ANNUAL REPORT
2015




OMBUDSMAN
FOR LONG-TERM INSURANCE

Chargeable complaints received

5 018

Full cases finalised

3 491

Percentage of cases finalised within six months

75%

Percentage of cases resolved wholly/ partially in favour of complainants

29.8%

KEY FIGURES

Total expenses for the year

R18.875m

Cost per standard case

R3 250

Recovered for complainants

R184.4m

Compensation awarded

R527 666




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FOREWORD BY THE CHAIRPERSON OF THE OMBUDSMAN'S COUNCIL

In my foreword to the 2014 Annual Report of the office I pointed out that, in accordance with accepted best practice corporate governance principles, the Council had approved the appointment of Dr E de la Rey to conduct an external review or a "performance audit" – as it was called on page 3 of the office's 2005 Annual Report. I then said that this "comprehensive review will entail an in-depth investigation and a qualitative assessment of key aspects of the office's business". Dr De la Rey's report of her independent review of the office was submitted to the Council on 22 April 2015. Dr De la Rey used an international standard as the yardstick against which the performance of the office was measured. The International Network of Financial Services Ombudsman Schemes ("INFO Network") has 58 members spread across 37 countries. During 2014, the INFO Network published a guide setting out seven fundamental principles to which its members should aspire. Dr De la Rey assessed the performance of the office with reference to those principles.

I am pleased to say that the office passed the performance audit with flying colours and I congratulate it on this achievement which is encapsulated in the last two paragraphs of the report, where Dr De la Rey said:

> "During the investigation I was struck by the respect the office enjoys, by the culture of professionalism and respect, by the helpfulness and teamwork. There is an enviable enthusiasm for the work they do, despite limited career paths. There is an openness in the management style, but at the same time strict discipline; there is respect and dedication. There is also a continued willingness to adjust and to implement possible improvements.
>
> OLTI complies with and exceeds international standards and expectations for a financial ombud scheme and continues to serve as a benchmark for other financial ombud schemes."

During the year Mr J Dixon and Judge N Hurt resigned as members of the Council. I thank them for the effort and time which they spent on the Council's affairs. I am pleased to welcome Ms F Badat of the Financial Services Board as Mr Dixon's successor on the Council.

On 27 October 2015 the Minister of Finance tabled the Financial Sector Regulation Bill, 2015 ("the 2015 Bill"). If the 2015 Bill is implemented in its current form it will have a profound effect on the Council, the office and the three other statutorily recognised voluntary financial ombudsman schemes. In my view it is premature to say anything more about the 2015 Bill than what the Ombudsman states in his report.

In terms of section 10(1)(b) of the Financial Services Ombud Schemes Act, 37 of 2004, the Council is obliged to "monitor the performance and independence of the

"I am pleased to say that the office passed the performance audit with flying colours and I congratulate it on this achievement...."

Ombud and ... the continued compliance by the scheme with its constitution, the provisions of the scheme and this Act."

In last year's foreword I also referred to the Council's appointment of Judge R Cleaver as the office's new Independent External Assessor. In the performance of its corporate governance duty, the Council received a report from the office on the three complaints which had been lodged against the office by a complainant during 2015. Further particulars of these complaints appear on page 13 of this Annual Report. Given the outcome of two of the complaints; the true nature of the third complaint and the office's expressed intention to follow Judge Cleaver's advice, the Council did not consider it necessary to take any action in connection with this matter.

On behalf of the Council it is my pleasure to declare that the Council is satisfied that during 2015 the Ombudsman and the office fulfilled their mission, complied with all their obligations and maintained the independence which is vital to their function.

I thank the members of the Council for their continued support and valued contributions during 2015.

Leona Theron

Dr De la Rey's report is on our website:
http://www.ombud.co.za/useful-information/independent-review.

MISSION

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.

The Ombudsman shall seek to ensure that:

- 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;
- he or she follows informal, fair and cost-effective procedures;
- he or she keeps in balance the scale between complainants and subscribing members;
- he or she accords due weight to considerations of equity;
- he or she maintains confidentiality, in so far as it is feasible to do so and subject to Rules 3.8 and 7, in respect of every complaint received;
- 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;
- 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.

MEMBERS OF THE OMBUDSMAN'S COUNCIL

Judge Leona Theron
(Chairperson)
Judge of the Supreme Court of Appeal

Ms Thandiwe Zulu
Regional Manager of the Black Sash

Mr Ken Baldwin
(Deputy Chairperson)
Retired senior partner of KPMG

Judge Noel Hurt
Retired judge of the KwaZulu-Natal High Court

Adv Moses Moeletsi
Independent consultant; formerly Chairperson of the Board of the Ombudsman for Short-term Insurance

Ms Farzana Badat
(ex officio)
Head of Department: Insurance Compliance, Financial Services Board

Mr Desmond Smith
Chairperson of Reinsurance Group of America (South Africa); Chairperson of Sanlam; director of companies

Ms Dorea Ozrovech
(ex officio)
Manager:Client Relations, Sanlam Life; Chairperson of the Ombudsman's Committee

Ms Mpho Lekala
Director of What Went Wrong Consulting; formerly head of the Debt Review Centre at FNB Shared Services

Judge Ron McLaren
(ex officio)
Ombudsman

FOREWORD BY THE CHAIRPERSON OF THE OMBUDSMAN'S COMMITTEE

The office of the Ombudsman for Long-term Insurance plays a vital role in the dispute resolution structures in the financial industry in South Africa. As such it provides clients with cost-effective recourse when they feel they are not treated fairly by insurance companies. At the same time the office gives guidance to the industry on fairness and the interpretation of certain legislation.

The Ombudsman's Committee is a liaison body between subscribing members and the Ombudsman's office. Any subscribing member may ask to be represented on the Committee. At present the Committee is made up of 14 representatives from a variety of subscribing members, a representative of ASISA and the management team of the Ombudsman's office. We meet twice a year to discuss topics of mutual interest and with the objective to ensure that complaints are handled effectively and with fair outcomes to complainants. We share experiences and trends and ensure that processes between the industry and the office run smoothly. This gives a platform for the Ombudsman's office to provide comments, to make recommendations and to share information about systemic issues.

The industry is very pleased to see that, for the second year in a row, there were slightly fewer chargeable complaints received by the Ombudsman's office during 2015. We also noted a further decline in the number of cases marked as "incompetent" by the Ombudsman's office. The resolutions in favour of complainants remained stable at around 30% of cases.

During 2015 the industry reported on continued efforts to ensure proper internal complaints management processes as part of their TCF readiness. There were more social media complaints as well as continued trends of more complex and complicated complaints and more persistent complainants. It was clear from consumer behaviour that many clients experienced financial hardship in the economic situation of our country.

The transfer process of cases to insurers is now well established in the Ombudsman's office and the industry welcomes it to have an opportunity to first try to resolve complaints directly with complainants. This process alleviates some of the pressure on the Ombudsman's office with service-related issues and the easier complaints, but it also implies that most of the cases in the Ombudsman's office are now difficult and technically involved. The majority of insurers also welcomed the initiative of the office to launch its 2014 Annual Report to subscribers via a webinar.

Insurers have a lot of appreciation for the Ombudsman's office – their processes and people and their time to give training and guidance to assist with the complaints resolution processes and to discuss cases for possible solutions. We also want to congratulate them on the positive feedback they received from the external review of the office's processes.

We look forward to the year ahead – where we expect more legislative changes to impact on the industry and delivery expected on TCF outcomes. We appreciate the Ombudsman's guidance in this regard.

Dorea Ozrovech

REPORT BY THE OMBUDSMAN

OVERVIEW OF 2015

Comprehensive statistics for the year appear on pages 14 to 19 of this Annual Report. By way of synopsis of those statistics, I refer only to the following: 9 815 written requests for asistance were received, which represents an increase of 6% over 2014; complaints in which the complainants were wholly or partially successful (in office parlance, the "W/P percentage") was 29.8%, compared to 29.7% in 2014.

In last year's Annual Report it was pointed out that, despite the continued existence of the trends which could have been responsible for the consistent increase in the number of complaints received during the past few years, the office received nearly 8% fewer written requests for assistance in 2014 than in 2013. I then said that it would be premature to forecast any complaint trend for 2015, but the tenor of my statement was that a further reduction in the number of complaints could be expected. It was prudent not to have made a forecast because it would have been wrong. The office experienced a marked increase in the number of complaints received during the last quarter of the year and this resulted in a build-up of current cases at the end of 2015.

The office constantly monitors the number of complaints received and it will suitably and timeously adapt to any significant change in the trend of the complaint volumes.

NEW BUSINESS MODEL

The essence of the office's new business model is its requirement that any complaint not previously considered by a subscribing member will be forwarded to it in the first instance with a view to affording it an opportunity to resolve the complaint. In 2013 the new business model started as a pilot project involving a few insurers and during 2014 it was incrementally expanded to other subscribing members. As matters turned out, 2015 was the first year for which a meaningful comparison could be made with a previous year. On page 12 of our 2014 Annual Report an analysis was done of the 2014 Transfers, namely those matters which had been sent to the insurers by the office. This year the same analysis appears on page 14 of this Annual Report and the 2014 analysis is also reflected there for comparative purposes. It will be seen from this comparison that the pattern of the Transfers over those two years is quite consistent.

INDEPENDENT EXTERNAL REVIEW

By way of background and introduction I refer readers to Judge Theron's foreword on page 2.

In an addendum to her report Dr De la Rey made recommendations for the improvement of the way in which the office functions and of the service which it renders to consumers. Her principal recommendations (agreed to by the office and implemented or in the process of being implemented) are the following:




- That publicity should be given to the fact that our procedure provides complainants with sufficient assistance and safeguards to canvass any complaint in full, without legal assistance and at no cost.
- That more publicity should be given to the independence of the office.
- That our website should be more user friendly for complainants and that more prominence should be given in it to our independence; that compensation may be awarded; that we have an equity jurisdiction and that our service is free.
- That our letterhead should be improved, also to reflect that our services are offered free of charge.
- That we should publicise the facts that the office goes to a lot of trouble to actively investigate complaints and that the lodging of a complaint suspends any time limit for taking the dispute to a court of law.

We are proud of the good report which the office received and we will try to improve the high standards of service delivery of which the report speaks.

REGULATION OF THE FINANCIAL SECTOR

On page 9 of our 2014 Annual Report I referred to certain documents which had been published during December 2014, including the Financial Sector Regulation Bill, 2014 ("the 2014 Bill"). I briefly drew attention to the principal provisions of chapter 16 of the 2014 Bill, which related to "Financial Services Ombud Schemes" and said that it was "premature to comment extensively on the 2014 Bill and its effect".

On 27 October 2015 the Minister of Finance tabled the Financial Sector Regulation Bill, 2015 ("the 2015 Bill") in Parliament and issued a media statement dealing with its effect on "a Twin Peaks model of financial regulation for South Africa".

Chapter 14 of the 2015 Bill relates to "Ombuds" and differs vastly from chapter 16 of the 2014 Bill. For instance, the 2015 Bill provides for the establishment of an "Ombud Regulatory Council" and for the appointment of a "Chief Ombud". Save for saying that the legislature clearly intends to bring about sweeping changes in the regulation of financial ombudsman schemes, I think it is premature to comment extensively on the 2015 Bill and its effect.

Our office and the offices of the three other statutorily recognised voluntary financial ombudsman schemes submitted written submissions on chapter 14 and certain other relevant provisions of the 2015 Bill. We subsequently received an assurance from the National Treasury that it will engage in further consultation with the said ombudsman offices in connection with the 2015 Bill.

CONFERENCES

In 2015 three relevant conferences were held which were attended by members of the office. It is important for the office to be represented at and to participate in appropriate conferences. Such conferences offer an opportunity for us to be exposed to and to learn from the collective knowledge and experience of organisations which deliver services comparable to those which we render.

- During March the UK Financial Ombudsman Service presented its event, Spring15, in London. Jennifer Preiss and Ian Middup represented the office

Dr De la Rey's report is on our website:
http://www.ombud.co.za/useful-information/independent-review.




at the conference. The host organisation is, in its own words, "the largest ombudsman scheme in the world" and the stated objective of Spring15 was "to share our knowledge by offering ombudsman colleagues from around the world the opportunity to learn from our experience of running an ombudsman service". The conference admirably succeeded in achieving its purpose.

- The Ombudsman Association South Africa held its inaugural conference in Pretoria during July. The conference was attended by about 70 persons and the consensus of opinion amongst them was that the conference was a success and that similar conferences should be held in the future. Our office presented a well-received panel discussion on "Dealing with difficult complainants". See the article "Unreasonable complainants" on pages 24 and 25.
- The International Network of Financial Ombudsman Schemes ("INFO Network") has 58 members spread across 37 countries. The INFO Network 2015 conference was held in Helsinki during September and Jennifer Preiss attended it on behalf of the office. The conference had a specific theme and all the presentations were directed at "Solving Problems – Building Trust". Emphasis was placed on the need to resolve complaints speedily by means of a more informal process, notably telephonic communication, which calls for "active listening". Offices like ours operate in an industry in which the abstract concept of trust cannot be over-estimated. In order to gain the trust of consumers and our subscribing members, we have to demonstrate our expertise, independence and knowledge. Following some of the lessons learnt at the latest INFO Network conference the office started a pilot project, involving three insurers and a team of four persons in the office, to deal with certain selected complaints on a "fast track" basis. In these complaints we attempt to achieve significant reductions in the turnaround times, without sacrificing the quality of our service to the parties. We intend to use this more expeditious and less formal complaints resolution process to good effect in disability cases, which are invariably complicated and time-consuming. It is too early to make a definitive assessment of the success of this pilot project, but the signs are encouraging.

INSURANCE BILL, 2015

On 17 April 2015 a media statement was issued by the National Treasury and the Financial Services Board to announce the publication of the above Bill which had been approved by the Cabinet on 15 April 2015. In the statement the following was said:

- "The enhanced prudential framework for insurers forms part of the Twin Peaks reforms, which seek to significantly enhance South Africa's financial regulatory and supervisory framework, by also enabling an intensive, intrusive and effective system of regulating the financial sector. The Bill facilitates a seamless transition into the Twin Peaks that is envisaged in the Financial Sector Regulation Bill, 2015 in respect of prudential supervision of insurers, which will be enforced by the envisaged new Prudential Authority under the South African Reserve Bank."
- "The Bill provides a consolidated legal framework for the prudential supervision of the insurance sector that is consistent with international standards for

"In order to gain the trust of consumers and our subscribing members, we have to demonstrate our expertise, independence and knowledge."

insurance regulation and supervision. It also seeks to replace and consolidate substantial parts of the Long-term Insurance Act, 1998 (Act No. 52 of 1998) and the Short-term Insurance Act, 1998 (Act No. 53 of 1998) relating to prudential supervision."

- "The Bill gives effect to the National Treasury's Micro-insurance Policy Document released in July 2011.... It supports the development of an inclusive insurance sector through providing affordable insurance, while also having proportionate and appropriate regulation and supervision of micro-insurance."

TREATING CUSTOMERS FAIRLY

According to the Financial Services Board its regulatory programme known as Treating Customers Fairly ("TCF") seeks to ensure that specific, clearly articulated "fairness outcomes" for financial services customers are demonstrably delivered by regulated financial institutions. These six outcomes are:

- Customers can be confident they are dealing with firms where TCF is central to the corporate culture.
- Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.
- Customers are provided with clear information and kept appropriately informed before, during and after point of sale.
- Where advice is given, it is suitable and takes account of customer circumstances.
- Products perform as firms have led customers to expect, and service is of an acceptable standard and as they have been led to expect.
- Customers do not face unreasonable post-sale barriers imposed by firms to change a product, switch providers, submit a claim or make a complaint.

At the inaugural conference of the Ombudsman Association South Africa during July 2015 Ms L Jackson of the Financial Services Board delivered "An update on Treating Customers Fairly". During the course of the presentation Ms Jackson drew attention to the following:

- One of the objectives of the Financial Sector Conduct Authority (which will be established with the enactment of the 2015 Bill) is to ensure that financial institutions treat financial customers fairly.
- TCF fulfils the need for a "holistic, co-ordinated and consistent financial consumer protection regulatory framework – with a mix of principles-based and rules-based regulation".
- There is no formal "start date – incremental implementation" is envisaged.
- "The principles of TCF have been consistently communicated for five years. The FSB therefore expects regulated firms to already be applying these principles in the way they conduct business."
- "In time, TCF principles will be fully reflected in overarching Twin Peaks legislation – but existing frameworks already allow for application of many aspects."
- "The FSB published a TCF Complaints Management Discussion Document in 2014 – after prior industry consultation and international research."




In the latest FSB Bulletin Mr J Dixon of the Financial Services Board said this:

> "It is expected that by 2016, the Twin Peaks model of financial regulation will have been implemented, bringing in a new approach to market conduct regulation and supervision informed by Treating Customers Fairly (TCF) principles."

RETAIL DISTRIBUTION REVIEW

During December 2015 the Financial Services Board published a voluminous "General Status Update: Retail Distribution Review". It referred to the Retail Distribution Review ("RDR") discussion document which had been published in November 2014. Of that document the following was said:

> "Against the background of the Treating Customers Fairly approach to regulating conduct of business in financial services, the document proposed far-reaching reforms to the regulatory framework for distributing financial products to financial customers. The RDR put forward a total of 55 specific regulatory proposals, to be implemented in phases."

The December 2015 publication "provides a high level status update on the FSB's approach to implementing the RDR proposals, including process and planned next steps" and points out that the 55 "proposals would be effected in three broad phases, aligned to the broader reform of financial regulation in terms of the Twin Peaks regulatory model".

In summary it can be said that the expectation of the Financial Services Board is that the said three phases will be implemented "from July 2016 onwards" to "early 2018".

PUBLICATION OF DETERMINATIONS AND OTHER MATERIAL

During the year the office concluded an agreement with Juta and Company (Proprietary) Limited ("Juta") in terms of which Juta was granted "permission to download approved Determinations and other material, such as the Practice Notes and Rules, from its website for use in Juta products". We believe that this agreement will serve the interests of consumers and our subscribing members. It will also promote the public awareness of the office, which will receive "one free online subscription of the primary Determinations database".

RELEASE OF 2014 ANNUAL REPORT

Traditionally the office released its Annual Report at a gathering of interested parties, after it had been presented to the Ombudsman's Council. At such a meeting representatives of the office and our subscribing members were present and it was usually concluded with a "question and answer" session. During 2015 we decided to move with the technological times. Instead of having a "live" release of the 2014 Annual Report we held a so-called "webinar". We think the webinar worked well and in our assessment the majority of the persons who participated in it would prefer to do so in the future, rather than to attend a live release of our Annual Report.




APPEAL

One complainant was granted leave to appeal against a final determination which had dismissed his complex claim against an insurer, for damages in an amount in excess of R0.5 million. A retired judge was appointed as the Appeal Tribunal and in the decision, dismissing the appeal, the following was said with reference to certain provisions of the Income Tax Act, 1962:

> "The issues in this appeal are whether the respondent withheld or deducted excessive tax from the appellant's annuity income and, secondly, whether it employed the correct source codes on the relevant tax certificates.
>
> Now it is not open to doubt that the terms of an annuity contract cannot override the provisions of the Act. Any term in a contract which is contrary to or inconsistent with the statute is thus regarded as pro non scripto. In terms of paragraphs 2(1)(b) and 9 of the Fourth Schedule an administrator of a retirement annuity fund is obliged to deduct employees' tax from an annuitant's annuity income. The amount to be deducted is, according to paragraph 9, to be determined according to the tables prescribed by the Commissioner unless he grants authority to the contrary. The tables do not make provision for exemptions or exceptions and the provisions of section 10(1)(gC) of the Act do not permit the administrator of a fund to take these provisions into account in making the deductions without the Commissioner's authority. As mentioned above, it was only some years after 2008, when the funds commenced, that the respondent was authorised by SARS to have regard to the exemptions in section 10(1)(gC).

The appellant's argument is, and was throughout, largely based on the terms of the contract. This, he accepted, meant that the insurer was obliged to deduct tax in accordance with the tables under the Act. Where he differed from the respondent's submission and, in effect, with the conclusions arrived at by both the Deputy and the Ombudsman, was his view that, in order to apply the tables under the Act, the insurer had to establish and have regard to the source of the income. This, however, is not what the contract says and nor does the Act provide for such a construction. In terms of the tax tables the deduction or withholding of a tax is to be made against the income of the annuitant. In terms of section 10(1)(gC) of the Act the taxpayer is exempt from tax in respect of income which he receives or accrues to him. The administrator of a fund is not called upon to decide whether the income is exempt: he is merely obliged to deduct or withhold tax from annuity income. It is not his function to even consider whether the source is outside the Republic unless authorised to do so by SARS. I therefore agree with the conclusion expressed by the Ombudsman in paragraph 13 of his determination.

I am now concerned with the question of the source codes. This is an aspect on which the complainant placed much emphasis. It is, however, not a separate issue or one that is distinct from the question relating




to the way in which tax should be deducted according to the Act. Apart from all other considerations, once the respondent had decided that it could not treat the appellant's income as exempt from tax (for whatever reason) and had made tax deductions on that assumption, it could hardly have entered the exemption codes on tax certificates in respect of the same income. It would have been completely inconsistent for it to have done so. The respondent stated, and this view seems to be unanswerable, that the source code on the tax certificate is merely the outcome of the process....

In short, and in the absence of any authority to the contrary from SARS, the insurer was obliged not to regard the complainant's annuity income as exempt from normal tax or to record the source of his income as exempt on his IRP5 tax certificate."

TRIBUTE TO STAFF

In her foreword Judge Theron refers to the report of Dr De la Rey on her independent review of the office. That report is eloquent testimony of the sustained and dedicated efforts of the staff to improve the standard of service provided by the office. I am proud of the staff and I thank them for the pleasure which it gives me to say that. Once again, I received immeasurable assistance and support from Jennifer Preiss and Ian Middup, for which I am grateful.

Ron McLaren

FINALISATION PERIOD	**2015**	2014
0 – 30 days	**8%**	11%
31 – 60 days	**16%**	16%
61 – 90 days	**17%**	17%
91 – 180 days	**34%**	30%
181 – 365 days	**20%**	20%
Over 365 days	**5%**	6%

The table reflects all cases finalised, including Transfers, Reviews and Full Cases.



INDEPENDENT EXTERNAL ASSESSOR

The appointment of Judge R Cleaver in the above position was reported on page 11 of our 2014 Annual Report. It was pointed out that the Independent External Assessor receives and considers service complaints against the office by complainants and insurers. A service complaint is about the practical handling of a complaint and it does not relate to the outcome of a complaint. A special procedure is provided for dealing with such service-related complaints. Further information can be obtained on our website, www.ombud.co.za.

The only service complaints against the office during 2015 were the three which one complainant lodged simultaneously. In the ruling of Judge Cleaver the first two complaints were summarily dismissed as being unfounded. The third complaint related to the office's interpretation of a letter from the complainant, dated 27 February 2015. The office construed the letter as being a challenge of its provisional ruling and proceeded to make a final determination. This is what Judge Cleaver said in relation to the third complaint:

"18. To sum up, my view is that if the office intends to act on the basis of an interpretation made by it on correspondence from a claimant or an insurer, the author of the correspondence should be invited to agree or disagree with that interpretation before the office acts on it. Even though this may appear to be unduly cautious it will eliminate any misunderstanding of the correspondence.

19. Although the complainant was not afforded an opportunity to disagree with (the office's) interpretation of his response it seems that ultimately no great harm was done for it will be remembered that in his letter of 27 February 2015 the complainant had indicated that he had nothing more to put before the Ombudsman. It appears that his only real complaint is against the amount awarded as compensation. This is an issue relating to the merits with which I am not concerned."

The office will follow the advice given by Judge Cleaver in paragraph 18 of his ruling.

We routinely inform disgruntled complainants who are dissatisfied with our service that they have the right to follow the said special procedure.




STATISTICS

REQUESTS FOR ASSISTANCE RECEIVED

The office received 9 815 written requests for assistance during 2015 – 6% more than in 2014, but 2% less than in 2013, again confirming the difficulty of forecasting complaints volumes. The timing of the requests was also interesting – 2 659 were received in the final quarter of the year, compared to 2 156 the previous year.

Of the requests received 5 018 were chargeable cases (the aggregate of the complaints described under the next rubric) 86 fewer than the previous year.

The composition of the chargeable cases shows a slightly different trend from the previous year – Transfers, those cases not previously seen by insurers, increased by almost 7%, with Full Cases decreasing by 14%.

DESCRIPTION OF CHARGEABLE COMPLAINTS

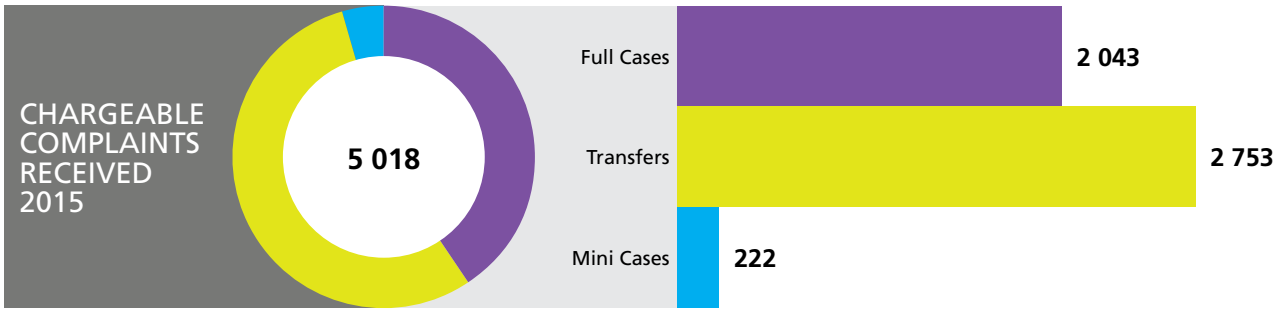
Mini Cases – Simple complaints that are within the jurisdiction of the office, but which insurers can more readily handle at source.

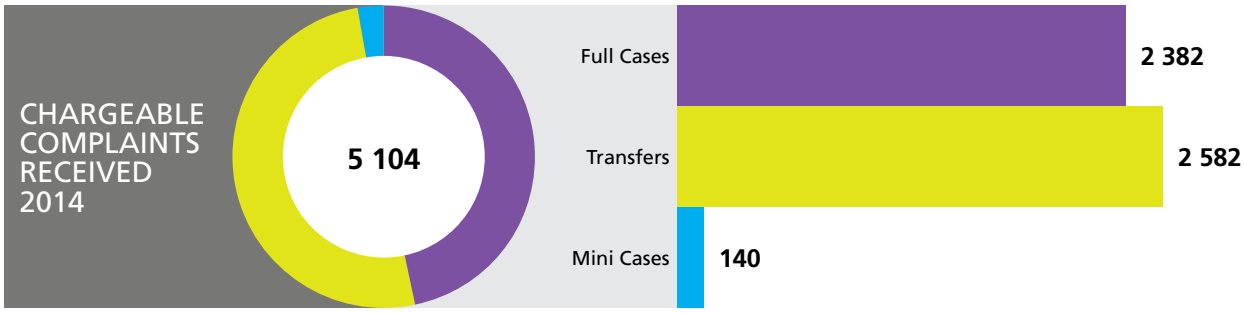
Transfers – Complaints not previously seen by insurers and referred to them in the first instance. These are forwarded to the insurer to settle directly with the complainant or, if not settled, they are taken up by the office as Reviews and handled in the same manner as Full Cases.

Full Cases – Complaints already seen by insurers and handled by the office from inception to finality. The year on year decline in this category is as a result of the increased number of Transfers under the new business model.

ANALYSIS OF TRANSFERS	**2015**	2014
Settled in favour of the complainant by the insurer	**643**	632
Returned to the office and taken up as Reviews	**1 065**	1 115
Required no further action or the complainant did not respond	**400**	282
Awaiting response from the insurer or the complainant	**645**	553
TOTAL	**2 753**	2 582





CHARGEABLE COMPLAINTS RECEIVED 2015
5 018
Full Cases
2 043
Transfers
2 753
Mini Cases
222


CHARGEABLE COMPLAINTS RECEIVED 2014
5 104
Full Cases
2 382
Transfers
2 582
Mini Cases
140




CASES FINALISED

Cases finalised by the office encompass those submitted as Full Cases and those Transfers not settled in favour of the complainant, but returned to the office as Reviews – in other words, all the cases that the Adjudicators and Assessors have to consider and finalise.

In 2015 the number of cases finalised by the office was 3 491, lower than the 3 822 finalised in 2014.

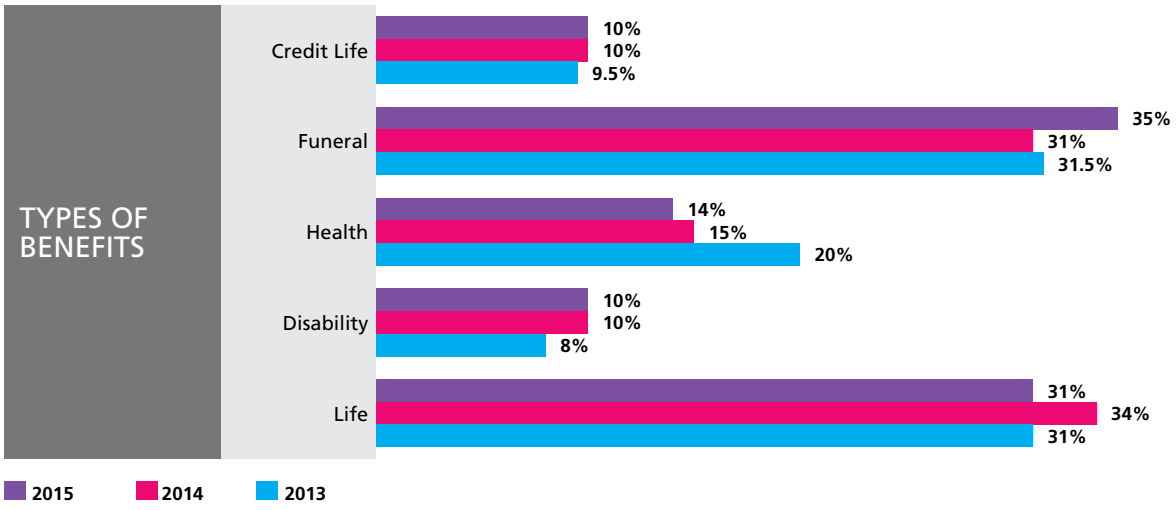
An analysis of cases finalised shows the following:

Standard Cases – the office's benchmark declined marginally, but still makes up 75% of the closures. Included here are the Full Cases received by the office, as well as the Transfers that have been returned to the office as Reviews.

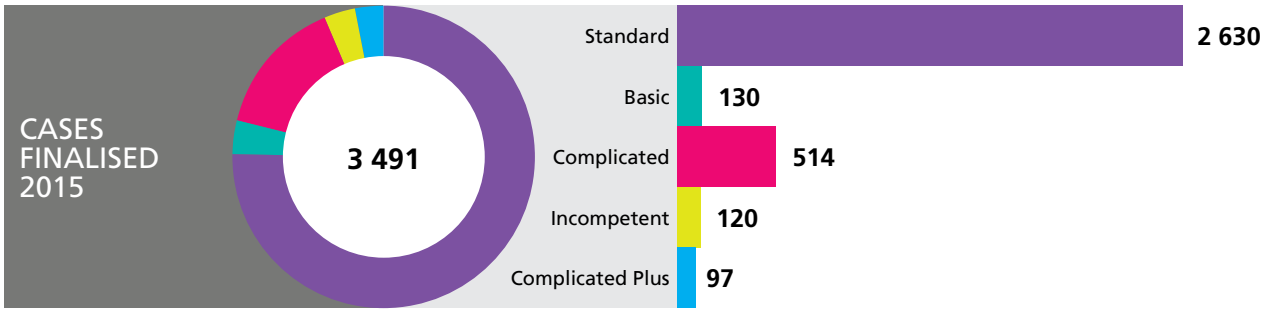
Incompetent Cases – a 46% reduction and a very welcome trend. The 2015 Incompetent Cases appear to be the lowest number on record.

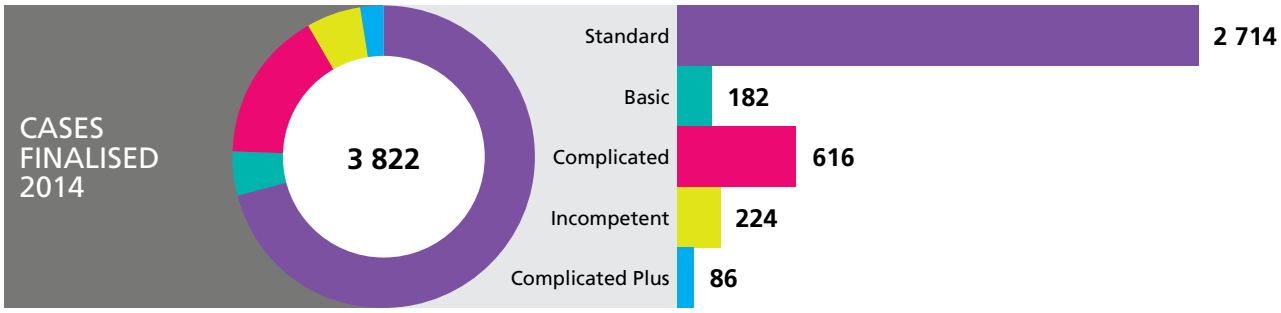
Complicated and Complicated Plus Cases – the number of cases in the Complicated categories, taken together, reduced marginally.

Basic Cases – a reduction which is probably due to the implementation of the new business model across the board.







CASES FINALISED 2015
3 491
Standard
2 630
Basic
130
Complicated
514
Incompetent
120
Complicated Plus
97


CASES FINALISED 2014
3 822
Standard
2 714
Basic
182
Complicated
616
Incompetent
224
Complicated Plus
86




SUMMARY OF CASES FINALISED

The table below summarises key aspects of cases that were finalised during the past two years, namely the nature of the complaint; the percentage of each of the total; the nature of the insurance benefit and whether the case was finalised wholly or partially in favour of the complainant. These statistics also form the basis of each insurer's published complaints data for the period.

	LIFE				DISABILITY			
Nature of complaint	**2014**	**W/P***	**2015**	**W/P***	**2014**	**W/P***	**2015**	**W/P***
Poor communications/documents or information not supplied/poor service	979	37%	743	39%	27	33%	41	44%
Claims declined (policy terms or conditions not recognised or met)	1 221	27%	1 262	25%	289	37%	248	40%
Claims declined (non-disclosure)	85	21%	79	22%	58	21%	42	21%
Dissatisfaction with policy performance and maturity values	131	22%	91	12%	0	0%		0%
Dissatisfaction with surrender or paid-up values	72	14%	49	14%	0	0%	0	0%
Misselling	12	17%	7	14%	0	0%	0	0%
Lapsing	167	35%	158	31%	2	100%	1	0%
Miscellaneous	198	16%	240	20%	9	22%	24	29%
Total	**2 865**	**29.4%**	**2 629**	**32.0%**	**385**	**34.3%**	**356**	**37.1%**

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

NATURE OF COMPLAINT

Claims declined – traditionally the largest category and in 2015 comprises 55% of the total, with the W/P rate similar to the previous year.

Poor communications – has shown an annual decrease in numbers and percentage since the implementation of the new business model.

Health complaints – decreased for the third consecutive year as a result of fewer complaints about hospital cash plans.




	HEALTH				TOTALS				% OF TOTAL	
	2014	W/P*	2015	W/P*	2014	W/P*	2015	W/P*	2014	2015
	109	46%	55	45%	1 115	38%	839	40%	29.17%	24.03%
	414	20%	402	28%	1 924	28%	1 912	29%	50.34%	54.77%
	38	16%	39	15%	181	21%	160	20%	4.74%	4.58%
	1	0%	1	100%	132	22%	92	13%	3.45%	2.64%
	1	0%	1	0%	73	14%	50	14%	1.91%	1.43%
	0	0%	0	0%	12	17%	7	14%	0.31%	0.20%
	1	0%	4	25%	170	36%	163	31%	4.45%	4.67%
	8	25%	4	0%	215	16%	268	20%	5.63%	7.68%
	572	**24.7%**	**506**	**27.9%**	**3 822**	**29.7%**	**3 491**	**29.8%**	**100%**	**100%**

RESOLVED WHOLLY OR PARTIALLY IN FAVOUR OF COMPLAINANTS

At 29.8%, this is very similar to the 2014 percentage. This reflects the impact of the first full two years of the implementation of the new business model, as a result of which a lower W/P percentage was anticipated. However, if the Transfers settled by insurers are included in this figure, as they would probably have resulted in the same outcome if handled by the office, the W/P percentage would have been 37.1% (38% in 2014).




MATTERS OF INTEREST

DISPUTES OF FACT

Most of the cases in our office can be resolved on the papers but occasionally there are disputes of fact which make this impossible. In terms of our Rules we can in appropriate circumstances, and with the consent of both parties, hold a hearing to determine a material and conclusive dispute of fact. The process is an informal one, as explained on page 22 of our 2005 Annual Report.

We seldom have more than five hearings in a year, so it is not a regular occurrence but it is always useful in resolving disputes as the following cases demonstrate.

CASE 1

Courts are sometimes faced with the so-called "mutually destructive versions" of the litigants about the facts in issue. Even significantly abridged versions of the averments by the parties to a complaint in our office, give a new dimension to the expression, "mutually destructive versions".

The complainant claimed the insured benefit under an income protection policy on the basis that he had suffered a permanent disabling back injury a few months after the inception of a policy in 2011. The insurer declined the claim on the ground that the complainant had failed to disclose a 2008 back injury.

In a provisional ruling our office upheld the insurer's repudiation and, in doing so, referred to certain information which had been furnished to the insurer by an orthopaedic surgeon who had treated the complainant. In the provisional ruling it was said, with reference to this information, that "the MRI scan shows disc prolapse".

The complainant challenged the correctness of the provisional ruling and there followed an exchange of documents, information and submissions by the parties, whose cases could be summarised as follows:

The complainant: Following a minor back injury at his place of employment in 2008, he saw a general practitioner who prescribed an ointment and he was back at work the next day. Thereafter he never received any treatment whatsoever for his back before his 2011 injury.

The insurer: The orthopaedic surgeon's notes reflect that, on 23 July 2008, the complainant was admitted to a certain hospital and the following was noted on 30 July 2008:

> "Continue with physio. Book for radiofrequence and MRI Scan – disc prolapse."

It appeared that the dispute of fact between the parties was of such a nature that the complaint could more appropriately be dealt with by a court of law and a final determination was made, dismissing the complaint in terms of our Rule 3.3.3.



Thereafter the complainant produced a telling piece of evidence, namely a letter from the hospital to which the complainant had allegedly been admitted on 23 July 2008, to say that no MRI scan could have been performed there because the MRI scanner was only installed at the end of 2012!

The next development was that the complainant produced an account in his name from another hospital which reflected entries on 14, 16 and 23 July 2008; an "inpatient" debit of more than R10 000 on 11 August 2008 and final "outpatient" debit on 14 January 2009.

To add to the mystery, the insurer then provided information that the MRI scan had not been done at the first-mentioned hospital to which the complainant had allegedly been admitted on 23 July 2008, but at the second-mentioned hospital where he was allegedly treated on the same day!

Something was amiss. In terms of our Rule 2.2.2 a complaint in which a final determination was made may be re-opened if thereafter material new evidence becomes available. With the consent of the parties an informal hearing was held at our office at which the complainant and representatives of the insurer were present.

At the hearing the following was asserted by the complainant: that he had never been admitted to any hospital for any back problem; that he had established that the orthopaedic surgeon practices at the second-mentioned hospital in Gauteng; that he had never received any account from that hospital; that he had no medical aid and that he had not paid any account of that hospital. The complainant denied that he had ever undergone any MRI scan or any operation to his back and at the hearing showed the absence of any operation scar on his back. He also denied that he had ever set eyes on the orthopaedic surgeon.

It got "curiouser and curiouser". The orthopaedic surgeon completed a medical report to the effect that he/she had also seen the complainant on 8 October 2008 and on 14 January 2009. The account from the second-mentioned hospital reflected a debit for 14 January 2009. The complainant produced a formidable body of evidence (including a number of dated photographs) which established as an incontrovertible fact that from about September 2008 until about December 2009 he lived in the Eastern Cape. In the light of this evidence, the inescapable conclusion was that it was just about impossible that this doctor could have seen the complainant on 8 October 2008 or on 14 January 2009. The virtual impossibility that the doctor could have treated the complainant in October 2008 and January 2009 raised serious misgivings about the insurer's case, as summarised above.

The insurer's representatives had the opportunity to observe for themselves the convincing manner in which the complainant related his version of the events and to assess for themselves his demeanour, the probabilities and his credibility or lack thereof. In the light of the apparent unreliability of the medical information which had been provided to the insurer, it did not need to call any witness and at the conclusion of the hearing it accepted the validity of the claim which it undertook to assess.



CASE 2

This matter concerned an insurer's decision to decline a claim based on non-disclosure.

The complainant's policy commenced on 3 March 2013 with disability, income protector and temporary income protector cover. The complainant disclosed the following information to the insurer at application stage:

- Barlow syndrome
- Hysterectomy
- Depression
- Hypermobility syndrome
- Non-malignant tumours on both ovaries
- Drinks 10 units of alcohol per week
- Use of Cymgen for pain

The complainant underwent a medical examination which indicated that she was clinically healthy. The insurer added a mental exclusion clause to all the benefits on the policy.

The following questions were posed to the complainant at application stage:

"Het u ooit mediese advies ontvang of deelgeneem aan 'n rehabilitasieprogram om alkohol- en/of dwelmmisbruik te verminder?"

The complainant answered "No" to this question.

"Dwelms, kalmeermiddels of enige ander medisyne Neem u tans, of het u voorheen enige medisyne, dwelms of kalmeermiddels in enige vorm geneem vir enige ander rede as verkoue of griep (bv. Antidepressante, homeopatiese medisyne, anaboliese steroïde, dagga of kokaïen)?"

The complainant answered "Yes" to this question and disclosed that she had used anti-depressants in 2007.

The complainant submitted a disability claim for hypermobility syndrome in May 2013 (two months after commencement of the policy). The insurer declined the claim and repudiated the policy on the basis of the non-disclosure of the use of Antabuse, six months prior to the application of the policy. Antabuse is described as medication for alcoholism and possible detoxification.

The complainant admitted that she had used Antabuse for two weeks but stated that it had been prescribed by her doctor to lose weight. The complainant argued that she had considered the use of Antabuse irrelevant and did not think to mention it in her application. Her medical practitioner confirmed that the Antabuse had been prescribed for "off label" use for weight loss. Another medical practitioner confirmed that the complainant was not an alcoholic and that her alcohol intake was acceptable. He further confirmed that he had never consulted with the complainant for alcohol abuse and that she had never been booked into a rehabilitation centre.

The insurer was of the view that the use of Antabuse was to prevent the complainant from using any alcohol.

We asked a re-insurer for their opinion and they confirmed that they had never come across the use of Antabuse for weight loss.



A hearing was held in order to ascertain the reason for the complainant's use of the Antabuse. The complainant, her medical practitioner and representatives of the insurer attended the hearing. At the hearing the complainant's version regarding the use of Antabuse was accepted by all present. It also transpired, however, that there had been under-reporting of some of the medical conditions as at the date of inception of the policy. This had been caused by the complainant's financial adviser delaying the application process for more than a year, during which time the complainant's medical condition had deteriorated.

In the circumstances the insurer offered a 50% benefit without admission of liability, which the complainant accepted.

CASE 3

This case also concerned non-disclosure and the insurer's decision to repudiate part of a policy.

The complainant had a policy with the insurer with cover of R300 000. The complainant disclosed in her application form that her mother had been diagnosed with breast cancer. Although the insurer had initially imposed a breast cancer exclusion it later removed the exclusion after a request from the complainant. On 2 July 2013 the complainant applied for an increase in cover to R1 500 000 and the application was accepted by the insurer on 22 July 2013. The complainant went for genetic tests BRCA1 and BRCA2 on 27 July 2013 to establish whether she had a predisposition to developing breast cancer. 1 August 2013 was the inception date for the higher cover. The positive test results were conveyed to the complainant on 2 August 2013. The complainant did not disclose the fact that she had undergone the tests after the acceptance of the application, but before the inception date.

The complainant claimed a benefit under a dread disease policy after undergoing a risk reducing bilateral mastectomy with reconstruction on 22 November 2013.

The insurer paid the claim under the initial amount of cover, but declined the claim under the increased cover.

In a provisional ruling we upheld the insurer's decision not to pay the increased cover on the basis that the duty of disclosure continued until the cover commenced and that a reasonable person would have disclosed the information about undergoing the tests, even if the results were unknown.

The complainant responded to the ruling by stating that the test results were unknown to her at the inception date and that the insurer could therefore not rely on non-disclosure. The office decided to hold a hearing to obtain a clearer picture of the facts. The complainant did not impress as a witness at the hearing.

At the hearing it was established that the complainant and her sister (who was also insured with the same insurer) had increased their cover prior to the genetic tests, but after making the appointments for the tests. It also transpired that the complainant had not disclosed in her application form for increased cover that her father had suffered from prostate cancer, which had occurred after the initial application but before the application for increased cover. Although the complainant argued




strongly that this could not affect her risk rating the insurer imposed a total cancer exclusion on the increased cover.

In a final determination we upheld the insurer in its reconstruction of the policy and its payment of the benefit based on the initial cover.

OMBUZZ

Our newsletter was published on our website, www.ombud.co.za, during March, June, August and November 2015.

PUBLICATION OF FINAL DETERMINATIONS

Rule 3.8 of our Rules relates to any final determination which is made against a subscribing member and to any appeal in which a ruling is made that the complainant is substantially successful in the appeal. In terms of that Rule we must, subject to certain provisos, "publish such determination or ruling, including a summary of the facts concerned, the reason for the determination and the identity of the subscribing member".

During 2015 the office made the following final determinations against subscribing members:

- Three determinations against Liberty Life; one awarding compensation; one concerning a claim for income disablility and the other relating to a claim declined on the basis of a pre-existing condition.
- One determination against Sanlam Sky (Sanlam Developing Markets) awarding compensation.

The office duly complied with the provisions of Rule 3.8. Full particulars of the three complaints referred to above can be found on our website, www.ombud.co.za, under "Useful Information".

UNREASONABLE COMPLAINANTS

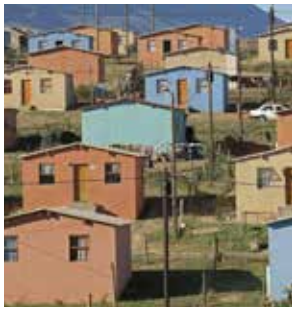
In our experience there has been a steady increase in the number of unreasonable complainants and in the number of complex complaints. By all accounts this appears to be a worldwide phenomenon. We also find that there seems to be a correlation between unusually persistent complainants and complex complaints. They just seem to go together – which can make life difficult. It is not surprising that such complainants are sometimes aptly referred to as "resource intensive" complainants or "high maintenance" complainants or, most often, "difficult" complainants. Fortunately, only a small number of the complainants in our office fall into this category. The distinguishing feature which is common to all these complainants is their unreasonable conduct which falls into five broad categories:

- Unreasonable arguments
- Unreasonable behaviour
- Unreasonable demands
- Unreasonable lack of co-operation
- Unreasonable persistence

The unreasonable conduct in a particular complaint often includes more than one of these categories. A disconcerting development in the handling of a complaint is when a parallel complaint against the office arises in it. This can be an unnerving form of intimidation, which could be aimed at manipulating the office towards a favourable complaint outcome.

The reasons for unreasonable conduct include anger, frustration and an exaggerated sense of entitlement. Some complainants claim to be seeking "justice" or "a






moral outcome" and they often appear to focus rigidly on a "principle". We have had complainants who appear to enjoy driving their complaints. One of them kept a tally of the number of hours he spent working on the complaint. It had reached over 400 hours before a final determination, dismissing his complaint, put an end to what appears to have been a pleasurable pastime.

There are certain unmistakable telltale signs by which one can identify a complainant who is prone to unreasonable conduct:

- The inappropriate use of medical or legal terms in correspondence. For instance, a letter which starts with a greeting in Latin is a dead giveaway.
- The use of unusual ways to emphasise words. These may include the use of highlighters, the repeated underlining of words and copious marginal notes.
- One source refers to the "increased frequency and voluminous nature of material generated" and another to the "increasingly frenetic and energised communication styles". Once a complainant wrote ten letters to the office in two days.
- The complainant's history could reveal that he or she is a person from whom unreasonable conduct can be expected.

We follow these guidelines for dealing with unreasonable complainant conduct:

- Prevention is better than cure. An effective and efficient complaints handling process presents less opportunity and less scope for unreasonable complainant conduct.
- Manage complainant expectations. Unrealistic or even simply incorrect complainant expectations constitute fertile breeding ground for unreasonable conduct.
- Give reasons for rulings. Some complainants only resort to unreasonable conduct after receiving an unfavourable complaint outcome. If adequate reasons are furnished for a decision, those will inform the complainant why the complaint was dismissed and may avert unreasonable behaviour.
- Stay in control. If a complainant makes any attempt to take over our function he or she is politely, but firmly, told to desist.
- Make personal contact. It has been our experience that complainants who write the rudest and most insulting letters are often meek and mild in a personal meeting or a telephone conversation.
- Never lose your cool!



COMPLAINTS DATA FOR SUBSCRIBING MEMBERS

The office published individual insurer complaints data for the period 1 January 2015 to 31 December 2015 on its website, www.ombud.co.za.

The publication is done in order to promote accountability and transparency. It will also encourage insurers to benchmark their standards of complaints handling against other insurers and to learn from insurers who appear to be better at complaints handling.

The information published on the website under the heading "Complaints Data" and herein, shows the number of complaints received; the number of cases considered; the number of cases finalised and the number of cases resolved in favour of the complainant or the insurer, i.e. the W/P (Wholly or Partially) percentage. In addition, Table 2 on the website reflects the nature of the complaints.

The office does not interpret what any of the figures may mean. That is left to insurers, intermediaries and industry bodies, reporters and consumer organisations, as we are of the view that such interpretation and comment by us would not be consistent with our role in impartial dispute resolution.

Although there a number of published reports reflecting market share in the long-term insurance industry, there is no single generally accepted measure for it and, therefore, this is not reflected in the published data. Another reason for not including market share is that the office does not hold the underlying data that could be used to determine market share and this makes it impossible for the office to verify its correctness. The only context is the individual insurer's complaints expressed a percentage of the total complaints received.

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

We wish to caution against an over-emphasis of the W/P percentage, which should not be viewed in isolation. A low W/P percentage in favour of complainants is, by itself, not necessarily good or an indication that the insurer has exemplary complaints handling processes. Neither is a higher percentage necessarily negative or an indication that the insurer's complaints handling is poor.

Some insurers are more inclined than others to settle matters. Such insurers choose to settle matters, either wholly or partially, when there may, strictly speaking, be doubt about legal liability.

There may also have been a bulk case situation, i.e. a large number of cases on the same issue. This can "skew" the W/P percentage either up or down for one or more years. This effect is noticeable when an insurer's W/P percentage changes markedly from previous years.

Of course, if an insurer has a disproportionately high percentage of complaints and has had a high W/P percentage for a number of years, that would




raise a question about its complaints management and other practices.

A W/P classification applies whenever a case is resolved either wholly or partially in favour of a complainant, whether by settlement or determination. This includes so-called ex gratia settlements. The W/P classification is not limited to cases where the office issued a determination. The classification is also not limited to cases where a sum of money is paid to a complainant – it can apply to service complaints, reinstatement of policies, adjustment of benefits, etc.

The complaints data should be used by intermediaries, consumers and others in conjunction with other measures, such as an insurer's claims ratio, its efficiency generally, its products, etc. to give a full picture of an insurer's performance.

SECOND REMINDERS

Where an insurer has more than five second reminders per year, the number of reminders is published with the complaints data. The names of the insurers and the number of the second reminders sent to them during 2015 appear below.

African Unity	**17**
AIG	**6**
Assupol	**11**
Liberty Life	**10**

The table overleaf shows:

COMPLAINTS RECEIVED

This is the number of new complaints received in respect of an individual insurer. Some of these complaints will be sent to the insurer to deal with the complainant directly. If the complainant is not satisfied with the insurer's response we will then take up the case.

PERCENTAGE OF TOTAL

This indicates the complaints received in respect of an individual insurer expressed as a percentage (to two decimal places) of the total number of complaints received by our office.

CASES CONSIDERED

These are the complaints where case files are opened and complaints are investigated by our office.

CASES FINALISED

These are the cases finalised during 2015, of which some had been received in earlier years.

PERCENTAGE RESOLVED W/P IN FAVOUR OF COMPLAINANTS/INSURER

This refers to the percentage of cases which were resolved wholly or partially (W/P) in favour of the complainants or in favour of the insurer. These cases are resolved by way of settlement, mediation, conciliation, recommendation or determination. For 2015 the overall W/P percentage in favour of complainants was 29.8%.




COMPLAINTS DATA FOR SUBSCRIBING MEMBERS (continued)

	Complaints Received	% of Total	Cases Considered	Cases Finalised	% Resolved W/P in favour of Complainants	Insurer
1 Life Direct Insurance Limited	143	2.85%	93	98	27.6%	72.4%
ABSA Insurance and Financial Advisers (Pty) Limited	0	0.00%	0	3	33.3%	66.7%
ABSA Life Limited	170	3.39%	119	130	30.8%	69.2%
Acsis Limited	0	0.00%	0	0	0.0%	0.0%
African Unity Insurance Limited	53	1.06%	31	21	38.1%	61.9%
AIG Life South Africa Limited	167	3.33%	121	128	32.0%	68.0%
Alexander Forbes Life Limited	10	0.20%	5	5	20.0%	80.0%
Allan Gray Life Limited	2	0.04%	2	2	0.0%	100.0%
Assupol Life Limited	257	5.12%	153	172	38.3%	61.7%
AVBOB Mutual Assurance Society	91	1.81%	57	68	16.2%	83.8%
Bidvest Life Limited	5	0.10%	4	3	33.3%	66.7%
Centriq Life Insurance Company Limited	81	1.61%	60	51	15.7%	84.3%
Channel Life Limited	79	1.57%	58	65	38.5%	61.5%
Clientèle Life Assurance Company Limited	232	4.62%	124	166	25.3%	74.7%
Discovery Life Limited	150	2.99%	110	129	27.1%	72.9%
FedGroup Life Limited	1	0.02%	1	0	0.0%	0.0%
First Rand Life Assurance Limited	1	0.02%	0	0	0.0%	0.0%
Frank Life Limited	19	0.38%	14	14	21.4%	78.6%
Guardrisk Life Limited	77	1.53%	59	62	24.2%	75.8%
Hollard Life Assurance Company Limited	438	8.73%	304	316	36.4%	63.6%
Investec Assurance Limited	2	0.04%	2	2	0.0%	0.0%
Investment Solutions Limited	0	0.00%	0	0	0.0%	0.0%
JDG Micro Life Limited	14	0.28%	6	7	42.9%	57.1%
Just Retirement Life (S.A.) Limited	0	0.00%	0	0	0.0%	0.0%
Liberty Group Limited	533	10.62%	383	380	34.7%	65.3%
Lombard Life Limited	9	0.18%	9	13	15.4%	84.6%
Metropolitan Life Limited	288	5.74%	162	203	27.1%	72.9%



	Complaints Received	% of Total	Cases Considered	Cases Finalised	% Resolved W/P in favour of Complainants	Insurer
Momentum Group Limited	315	6.28%	240	221	33.0%	67.0%
***FNB Life Limited**	63	1.26%	37	33	21.1%	78.9%
Nedbank Limited	0	0.00%	0	0	0.0%	0.0%
Nedgroup Life Assurance Company Limited	132	2.63%	100	99	32.3%	67.7%
Nestlife Assurance Corporation Limited	13	0.26%	11	13	38.5%	61.5%
New Era Life Insurance Company Limited	2	0.04%	2	1	0.0%	100.0%
Old Mutual Alternative Solutions Limited	28	0.56%	17	23	60.9%	39.1%
Old Mutual Life Assurance Company (SA) Limited	697	13.89%	384	348	29.9%	70.1%
Outsurance Life Insurance Company Limited	16	0.32%	15	18	5.6%	94.4%
Professional Provident Society Insurance Company Limited	28	0.56%	25	31	38.7%	61.3%
PSG Life Limited	2	0.04%	2	3	33.3%	66.7%
Real People Assurance Company Limited	8	0.16%	5	7	57.1%	42.9%
Regent Life Assurance Company Limited	97	1.93%	60	61	26.2%	73.8%
Relyant Life Assurance Company Limited	0	0.00%	0	0	0.0%	0.0%
RMB Structured Life Limited	0	0.00%	0	0	0.0%	0.0%
SA Home Loans Life Limited	22	0.44%	19	15	6.7%	93.3%
Safrican Insurance Company Limited	110	2.19%	75	94	31.9%	68.1%
Sanlam Life Insurance Limited	198	3.95%	121	130	17.7%	82.3%
Sanlam Developing Markets Limited	305	6.08%	185	247	23.1%	76.9%
Union Life Limited	52	1.04%	29	36	33.3%	66.7%
Viva Life Insurance Limited	1	0.02%	0	0	0.0%	0.0%
Vodacom Life Assurance Company Limited	5	0.10%	3	1	0.0%	100.0%
Workers Life Assurance Company Limited	82	1.63%	64	61	24.6%	75.4%

* Awaiting approval of transfer of business to First Rand Life Assurance Limited in terms of Section 37 of the Long-term Insurance Act, 52 of 1998.




APPENDICES

APPENDIX 1: SUMMARY OF INCOME AND EXPENDITURE OF THE LONG-TERM INSURANCE OMBUDSMAN'S ASSOCIATION

	2015 R	2014 R
REVENUE		
Recoveries from Subscribing Members	**18 096 197**	17 312 554
Investment income	**778 992**	667 989
	18 875 189	17 980 543
EXPENSES		
Administration and professional fees	**35 475**	220 600
Annual report	**95 688**	98 472
Call centre costs	**105 692**	133 347
Computers and communications	**439 642**	320 329
Council – travel and accommodation	**70 010**	65 339
Council fees	**86 000**	80 500
Depreciation	**32 670**	45 588
Electricity	**241 572**	235 509
Employee costs	**11 209 990**	10 810 830
Employee costs – contract staff	**2 555 809**	2 601 476
Employee costs – contributions	**658 364**	613 367
Employee costs – other overheads	**106 211**	79 338
International travel	**108 316**	52 287
Marketing and brochures	**67 149**	100 568
New Case Management system	**240 000**	–
Other expenses	**375 667**	371 833
Professional advice	**357 008**	190 868
Quality control	**8 000**	11 646
Rent – parking	**291 131**	281 743
Rent – premises	**1 384 784**	1 273 978
Repairs and maintenance	**1 250**	1 524
Stationery	**120 761**	104 444
Telephone	**163 264**	172 854
Travel and accommodation	**120 736**	114 103
	18 875 189	17 980 543

The audited and approved Annual Financial Statements are available on our website, www.ombud.co.za.

APPENDIX 2: SUBSCRIBING MEMBERS as at 31 December 2015

1 Life Direct Insurance Limited

ABSA Life Limited
Allied Insurance
UBS Insurance

ABSA Insurance and Financial Advisers (Pty) Limited

Acsis Limited

African Unity Insurance Limited

AIG Life South Africa Limited
Chartis Life

Alexander Forbes Life Limited

Allan Gray Life Limited

Assupol Life Limited
Prosperity Life

AVBOB Mutual Assurance Society

Bidvest Life Limited
Mclife

Centriq Life Insurance Company Limited

Channel Life Limited
PSG Anchor Life

Clientèle Life Assurance Company Limited

Discovery Life Limited

FedGroup Life Limited

First Rand Life Assurance Limited

Frank Life Limited

Guardrisk Life Limited
Platinum Life

Hollard Life Assurance Company Limited
Crusader Life
Fedsure Credit Life
Investec

Investec Assurance Limited

Investment Solutions Limited

JDG Micro Life Limited

Just Retirement Life (S.A.) Limited

Liberty Group Limited
AA Life
ACA Insurers
Amalgamated General Assurance
Capital Alliance Life
Fedsure Life
IGI Life
Liberty Active
Manufacturers Life
Norwich Life
Prudential
Rentmeester Assurance
Rondalia
Saambou Credit Life
Standard General
Sun Life of Canada
Traduna

Lombard Life Limited
Pinnafrica Life

Metropolitan Life Limited
Commercial Union
Homes Trust Life

Momentum Group Limited
African Eagle Life
Allianz Life
Anglo American Life
Guarantee Life
Legal and General
Lifegro
Magnum Life
Metropolitan Odyssey
Protea Life
Rand Life
Sage Life
Shield Life
Southern Life
Yorkshire

Nedbank Limited

Nedgroup Life Assurance Company Limited
NBS Life
BOE Life

Nestlife Assurance Corporation Limited

New Era Life Insurance Company Limited

Old Mutual Alternative Solutions Limited
MS Life

Old Mutual Life Assurance Company (South Africa) Limited
Colonial Mutual

Outsurance Life Insurance Company Limited

Professional Provident Society Insurance Company Limited

PSG Life Limited
M Cubed Capital
Time Life

Real People Assurance Company Limited

Regent Life Assurance Company Limited

Relyant Life Assurance Company Limited

RMB Structured Life Limited

SA Home Loans Life Assurance Company Limited

Safrican Insurance Company Limited

Sanlam Developing Markets
African Life
Permanent Life
Sentry Assurance

Sanlam Life Insurance Limited

Union Life Limited

Viva Life Insurance Limited
Resolution Life

Vodacom Life Assurance Company Limited

Workers Life Assurance Company
Sekunjalo Investments

APPENDIX 3: MEMBERS OF THE OMBUDSMAN'S COMMITTEE

Dorea Ozrovech
Chairperson
Sanlam Life Insurance Limited

Eheila Engelbrecht
Sanlam Developing Markets

Paul van Onselen
Hollard Life Assurance Company Limited

Anna Rosenberg
ASISA

Glenn Hickling
Discovery Life Limited

Jacolien Potgieter
Assupol Life Limited

Russel Krawitz
Guardrisk Life Limited

Ryan Sacks
Clientèle Life Assurance Company Limited

Sue du Plessis
MMI Group Limited

Werner du Plessis
MMI Group Limited

Chris Howarth
Old Mutual Assurance Company (SA) Limited

Mariza Schlushe
Metropolitan Life Limited

Mellony Ramalho
Liberty Group Limited

Audrey Rustin
Nedgroup Life Assurance Company Limited

Pieter van Zyl
1 Life Direct Insurance Limited

Johann van der Lith
Workers Life Assurance Company

APPENDIX 4: STAFF IN THE OMBUDSMAN'S OFFICE

Management Team
Judge Ron McLaren
Jennifer Preiss
Ian Middup

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

Support Staff
Clyde Hewitson
Rosemary Galolo
Charmaine Bruce
Marshalene Williams
Tamara Sonkqayi
Angelo Swartz
Sureena Gallie
Andrea Lennox
Sithandwa Tolashe
Lisa Fincham
Yolanda Augustine
Colline Alexander
Shanon Augustine
Tania Thomas
Phindiwe Fana
Puleka Ngalo
Nosiphiwe Sifingo
Virginia Smith
Colleen Louw

APPENDIX 5: **RULES**

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 have 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, or in suitable circumstances cause, 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, or in which in an appeal by a complainant a ruling is made by the Appeal Tribunal holding that the appeal is substantially successful as envisaged in Rule 6.8.3, the Ombudsman shall publish such determination or ruling, 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, the policyholder, a successor in title or beneficiary, a life insured or a premium payer; provided further that there will be no publication of a determination by the Ombudsman against a subscribing member if on appeal the subscribing member is substantially successful as envisaged in Rule 6.9.1.

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.

APPENDIX 6: **OTHER OFFICES**

Ombudsman for Banking Services
PO Box 87056, Houghton 2041
Tel: 011 712 1800
Fax: 011 483 3212
E-mail: info@obssa.co.za

Credit Ombud
PO Box 805, Pinegowrie 2123
Tel: 011 781 6431
Fax: 086 683 4644
E-mail: ombud@creditombud.org.za

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

Ombud for Financial Services Providers
PO Box 74571, Lynnwoodridge 0040
Tel: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

Pension Funds Adjudicator
PO Box 580, Menlyn 0063
Tel: 012 346 1738
Fax: 086 693 7472
E-mail: enquiries@pfa.org.za

Statutory Ombud
PO Box 74571, Lynnwoodridge 0040
Tel: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

Financial Services Board
PO Box 35655, Menlo Park 0102
Tel: 012 428 8000
Fax: 012 346 6941
E-mail: info@fsb.co.za

National Consumer Commission
Private Bag X84, Pretoria 0001
Tel: 012 761 3200
Fax: 086 758 4990
E-mail: complaints@thencc.org.za

National Credit Regulator
PO Box 209, Halfway House, Midrand 1685
Tel: 011 554 2600
Fax: 011 554 2871
E-mail: complaints@ncr.org.za

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

Public Protector
Private Bag X677, Pretoria 0001
Tel: 012 366 7000
Fax: 012 362 3473
E-mail: registration2@pprotect.org

Tax Ombud
PO Box 12314, Hatfield 0028
Tel: 012 431 9105
Fax: 012 452 5013
E-mail: complaints@taxombud.gov.za

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

Johannesburg Office
PO Box 787465, Sandton 2146
Tel: 011 214 0960
Fax: 011 447 5018
E-mail: info@asisa.org.za

Ombudsman's central helpline

Sharecall 0860ombuds
0860662837

Sunclare Building
3rd Floor
21 Dreyer Street
Claremont 7700
Private Bag X45
Claremont 7735

Telephone: 021 657 5000
Sharecall: 0860 103 236
Fax: 021 674 0951
E-mail: info@ombud.co.za
www.ombud.co.za

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FOR LONG-TERM INSURANCE