Annual Report | 2010

OMBUDSMAN
FOR LONG-TERM INSURANCE

KEY FIGURES

Complaints received >> 9 236

Full cases finalised >> 4 124

Percentage of cases resolved wholly/partially in favour of complainants >> 46.5%

Percentage of cases finalised within six months >> 79%

Cost per standard case >> R2 000

Recovered for complainants (lump sum) >> R103 484 956

Compensation granted >> R411 337

Total expenses for the year >> R11 605 000

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Foreword by the Chairperson of the OMBUDSMAN'S COUNCIL

The Council met as usual on two occasions during 2010. At the first meeting, held on 23 April 2010, I was elected as chairperson to succeed Dawn Mokhobo who through personal circumstances had been forced to resign from the Council in February.

Dawn had been a member of the Council since its inception in 1999, for some years as vice-chairperson and ultimately, from 2007 onwards, as chairperson, and she always brought a sensible, balanced and practical view to bear on all issues dealt with by the Council. Her presence will be sorely missed.

Having at each meeting received from the Ombudsman, as usual, a comprehensive overview of the office's activities, and having monitored the performance of the Ombudsman and his office, the Council was satisfied that for the year concerned they had fulfilled their mission, had complied with their obligations under the scheme's rules and under the Financial Services Ombud Schemes Act of 2004, and had maintained the independence that is vital to their function. The Council also approved the office's budget for 2011.

During the year, the Council extended the appointment of Judge Galgut as Ombudsman for three years until 31 May 2013. The Council also had occasion to congratulate Moses Moeletsi on his appointment as CEO of the National Regulator for Compulsory Specification, Desmond Smith on his appointment as Chairman of Sanlam and Judge Leona Theron on her elevation to the Supreme Court of Appeal.

The Council is mindful of, and notes with appreciation, the consistently high standard of work performed by the Ombudsman and the members of his staff. The Council also commends the Ombudsman's office for the significant role it played in hosting the extremely successful international INFO 2010 Conference in Cape Town in September 2010.

On a personal level I would like to thank all the members of Council for the diligent way in which they perform their functions and their insightful and valuable contributions at Council meetings.

John Smalberger

Members of the Ombudsman's Council as at 31 December 2010

1 **Judge J Smalberger** (Chairperson)
Formerly Judge of the Supreme Court of Appeal; formerly Chairperson of the Electoral Court; presently Judge of the Lesotho Court of Appeal.

2 **Adv. S Baqwa** SC (Vice-chairperson)
Formerly the Public Protector; currently head of Enterprise Governance and Compliance, Nedbank Group.

3 **Mr K Baldwin**
Retired senior partner KPMG.

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

5 **Mr D Smith**
Chairperson of Reinsurance Group of America (South Africa); Chairman of Sanlam; director of companies.

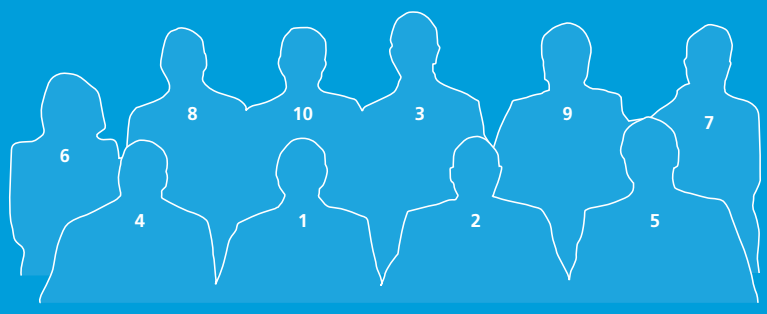
6 **Ms M Thekiso**
Head of the Debt Review Centre at FNB Shared Services; formerly Project Manager: Debt Counselling with the National Credit Regulator.

7 **Judge L Theron**
Judge of the Supreme Court of Appeal.

8 **Mr J Dixon** *(ex officio)*
Deputy Executive Officer: Insurance, Financial Services Board, as such Deputy Registrar of Insurance.

9 **Ms D Ozrovech** *(ex officio)*
Sanlam Life Principal Officer: Customer Relations; Chairperson of the Ombudsman's Committee.

10 **Judge B Galgut** *(ex officio)*
Ombudsman



Foreword by the Chairperson of the OMBUDSMAN'S COMMITTEE

On behalf of the long-term insurers who subscribe to the Ombudsman's scheme, it gives me pleasure to thank Judge Galgut and his team for a job well done during 2010. During the year the Ombudsman's office celebrated its 25 years of service and was involved in hosting the International Financial Ombudsman Conference in Cape Town. Congratulations on these well-organised events.

The Ombudsman reports that the office dealt with slightly more complaints than in the previous year and closed 79% of completed cases within six months. We also noticed that complaints finalised wholly or partially in favour of the complainant increased from 41% in 2009 to 46% in 2010. We were glad to again be able to report a decrease in the number of incompetent cases.

I was able to deliver a positive report to the Ombudsman's Council, in which the Ombudsman's office was once again thanked for their open-door relationship with the industry. Testimony to this are the informative workshops provided by the office, its visits to insurers and the publication of newsletters and articles providing views and guidance on sometimes difficult technical questions. These all added to the improvement of service delivery and complaints handling by subscribing insurers, to such an extent that the office was prepared to transfer more mini cases to insurers to solve the complaints directly with the complainants.

Going forward, we regard the Ombudsman's office as an important provider of guidance to help the industry understand the impact of legislation like the Consumer Protection Act and the Treating Customers Fairly initiative of the FSB. We trust that the office will continue to play a vital role in ensuring fair decision making for the benefit of both complainants and the industry.

The office deserves the industry's support.

Our best wishes for 2011.

Dorea Ozrovech

Members of the Ombudsman's Committee as at 31 December 2010

Dorea Ozrovech (Chairperson)
Sanlam Life Insurance Limited

Chantal Meyer
Sanlam Sky Life Assurance Company Limited

Gail Walters
Hollard Life Assurance Company Limited

Anna Rosenberg
ASISA

Glenn Hickling
Discovery Life Limited

Gary Simpson
Clientèle Life Assurance Company Limited

Brian Gibbon
Momentum Group Limited

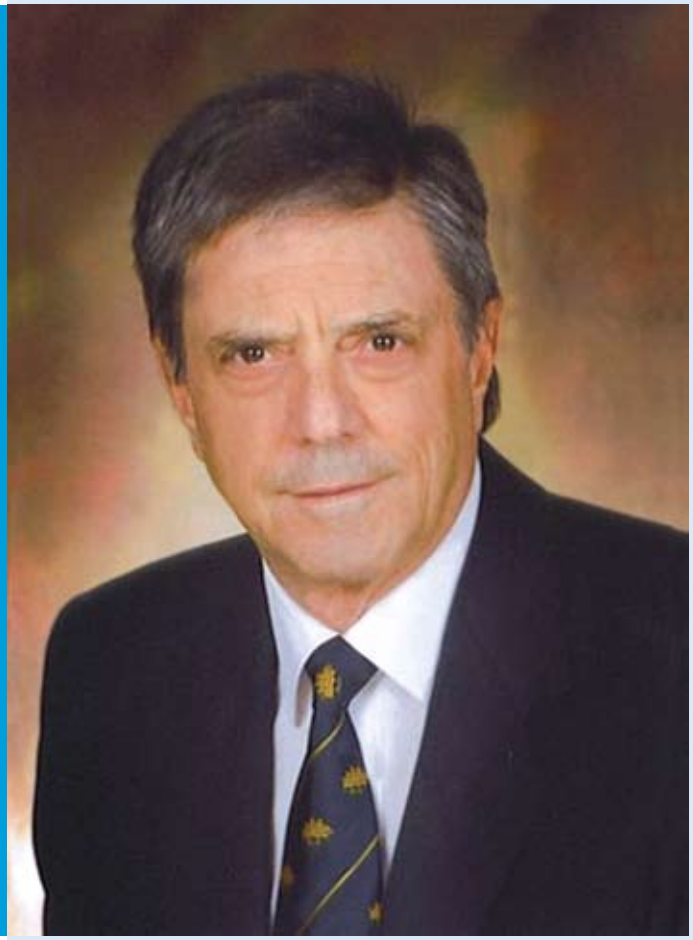
Andrew Raichlin
Old Mutual Life Assurance Company (SA) Limited

Esrom Kgaphole
Assupol Life Insurance Company Limited

Deidre Wolmarans
Metropolitan Life Limited

Hazel Lerman
Liberty Group

Foreword by the OMBUDSMAN



In this review:

The Ombudsman's Council

Upon the resignation of Dawn Mokhobo, Judge John Smalberger, who had been a member of the Council for some years and its vice-chairperson since 2007, was elected chairperson of the Council at its meeting in April 2010. Having served as a Judge of the High Court for 27 years until his retirement in 2002, the last 17 in the Supreme Court of Appeal, and having a practical and balanced approach to problems of all kinds, his chairmanship was welcomed and will help maintain public confidence in the Ombudsman's office. At the same meeting Adv Selby Baqwa SC, who had also been a member of the Council for some years, was elected as its vice-chairperson.

The Ombudsman's Committee

The Committee also acquired a new chairperson in April, when Dorea Ozrovech, Sanlam's Manager: Client Relations, was elected. She has been a member of the Committee since 2005, has considerable experience in complaints handling, and is well suited to her new role.

Comment on 2010 generally

It has been a successful year for the office, in which we strove as in previous years to fulfil our mission. The statistics set out in this report will reflect the office's relevant figures and the remainder of it deals with matters that will hopefully be of interest to readers.

The numbers of complaints received by the office during the year rose to 9 236, which was a record, of which 4 115 turned into full cases. The lump sum of payments recovered for complainants amounted to R103 484 956, which was also the highest ever achieved by the office.

Final determinations against insurers

During 2010 five final determinations were made against insurers, the full relevant details of which are available on the office's website at www.ombud.co.za.

In two of them the issue was the enforcement of a time-bar provision where the complainants' claims had been lodged out of time. In both it was held that on their particular facts it was unfair to hold the complainant to the time-bar.

In the third case the insurer, after issuing a policy, failed for more than a year to furnish the complainant with a copy thereof and failed to provide responses to the office's queries. A final determination was made against the insurer for payment of compensation for its poor service.

The fourth case (see page 20) involved the reinstatement of a funeral policy that lapsed because of the complainant's failure to pay a premium. Premiums received after the reinstatement were in each month allocated to the previous month, and at the same time the insurer maintained that for each month the cover remained subject to a three-month waiting period. The office held that the wording of the reinstatement did not allow for this.

The last case involved the question whether there had been non-disclosure as alleged by the insurer. The probabilities were evenly balanced, and because the onus was on the insurer the office held that its defence could not be upheld.

Ombudsman's Council meeting in April 2010

COST SAVING

Expenditure during the year totalled R11 605 000 – a saving of R610 000 on budget.

Foreword by the Ombudsman (continued)

INFO 2010 Conference

The annual Conference of the International Network of Financial Services Ombudsman Schemes was held at The Pavilion in the V&A Waterfront in Cape Town. The conference, which was a joint effort of our office, the Ombudsman for Banking Services, the Credit Ombud and the Ombudsman for Short-term Insurance was a success. 118 Delegates from 20 countries attended. Representatives from 23 different ombudsman schemes were among the 36 speakers, and delegates from Tanzania, Saudi Arabia and Senegal were amongst the first time attendees.

The presentations were interesting and informative and can be accessed on the website www.info2010.org.za The feedback received from delegates was positive. One of the presentations which was particularly helpful was on 'Fairness in the Circumstances' (discussed on pages 22 – 23).

The welcome address was by Prof Tanya Woker, the Chairperson of the FSOS Council. The other two keynote speakers were Prof Matthew Lester, and Ismail Momoniat, Deputy Director General: Tax and Financial Sector Policy at Treasury. The format of the conference was made up of general plenary sessions but included break-away sessions where more industry specific problems could be discussed.

In an effort to make the conference as 'green' as possible, the following initiatives were included:

- Instead of buying gifts for delegates, the conference sponsored the planting in a disadvantaged area of 110 indigenous and fruit trees by Food & Trees for Africa.
- Tap water and recyclable water bottles were used in place of normal bottled water.
- Local suppliers were used.
- Waste was recycled. We encouraged re-use of name badges and lanyards. Conference bags were collected after the conference for re-use (the bags were donated to the Baphumelele Children's Home).
- Seasonal and local ingredients for food were used.

Prof Tanya Woker

25th anniversary

The office staff, previous staff members, the office's Council and Committee, subscribers, members of the press and people who have assisted the office in its function over the decades were invited to celebrate the office's 25th anniversary gathering held on 22 April 2010. The previous Ombudsman, Judge Peet Nienaber, and a past chairperson of our Council, Judge Gerald Friedman, were also present. Our Council's vice-chairperson, Adv S Baqwa SC and I addressed the party, and so too did Lorraine Allan and Audrey Rustin who shared their memories about the early days of the office.

New subscribers

During the year we welcomed three new subscribers to our scheme, being Frank.Net, KGA Life and African Unity.

Tanzanian Mission

We readily acceded to a request to receive a Tanzanian delegation, who needed assistance in establishing a financial ombudsman scheme in their country. For this purpose they spent two days at the office in 2010, during which we furnished them with all necessary information about our process and system, and explained how our office operates.

Financial Complaints Helpline

The Ombudsman's central helpline (0860OMBUDS), was terminated early in 2010 as a result of the service provider closing down. Using a different supplier the service was re-instated with effect from 2 January 2011, and at the same time was enlarged to host other offices as well.

The offices represented are the Ombudsman for Long-term Insurance, the Ombudsman for Short-term insurance, the Ombudsman for Banking Services, the Credit Ombud and the National Credit Regulator. The same supplier also hosts the Financial Services Board and the FAIS Ombud's call centre, with the Pension Funds Adjudicator also to join.

Consumers now have a central contact point which can advise and transfer them directly to the office they require.

Changes to the adjudicating staff

Early in 2010 three members of the adjudicating staff, Don McKay, Prof Giel Reinecke and Lihle Sidaki, left the office. They were replaced by Nuku van Coller, who had for some years been a member of the staff of the Pension Funds Adjudicator (PFA), and Lisa Shrosbree, who had previously been with the PFA and thereafter practised as an attorney specialising in pension funds law.

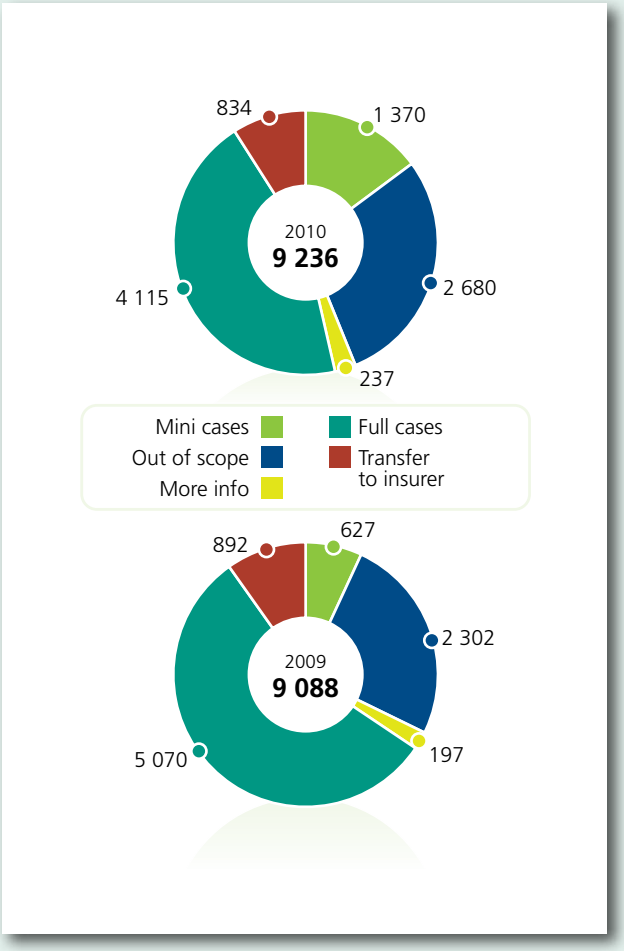
Mr Ismail Momoniat

Tribute to staff

Each year I pay tribute to the staff, but it is no mere formality. The success of any office depends almost entirely on the ability and motivation of the staff, adjudicating and support staff alike, and mine have acquitted themselves well on both scores. I applaud and thank them for their efforts, and in addition I give a special vote of thanks to my deputy, Jennifer Preiss, and my finance and operations manager, Ian Middup, for their unstinting support.

Brian Galgut

Complaints
VOLUMES



Complaints received

Complaints received totalled 9 236 for the year, an increase of 2% from the previous year, and is a new record for the office. The increased volumes were spread fairly evenly throughout the year, closely mirroring 2009.

Continuing the trend of 2009, the office received 1 370 complaints where it was felt that the insurer had not been given sufficient opportunity to adequately respond to the complainant, and these were referred to the relevant insurer as mini cases. The office has extended the analysis of complaints for 2010 (with comparative figures for 2009) to include complaints received that require more information before they can be forwarded to the insurer for a response. A great deal of time is taken by the support staff to obtain information for this category of complaint.

Productivity

The productivity of the office, measured by the number of cases finalised per adjudicator/assessor on average each week, fell by 12% in 2010 – largely the result of the loss of experienced staff members and the time taken to train new staff.

	2008	2009	2010
Opening work in progress	1 348	1 828	**1 518**
New full cases	4 764	5 070	**4 115**
Cases finalised	4 284	5 380	**4 124**
Closing work in progress	1 828	1 518	**1 509**
Productivity	8.2	8.2	**7.2**

Cases finalised

Cases finalised encompass only full cases.

We closed more cases (4 124) than the number of full cases received (4 115). We therefore managed to keep the work in balance. The work in progress, numbering 1 509 cases, was at the same level as in 2009.

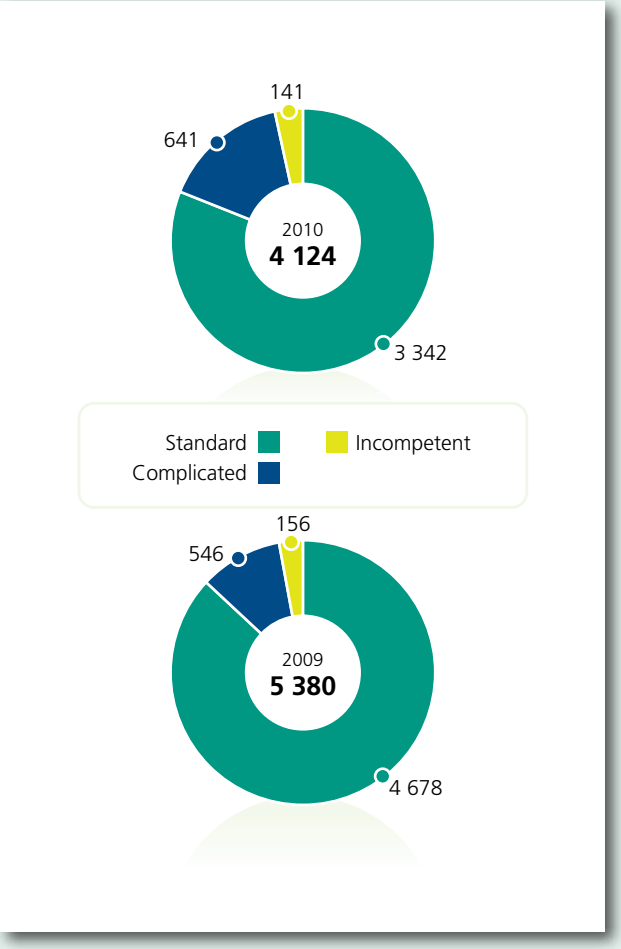
However, the number of cases finalised for 2010, 4 124, was well down from the 5 380 finalised in the previous year.

This decrease is mainly as a result of

- Fewer cases being designated as full cases.
- The loss early in the year of three staff members (two part time and one full time).
- Their two replacements both being part time and starting later in the year.
- The high base of 2009, which contained over 500 'cost cases' that had been worked on in previous years but could only be finalised in 2009 after delivery of a long awaited court judgment.

2010 showed an increase to 15% in the proportion of complicated cases finalised by the office while in previous years it had averaged about 10%. This increase reflects the fact that the office is dealing with more complex cases that take longer to finalise. Furthermore the persistence of complainants appears to be on the increase.

The number of incompetent cases remained steady on a year-on-year basis.



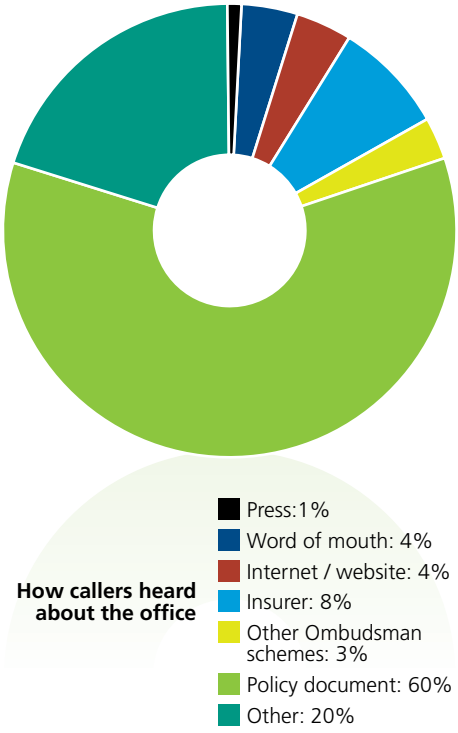
WRITTEN COMPLAINTS

On average, the office receives 55 written complaints per day – 30 of these are faxed to us, closely followed by the number received by e-mail. A smaller proportion comes from post and the website.

COMPLAINANTS

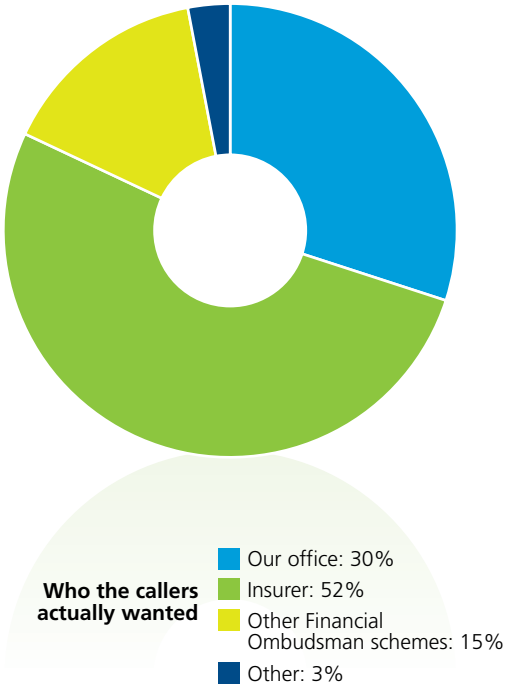
Telephone calls received

How callers heard about the office



Telephone calls received

Who the callers actually wanted

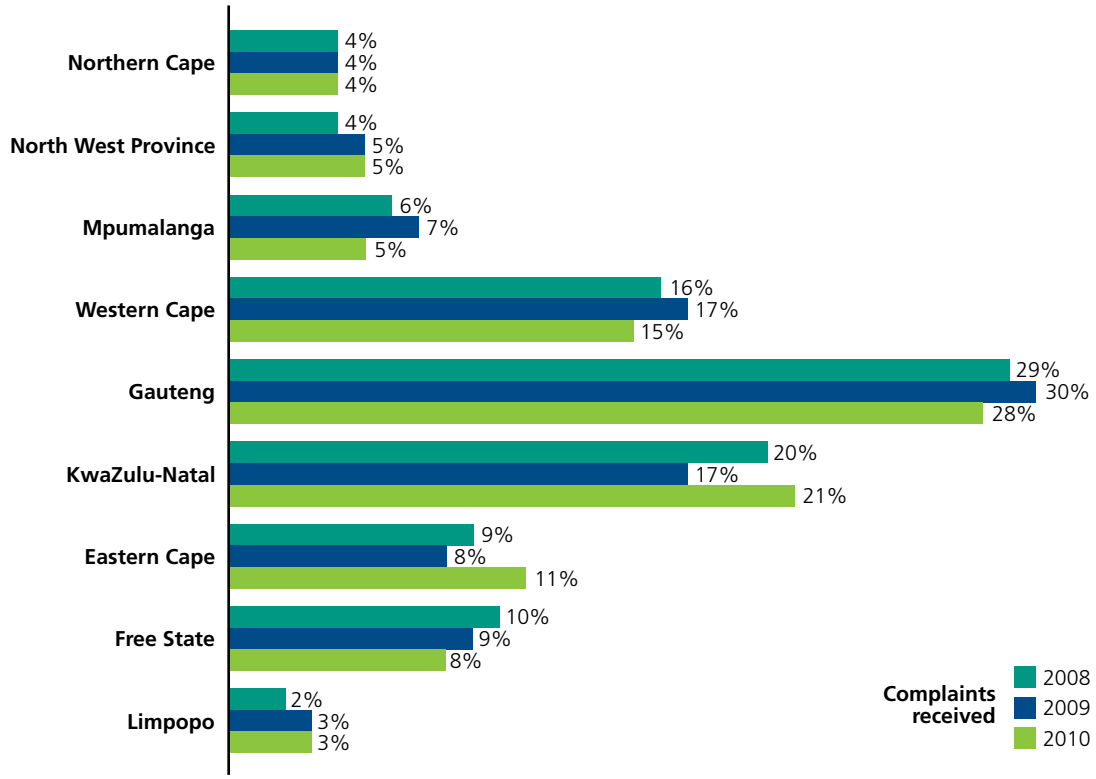


TELEPHONE CALLS

Our switchboard receives an average of 200 calls per day from first-time callers. Sixty per cent of callers who phone the office obtained our details from policies. The next highest category is 8%, being those who heard about us from the insurer concerned. More than 50% of these calls are actually intended for insurers and we then provide the insurer details to the callers.

We once again urge insurers to give more prominence to their own contact details in their policies.

Complaints received per province 2008 to 2010



The distribution of complainants has not changed significantly from 2008 and 2009. No reliable figures are available as yet of the distribution of policies in the different provinces. Once that is available it will be interesting to compare our complaint distribution with the policy distribution.

Nature of COMPLAINTS

NATURE OF COMPLAINT	LIFE				DISABILITY			
	2009	W/P *	2010	W/P *	2009	W/P *	2010	W/P *
Poor communications/ documents or information not supplied/poor service	1 173	56%	925	54%	8	38%	9	33%
Claims declined (policy terms or conditions not recognised or met)	2 106	43%	1 736	47%	263	37%	240	42%
Claims declined (non-disclosure)	77	21%	55	25%	56	16%	34	24%
Dissatisfaction with policy performance and maturity values	180	23%	158	28%	0	0%	1	0%
Dissatisfaction with surrender or paid-up values	606	11%	201	25%	1	0%	0	0%
Misselling	170	54%	94	38%	2	0%	0	0%
Lapsing	207	46%	156	44%	2	0%	4	25%
Miscellaneous	208	34%	146	33%	4	25%	5	40%
Total	**4 727**	**41%**	**3 471**	**46%**	**336**	**32%**	**293**	**39%**

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

RESPONSES FROM INSURERS

On average, the office receives 40 e-mails per day from insurers responding to initial complaints forwarded to them by the office.

Cases resolved wholly or partially in favour of the complainant (W/P)

The overall W/P for 2010 was 46%, higher than the 41% in 2009 (which had been lower than normal primarily due to the large number of cost cases closed not in favour of complainants in that year) and also higher than the 44% in 2006, 2007 and 2008.

	HEALTH				TOTAL				% OF TOTAL	
	2009	W/P *	2010	W/P *	2009	W/P *	2010	W/P *	2009	2010
	22	68%	31	68%	1 203	56%	965	55%	22%	23%
	276	48%	303	50%	2 645	43%	2 279	47%	49%	53%
	13	31%	16	25%	146	20%	105	25%	3%	3%
	0	0%	0	0%	180	23%	159	28%	3%	4%
	2	0%	0	0%	609	11%	201	25%	11%	5%
	1	100%	1	100%	173	53%	95	38%	4%	4%
	2	0%	3	67%	211	45%	163	44%	4%	4%
	1	0%	6	17%	213	34%	157	32%	4%	4%
	317	**48%**	**360**	**51%**	**5 380**	**41%**	**4 124**	**46%**	**100%**	**100%**

The main reasons for the increase are:

- The increase from 43% to 47% of the W/P for the Claims Declined category. As this category makes up 53% of the complaints finalised by the office during the year, the increase has a significant impact.
- The credit life and funeral cases, which together make up 47% of cases finalised, experienced an increased W/P from 40% in 2009 to 47% in 2010.

The W/P percentage is a key figure for both the office and its subscribing members, and the change experienced this year will as always be closely monitored in 2011.

Issues of CONCERN

The protection contained in section 63 of the Long-term Insurance Act

Is there really protection?

The legislature recognises that when an individual suffers a disability for which compensation from any source is due, such compensation should be protected from creditors and others so that the disabled person can rehabilitate himself or herself without the burden falling upon the State.

So it is that the Insolvency Act, 24 of 1936, provides that –

> *"23(8) The insolvent may for his own benefit recover any compensation for any loss or damage … he may have suffered by reason of any … personal injury." ;*

and the Matrimonial Property Act, 88 of 1984, that –

> *"18 Notwithstanding the fact that a spouse is married in community of property –*
>
> *(a) any amount recovered by him by way of damages, other than damages for patrimonial loss, by reason of a delict committed against him, does not fall into the joint estate but becomes his separate property…"*

In similar vein, section 63 of the Long-term Insurance Act, 52 of 1998, seeks in certain respects to provide protection *inter alia* for disability benefits that become payable in terms of a long-term policy. Unlike in the Insolvency Act and the Matrimonial Property Act, however, section 63 places a limit on the protection. While it stipulates that the disability benefits will not be liable to be attached or subjected to execution under a judgment or form part of an insolvent's insolvent estate, this protection is limited (in addition to other limits which are for the moment irrelevant) to a maximum of R50 000. The effect of the section is in other words that, save for protection up to R50 000, where the disability benefits would otherwise be payable to the policyholder, in the case of his insolvency they will become payable instead to the trustee in his insolvent estate.

Because the Insolvency Act provided for limitless protection, one may question why the legislature saw fit, in the Long-term Insurance Act of 1998 and in its predecessor the Insurance Act, 27 of 1943, to place any limit on the protection. By now the protection of R50 000 is in any event substantially inadequate, as the following case that came before the office in 2010 illustrates.

The complainant had for many years owned and managed a successful business and during that time had taken out a life policy which included disability cover. In October 2007 he was involved in a collision and sustained brain damage, and he was no longer able to run his business successfully. As a result he was sequestrated provisionally on 21 May 2009 and finally on 18 June 2009. The insurer did not dispute that the complainant's brain damage had rendered him disabled for the purposes of the policy and that the disability benefits in terms thereof became payable. The sole issue in the case was whether the disability benefit in the sum of R1.1 million was payable to the complainant himself or to the trustee in his insolvent estate, and because of the express and clear wording of section 63 of the Long-term Insurance Act we were forced to hold that, save for R50 000, the whole of the disability benefit was payable to the complainant's insolvent estate.

That the protection provided for by section 63 is inadequate is easy to recognise. For some years before the collision the complainant had taken the sensible step, at his own considerable expense, to provide for the possibility of him becoming disabled, and his later disablement and sequestration were in no way attributable to any fault on his part.

The Ombudsman addressed submissions in this regard to the SA Law Commission, the Financial Services Board and Treasury, but any amendments that might in due course be brought to section 63 of the Act will not, of course, avail the complainant.

Telesales

Primarily because direct sales are seen to be cost-effective and have a wider reach, it is understandable that in recent years insurers have increasingly made use of telesales, or have developed products suitable for such marketing. There are obviously also some advantages for the consumers, but in the scores of complaints in which it has become necessary for the office to ask for and listen to recordings of the telesales, it has become evident that in some respects there is potential prejudice for consumers.

When consumers make use of a broker or an agent, they will presumably receive advice enabling them to make informed decisions on whether a given product will be suitable. In telesales consumers do not have that advantage, however, so that it is legally necessary during a telesale that the material terms of the policy being offered are satisfactorily explained. For this reason insurers who market products by telesales are generally alive to their obligations, and provide the telesales agents with a text setting out what they are required to convey to consumers during a telesale.

Council member Ken Baldwin and Ian Middup

Provided the text is accurate in everything it covers, and provided it covers all terms and conditions that are material, no difficulty should arise if the agent adheres to the text. The text is not always accurate or complete, however, and problems can also arise when the consumer asks questions not covered by the text or gives an unexpected answer to its questions. The agent's lack of knowledge is then exposed if he or she does not transfer the call to a qualified staff member. A further complication is that agents are almost universally remunerated by commission, which puts them under pressure to ensure sales.

Issues of concern (continued)

The dangers for a consumer are obvious, and while the recording of the telesale will readily enough expose any shortcomings, resolving issues that result from them might remain difficult. If the consumer would not have purchased the product had accurate and complete information been furnished, the strict legal position, because of the resultant absence of consensus, is that no binding contract would have come about. In such a case the usual remedy is that premiums must of course be repaid but this would often be of little consolation to the consumer.

That the telesales text may be accurate and complete and that the agent may recite it exactly still does not necessarily mean, however, that the telesale is in order. The information concerned must also be conveyed such that the consumer will be enabled to both absorb and understand it. To achieve this it is necessary that the agent speaks slowly and clearly, does not outpace the consumer, and makes certain at all stages that the consumer has understood.

In this regard the office's experience, when listening to recordings, has uncovered a disturbing fact. It is usually within a space of only a few minutes that the necessary information is conveyed to the consumer, and often it is delivered in an unbroken torrent and at an undue pace. At the same time the agent often will not pause between sentences but will continue loading information onto the consumer. While it is true that they will from time to time ask the consumer if he or she understands, the question is posed perfunctorily, and although the answer might be "yes" there is no doubt that few of the consumers concerned, no matter what they say, would really be able to absorb everything he or she has heard, let alone understand the implications.

In many such telesales consumers are informed, after agreeing to take the product, that a copy of the policy will be posted to them, or that they can obtain one on application at any branch of the insurer concerned. This is not enough unless at the same time the consumer is expressly warned that what has been conveyed during the course of the telesale is only a broad summary, that the terms of the policy may not accord exactly with what was conveyed during the telesale, and that the consumer should carefully read the contents of the policy itself in order to understand the policy's full impact, and to avail himself or herself of the right to cancel it within the 30-day cooling off period.

Another area of concern is that the text sometimes uses industry terms, often using jargon which insurers mistakenly assume all consumers will understand. A common example occurs where the consumer is told that there will be no cover for the event of a claim arising from "a pre-existing health condition". Unless the meaning of an expression of that sort is explained, the average consumer will not appreciate its meaning or implications.

In all of the above respects insurers are urged to tighten up their telesales procedures, something which falls squarely within the Treat Customers Fairly initiative that the Financial Services Board is seeking to put in operation.

INFO 2010 bags delivered to the Baphumelele Children's Home by Nuku van Coller and Sithandwa Tolashe

INFO 2010 cultural evening

Complaints HANDLING

Systemic issues

During 2010 we dealt with a number of systemic issues, which arise where a complaint has wider implications and as such might be identified as being a problem with a specific insurer or might even be industry wide.

The importance of identifying and reporting systemic issues is that:

- It can assist consumers who don't complain to the office, because a possible change in practice will apply to all policies, not only complainants.
- It can therefore prevent future complaints and problems.
- It improves general conduct and practice particularly if the systemic issue is industry wide.
- It can by this means root out undesirable practices.
- It can at times result in supervisory and regulatory changes.

Here are some examples of systemic issues we dealt with during 2010.

Case 1

Application of premiums after reinstatement

We questioned an insurer's practice of applying premiums paid after a reinstatement of the policy to arrear premiums where the policy made no provision for it. The practice resulted in the complainant's policy continually remaining subject to a three month waiting period. A life insured died during the waiting period and the claim was refused. We instructed the insurer to pay the claim, as the practice was not in accordance with the policy terms. (See the final determination on our website at www.ombud.co.za)

We pointed out to the insurer that they would not be able to apply this practice in other cases in future. The insurer agreed but subsequently changed their policy terms so that the practice was reflected in their policies.

As with all other systemic issues, the matter was reported to the Financial Services Board.

Case 2

Twelve-month delay for funeral cash benefit

A complainant approached our office because a funeral benefit under a policy would become due for payment only 12 months after the death of the life insured. The policy provided a funeral service immediately but the alternative cash benefit was to be paid to the executor after a 12-month waiting period.

We considered the policy provision to be unfair because having a funeral benefit which is delayed for a year defeats the object of funeral insurance, and cannot therefore be regarded as a sound practice. We determined that the benefit should be paid even though the 12-month period had not yet elapsed.

The insurer agreed to pay the claim. At the same time it undertook that it would change its stance in future cases and would amend its policy accordingly.

Case 3

Administration fees

We had instances during 2010 with two different insurers that deducted administration fees from benefits without the policy sanctioning such fees. The fees were refunded to the complainants and in both instances the insurer agreed that it would not continue with its practice in future.

Case 4

Deductions from compulsory annuities

The life assured, who was in receipt of a compulsory annuity, died on 25 March 2010. The insurer paid the monthly amount due on 28 March. It was then advised that the life insured had died prior to the due date. The insurer recovered the 'overpaid' amount from another compulsory annuity, one payable to the deceased's ex-wife, who was the nominated beneficiary under the deceased's annuities (although the annuity had in fact ceased on the life insured's death, as the guarantee period of the annuity had been exceeded). The beneficiary complained to us.

We pointed out to the insurer that it is not permissible to make deductions of this nature from compulsory annuities. The insurer agreed to refund the deducted amounts to the complainant.

We also questioned the insurer on the systemic aspect, being its practice of making such deductions from compulsory annuities. The insurer agreed that overpayments will in future be reclaimed from the estate of the deceased annuitant and would not be deducted from a beneficiary's annuity.

Audrey Rustin (subscriber representative) and Sharai Gaka at INFO 2010

ENQUIRIES

Each month the office receives on average 85 written enquiries that do not have any connection with the financial services industry.

Complaints handling (continued)

Quality control

In accordance with our new process, 192 cases were given to an adjudicator tasked with quality checking. That adjudicator completes a quality control sheet after the file has been assessed for procedural correctness, and the outcome for reasonableness. After this the assessor/adjudicator who dealt with the case receives feedback on it. Any negative feedback is furnished to the Deputy Ombudsman, who then implements any action required in respect of the particular case or in the office's general process.

Cases are also re-allocated from one adjudicator or assessor to another adjudicator to be re-evaluated after a complainant disagrees with a provisional determination. So it was that 856 cases were re-allocated in 2010. This 'peer review' is a form of quality control which has been part of our process for a number of years.

Fairness/equity

At the INFO2010 Conference one of the topics was:

> **Fairness in the Circumstances?**
>
> Does what is fair depend on the unique circumstances of the complainant?
>
> Does the age, level of sophistication, language ability or economic circumstances enter into the determination of what is fair?

Larry Hattix, the Ombudsman in the office of the Comptroller of the Currency in the United States, was one of the speakers and his presentation* gave a refreshing new perspective on fairness in complaints handling.

For purposes of the presentation he defined fairness as an "absence of bias in this specific realm". For him the question then becomes: How would you know if fairness in your process is being negatively influenced by factors such as age, economic circumstances, language ability or level of sophistication? His view is that any firm and any ombudsman scheme needs to look specifically at awareness, access, accountability and outcome to assess whether fairness in the complaints process is being negatively influenced by those factors.

1. **Awareness**
   In order for a complaints system to be fair, consumers need to be aware of how to complain. The question is therefore: How does the consumer know how to complain about your product/service? Is every client, irrespective of age, language ability, level of sophistication, etc. aware of your complaints process, and how do you go about making sure that that is the case? Firms are very effective at getting product awareness out to consumers across the board, and so it should also be in respect of the complaints process.

2. **Access**
   Fairness demands that there has to be access, the challenging questions being:

   - How does the consumer access your complaints process?
   - Is it more expensive or more difficult for certain groups to access your complaints process? To the extent that a consumer's age, social and economic situation, language ability, etc. hinder access to the complaints process, fairness would be negatively impacted.
   - If there are barriers to access, you have to ask whether they are really necessary. For example, if an illiterate or semi-literate complainant phones into a call centre to lodge a complaint, is it really fair to insist that he must lodge a complaint in writing to the organisation, and is it in any event fair to one who does not have easy access to email or fax facilities?

* See Papers and Presentations on our website at www.ombud.co.za

3. **Accountability**
   The relevant questions are: Are the complaints handlers accountable, and are they able to make decisions in an independent and unbiased manner? Once again the level of sophistication, language ability, age, etc. of the complainant should be taken into account by the complaints handler.

4. **Outcome**
   It is important to look across the body of complaints as a whole to see whether there is disparity in the outcome because of complainant's age, level of sophistication, language ability, etc. While it is important to look at each complaint as unique, it is also important to detect patterns in the complaints as a whole.

   Therefore, if there is disparity in outcomes because of any of the above aspects, it may be a challenge to fairness.

   Fairness, according to Larry Hattix, does not guarantee a particular outcome but you should ensure that the outcome is not negatively influenced by the above mentioned circumstances of the specific complainants.

In the light of the Treating Customers Fairly (TCF) initiative by the FSB, this additional angle to the process/approach is useful for evaluating a complaints handling process (or any other aspect of business) to check for fairness.

Cikizwa Nkuhlu

REQUESTS TO INSURERS

The office receives on average 200 written requests per month from complainants for change of beneficiary or banking details, cancellation of policies, etc – all of which should have been directed in the first place to insurers.

APPEALS

Because fairness demands it, the availability of an appeal process is essential. While this applies to both insurers and complainants, it is complainants who are the more likely to be adversely affected by the absence of an appeal process. To say to an unsuccessful complainant that he or she will still have the right to sue the insurer in court in the usual way would be an illusion for those who do not have the financial ability to exercise it. Most of them, even those who cannot be classed as poor, will simply not be able to afford it. In the majority of cases the amounts in issue are furthermore modest – funeral policies for example, which are the subject of a large proportion of complaints to the office, may have a benefit of as little as R5 000.

It was for the very reason that fairness demands it that the office's internal appeal procedure, since embodied in its Rule 6, was introduced in 1997.

A complainant who is dissatisfied with a determination made by the Ombudsman may apply to the Ombudsman for leave to appeal, which will be granted if there is a reasonable prospect of success in the appeal or if the issue is of considerable public or industry interest. The Ombudsman then appoints the appeal tribunal, traditionally always a retired judge of the High Court who otherwise has nothing to do with the office and, if possible, who lives in the complainant's province so that it would be cost efficient should a hearing become necessary.

The process before the appeal tribunal, in which the Ombudsman plays no further role, is in fact a re-hearing, which means that the parties are free to introduce evidence which had not been placed before the office when the determination at issue was made. The procedure adopted in the appeal is entirely at the discretion of the appeal tribunal and, as such, it is informal, fair, expeditious and cost effective.

The appeal costs the complainant nothing, the sole exception being that if the complainant is the appellant he or she may be required to lodge a small deposit in trust which will be repaid if the appeal succeeds, but which will be used by the Ombudsman to help defray the office's costs of the appeal if it fails. The deposit is only sought in rare cases, where the complainant is able to pay it, and the amount in dispute is not insubstantial.

Not all financial ombudsman offices have an appeal process. The two statutory schemes, being the Pension Funds Adjudicator (the PFA) and the Ombud for Financial Services Providers (the FAIS Ombud), have appeal processes; in the case of the PFA, to court and in the case of the FAIS Ombud, to the FSB Appeal Board. Of the four remaining financial ombudsman schemes, being voluntary schemes, only this office and one other provide for appeals. The Financial Services Ombud Schemes (FSOS) Council, empowered to do so by section 8(1)(d) of the FSOS Act, 37 of 2004, is at present considering whether the other two voluntary schemes should not introduce appeal processes and if so whether the appeals from decisions of all four of the voluntary schemes should be to a single common appeal tribunal.

The additional question that may arise is whether such an appeal tribunal should be statutory rather than voluntary. While there will obviously be no difference in the quality of decisions by a statutory appeal body rather than a voluntary one, it is inevitable that a statutory scheme will not be as simple, informal, expedient or cost-efficient as an appeal in a voluntary process.

Fairness also requires that the appeal process be made equally available to subscribing insurers, and our appeal process does exactly that. While insurers had previously made use of the process, it will be seen from the adjoining block that for almost four years no insurer has appealed. In fact, no insurer has in that time even sought leave to appeal against a determination made against it.

The office's adjudication process is first to make a provisional determination in which the parties are invited to furnish any further facts or submissions before a final

	Appellant	Result of Appeal
2003	Complainant	Dismissed
	Complainant	Upheld
2004	Complainant	Dismissed
	Complainant	Upheld
2005	Insurer	Dismissed
	Complainant	Dismissed
2006	Insurer	Upheld
	Complainant	Upheld
2007	Insurer	Upheld
2008	Complainant	Appeal abandoned (complainant emigrated)
	Complainant	Appeal abandoned
	Complainant	Settled
2009	Complainant	Dismissed
	Complainant	Not yet Finalised
	Complainant	Insurer conceded on leave being granted
	Complainant	Settled
2010	Complainant	Dismissed
	Complainant	Dismissed
	Complainant	Upheld*

* Dealt with at pages 26 – 27.

Rosemary Galolo, Clyde Hewitson, Yolanda Augustine and Deon Whittaker

determination is made, and it is only a final determination, of which there have been a few against insurers in the last four years, which is binding on insurers and against which there can be an appeal. For the rest, provisional determinations have in that period been made against insurers in scores of cases and in all of them the insurers have accepted the provisional determination despite the fact that in many of them they indicated expressly that they did not agree with them.

Appeals (continued)

Heinrich Engelbrecht, Sue Myrdal and Lisa Shrosbree

RECORD RECOVERY AMOUNT

The largest individual amount recovered for a policyholder by the office, R21 000 000, was achieved in the 2010 financial year.

Telesale – Misrepresentation to complainant of extent of cover for retrenchment

The complainant had obtained a credit card with a bank, and a credit life policy had later been sold to him by the insurer concerned by means of a telesale. The salesperson had informed the complainant during the telesale that the policy would cover him for the balance on his credit card up to a maximum of R50 000 in the event of his death, disability or retrenchment. As to death and disability, that statement had been correct. The policy itself provided, however, that in the case of retrenchment the benefit payable would not be the full balance owing on his credit card, but would instead be calculated by means of a formula the effect of which, so it later turned out, was that it would be substantially less than the balance. The recording of the telesale disclosed that he had been informed that the policy would be posted to him by the insurer, and that he could in any event obtain a copy at any branch of the insurer or of the bank.

During the telesale, however, the complainant was not told of the limitation to the retrenchment cover. Upon his later retrenchment, he claimed the balance owing on his credit card, being R9 918.83, but in terms of the formula was paid substantially less. His complaint to the office was not upheld, but he was granted leave to appeal.

The appeal tribunal was a retired judge, Mr Justice P Levinsohn, who found that the insurer was bound by what the complainant had been told in the telesale, and who stressed that the failure of the agent to advise the complainant during the telesale that there would be a limit to the benefit in the event of a retrenchment claim was a representation on which the complainant relied when agreeing to take the policy. Despite assuming in favour of the insurer that the complainant had subsequently been furnished with the statutory documentation, including a copy of the policy, the Judge said -

"That in my view would not have availed it. Having materially misrepresented the situation there rested a heavy burden on it to take steps to draw the appellant's attention to the correct information because, quite simply, in all the circumstances the appellant would have been entitled to assume that the terms of the written contract of insurance submitted to him accorded substantially with what he had been told. This is a well-known principle of our law of contract - see Shepherd v Farrell's Estate Agency 1921 TPD 62.

In my opinion, applying principles of equity, which the Ombudsman is enjoined to do in terms of his rules, the appellant is entitled to relief. I consider that it is just and equitable that he be awarded damages which will place him in the position he would have been had the representations in regard to the terms of the contract been true."

He then stated that the insurer was liable to pay the complainant the full balance owing on his credit card.

The decision is significant. Its effect is that where the person speaking on behalf of the insurer is guilty of a material misrepresentation which induces the contract, and the complainant's attention is neither then nor thereafter somehow drawn to the correct provision in the policy, an insurer will be held to the misrepresentation, and it may be that in given circumstances the same would apply to misleading advertisements and other marketing material. Insurers should therefore be careful that those selling their products do not misrepresent their terms.

Puleka Ngalo and Tania Thomas

STAFF

Management Team
Judge Brian Galgut
Jennifer Preiss
Ian Middup

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

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




Judy Lennox




APPENDICES

Appendix 1

Subscribing members as at 31 December 2010

1 Life Direct Insurance Limited

Absa Life Limited
Allied Insurance Co. Ltd
UBS Insurance Co. Ltd

Absa Insurance and Financial Advisers (Pty) Ltd

Acsis Ltd

African Unity

Chartis Life SA Ltd (AIG Life)

Allan Gray Life Ltd

Alexander Forbes Life Ltd

Assupol Life

AVBOB Mutual Assurance Society

Channel Life Ltd
Rentmeester Group Schemes
PSG Anchor Life

Clientèle Life Assurance Co. Ltd

Discovery Life Ltd

Frank.Net

Guardrisk Life Ltd
Platinum Life

Hollard Life Assurance Co. Ltd
Crusader Life
Fedsure Credit Life
Investec

Investec Assurance Ltd

Investment Solutions Ltd

JDG Microlife Ltd

KGA Life

Liberty Group Limited
Manufacturers Life
Prudential
Sun Life of Canada
Capital Alliance Life Ltd
AA Life
ACA Insurers Limited
Amalgamated General Assurance
Fedsure Life
IGI Life
Norwich Life
Saambou Credit Life
Standard General – pre-1999
Traduna
Rentmeester Assurance Ltd
Rondalia

Liberty Active Ltd
Charter Life

Lombard Insurance Group
Pinnafrica Life Ltd

McLife Assurance Co. Ltd

Medscheme Life Assurance Co. Ltd

Metropolitan Life Limited
Commercial Union
Homes Trust Life

Metropolitan Odyssey Ltd
Protea Life

Momentum Group Limited
African Eagle Life
Allianz Life
Anglo American Life
FNB Life
First Rand
Guarantee Life
Legal and General
Lifegro
Magnum Life
Rand Life
Sage Life
(National Mutual of Australasia)
(Ned Equity)
(Netherlands of 1845)
Shield Life
Southern Life
Yorkshire

Nedbank Financial Planning

Nedgroup Life Assurance Ltd
NBS Life
BOE Life Ltd

Nestlife Assurance Corp. Ltd

New Era Life Insurance Co. Ltd

Old Mutual Life Assurance Co. (SA) Ltd
Colonial Mutual

Outsurance Life Insurance Co. Ltd

Professional Provident Society Ins Co. Ltd

Prosperity Insurance Co. Ltd

PSG Futurewealth Ltd
M Cubed Capital Limited
Time Life

Real People Assurance Company Ltd

Regent Life Assurance Co. Ltd

Relyant Life Assurance Co. Ltd

RMB Structured Life Ltd

Safrican Insurance Co. Ltd

Sanlam Life Insurance Ltd

Sanlam Sky (African Life Assurance Co. Ltd)
Permanent Life
Sentry Assurance

SA Home Loans Life Ltd

Union Life Ltd

Workers Life Limited
Sekunjalo Investments Ltd

Appendix 2

Rules

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

1. Mission

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

1.2 The Ombudsman shall seek to ensure that:

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

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

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

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

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

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

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

2 Jurisdiction

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

2.2 The Ombudsman shall not consider a complaint:

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

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

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

3 Procedure

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

3.2 The determination aforesaid may be to:

3.2.1 decline to consider the complaint;

3.2.2 uphold the complaint, either wholly or in part;

3.2.3 dismiss the complaint;

3.2.4 make a ruling of a procedural or evidentiary nature;

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

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

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

3.2.8 issue a declaratory order.

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

3.3.1 the complaint has no reasonable prospect of success; or

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

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

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

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

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

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

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

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

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

4. Prescription

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

5. Determination of disputes of fact

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

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

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

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

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

6. Appeals

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

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

6.3 Such leave to appeal shall be granted:

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

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

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

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

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

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

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

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

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

6.8 When the complainant is the appellant:

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

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

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

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

6.9 When the subscribing member is the appellant:

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

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

7. Enforcement

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

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

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

7.2 The Ombudsman may thereupon:

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

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

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

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

8 Report

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

Design by **GroundPepper**

Useful information about other offices

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

The Banking Ombudsman
P O Box 5728, Johannesburg 2000
Share Call: 0860 800 900
Telephone: 011 838 0035
Fax: 011 838 0043 / 0866 766 320
E-mail: info@obssa.co.za

The Credit Ombud
Postnet Suite 444, Private Bag 1,
Jukskei Park 2153
Call Centre: 0861 662 837
Fax: 0866 756 217
E-mail: ombud@creditombud.org.za

The Ombud for Financial Services Providers
P O Box 74571, Lynnwoodridge 0040
Share Call: 0860 324 766
Telephone: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

The Pension Funds Adjudicator
P O Box 651826, Benmore 2010
Telephone: 087 942 2700
Fax: 087 942 2644
E-mail: enquiries-jhb@pfa.org.za

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

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

Public Protector
Private Bag X677, Pretoria 0001
Telephone: 012 366 7000
Fax: 012 362 3473 / 0865 753 292
E-mail: elainei@pprotect.org

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

Johannesburg office:
P O Box 787465, Sandton 2196
Telephone: 011 369 0460

The Statutory Ombud
P O Box 74571, Lynnwoodridge 0040
Share Call: 0860 324 766
Telephone: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

The National Credit Regulator
P O Box 209, Halfway House, Midrand 1685
Call Centre: 0860 627 627
Fax: 011 805 4905
E-mail: info@ncr.org.za or complaints@ncr.org.za
National Credit Regulator (N.C.R.)
Telephone: 011 554 2600

Ombudsman's Central Helpline
Sharecall 0860 OMBUDS / 0860 662837

Office of the Ombudsman for Long-term Insurance

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

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

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