or

2.2.3 if three years or more has elapsed from the date on which the complainant became aware or should reasonably have become aware that he or she had cause to complain to the Ombudsman, unless the failure so to complain within the said period was due to circumstances for which, in the opinion of the Ombudsman, the complainant could not be blamed.

3 Procedure

3.1 The Ombudsman shall require all complaints to be reduced to written or electronic form, shall elicit such further information or expert advice as is regarded as necessary and shall seek to resolve every such complaint through mediation, conciliation, recommendation, failing which, by determination.

3.2 The determination aforesaid may be to:

3.2.1 decline to consider the complaint;

3.2.2 uphold the complaint, either wholly or in part;

3.2.3 dismiss the complaint;

3.2.4 make a ruling of a procedural or evidentiary nature;

3.2.5 award compensation, irrespective of a determination made in terms of Rule 3.2.2 or 3.2.3, for material inconvenience or distress or for financial loss suffered by a complainant as a result of error, omission or maladministration (including manifestly unacceptable or incompetent service) on the part of the subscribing member; provided that the amount of such compensation shall not exceed the sum of R30 000 or such other sum as the Long-term Insurance Ombudsman's Council ("the Council") may from time to time determine;

3.2.6 order a subscribing member, in addition to any other recommendation or determination made, to pay interest to a complainant on the pertinent sum at a rate and from a date that is considered to be fair and equitable in the circumstances.

3.2.7 order a subscribing member to take, or refrain from taking, any such action in regard to the disposal of a specific complaint as the Ombudsman may deem necessary.

3.2.8 issue a declaratory order.

3.3 The Ombudsman may decline to consider or may dismiss a complaint, without first referring it to the subscribing member concerned, if it appears to him or her, on the information furnished by the complainant, that:

3.3.1 the complaint has no reasonable prospect of success; or

3.3.2 the complaint is being pursued in a dishonest, frivolous, vexatious or abusive manner; or

3.3.3 the complaint can more appropriately be dealt with by a court of law; or

3.3.4 the complaint is predominantly about investment performance or the legitimate exercise by a subscribing member of its commercial judgment; or

3.3.5 the complainant has not suffered, and is not likely to suffer, material inconvenience or distress or financial loss either within the meaning of Rule 3.2.5 or at all.

3.4 If a complainant or a subscribing member fails or refuses to furnish information requested by the Ombudsman within the period fixed for that purpose, the Ombudsman shall be free to make a determination on the information as may then be available to him or her.

3.5 A determination made by the Ombudsman shall be binding on the subscribing member concerned.

3.6 A determination made by the Ombudsman shall not preclude the complainant from thereafter instituting legal proceedings against a subscribing member in respect of any such complaint.

3.7 All exchanges between, on the one hand, the office of the Ombudsman and a complainant and, on the other, the office and a subscribing member in relation to a complaint and all the documentation generated in regard thereto, shall by agreement be regarded as privileged and shall as such be immune from disclosure in evidence, save by an order of court or the consent of the parties concerned.

3.8 In any case in which a determination as provided for in Rule 3.2.2 is made against a subscribing member, the Ombudsman shall publish such determination, including a summary of the facts concerned, the reasons for the determination and the identity of the subscribing member; provided that the Ombudsman shall not publish as aforesaid in any case in which there is reason to believe that such publication will expose the identity of the complainant.

4 Prescription

The receipt of a complaint by the Ombudsman suspends any applicable contractual time barring terms or the running of prescription in terms of the Prescription Act (Act 68 of 1969), for the period from such receipt until the complaint has been withdrawn by the complainant concerned, been determined by the Ombudsman or any appeal in terms of these Rules has been disposed of.

5 Determination of disputes of fact

5.1 The Ombudsman shall resolve material disputes of fact on a balance of probabilities and with due regard to the incidence of the onus.

5.2 If the Ombudsman is of the opinion that a material and conclusive dispute of fact cannot be resolved on a balance of probabilities and with due regard to the incidence of the onus, the parties concerned shall be advised that a determination in favour of the one or the other party cannot be made.

5.3 Notwithstanding Rule 5.2, if the Ombudsman and all the parties concerned are in agreement that a complaint or a material and conclusive dispute of fact can best be determined by the hearing of evidence, it may be so determined.

5.4 A hearing as aforesaid may be conducted by the Ombudsman or any other person or persons appointed for that purpose by the Ombudsman.

5.5 At such a hearing all issues of a procedural or evidentiary nature shall be determined by the Ombudsman or other person or persons so appointed.

6 Appeals

6.1 A complainant who or a subscribing member which feels aggrieved by any determination by the Ombudsman may apply to the Ombudsman for leave to appeal against it to a designated Appeal Tribunal.

6.2 Such an application shall be made within a period of one calendar month from the date on which the determination that is challenged has been made.

6.3 Such leave to appeal shall be granted:

6.3.1 if the determination is against a subscribing member and involves an amount in excess of R250 000 or such other sum as the Council may from time to time determine; or

6.3.2 if the Ombudsman is of the opinion that the determination as such or the particular issue in dispute is of considerable public or industry interest; or

6.3.3 if the Ombudsman is of the opinion that the aggrieved complainant or subscribing member has a reasonable prospect of success in an appeal before a designated Appeal Tribunal.

6.4 The member or members of the Appeal Tribunal shall be appointed by the Ombudsman with the consent of all the parties concerned or, failing such consent, with the approval of the Chairman of the Council or, if he or she is unavailable, two members of the Council not connected with the Industry.

6.5 The Ombudsman shall prepare the record for consideration by the Appeal Tribunal.

6.6 All issues of a procedural or evidentiary nature shall be determined by the Appeal Tribunal itself.

6.7 The decision of the Appeal Tribunal shall be final and binding:

6.7.1 if the complainant is the appellant, on all the parties concerned;

6.7.2 if the subscribing member is the appellant, on it.

6.8 When the complainant is the appellant:

6.8.1 he or she may be required to deposit such amount as the Ombudsman may consider appropriate into the trust account of an attorney designated by the Ombudsman;

6.8.2 such amount shall be held in trust pending the outcome of the appeal;

6.8.3 if the appeal is, in the view of the Appeal Tribunal, substantially successful, such amount shall be refunded to the complainant;

6.8.4 if the appeal is, in the view of the Appeal Tribunal, substantially unsuccessful, such amount shall be applied by the Ombudsman to defray, either wholly or in part, the costs incurred by the Ombudsman in connection with the appeal proceedings and to refund any surplus to the complainant.

6.9 When the subscribing member is the appellant:

6.9.1 if the appeal is, in the view of the Appeal Tribunal, substantially successful, the Ombudsman shall defray the costs incurred by him in connection with the appeal proceedings;

6.9.2 if the appeal is, in the view of the Appeal Tribunal, substantially unsuccessful, the subscribing member shall defray the costs incurred by the Ombudsman in connection with the appeal proceedings.

7 Enforcement

7.1 If a subscribing member should fail or refuse to comply with a determination made by the Ombudsman:

7.1.1 it shall be given notice by the Ombudsman that it is to comply with such determination within a period of four weeks or such further period as the Ombudsman may determine;

7.1.2 on the failure or refusal by the subscribing member to comply with such notice, the Ombudsman shall report such failure or refusal to the Chairman of the Long-term Insurance Ombudsman's Committee ("the Committee").

7.2 The Ombudsman may thereupon:

7.2.1 determine what, if any, further opportunity should be afforded to the subscribing member concerned to make representations as to why the measures described below should not be implemented;

7.2.2 publish, in whatever manner the Ombudsman considers to be appropriate, the fact of such failure or refusal;

7.2.3 suspend or terminate, with the consent of the Chairmen of both the Council and the Committee, the membership of the subscribing member concerned; and, in that event,

7.2.4 publish in whatever manner the Ombudsman considers to be appropriate, the fact of such suspension or termination of such membership.

8 Report

The Ombudsman shall report publicly on or before 31 May of each year on his or her activities during the previous calendar year.

USEFUL INFORMATION ABOUT OTHER OFFICES

The Ombudsman for Short-term Insurance
PO Box 32334, Braamfontein 2017
Sharecall: 0860 726 890
Telephone: 011 726 8900
Fax: 011 726 5501
E-mail: info@osti.co.za

The Ombudsman for Banking Services
PO Box 87056, Houghton 2041
Sharecall: 0860 800 900
Telephone: 011 712 1800
Fax: 011 483 3212
E-mail: info@obssa.co.za

The Credit Ombud
Postnet Suite 444, Private Bag 1
Jukskei Park 2153
Call centre: 0861 662 837
Fax: 0866 834 644
E-mail: ombud@creditombud.org.za

The Ombud for Financial Service Providers
PO Box 74571, Lynnwoodridge 0040
Sharecall: 0860 324 766
Telephone: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

The Pension Funds Adjudicator
PO Box 651826, Benmore 2010
Telephone: 087 942 2700
Fax: 087 942 2644
Email: enquires-jhb@pfa.org.za

The Financial Services Board
PO Box 35655, Menlo Park 0102
Toll-free: 0800 110 443 or 0800 202 087
Telephone: 012 428 8000
Fax: 012 347 0870
E-mail: info@fsb.co.za

The Council for Medical Schemes
Private Bag X34, Hatfield 0028
Telephone: 012 431 0500
Fax: 012 430 7644
E-mail: support@medicalschemes.com

Public Protector
Private Bag X677, Pretoria 0001
Telephone: 012 366 7000
Fax: 012 632 3473/0865 753 292
E-mail: Elainei@pprotect.org

ASISA
Cape Town office:
PO Box 23525, Claremont 7735
Telephone: 021 673 1620
Fax: 021 673 1630
E-mail: info@asisa.org.za

Johannesburg office:
PO Box 787465, Sandton 2146
Telephone: 011 369 0460

The Statutory Ombudsman
PO Box 74571, Lynnwoodridge 0040
Sharecall: 0860 324 766
Telephone: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

The National Credit Regulator
PO Box 2209, Halfway House, Midrand 1685
Call centre: 0860 627 627
Fax: 011 805 4905
E-mail: info@ncr.org.za or complaints@ncr.org.za
Telephone: 011 554 2600

OMBUDSMAN'S CENTRAL HELPLINE
Sharecall 0860OMBUDS/0860662837

3rd Floor
Sunclare Building
Dreyer Street
Claremont 7700
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