ANNUAL REPORT 2016

OMBUDSMAN
FOR LONG-TERM INSURANCE

KEY FIGURES

Chargeable complaints received
5 284

Full cases finalised
3 324

Percentage of cases finalised within six months
78%

Percentage of cases resolved wholly/ partially in favour of complainants
28.1%

Total expenses for the year
R21.454m

Cost per standard case
R3 650

Recovered for complainants
R187.7m

Compensation awarded
R487 335

TABLE OF CONTENTS

APPENDICES

FOREWORD BY THE CHAIRPERSON OF THE OMBUDSMAN'S COUNCIL

In terms of section 10(1)(b) of the Financial Services Ombud Schemes Act, 37 of 2004, ("the Act") the Council is obliged to "monitor the performance and independence of the Ombud and ... the continued compliance by the scheme with its constitution, the provisions of the scheme and this Act".

In the performance of its corporate governance oversight function the Council met twice during 2016. At each of these meetings the Council received a comprehensive overview of the office's activities from the management team. The Council has a standing Audit and Risk Committee which meets twice a year. During 2016 the Council appointed an ad hoc Committee which investigated and reported on the office's remuneration system. Although the Council has a corporate governance oversight function, I believe that sound corporate governance is the shared responsibility of every member of the office. This responsibility is underpinned by a healthy work ethos and the office's Code of Ethics.

At its first meeting the Council resolved that an application should be made in terms of the Act for certain amendments of the Rules which regulate the procedure in the Ombudsman's office. It was the view of the Council that the amendments were necessary to improve the way in which the office operates and to enhance the standard of service which it renders for consumers and for subscribing members. Full particulars of these amendments appear in the Report by the Ombudsman on pages 6 and 7 of this Annual Report.

In his report the Ombudsman refers to the impact which the enactment of the Financial Sector Regulation Bill will have on the office. During the legislative process relating to the Bill the Council received reports thereon from the office. The Council will continue to ensure that it is kept informed of material developments in this regard in order to enable it to suitably meet any challenge which may arise from the implementation of the Bill.

At the second meeting Ms Ozrovech announced her resignation from the Ombudsman's Committee and, hence, the termination of her ex officio appointment as a member of the Council. Ms Ozrovech has diligently served as a member of the Committee since 2005 and on the Council since 2010. On behalf of the Council I express our sincere appreciation for her faithful and long-standing contribution to the Council. Our best wishes go to her for her well-deserved retirement. At that meeting it was my pleasure to welcome to the Council the newly appointed Chairperson of the Committee, Mr G Hickling, who is a lawyer with more than 20 years' experience in the long-term insurance industry.

On reflection, the Council was satisfied that during 2016 the Ombudsman and the office had fulfilled their mission, complied with their obligations under the scheme's rules and under the Act, 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 2016.

Leona Theron

"I believe that sound corporate governance is the shared responsibility of every member of the office."

MEMBERS OF THE OMBUDSMAN'S COUNCIL

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

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

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

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

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

Ms Thandiwe Zulu
Regional Manager of the Black Sash

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

Mr Glenn Hickling
(ex officio)
Head of Legal Department: Discovery Life Limited; Chairperson of the Ombudsman's Committee

Judge Ron McLaren
(ex officio)
Ombudsman

REPORT BY THE OMBUDSMAN

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.

OVERVIEW

The first thing that strikes me when writing this, my fourth Annual Report Overview, is the degree of consistency in the work of the office. Comprehensive statistics for the year appear on pages 10 to 13 of this Annual Report. By way of synopsis of those statistics I refer only to the following: we received 9 871 written requests for assistance; 5 284 chargeable complaints were received and 3 324 cases were finalised, of which 28.1% were resolved wholly or partially in favour of the complainants. Since the implementation of the office's new business model (see page 6 of our 2015 Annual Report) these figures have been consistent over the past three years, despite an increase in the number of policies sold by insurers. Our staff numbers remain consistent and we experience a very low staff turnover. We will continue to strive to render an effective, efficient and fair complaints resolution service for complainants and insurers.

INDEPENDENT EXTERNAL ASSESSOR

During 2014 Judge R Cleaver was appointed in the above position to receive and to consider service complaints against the office by complainants and insurers. A service complaint is about the practical handling of a complaint by the office 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.

Judge Cleaver dismissed the three service complaints which had been lodged with him against the office during 2016.

REGULATION OF THE FINANCIAL SECTOR

After referring to relevant documents which had been published during December 2014, I said this on page 9 of our 2014 Annual Report:

> "What emerges clearly from the publications referred to under this rubric is that change is in the air for the financial regulatory landscape."

Subsequent events bear out this prediction.

On page 7 of the 2015 Annual Report I referred to the publication of the Financial Sector Regulation Bill ("the Bill") and said that this office and the offices of the other three statutorily recognised voluntary financial ombudsman schemes had "received an assurance from the National Treasury that it will engage in further consultation" with those offices in connection with the Bill. Such engagement took place during 2016 and it culminated in a constructive meeting with representatives of the National Treasury on 4 August 2016.

The legislative process is under way and the general expectation is that the Bill will find its way into the statute book during 2017, but there may be various effective dates for different sections.

The enactment of the Bill will bring about the implementation of the Twin Peaks model of financial regulation which provides for a prudential regulator within the Reserve Bank and a market conduct regulator which will supervise the way in which financial services firms conduct their business, including their compliance with the Treating Customers Fairly regulatory programme which was initiated by the Financial Services Board.

Chapter 14 of the Bill contains extensive provisions which relate to the office and to the other three schemes. Section 176 envisages the establishment of the Ombud Council and section 177 provides that the objective of the Ombud Council is to ensure that financial customers have access to and are able to use affordable, effective, independent and fair alternative dispute resolutions for complaints about financial institutions in relation to financial products and financial services.

Although it is premature to predict the long-term effect which the enactment of the Bill will have on these offices, we have identified the following specific areas of impact:

- **Continued existence**
  Our office will continue to exist as a recognised industry ombudsman scheme for a period of 12 months, during

"We will continue to strive to render an effective, efficient and fair complaints resolution service for complainants and insurers."

which application must be made for recognition under the new Act. The Bill thus ensures continuity of our service with the least disruption.

- **Raising awareness**

  The objective of promoting public awareness of financial services ombudsman schemes is entrenched.

- **Consistency and co-operation**

  The call for "a consistent approach and consistent requirements for all ombudsman schemes" and for co-operation between the offices will benefit the financial customer.

- **Effectiveness**

  The objective is to ensure greater effectiveness of the financial services ombudsman schemes – for instance, through the compulsory membership of an appropriate scheme.

- **Quality control**

  A number of sections contain quality control and oversight provisions which aim to improve the service rendered by an ombudsman scheme.

Closely related to the Bill is the draft Financial Sector Levies Bill, 2016 ("the Levies Bill"), published on 21 November 2016. The Levies Bill sets out the levy requirements to fund the new authorities established under the Bill.

Proposed amendments of the Regulations to the Long-term Insurance Act, 52 of 1998, and changes to the Policyholder Protection Rules are also envisaged in 2017. These amended Rules are part of government's reform of the financial sector to ensure that customers of insurers are treated fairly. The proposed amendments address risks and abuses that have been identified by the financial services regulators and will be a first step in the broader Twin Peaks reform.

AMENDMENT OF RULES

At its meeting on 7 April 2016 the Ombudsman's Council approved certain amendments of the Rules which regulate the procedure in this office.

Rule 2.1 circumscribes the jurisdiction of the office. On occasions the issue arose whether a complaint fell within our jurisdiction because a dispute existed about the very question whether the complainant was, in fact, a policyholder or a beneficiary. The proposed amendment would widen the jurisdiction of the office and would enable us to deal with a complaint despite such a dispute. The jurisdiction would be further increased by extending it to every complaint which arises from the use by the complainant of the services of a subscribing member.

Rule 3.2.5 confers the power on the office to make an award of compensation in appropriate circumstances.

Over the years the value of money has steadily reduced as a result of inflation and it was proposed that the jurisdictional limit of R30 000 should be increased to R50 000.

In terms of Rule 3.3 the office may, in certain circumstances, decline to consider a complaint or it may dismiss a complaint, without first referring it to the subscribing member concerned. A number of complainants submitted that, once the complaint had been referred to the insurer, Rule 3.3 no longer found application. These illogical submissions always failed, but it was felt that the temptation to take such a technical point should be removed by a suitable amendment.

Rule 3.3.2 empowers the office to dismiss a complaint if it is being pursued in a particular manner. On pages 24 and 25 of our 2015 Annual Report I wrote about "Unreasonable Complainants". In our experience it happened that conduct which was manifestly unreasonable did not always readily fit the descriptions of "vexatious" or "abusive" conduct in Rule 3.3.2. The increase in the number of complainants who act in an unreasonable manner necessitated an amendment to enable the office to deal effectively with a complainant who acts unreasonably. I point out that, as a matter of procedure, we do not usually invoke Rule 3.3.2 without first having cautioned a complainant about its provisions.

The Financial Services Ombud Schemes Council approved the amendments of Rules 2.1, 3.2.5 and 3.3 on 6 June 2016 and the amendment of Rule 3.3.2 on 30 June 2016.

CONCILIATION PROCESS

The international trend in the offices of financial ombudsman schemes is towards less formal dispute resolution processes, including early intervention and conciliation in appropriate complaints. During 2015 the office started a pilot project involving three insurers to deal with certain selected complaints by early intervention and conciliation. At our invitation a fourth insurer now participates in the project.

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.

The office is committed to continue with its efforts to render the best service for consumers and for our subscribing members. To this end we will develop and expand the above procedure.

FINAL DETERMINATIONS AGAINST INSURERS

In accordance with our usual procedure a final determination is preceded by a provisional ruling.

It is by now well known that the office's process, if attempts at settlement fail, is initially to issue a provisional ruling setting out our preliminary view and asking the parties whether they have any further facts or contentions to submit before the matter is reconsidered for the purpose of making a final determination. It is our experience that if a provisional ruling is made against an insurer and if it has no new evidence or submissions, the insurer nearly always accepts the office's provisional ruling, despite the fact that it does not agree with it. In some instances an insurer may expressly record its disagreement with a provisional ruling, without formally challenging it.

If an insurer challenges the correctness of a provisional ruling against it, a final determination may be made at a meeting of the Adjudicators in the office. If the final

determination is made against the insurer, particulars thereof, including the name of the insurer, will be published on our website.

The office published two final determinations against insurers during 2016.

In Case 24 it was held that adequate documents had been submitted to Bidvest Life to assess the claim and that it had not proved its entitlement to rely on an alleged non-disclosure by the deceased or on the applicability of an exclusion clause.

Case 25 was resolved through the exercise by the office of its equity or fairness jurisdiction. Such jurisdiction is a statutory prerequisite for the recognition of this office in terms of section 10(1)(e)(iv) of the Financial Services Ombud Schemes Act, 37 of 2004, and it is entrenched in our Rule 1.2.4. For its refusal of a claim, Liberty Life relied on the late submission thereof. Our equity jurisdiction is usually exercised against an insurer by a unanimous decision at a meeting of the Adjudicators in the office at which the Ombudsman or the Deputy Ombudsman presides. After considering all the relevant facts, including the absence of any proof by Liberty Life that it would suffer prejudice specifically in relation to this claim, such a decision was taken that the insurer should assess the claim on its merits.

Full particulars of these two cases and all the other final determinations against subscribing members can be found on our website, www.ombud.co.za.

OUTREACH

Our Rule 1.2.6 provides as follows:

> "The Ombudsman shall seek to ensure that 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."

The office continuously strives to give effect to the spirit of Rule 1.2.6 and to promote greater awareness of the office and of the public service which it renders. In pursuance of our objective to reach the widest range of consumers the office engaged in a number of consumer awareness initiatives during 2016. These included the distribution of desk calendars and our 2015 Annual Report and the regular publication of our newsletter, Ombuzz. Various media interviews were conducted with members of the office and the office enjoyed extensive and favourable press coverage.

DR SWANEPOEL

In December 2016 we bade farewell to Dr André Swanepoel on his retirement. We thank him for his invaluable input over the last 20 years when he assisted the office with independent medical opinions.

Following a recommendation in the report on the 2015 independent review of the office that our website should be more informative and more user friendly for complainants we decided to rebuild it completely. The result is a new website which was implemented at the time of the release of our 2015 Annual Report during May 2016. This makes it easier for complainants to submit complaints, while it retains all the additional elements built up over the years. There has been an increase in the number of complaints submitted to the office via the new website, which allows future development by combining it with our new Respond case management system and various social media initiatives which may be undertaken in the future.

Through the Ombudsman Association of South Africa ("OASA") and in conjunction with five other Ombudsman offices an informative brochure was printed containing a concise description of the service which each office renders. This brochure was widely circulated by the six offices featuring in it. This is a good example of the benefits which flow from membership of OASA and the closer co-operation between the various ombudsman offices which it promotes.

TERMINATION OF MEMBERSHIP

Any long-term insurer may apply to join our scheme and, once it does so, it is contractually bound by the Rules which regulate the procedure in this office and which appear on pages 34 to 37 of this Annual Report. Of particular significance in this regard is Rule 7, which deals with "Enforcement".

Given the voluntary nature of the membership of our subscribing members (particulars of which appear on page 33 of this Annual Report) any member may at any time terminate its membership without having to furnish any reason therefor. During 2016 African Unity Insurance Limited terminated its participation in our scheme.

APPEAL

Only one appeal was finalised during the year.

The complainant successfully applied for leave to appeal against our final determination. A retired High Court judge was appointed as the Appeal Tribunal and this is what he said in the concluding paragraph of his decision, dated 1 July 2016:

> "It follows that I hold that (the insurer) correctly determined that the 100% incapacity benefit is to take effect on 12th September 2012 and not, with respect, on the 1st March 2012. Accordingly the appeal is dismissed."

TRIBUTE TO STAFF

The office's greatest asset is its staff and it is to them that I express my appreciation and I render my thanks for their dedicated efforts to maintain our high standard of service. The office has always been proud of the quality of its service. This is a direct result of the ability of the staff. To consistently achieve this in an office such as ours requires that the staff must be experienced, motivated and well qualified. They have those qualities and the office fortunately has an extremely low staff turnover. I am privileged to serve in this environment where we strive for excellence and I am pleased to publicly say so. A special word of thanks goes to the other two members of the management team, Jennifer Preiss and Ian Middup, for their continued assistance and support.

Ron McLaren

STATISTICS

REQUESTS FOR ASSISTANCE RECEIVED

The office received 9 871 written requests for assistance during 2016, marginally exceeding the 9 815 of the previous year.

Of those requests 5 284 were chargeable complaints (the aggregate of the complaints described under the next rubric) exceeding the 2015 volume by 266. The other requests were intended for other ombudsman's offices or were unconnected with life insurance or for some other reason were not within the jurisdiction of this office. While no case fee is recovered for these other requests, they follow the same initial assessment and recording process and are then forwarded to their correct destinations within a few days of being received.

Transfers increased by 11% while Full Cases decreased by 3.5%.

An analysis of the Transfers (which in 2016 was 58% of the chargeable complaints) over the past three years since implementation of the office's new business model, shows that the total number increased and the percentage (currently 24.5%) settled in favour of the complainants by the insurers.

DESCRIPTION OF CHARGEABLE COMPLAINTS

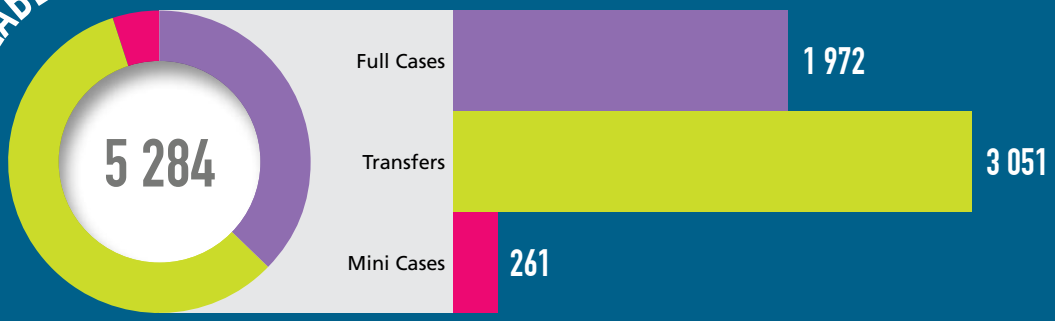
Mini Cases – these are simple complaints that are within the jurisdiction of the office, but which insurers can more readily handle at source. There are some complaints which have no prospect of success. The assessing staff dismiss these complaints and explain the reasons for the dismissal to the complainants. This is done as a service to the complainants and at a minimal charge to the insurers.

Transfers – these are 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.

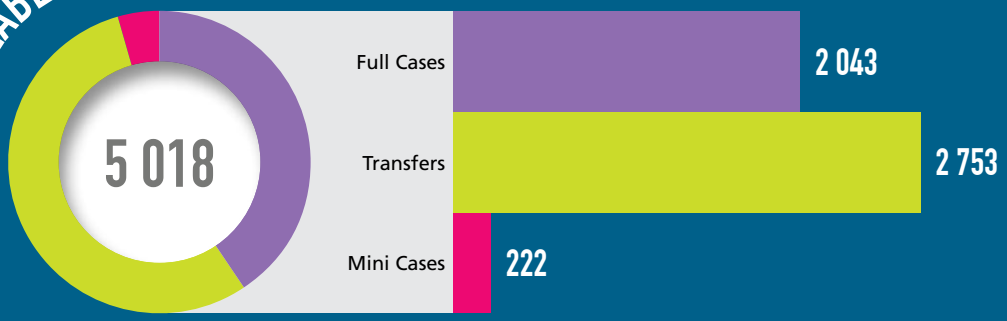
Full Cases – these are complaints already seen by insurers and handled by the office from inception to finality. The decline in this category over the past four years is a result of the increased number of Transfers under the office's new business model.

ANALYSIS OF TRANSFERS	2016	2015	2014
Settled in favour of the complainant by the insurer	**747**	643	632
Returned to the office and taken up as Reviews	**1 324**	1 065	1 115
Required no further action or the complainant did not respond	**440**	400	282
Awaiting response from the insurer or the complainant	**540**	645	553
TOTAL	**3 051**	**2 753**	**2 582**

CHARGEABLE COMPLAINTS RECEIVED 2016



CHARGEABLE COMPLAINTS RECEIVED 2015



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 2016 the number of cases finalised by the office was 3 324, marginally lower than the 3 491 finalised in 2015.

For costing purposes cases finalised are categorised as follows:

Standard Cases – these cases made up almost 80% of cases in 2016 and were charged at the office's benchmark case fee of R3 650.

Incompetent Cases – the volumes are very similar to last year. A case is categorised as "incompetent" when responses by the insurer are late or inadequate, and it attracts a surcharge.

Complicated and Complicated Plus Cases – these cases are of a complex legal, medical or financial nature.

Basic Cases – volumes have been reducing over the years since the introduction of the office's new business model, prior to which they peaked at 255 in 2013.

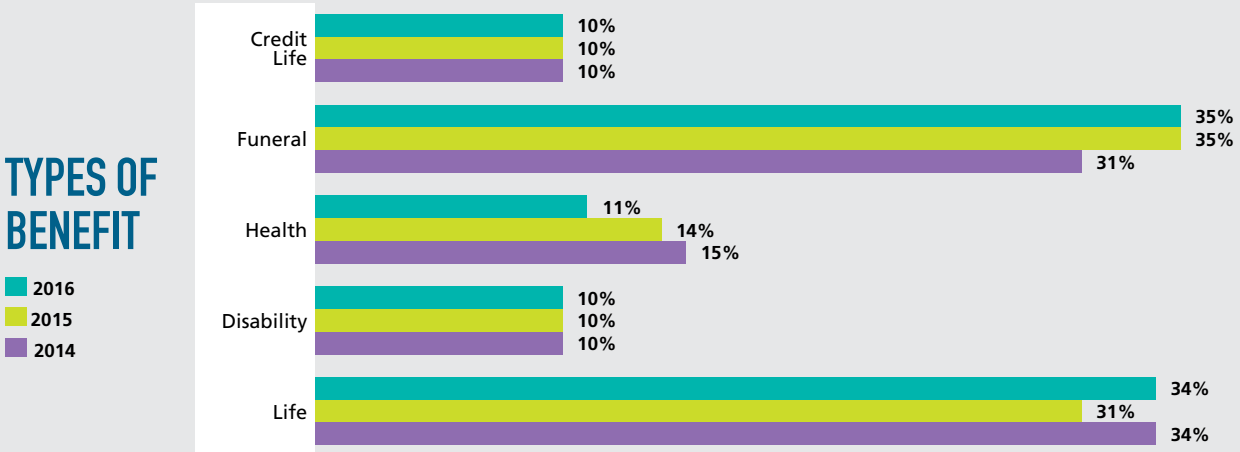
TYPES OF BENEFIT

The three-year trend below is fairly consistent, with only the declining health complaints showing significant change. Health benefit complaints are returning towards the levels at which they were in 2011 before the office was inundated with Hospital Cash Plan complaints.

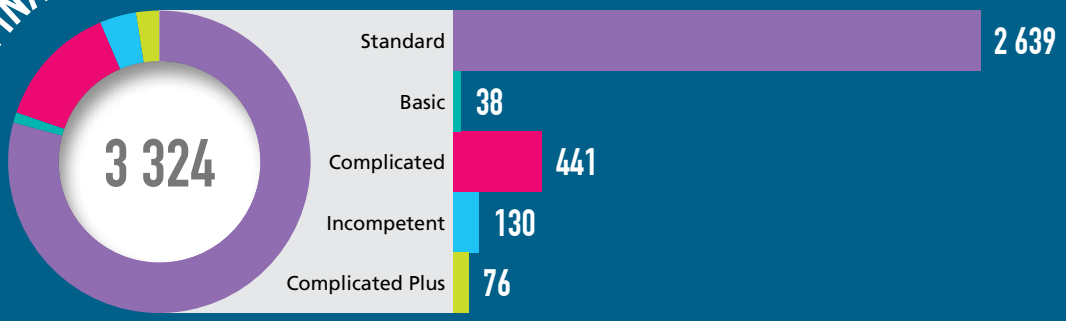
FINALISATION PERIOD	2016	2015
0 – 30 days	5%	8%
31 – 60 days	16%	16%
61 – 90 days	22%	17%
91 – 180 days	35%	34%
181 – 365 days	17%	20%
Over 365 days	5%	5%

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

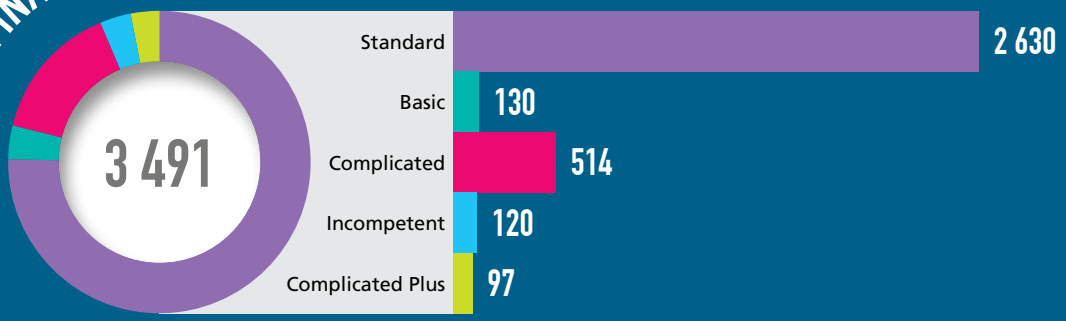
TYPES OF BENEFIT



CASES FINALISED 2016



CASES FINALISED 2015



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	**2015**	**W/P***	**2016**	**W/P***	**2015**	**W/P***	**2016**	**W/P***
Poor communications/documents or information not supplied/poor service	743	39%	938	38%	41	44%	38	34%
Claims declined (policy terms or conditions not recognised or met)	1 262	25%	1 099	24%	248	40%	267	37%
Claims declined (non-disclosure)	79	22%	87	15%	42	21%	50	16%
Dissatisfaction with policy performance and maturity values	91	12%	117	10%	0	0%	1	0%
Dissatisfaction with surrender or paid-up values	49	14%	50	8%	0	0%	0	0%
Misselling	7	14%	6	17%	0	0%	0	0%
Lapsing	158	31%	127	33%	1	0%	1	100%
Miscellaneous	240	20%	159	15%	24	29%	11	36%
Total	**2 629**	**32.0%**	**2 583**	**28.0%**	**356**	**37.1%**	**368**	**34.0%**

* Resolved wholly or partially in favour of the complainant.

NATURE OF COMPLAINT

CLAIMS DECLINED – these account for almost 50% of the overall total, but volumes are the lowest in recent years. The W/P at 26% is also the lowest in the recent history for this category.

POOR COMMUNICATIONS – these have increased to over 30% of cases finalised. The volumes are starting to increase after a few years of being in decline.

The above two categories make up approximately 80% of the cases finalised.

HEALTH				TOTALS				% OF TOTAL	
2015	W/P*	2016	W/P*	2015	W/P*	2016	W/P*	2015	2016
55	45%	46	39%	839	40%	1 022	38%	24.03%	30.75%
402	28%	278	23%	1 912	29%	1 644	26%	54.77%	49.46%
39	15%	40	8%	160	20%	177	14%	4.58%	5.32%
1	100%	0	0%	92	13%	118	10%	2.64%	3.55%
1	0%	1	0%	50	14%	51	8%	1.43%	1.53%
0	0%	0	0%	7	14%	6	17%	0.20%	0.19%
4	25%	2	50%	163	31%	130	35%	4.67%	3.91%
4	0%	6	17%	268	20%	176	16%	7.68%	5.29%
506	**27.9%**	**373**	**23.1%**	**3 491**	**29.8%**	**3 324**	**28.1%**	**100%**	**100%**

RESOLVED WHOLLY OR PARTIALLY IN FAVOUR OF COMPLAINANTS

At 28.1% this is the lowest by about 1.6 percentage points in the three years that the office's new business model has been in operation. However, if the Transfers settled by insurers are included in the figure, as they would probably have resulted in the same outcome if handled by the office, the W/P percentage would have been 37.4%, which is in line with the figure for the past five years.

MATTERS OF INTEREST

HEART PACEMAKER SCAM

During 2016 the office received a number of complaints which appeared to have an unusual number of similarities. For instance, in six of those complaints the two insured lives each had a policy for a substantial insured amount with each of the same three insurers. Claims were submitted by the insured, following medical operations for the implantation of pacemaker devices. Each of the three insurers repudiated liability for the two claims against it. Four claims were declined on the footing that the insured lives had made material non-disclosures to each of the two insurers about their incomes and about their applications for similar insurance with the other insurers. In four of the complaints against two of the insurers the office made final determinations, dismissing the complaints. In the two remaining complaints the insurer raised a pending investigation by the South African Police Service of a possible case of fraud and it relied on this investigation for its inability to deal with the merits of the claims against it. The office upheld this insurer's stance in our two final determinations relating to the complaints against it. These two complaints against the third insurer were thus also, for all practical purposes, unsuccessful. The commonality between the six complaints by the same insured lives against the same three insurers is quite remarkable. The office considered these matters to be sufficiently newsworthy to report on them in issue 35 of our Ombuzz newsletter which appears on our website, www.ombud.co.za.

A press release which was published subsequently makes interesting reading:

> *"Are pacemakers being stuck into people's healthy hearts as an easy way to swindle insurance companies? This is the question the long-term insurance industry must grapple with while police investigate a so-called 'pacemaker scam'.*
>
> *The Ombudsman for Long-term Insurance Judge Ron McLaren recently received similar complaints from two people who had each undergone an operation for the implantation of a pacemaker.*
>
> *The claims by these complainants against insurers were declined by the insurers – they had illness insurance totaling R30.5m – and they, therefore, turned to the Ombudsman.*
>
> *An insurer disclosed to the office of the Ombudsman particulars of a police investigation into a so-called 'pacemaker scam' which if it is established, according to the Ombudsman, will constitute fraudulent conduct by the participants.*
>
> *The elaborate fraudulent scheme involves the unnecessary implantation of a pacemaker device into somebody who has significant insurance for such a claim event.*
>
> *In a genuine case a pacemaker provides an electric impulse to the muscles of the heart in order to ensure that the heart beats regularly. The implantation of a pacemaker for a person who has no need, therefore, is questionable, to say the least.*
>
> *...*
>
> *It is believed the insurer which reported the pacemaker scam to the Ombudsman's office said that the scam is financed by persons who find indigent participants to apply for insurance cover. For a couple of months substantial premiums are paid by means of loans from the financiers to the participating applicants at*

allegedly exorbitant rates of interest. It is yet unknown what happens to the proceeds of a successful claim against an insurer.

When questioned about the complainants' inflated incomes, the Ombudsman's office expressed the view that it is an inescapable inference that the reason for the falsity of the complainants' disclosed incomes is to justify the substantial cover applied for and that they can afford the premiums.

Likewise, their false negative replies to the questions relating to other insurance flow from their desire to hide from the insurers the extent of their cover for similar benefits, the Ombudsman's office said."

CASES BECOMING MORE DIFFICULT TO FINALISE

The sense in the office is that cases have become more difficult to finalise than in the past. This is for a variety of reasons – e.g. more complex products, more persistent complainants and the impact of the office's new business model. The simpler complaints are now mainly resolved on transfer by the insurers, in terms of that process.

The following are indicators of the trend of a higher percentage of cases that are difficult to finalise.

- In 2016 we had 331 final determinations; this comprises 10% of our closed cases. As we point out on page 20 of this Annual Report, in 2008 only 0.8% of cases resulted in final determinations. In each case in which a final determination was issued, either a second staff member had reviewed the case or the case had been to an Adjudicators' meeting for discussion and determination.
- In 2011, 45% of our cases were finalised by the Assessors in the office and 55% by the Adjudicators; in 2016 36% of our cases were finalised by the Assessors, 64% being finalised by the Adjudicators. (The Assessors deal with less complicated matters in the office.)
- The Assessors escalated, on average, 21 cases per month to the Adjudicators in 2016, when the cases became too difficult for them to handle. This once again means that more than one adjudicating staff member would have been involved in the resolution of the case.
- In 2016 a total of 598 cases were reallocated from one adjudicating staff member to another, for resolution.

WHAT KEEPS AN OMBUDSMAN AWAKE AT NIGHT?

The Assessors and Adjudicators in the office were canvassed about the issues that currently fall into this category. The following are some of the issues raised by them and some examples thereof.

1. **Bad bargains**

   Products that do not provide value for money or do not deliver on their perceived promises. These include products that have the following features:

- Policies that provide very limited cover.

  E.g. a policy termed a "Cancer policy" which in effect only provides cover for female cancers or male cancers, but it is only by reading one particular clause in the policy that the policyholder will discover that the cover is limited in this way.

- Unexpected or unusual provisions in policies. These are terms and conditions that are not part of standard policy terms or conditions and that we have seldom or never encountered previously. The question then arises whether policyholders, or even intermediaries, were aware of these unusual provisions when the policies were purchased.

  E.g. policies that reverse the normal onus of proof; whole life risk policies that give the insurer a right to cancel the policy.

- Policies which are unsuitable for their target market.

  E.g. capital protector policies with premium reviews sold to pensioners. Although the concept of a capital protector policy has distinct advantages, if there is a premium review which results in a high increase in the premium it could make the premium unaffordable for a pensioner who is on a fixed annuity. We have had many complaints about such premium increases following premium reviews.

- Legacy products that have become outdated.

  E.g. critical illness policies with outdated definitions which are difficult to apply because of advances in medical science.

- Policies that are sold that raise expectations that have no chance of being fulfilled. The following case study demonstrates this aspect.

Case study

The policy was initiated telephonically by the insured's partner on 3 February 2015. The insured's partner disclosed that the insured was on ARVs that did not appear to be working as he had lost a considerable amount of weight; that he had a productive cough; that he was unable to work as he was too weak; that following his last test in January 2015, the insured's CD4 count was 15.

The call centre agent assured the insured's partner that the information conveyed would not be a problem.

The insured's partner was assured that the policy did not have a waiting period; that if she claimed within the month, the claim would be paid.

When the insured was contacted, it was clear that he was not in good health as he had difficulty responding between bouts of continuous coughing.

The policy was issued on 15 March 2015 with full cover.

The insured passed away on 16 March 2015.

The claim was declined as at the date of death the policy only provided accidental cover because the underwriting process (three months) had not been completed and passed.

Although the claim could not be enforced the insurer was instructed in terms of our Rule 3.2.5 to pay compensation for the inconvenience and distress suffered by the insured's partner, who was the complainant in our office.

- Investment policies that do not provide good value for money because the costs on these policies

are high. This feature is built into the design of the policy and there is little we can do to assist in complaints about these policies. The charges are disclosed in the contractual documentation but it is unlikely that the policyholder fully appreciates the eroding effect of such charges. The impact of these charges is even more devastating to the policyholder if the investment returns do not measure up to the growth that was illustrated at the sales stage. Although the industry no longer uses illustrative maturity values in their marketing material and policies, many of the complaints in the office relate to policies that were sold at a time when illustrative maturity values were used.

E.g. we have seen some policies where the charges amount to up to 33% of the premium or where the Reduction in Yield was illustrated as 10% which reflects the impact of costs on the return of the investment. The chances of a policyholder getting a real return on such a policy are slim.

2. The difficulty of applying some products

- There are some extremely complex products in the market. The majority of these policies are critical illness and disability policies with cover for a myriad of conditions. Some of these policies consist of more than 100 pages. We find it difficult to interpret and understand the policies. The question is how many policyholders would be able to understand these policies. We have cases where legal experts differ on the interpretation of policy wording as the drafting is not always clear, particularly where there are medical or actuarial terms involved.
- There are products that have design flaws. This can lead to difficulty at claim stage when applying the wording in the policies to the conditions they are supposed to cover. These are products that have not been tested in the "real world" or have not been "thought through".

  E.g. a benefit that pays out if the insured suffers from four grand mal epileptic seizures during a specified period. However, the insurer had not indicated in what manner the insured would have to prove the incidence of such seizures.

  Funeral policies covering "cousins". It is of course not that easy to prove that someone is a cousin. In certain indigenous languages there is no distinction drawn between a cousin and a second cousin. We have had a number of complaints where a policyholder covered a second cousin but described the insured as a "cousin" because of this difference in terminology.

NEW TELEPHONE SYSTEM

During 2016 the office replaced its long-serving switchboard with a modern board which enables additional tracking of incoming and outgoing calls and the ability to record calls if required. In addition, while retaining its current telephone numbers, the office also migrated from Telkom telephone lines to fibre optic lines for all voice requirements, resulting in a significant cost saving which negates the cost of the new switchboard.

- Products that provide perverse incentives that then lead to unintended consequences.

  The problem of excessive claims on the hospital cash plans is an example of this. We have written about this problem in the previous four Annual Reports.

3. Complainant behaviour

We wrote about difficult complainants in the 2015 Annual Report on pages 24 and 25. This problem is not going to disappear and there have been several complaints in the last year that have taken on nightmarish dimensions precisely because of the unreasonable behaviour of complainants.

The persistence of complainants impacts on our productivity as more time has to be spent on such complaints. This is a growing trend. We measure persistency by the percentage of complainants who reject the office's provisional determinations where we then have to issue final determinations.

2008 – 0.8% of cases closed had final determinations issued;

2012 – 5.8%;

2016 – 10%.

4. Insurer behaviour

There is also insurer behaviour that makes our role difficult.

- Insurer behaviour that suggests that a claim is being avoided at all costs. This is where the insurer is evidently/demonstrably looking for reasons not to pay what appears to be a valid claim, often by raising a new defence if the original reason for declining a claim does not succeed.

Case study

The life insured had a policy with cover for female cancers and accidental death since March 2005. On the evening of her death, she took her prescribed medication, which included anti-depressants and anti-inflammatories, and thereafter had a bath. She subsequently (allegedly) fell asleep in the bath and drowned. The complainant, the deceased life insured's mother, submitted a claim in June 2014. The insurer advised the complainant that it required the results of the autopsy report before making a decision whether to pay out the claim. It took two years to obtain the post-mortem report. When obtained, the report stated that the cause of death was found to be "in keeping with drowning in a patient with toxic/lethal drug levels." Based on this report, the insurer initially declined the claim relying on the suicide exclusion in the policy.

After the complainant approached our offices, the insurer reviewed the matter and advised that it could possibly rely on the following exclusion to decline:

> *"... consumption by the life insured of alcohol, recreational drugs, narcotic drugs, habit-forming drugs or dependence-producing drugs, except, in respect of all the aforementioned, as bona fide prescribed by a duly qualified and registered medical practitioner."*

The toxicology report, submitted with the post-mortem report, indicated that at least two anti-depressants, codeine, nonsteroidal anti-inflammatories, cyclizine and paracetamol were found in the insured's blood.

The insurer also declined the claim by relying on an exclusion for:

"... intentional self-inflicted injuries or deliberate exposure of the life insured to unnecessary danger."

The insurer was adamant that the insured had taken a lethal dose of medication which, in the insurer's view, was of a significant level and would thus amount to an "unprescribed" amount from her doctor. The complainant provided a report from the insured's doctor, who specified that the medication prescribed to the insured included anti-depressants, anti-inflammatories and mood stabilisers. The complainant further provided WhatsApp messages from the insured's cell phone to her partner. These messages did not indicate any intention to cause harm to herself, the insured stated that she needed to take a bath as she was very cold, but she would respond to her partner's messages after her bath. The insurer found the information helpful and decided to pay the claim.

- Insurers that act unreasonably.

  E.g. expecting a claimant to provide information to prove an exclusion on which the insurer wishes to rely to decline a claim instead of the insurer obtaining the information itself.

  Insurers expecting claimants to undergo surgical procedures or electroconvulsive therapy when considering disability claims, in the absence of policy wording requiring such treatment.

- Insurers that have poor underwriting practices by, for instance, not conducting proper investigations at underwriting stage, but then relying on a non-disclosure defence to repudiate the policy when a claim arises. This involves the practice of "shutting the eyes to the light" at application stage.

- Insurers that have poor claims handling.

Case study

A claimant claimed under a hospital cash plan for the 72 days she spent in Tara Hospital for treatment of major depression. She lodged the claim and the insurer required her to submit the admission form, the discharge form, a copy of her identity document and a report from the treating doctor. The report from the doctor disclosed that the claimant had experienced the following psychosocial stressors before her admission to the hospital: her daughter of 16 had died in 2014, her engagement of 3 years had recently ended and her son of 9 had been hospitalised at Tara Hospital following sexual assault.

RESPOND CASE MANAGEMENT SYSTEM

The current case management system, Ombud, has been in use for almost 20 years and even after various updates the changing nature of the industry and the requirement for more information dictated that a new system was required. The implementation of the new system, Respond, is still in its infancy and in some areas a work in progress. Since September 2016 all new cases are recorded on the Respond system and the existing cases will remain on the Ombud system until finalisation.

After receiving these documents the insurer then requested the "day-to-day bed record" to show continuous hospitalisation. The insurer persisted in this request even though the doctor pointed out that the admission and discharge forms provided the necessary information. After the claim had been delayed for more than 5 months the insurer finally realised that the policy benefit was excluded if the claim was in respect of hospitalisation in a hospital for treatment of mental conditions and declined the claim on these grounds.

Although the claim could not succeed the insurer agreed to pay compensation to the insured in terms of our Rule 3.2.5 for "material inconvenience or distress".

- The attitude of some insurers, after all these years, to our equity/fairness jurisdiction; they shy away from the very concept, yet they themselves make so called *"ex gratia"* or *"goodwill"* payments. These payments are probably based on grounds that are not that different from our concept of equity/fairness. This attitude to equity/fairness is difficult to reconcile with the TCF (Treating Consumers Fairly) approach which has been introduced by the Financial Services Board.

5. Systemic issues

These are complaints that have a wider impact than the complaints in our office. These are difficult complaints to resolve precisely because of their wider impact. The impact that a decision in a single case in our office might have on the whole portfolio of policies complicates the issue.

Case study

An insurer sells policies that provide cover for people who are HIV positive. The life insured is accepted at application stage but then has to complete an underwriting process within three months. If the insured fails the underwriting process, usually because his/her CD4 count is below the cut-off count, only accidental cover is granted, but the premium remains the same. The insurer's motivation for this practice of not reducing the premium was that the insured may qualify for full cover (i.e. cover for claims arising from natural causes as well as accidents) in the future. Their systems could also not accommodate such transitions between accidental and full cover.

Our office was of the view that this practice was not acceptable. The insurer has subsequently agreed to change its practice and reduce the premium if the cover is limited to only accidental causes. They have also implemented additional measures to ensure that both the insured and the premium payer (if it is a different person) are aware that the cover is limited to accidental cover.

COMPENSATION FOR POOR SERVICE

In terms of our Rule 3.2.5 the office may, regardless of whether a complaint is upheld or not, "award compensation 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 R50 000".

Rule 3.2.5 came into operation during 2003 and, leaving aside the maximum amount of compensation of R15 000, its provisions have remained largely unchanged since then. By 2006 the maximum amount had been increased to R20 000; this was increased to R30 000 in 2009 and in 2016 to the current amount of R50 000. The steady increase in the maximum amount of compensation which the office may award is attributable to inflation. As a result the awards of compensation made by the office also increased with the passage of time. This fits in well with Rule 1.2.4 in terms of which the office must give weight to considerations of equity or fairness.

Sometimes there appears to be uncertainty about the manner in which the office applies Rule 3.2.5. Two examples show this. An unsuccessful complainant expects the amount of compensation to be in line with the amount of the insured benefit. An insurer perceives an award of compensation as a form of punishment for poor service. Both approaches are fundamentally wrong.

For a better understanding of how we deal with compensation for poor service one must bear in mind what is said in **Life Insurance in South Africa** by Nienaber and Reinecke on pages 61 and 62:

> "There must be evidence of some culpability on the part of the insurer and some harm, emotional or financial, on the part of the complainant. Such an award is not simply there for the asking nor is it, as it has been put, 'an award for disappointed expectations' ... Like any ruling it is susceptible to an appeal but being discretionary in nature leave to appeal will not readily be granted."

The authors refer to the following examples of "culpability" or "poor service", but the list is obviously not complete:

> "Such as imprecise or confusing draftsmanship of contractual documentation, misleading marketing of products, wrong information furnished, misplacing of or ignoring correspondence, poor responses to queries, fraud by agents, inordinate or persistent delays, recalcitrance, miscalculation of benefits and general incompetence."

The office prepared guidelines which assist us in applying Rule 3.2.5 and these appear under "Useful Information" on our website, www.ombud.co.za.

For two illustrative examples of how we deal with compensation for poor service the reader is referred to issue 29 of our Ombuzz newsletter, which appears under "Publications" on our website.

We regard the issue of compensation in a serious light; we strive to be even-handed and fair; we try to avoid awards of compensation which are out of line with other awards in complaints which are more or less similar and we use our collective experience and common sense in determining the amount of compensation for poor service.

In terms of Rule 1.2.3 we must keep "in balance the scale between complainants and subscribing members". The following words of Holmes J in **Pitt v Economic Insurance Co. Ltd** 1957 (3) SA 284 (N) 287 E–F reflect our approach to Rule 3.2.5:

> "I have only to add that the Court must take care to see that its award is fair to both sides – it must give just compensation to the plaintiff, but must not pour out largesse from the horn of plenty at the defendant's expense."

INFO 2016

In September 2016 the Deputy Ombudsman, Jennifer Preiss, and Assistant Ombudsman, Sue Myrdal, represented our office at the annual conference of the International Network of Financial Ombudsman Schemes ("INFO 2016") which was held in Yerevan, Armenia.

The small and recently formed office of the Financial System Mediator of Armenia hosted a first-class conference, with sessions combining talks from ombudsman offices around the world with group interaction and discussion. Topics covered included globalisation of financial services cultures, cultural particularities, fairness, mediation, media relations strategies in difficult situations, balancing transparency and confidentiality, jurisdictional limits and boundaries, intermediaries, and optimal business processes and financing models.

The famous Armenian hospitality ensured that mealtimes and evenings were a memorable chance to break bread (lavash) with other members of the international family of financial ombudsman offices – a great opportunity to swop notes and share problems and solutions.

Back in South Africa, the lessons learnt at INFO 2016 were shared with the office. One lesson that stands out was the trend towards less formal methods of dispute resolution. If determinations are necessary, they should be shorter and easy to understand, in keeping with the role of ombudsman offices as service organisations. Another theme was the challenge posed by diversity in languages and cultures, even within one country, and the need to recognise that one size does not fit all.

STAFF
IN THE OMBUDSMAN'S OFFICE

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Jennifer Preiss
Ian Middup

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Nceba Sihlali
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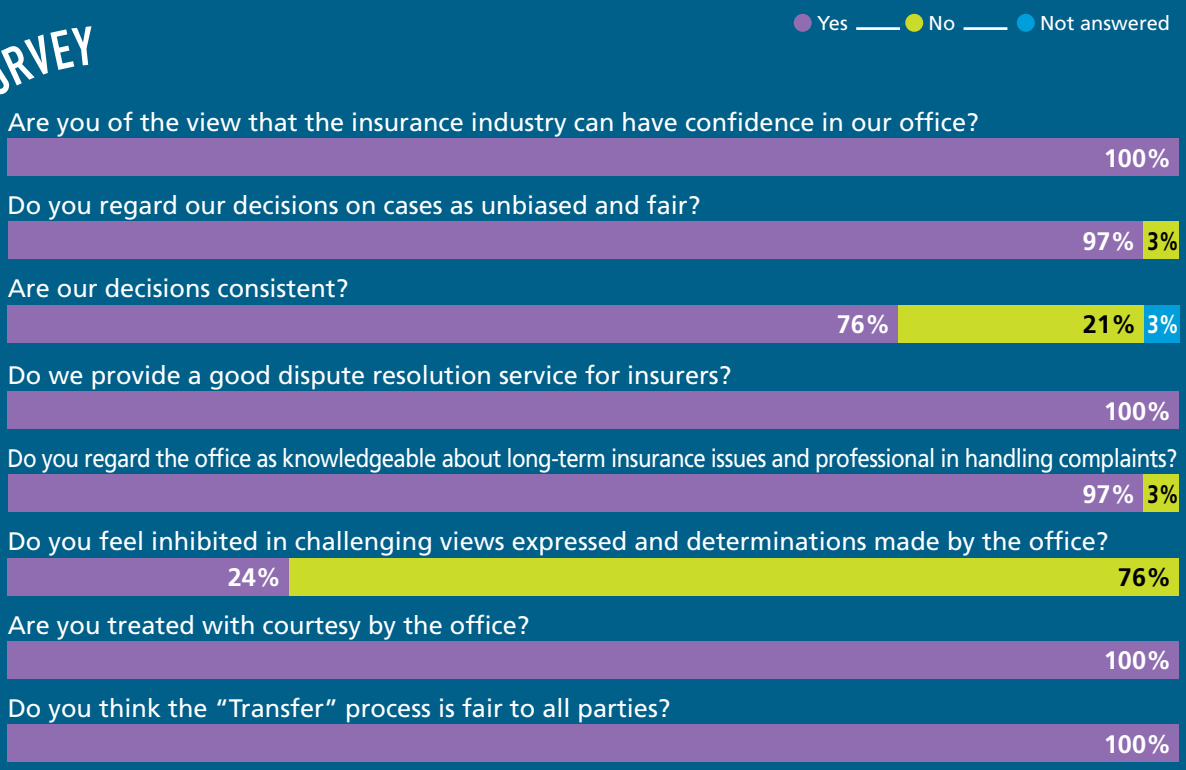
Nosiphiwe Sifingo
Virginia Smith
Colleen Louw
Lynn Fitzpatrick

SURVEYS

COMPLAINANT SURVEY

INSURER SURVEY



We use the survey results to improve our service to complainants and subscribing members.

COMPLAINTS DATA FOR SUBSCRIBING MEMBERS

The office published individual insurer complaints data for the period 1 January 2016 to 31 December 2016 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 are 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 as 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

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 2016 appear alongside.

African Unity	14
Nedgroup Life	84
Nestlife	8
Safrican	16

"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.

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 complainants directly. If a 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 2016, some of which 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 2016 the overall W/P percentage in favour of complainants was 28.1%.

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	166	3.16%	106	104	25.0%	75.0%
Abacus Insurance Limited	9	0.17%	7	4	50.0%	50.0%
ABSA Insurance and Financial Advisers (Pty) Limited	1	0.02%	1	0	0.0%	0.0%
ABSA Life Limited	200	3.81%	144	121	31.4%	68.6%
Acsis Limited	0	0.00%	0	0	0.0%	0.0%
African Unity Insurance Limited	26	0.50%	22	33	54.5%	45.5%
AIG Life South Africa Limited	110	2.09%	70	88	25.0%	75.0%
Alexander Forbes Life Limited	13	0.25%	10	6	50.0%	50.0%
Allan Gray Life Limited	12	0.23%	2	2	0.0%	100.0%
Assupol Life Limited	300	5.71%	141	137	29.2%	70.8%
AVBOB Mutual Assurance Society	88	1.68%	56	47	29.8%	70.2%
Bidvest Life Limited	7	0.13%	5	5	60.0%	40.0%
Centriq Life Insurance Company Limited	76	1.45%	74	63	9.5%	90.5%
Channel Life Limited	56	1.07%	39	35	34.3%	65.7%
Clientèle Life Assurance Company Limited	226	4.30%	138	126	15.9%	84.1%
Discovery Life Limited	184	3.50%	134	111	23.4%	76.6%
FedGroup Life Limited	0	0.00%	1	1	100.0%	0.0%
FNB Life Limited*	36	0.69%	31	35	31.4%	68.6%
First Rand Life Assurance Limited	10	0.19%	4	0	0.0%	0.0%
Frank.Net	1	0.02%	3	8	50.0%	50.0%
Guardrisk Life Limited	103	1.96%	52	50	28.0%	72.0%
Hollard Life Assurance Company Limited	492	9.37%	343	330	35.2%	64.8%
Investec Assurance Limited	3	0.06%	1	1	0.0%	100.0%
Investment Solutions Limited	0	0.00%	0	0	0.0%	0.0%

* 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, was granted during November 2016.

	Complaints Received	% of Total	Cases Considered	Cases Finalised	% Resolved W/P in favour of Complainants	Insurer
Just Retirement Life (S.A.) Limited	0	0.00%	0	0	0.0%	0.0%
Liberty Group Limited	587	11.18%	432	434	33.6%	66.4%
Lombard Life Limited	7	0.13%	7	6	16.7%	83.3%
Metropolitan Life Limited	376	7.16%	226	195	19.0%	81.0%
MMI Group Limited	316	6.02%	232	253	24.1%	75.9%
Nedbank Limited	1	0.02%	0	0	0.0%	0.0%
Nedgroup Life Assurance Company Limited	124	2.36%	102	100	23.0%	77.0%
Nestlife Assurance Corporation Limited	10	0.19%	12	10	60.0%	40.0%
New Era Life Insurance Company Limited	0	0.00%	0	1	100.0%	0.0%
Old Mutual Alternative Solutions Limited	21	0.40%	10	12	58.3%	41.7%
Old Mutual Life Assurance Company (SA) Limited	723	13.77%	454	469	20.0%	80.0%
Outsurance Life Insurance Company Limited	30	0.57%	21	23	13.0%	87.0%
Professional Provident Society Insurance Company Limited	36	0.69%	29	24	33.3%	66.7%
PSG Life Limited	4	0.08%	5	5	20.0%	80.0%
Real People Assurance Company Limited	5	0.10%	3	4	0.0%	100.0%
Regent Life Assurance Company Limited	67	1.28%	50	55	32.7%	67.3%
RMB Structured Life Limited	3	0.06%	1	1	0.0%	100.0%
SA Home Loans Life Assurance Company Limited	18	0.34%	15	20	10.0%	90.0%
Safrican Insurance Company Limited	124	2.36%	70	58	24.1%	75.9%
Sanlam Developing Markets	253	4.82%	190	190	16.8%	83.2%
Sanlam Life Insurance Limited	273	5.20%	153	139	12.9%	87.1%
Union Life Limited	40	0.76%	27	27	44.4%	55.6%
Viva Life Insurance Limited	5	0.10%	2	1	0.0%	100.0%
Vodacom Life Assurance Company Limited	13	0.25%	7	7	42.9%	57.1%
Workerslife Assurance Company Limited	97	1.85%	70	67	31.3%	68.7%

REPORT BY THE CHAIRPERSON OF THE OMBUDSMAN'S COMMITTEE

The mission of the office of the Ombudsman for Long-term Insurance is to receive and consider complaints against subscribing members and to resolve such complaints through mediation, conciliation, recommendation or determination. In the discharge of this role complainants and subscribing members receive a cost-effective, efficient and accessible service of the highest quality. At the same time the office develops the general body of insurance law through interpretation of contracts and legislation and its application of TCF principles. It goes without saying that the office plays a vital role in the financial services industry.

The Ombudsman's Committee performs a liaison function between subscribing members and the office. The Committee comprises representatives of various subscribing members and a representative from the Association for Savings and Investment South Africa. Through the Committee issues that affect the subscribing members and the industry in general are ventilated and recommendations made to enhance the effectiveness of the complaints handling and TCF processes of the members and the office.

The office continues to grow in stature and its legitimacy is entrenched through the dedication and enthusiasm of its staff. It gives me pleasure to be able to say that the office has adhered and given further content to every point of its mission statement. One just has to consider a few of the enhancements the office has introduced such as the Transfer process, its willingness to initiate face-to-face meetings with complainants and the new Respond case management system; all these highlight the fact that the office's procedures are not only fair and cost effective but can be seen to be so. This has become apparent to the Committee as we observe that more and more attorneys have availed themselves of the services the office provides.

From the feedback received from the Committee members it appears that all are experiencing an upsurge in complaints via social media and have dedicated departments to deal with these. As always the office is well prepared to deal with issues that affect the industry, such as the so-called pacemaker scam, the malevolent effects of which were felt during 2016. The office has provided examples of this in issue 35 of Ombuzz and on pages 16 and 17 of this Annual Report.

I thank the Ombudsman and each and every member of the staff for their hard work, professionalism and their role in delivering to the South African consumer a world-class dispute resolution system. I echo the tribute given to them in the 2015 Annual Report.

Glenn Hickling

MEMBERS OF THE OMBUDSMAN'S COMMITTEE AS AT 2016

GLENN HICKLING
Chairperson
Discovery Life Limited

DOREA OZROVECH
Former Chairperson
Sanlam Life Insurance Limited

EHEILA ENGELBRECHT
Sanlam Developing Markets

PAUL VAN ONSELEN
Hollard Life Assurance Company Limited

ANNA ROSENBERG
ASISA

JACOLIEN POTGIETER
Assupol Life Limited

RUSSEL KRAWITZ
Guardrisk Life Limited

RYAN SACKS
Clientèle Life Assurance Company Limited

SHELLY JONES
ABSA Life Limited

WERNER DU PLESSIS
MMI Group Limited

CHRIS HOWARTH
Old Mutual Life Assurance Company (SA) Limited

MARIZA SCHLUSHE
Metropolitan Life Limited

ELNA LOMBARD
Liberty Group Limited

PHILLIPA APUABI
Nedgroup Life Assurance Limited

PIETER VAN ZYL
1 Life Direct Insurance Limited

JOHANN VAN DER LITH
Workerslife Assurance Company Limited

APPENDICES

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

	2016 R	2015 R
REVENUE		
Recoveries from Subscribing Members	**20 631 185**	18 096 197
Investment income	**822 883**	778 992
	21 454 068	18 875 189
EXPENSES		
Administration and professional fees	**85 740**	35 475
Annual report	**96 469**	95 688
Call centre costs	**84 033**	105 692
Computers and communications	**570 438**	439 642
Council – travel and accommodation	**82 356**	70 010
Council fees	**78 750**	86 000
Depreciation and amortisation	**39 762**	32 670
Electricity	**293 845**	241 572
Employee costs	**14 038 613**	11 209 990
Employee costs – contract staff	**2 201 837**	2 555 809
Employee costs – contributions	**777 133**	658 364
Employee costs – other overheads	**104 132**	106 211
International travel	**93 251**	108 316
Marketing and brochures	**100 417**	67 149
New Case Management system	**–**	240 000
Other expenses	**356 164**	375 667
Professional advice	**164 101**	357 008
Quality control	**4 730**	8 000
Rent – parking	**323 909**	291 131
Rent – premises	**1 523 588**	1 384 784
Repairs and maintenance	**2 717**	1 250
Stationery	**119 297**	120 761
Telephone	**194 418**	163 264
Travel and accommodation	**118 368**	120 736
	21 454 068	18 875 189

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

APPENDIX 2: **SUBSCRIBING MEMBERS** as at 31 December 2016

1 Life Direct Insurance Limited

Abacus Insurance Limited

ABSA Insurance and Financial Advisers (Pty) Limited

ABSA Life Limited
Allied Insurance
UBS Insurance

Acsis 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.Net

Guardrisk Life Limited
Platinum Life

Hollard Life Assurance Company Limited
Crusader Life
Fedsure Credit Life
Investec

Investec Assurance Limited

Investment Solutions Limited

Just Retirement Life (S.A.) Limited

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

Lombard Life Limited
Pinnafrica Life

Metropolitan Life Limited
Commercial Union
Homes Trust Life

MMI Group Limited
African Eagle Life
Allianz Life
Anglo American Life
FNB Life
First Rand
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

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

Workerslife Assurance Company Limited
Sekunjalo Investments

APPENDIX 3: **RULES**

These Rules, effective from 1 January 1998 and last amended with effect from 30 June 2016, regulate the relationship between the Ombudsman for Long-term Insurance (the Ombudsman) and each member of the Long-term Insurance Industry who subscribes to the Ombudsman's scheme as well as between the Ombudsman and each complainant who lodges a complaint with the Ombudsman's office.

1 Mission

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

1.2 The Ombudsman shall seek to ensure that:

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

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

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

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

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

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

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

2 Jurisdiction

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

2.2 The Ombudsman shall not consider a complaint:

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

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

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

3 Procedure

3.1 The Ombudsman shall require, 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 R50 000;

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, at any stage of the complaints handling process, if it appears to him or her 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, abusive or unreasonable 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.

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: 086 674 7414
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
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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
PO Box 36628, Menlo Park 0102
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 52115, Saxonwold 2132
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Ombudsman's central helpline
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0860662837

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21 Dreyer Street
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