ANNUAL REPORT 2018

OMBUDSMAN
FOR LONG-TERM INSURANCE

KEY FIGURES

Written requests for assistance received	11 768
Chargeable complaints received	5 978
Full cases finalised	3 367
Percentage of complaints finalised within six months	91%
Percentage of cases resolved wholly or partially in favour of complainants	31.5%
Total expenses	R26.04m
Cost per standard case	R3 629
Recovered for complainants	R185.8m in lump sums
Compensation awarded	R632 737 in 160 complaints
Transfers settled in favour of complainants	1 132

STATISTICS

REQUESTS FOR ASSISTANCE RECEIVED

We received 11 768 written requests for assistance in 2018, which was an increase of 1 000 complaints compared to the 10 768 in 2017. Of those requests, 5 978 were chargeable complaints which fell within our jurisdiction – this was an increase of 10% compared to the 5 435 chargeable complaints received in 2017.

Of the chargeable complaints 3 951 were Transfers, and insurers managed to settle 1 132 directly with complainants. This amounted to 28.6% of Transfers, which is a higher percentage than the 24% in 2017. Reviews decreased slightly to 1 596 compared to the 1 610 in 2017.

It is not always clear what the drivers are for complaints to the office. Although we receive complaints throughout the year, there are certain months when the numbers are higher. Not surprisingly, after the Annual Report release and the corresponding publicity we usually see an increase, which occurred in May 2018. After the publicity surrounding the Ganas/Momentum case in November 2018 (see pages 16 to 17 of this Annual Report) we expected to see a spike in complaints, but the numbers stayed the same as in October. As can be expected, December usually has the lowest number of complaints in the year. However, complaint numbers and trends remain difficult to predict.

FINALISATION PERIOD

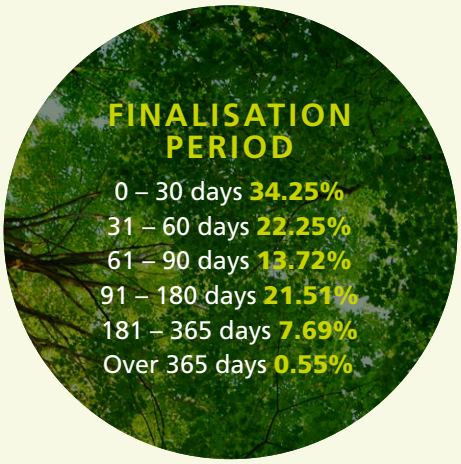
It is gratifying that the percentage of complaints finalised within six months increased to 91% (85% in 2017). The office's new business model assisted in this regard, as we include Transfers, Reviews and Full Cases in this calculation.

DESCRIPTION OF CHARGEABLE COMPLAINTS

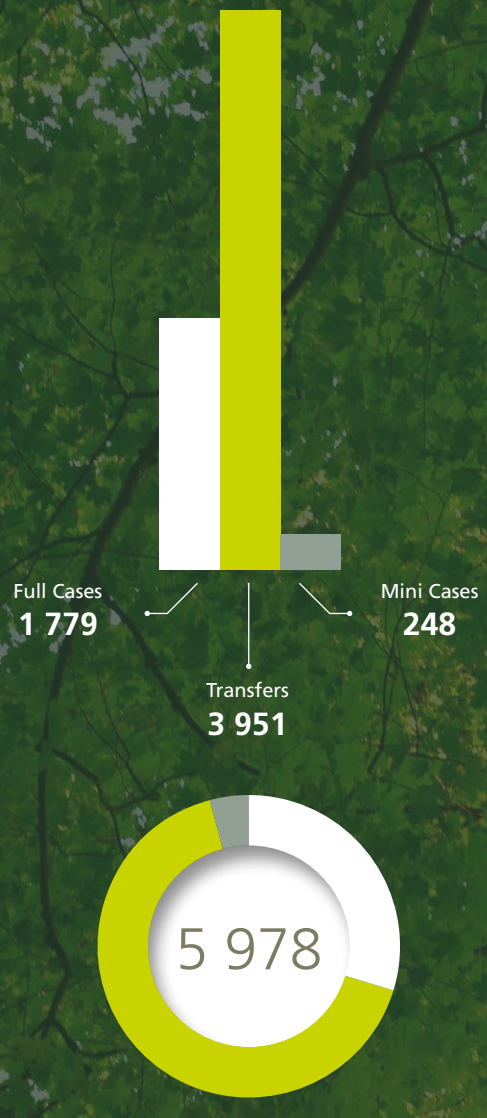
MINI CASES – consist of simple complaints that are within the jurisdiction of the office, but which insurers can handle without the office's involvement. The complainant is always advised that if the matter is not resolved he/she can revert to us. There are also some complaints which have no prospect of success. The assessing staff dismiss these complaints and explain the reasons for the dismissal to the complainants. These complaints are charged the reduced mini case fee.

TRANSFERS – these are complaints not previously seen by insurers and referred to them to try and resolve directly with the complainant. If not resolved and if the complainant, when contacted by the office, requests us to do so, they are taken up by the office as Reviews and handled in the same manner as Full Cases.

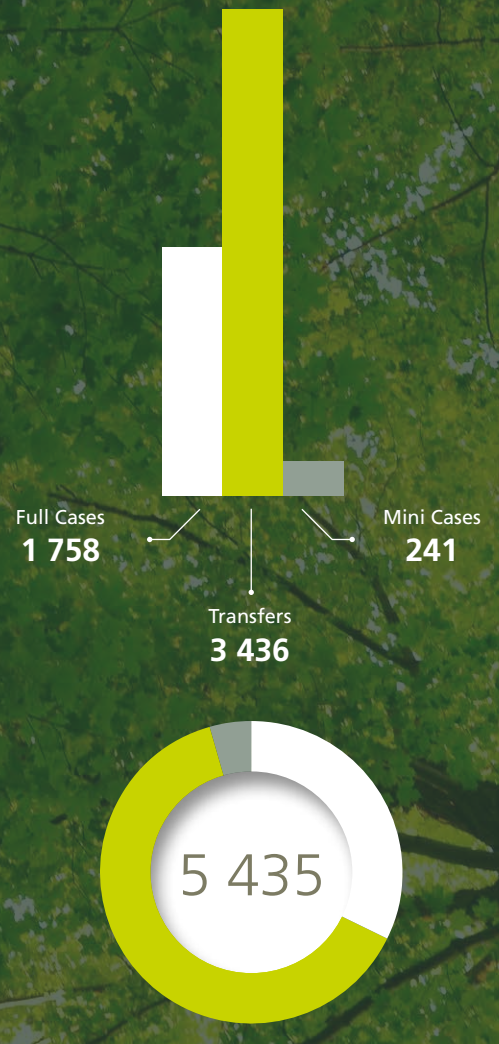
FULL CASES – these are complaints that have already been seen by insurers and they are handled by the office from inception to finalisation.



CHARGEABLE COMPLAINTS RECEIVED 2018



CHARGEABLE COMPLAINTS RECEIVED 2017



STATISTICS
CONTINUED

CASES FINALISED – cases finalised incorporate Full Cases as well as Reviews. These are the cases that the office considered and resolved during the year. In 2018 this amounted to 3 367, four less than the 3 371 in 2017.

CASE FEES – the office is funded by way of a levy which amounts to 10% of our funding and the rest is by way of case fees which are charged for cases handled by the office, irrespective of the outcome thereof. The Standard Case fee, which is the benchmark figure, was estimated to be R3 980 for 2018. The actual case fee is 8.6% lower at R3 629, which is even lower than the 2017 Standard Case fee of R3 707. This was due to the higher number of chargeable complaints received and the financial management in the office.

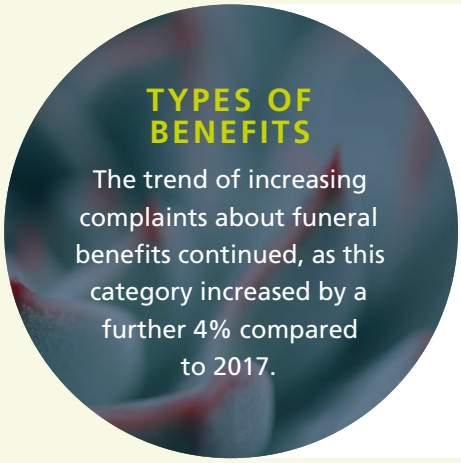
Cases finalised are categorised as follows for charging purposes:

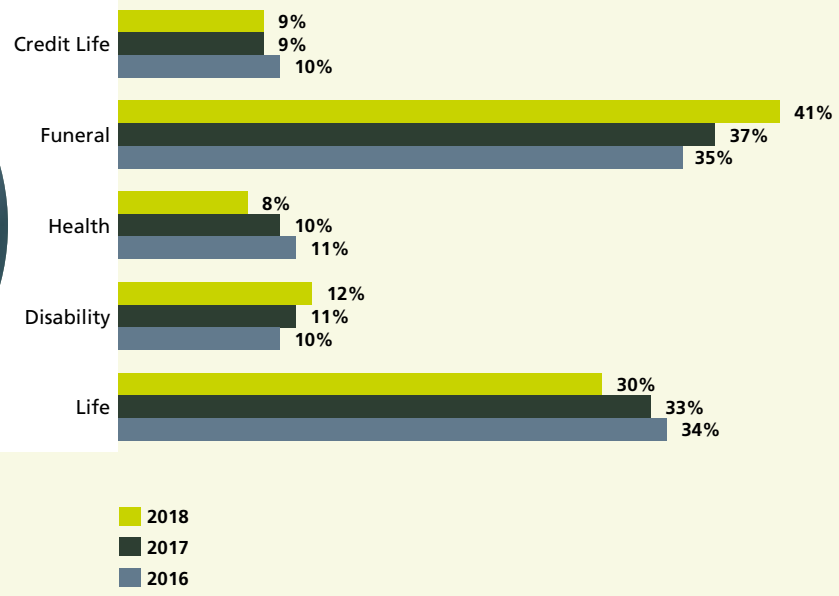
STANDARD CASES – this term refers to the benchmark category of cases charged at a case fee of R3 629.

INCOMPETENT CASES – these are cases where the insurer either gave a response outside of our time standards or gave an inadequate response. These cases are charged at either double or triple the Standard Case fee, depending on the extent of the incompetence. It is pleasing that there is a reduction in these numbers.

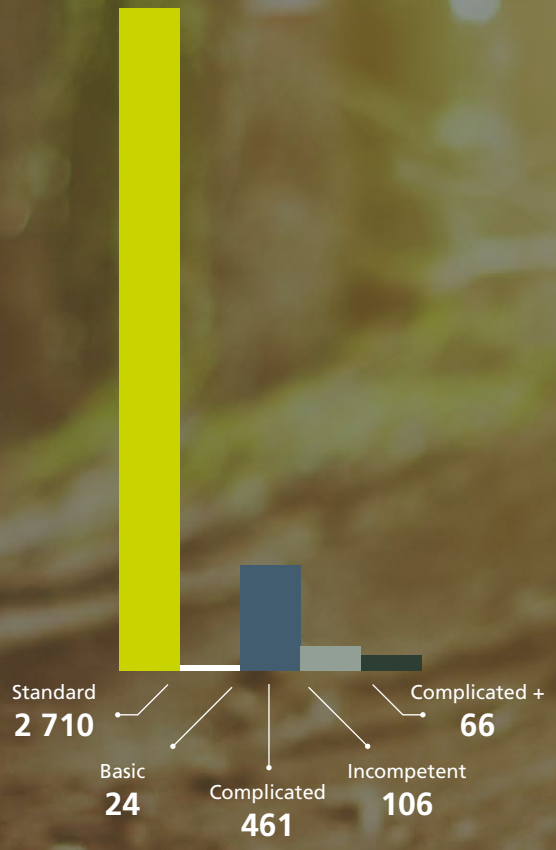
COMPLICATED CASES AND COMPLICATED PLUS CASES – these cases are difficult to deal with because of complex legal, medical or financial issues or as a result of the complainant's persistence. These categories increased, reflecting the increasing difficulty we experience with complaints.

BASIC CASES – these are cases involving complaints about funeral policies issued by small insurers where the complaint is resolved on the first response by the insurer. A reduced fee is charged for these cases.

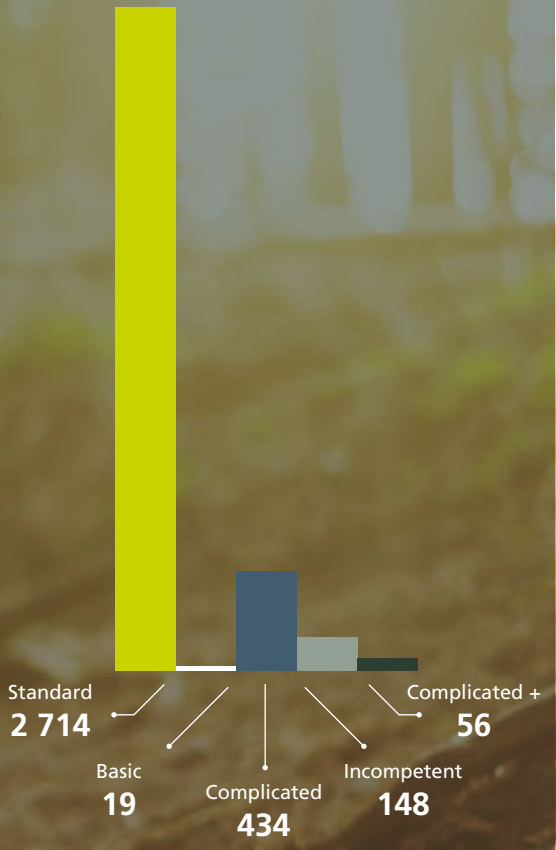




CASES FINALISED 2018



CASES FINALISED 2017



STATISTICAL SUMMARY

	LIFE				DISABILITY			
NATURE OF COMPLAINT	**2017**	**W/P***	**2018**	**W/P***	**2017**	**W/P***	**2018**	**W/P***
Poor communications/documents or information not supplied/poor service	928	35%	851	39%	49	33%	61	25%
Claims declined (policy terms or conditions not recognised or met)	1 103	28%	1 093	32%	265	34%	343	37%
Claims declined (non-disclosure)	88	25%	103	17%	73	16%	60	22%
Dissatisfaction with policy performance and maturity values	136	10%	101	11%	0	0%	0	0%
Dissatisfaction with surrender or paid-up values	67	15%	53	11%	0	0%	0	0%
Misselling	14	50%	22	32%	0	0%	1	100%
Lapsing	174	25%	203	33%	4	25%	3	33%
Miscellaneous	130	25%	172	23%	14	29%	4	25%
Total	**2 640**	**28.9%**	**2 598**	**31.8%**	**405**	**30.4%**	**472**	**33.5%**

* Resolved wholly or partially in favour of the complainant.

NATURE OF COMPLAINT

The Claims Declined category had the highest number of complaints, with the Poor Service category the second highest. This is the same pattern as in previous years. It is a matter of concern that more complaints about Lapsing of policies were received, even though it might be caused in part by the tough economic situation. The high lapse rate of policies in the long-term insurance industry has always been problematic.

During 2018 we started to record complaints according to the Treating Customers Fairly outcome categories which are reflected in the new Policy Protection Rules ("PPR"). See the table on page 23 of this Annual Report.

OF CASES FINALISED

	HEALTH				TOTALS				% OF TOTAL	
	2017	W/P*	2018	W/P*	2017	W/P*	2018	W/P*	2017	2018
	41	51%	25	44%	1 018	35%	937	38%	30.20%	27.83%
	239	25%	225	23%	1 607	29%	1 661	31%	47.67%	49.33%
	39	21%	35	0%	200	21%	198	15%	5.93%	5.88%
	0	0%	0	0%	136	10%	101	11%	4.03%	3.00%
	0	0%	0	0%	67	15%	53	11%	1.99%	1.57%
	0	0%	1	0%	14	50%	24	33%	0.42%	0.71%
	2	50%	4	75%	180	25%	210	34%	5.34%	6.24%
	5	40%	7	57%	149	26%	183	24%	4.42%	5.44%
	326	**27.9%**	**297**	**23.2%**	**3 371**	**29.0%**	**3 367**	**31.5%**	**100%**	**100%**

RESOLVED WHOLLY OR PARTIALLY ("W/P") IN FAVOUR OF COMPLAINANTS

The percentage of cases resolved in favour of complainants increased slightly from 29% in 2017 to 31.5% in 2018. Funeral benefits made up 48.8% of the W/P cases. If we add the Transfers settled, then the W/P percentage increases to 40%. This is slightly higher than the percentage the last few years, which was around 37%.

R185.8 million was recovered for complainants in the form of lump sums. This figure does not reflect the value of other benefits, such as recurring income disability benefits, annuities and reinstatement of policies, etc.