Ombudsman for LongTerm-Insurance Annual Report 2015| KPMG Summary

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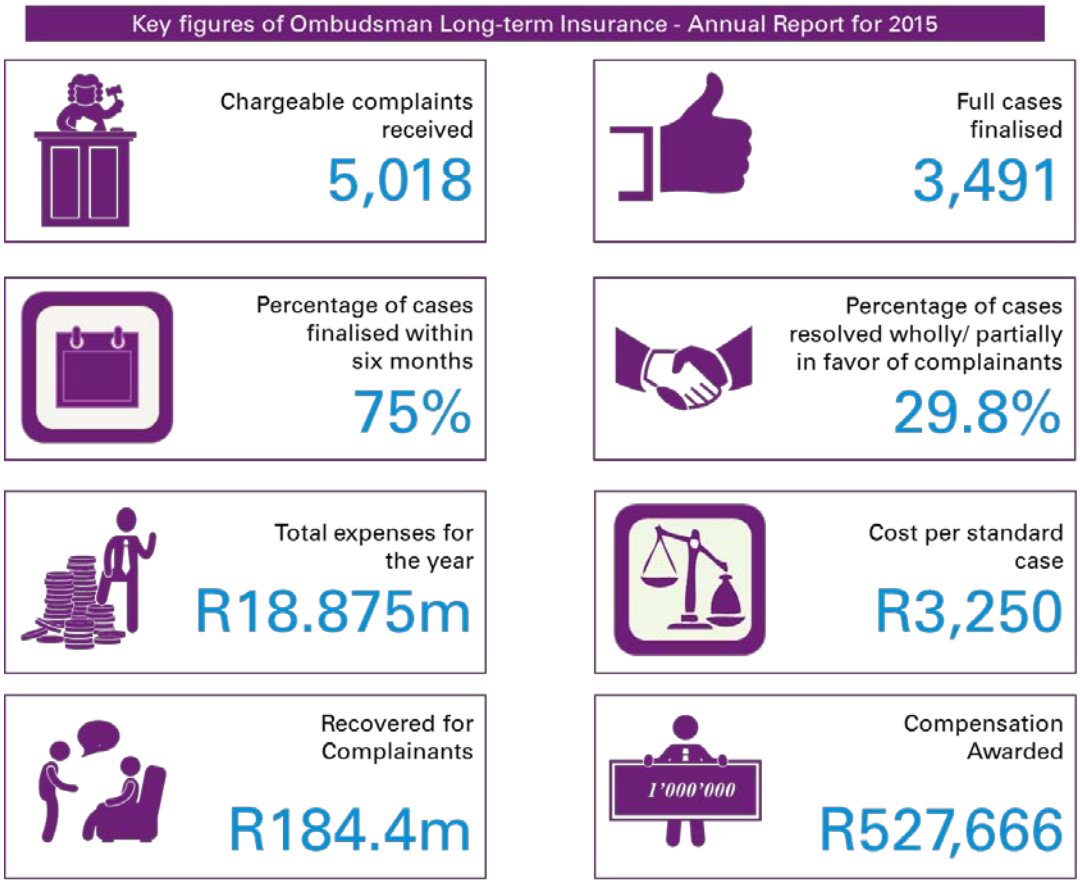
Overview of the Ombudsman for Long-Term Insurance - Annual Report for 2015

The Ombudsman for Long Term Insurance has released its Annual Report for 2015 which, amongst other things, provides comprehensive statistics for the year. A synopsis of those statistics follows below:

— 9,815 written requests for assistance were received, which represents an increase of six percent over 2014;

— Complaints in which the complainants were wholly or partially successful were 29.8 percent, compared to 29.7 percent in 2014.

In last year's Annual Report it was pointed out that, despite the continued existence of the trends which could have been responsible for the consistent increase in the number of complaints received during the past few years, the office received nearly eight percent fewer written requests for assistance in 2014 than in 2013. The office then experienced a marked increase in the number of complaints received during the last quarter of 2015 which resulted in a build-up of current cases at the end of the year.



Overview of the complaints

Nature of complaint	LIFE				DISABILITY			
	2014	W/P*	2015	W/P*	2014	W/P*	2015	W/P*
Poor communications / documents or information not supplied/poor service	979	37%	743	39%	27	33%	41	44%
Claims declined (policy terms or conditions not recognised or met)	1221	27%	1262	25%	289	37%	248	40%
Claims declined (non-disclosure)	85	21%	79	22%	58	21%	42	21%
Dissatisfaction with policy performance and maturity values	131	22%	91	12%	0	0%		0%
Dissatisfaction with surrender or paid up values	72	14%	49	14%	0	0%	0	0%
Misselling	12	17%	7	14%	0	0%	0	0%
Lapsing	167	35%	158	31%	2	100%	1	0%
Miscellaneous	198	16%	240	20%	9	22%	24	29%
Total	**2865**	**29.4%**	**2629**	**32.0%**	**385**	**34.3%**	**356**	**37.1%**

* Resolved wholly or partially in favour of the complainant.

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

Case Summaries

The majority of cases received by the Ombudsman can be resolved on the papers, however, occasionally there are disputes which require the Ombudsman to hold a hearing. These hearings are held to determine a material and conclusive dispute of fact. The Ombudsman has generally no more than five such hearings in a year.

Some of those cases can be illustrated as follows:

Facts of the case	Ombudsman's verdict
— The complainant who had suffered a permanent disabling back injury in 2011 had an "income protection policy". — On claim, the insurer denied compensation, claiming that the complainant failed to disclose a pre-existing back injury. — The court dismissed the complaint. — The complainant then produced evidence which claimed that there was no pre-existing illness.	The claim was deemed to be valid.
— This case was associated with "non-disclosure" of information while applying for disability, income protector and temporary income protector cover. — The complainant was of the view that all the necessary information was provided when the policy was taken. This was disputed by the company which further claimed that the complainant was consuming a drug used for alcoholism and possible detoxification. — The complainant agreed to the allegation but argued that the drug was prescribed and consumed for weight loss.	The insurance company and the complainant reached a settlement of 50 percent of the benefit.
— This case related to "non-disclosure" and was filed against the insurance company for repudiating a claim of increased cover. — The complainant had a policy with cover of R300 000 in place. — The complainant had disclosed that her mother had been diagnosed with breast cancer. — The complainant later opted to increase the cover to R 1 500 000 — This increase was accepted by the insurer. — During this time, the complainant had undergone genetic tests to determine if she had a predisposition to developing breast cancer and the result was positive. This was not disclosed at the time of increase of the insurance cover. — The complainant claimed the increased benefit. — The insurer paid the claim under the initial amount of cover, but declined the claim under the increased cover.	The Ombudsman upheld the insurer's decision of payment of the benefit under the initial cover.

Unreasonable complaints

The 2015 Annual Report notes a steady increase in both the number of unreasonable and complex complaints. According to the Ombudsman, these cases can be attributed to:

— Unreasonable arguments

— Unreasonable behaviour

— Unreasonable demands

— Unreasonable lack of co-operation

— Unreasonable persistence

The office has guidelines in place to deal with unreasonable complainant conduct and these focus on the efficient resolution of the claim and clear communication to all concerned parties, whilst remaining in control of the claims process at all times.

New Business Model

The 2015 Ombudsman Annual Report gives an outline of the new business model. This model requires that complaints that have not first been submitted to the subscribing member, be submitted to the member, providing them the opportunity to resolve the complaint. This business model was implemented in 2013 as a pilot project and has slowly expanded to include other subscribing members.

Conclusion

The 2015 Ombudsman Annual Report gives us insight into the new business model, improvements related to the independent external review, the impact of the changing regulatory landscape, and the principle based approach of Treating Customers Fairly, Retail Distribution Review, appeals and cases.

In summary, a decrease in the chargeable complaints has been received in the year 2015 compared to 2014. In 2015, the Ombudsman's finalisation for the majority of cases averaged at around 91 to 180 days.

Cases in 2015 were largely related to:

— Claims declined

— Poor communications

— Health complaints

Total complaints resolved for the 2015 year amounted to 29.8 percent which stood closely to 2014. This is understood to be as a result of the impact of the implementation of the new business model.