

## ISO Conference 2008

The Office of the ISO held its third bi-annual conference on 10 September 2008. Recognising that all facets of communication are vitally important where matters are in dispute, we adopted a theme of “*Communication*” for the conference.

The day focussed on workshops conducted by Allan Parker (keynote speaker) and Nina Harding, two well known and well respected international practitioners and trainers in the dispute resolution field. In their respective workshops, Allan and Nina provided a wide range of information, which we believe will be of assistance to all those who attended the conference.

Additional sessions were conducted by Christine Smith of the Write Group, on the power of plain English in today’s business documents and an ISO update was provided by the ISO, Karen Stevens and the ISO Team Leaders, Lionel Hinton and Iain Opray.

The feedback received from attendees was extremely positive with comments such as:

- “*Very informative, very enjoyable*”;
- “*It reinforced skills already being used and introduced new ones*”;
- “*All speakers very engaging*”; and
- “*Great idea to invite people from outside the insurance industry with a similar interest in good communication*”.

## ISO Scheme: Review Report

The Rules of the ISO Scheme require an independent Review of the ISO Scheme to be carried out at 5 yearly intervals. The Navigator Company was selected by the ISO Commission to conduct the 2008 Review. It is a Melbourne based company with extensive experience and knowledge of industry dispute resolution schemes and has had involvement in a number of scheme reviews internationally.

At the ISO Commission’s request, the Review addressed 2 specific Benchmarks for industry-based consumer dispute resolution schemes – Efficiency and Fairness.

In releasing the Navigator Company’s Review Report in August 2008, Alison Timms, Chair of the ISO Commission, said the Commission took pride in the overall finding of the Review that “... *in the ISO [Scheme] we found a very effective small to mid size EDR scheme, with an excellent reputation amongst the overwhelming majority of its stakeholders. We were impressed with the simplicity and efficiency of the operation, with the depth of knowledge of the industry displayed by staff and with the quality of service provided to consumers ... The Commission should be well pleased with the ISO’s operational performance ...*”.

The Report included 22 recommendations, which will be addressed by the ISO Commission and responses to them developed after careful consideration, with a view to improving the ISO Scheme.

The ISO Commission will work with the ISO Board on those Recommendations which require changes to the Terms of Reference and the Rules. The Report and the Recommendations can be accessed in the “News & Publications” section of the ISO website ([www.iombudsman.org.nz](http://www.iombudsman.org.nz)).

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*In this publication, the Insurance & Savings Ombudsman is referred to as “the ISO” and the ISO Terms of Reference are referred to as “TOR”. In the case studies, “P” is used to denote Participant and “C” to denote Complainant.*

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## A brief perspective on claims (with communication in mind) presented by Iain Opray at the recent ISO Conference

Most of the enquiries and complaints to the ISO relate to claims being declined for one reason or another.

When I first joined the insurance industry in 1961, I was told the claims department was the “shop window” for the insurance industry. I accepted this without question; after all, it was where the policy was tested and delivered, so why wouldn’t it be the “shop window”? I was soon disappointed.

The typical claims department always seemed to be an afterthought, the last to get new equipment or staff, often staff that management didn’t know what to do with. The focus was on sales, winning new business and retaining accounts. Branch managers were appointed from everywhere but the claims department and you could be forgiven for thinking that life in claims was very much that of a second-class citizen.

As recently as ten or even five years ago, claims was still considered a back-room function. Thankfully, I believe all of that has now changed and claims has experienced a transformation from an administrative function to a key business driver. It can be regarded in many cases as the biggest trigger to an organisation’s profit and loss, because the claims function is not about spending money but saving money. Therefore, reducing the cost of claims while treating customers in a fair and reasonable manner are two of the main issues facing claims officers today.

In the ever more competitive market-place, I believe an organisation’s claims operation is the main point of difference. A reputation for good claims performance will enhance customer satisfaction and customer retention, because making a claim and having your claim met is the fulfilment of the insurance contract. It is of fundamental importance to the industry.

Much of the change is the result of better claims management; new business processes and better technology. However, it is the people in claims, not processes, who are the key to improving customer satisfaction and reducing claims costs. Having the right claims professionals is vital in today’s climate where customers’ expectations are greater than ever, created in no small part by insurers with their wider policy covers and sometimes extravagant promises about how quickly claims can be dealt with. (Note: Consumers often take this to mean the time frame for resolving their claim).

Claims staff will continue to be required to be technical experts, in the sense of understanding their organisation’s policy covers and being able to correctly apply this to a claims situation. However, they also now require, more than ever, to have a broader set of skills to reflect the evolving demands of claims roles. I believe technical knowledge, “soft” skills and good communication skills are the 3 most important attributes of today’s claims professional. Therefore, I urge the development and upskilling of claims staff to be able to fairly and reasonably manage customer expectations and provide their entitlements under their policy.

Claims is also usually the largest brand “touch point” that an organisation has with its customers and, therefore, it is crucial to get it right, in order to impress.

Qualified and technical staff with a broad set of skills will ultimately improve service and reduce claims costs.

You have already heard examples of good and bad communication. Poor communication, often resulting in unacceptable delays in the claims process, figures in a large percentage of the enquiries and complaints the ISO Office deals with.

Some delays are quite acceptable and justified, particularly when the insurer is investigating a claim or making enquiries. If this is the case, it is essential to keep the claimant in the

### Case Study 1

In May 2007, C arranged insurance by telephone with P through a travel agent for his travel to the UK.

In July 2007, while C and his wife were in the UK, C felt a pain in his chest and arms. C went to a doctor he had seen when he had lived in the UK 6 years earlier. The doctor confirmed that C had had an angina attack and arranged for C to have some tests at a local hospital. C and his wife had to arrange alternative accommodation to be closer to the hospital. Three days later, C was admitted to the hospital, where he had a coronary angiogram and an angioplasty. C stayed overnight for observation.

In August 2007, C made a claim to P for the costs associated with the hospital and the alternative accommodation. P declined the claim, because C was in breach of a policy condition which required him to contact the Hotline when being admitted to hospital. The policy also specifically excluded cover where an insured sought “[p]rivate medical treatment when public treatment is available under a reciprocal health agreement between the New Zealand Government and the [UK]”.

### Assessment

The travel agent established that it did not give C a copy of the policy. In all the circumstances, the Case Manager believed the travel agent was acting on behalf of P when it sold C the policy and P had not fulfilled its responsibility under the Fair Insurance Code, to give C “a copy of [the] policy that sets out ... what is insured, what is not insured, and what [C’s] obligations are”.

Although C was given a policy wallet, requiring him to contact the Hotline, if he “was about to be admitted to hospital”, the Case Manager believed the policy wallet gave an impression that the Hotline was only for emergencies and it was arguable that C did not regard his circumstances as an emergency.

The policy wallet differed significantly from the policy, which imposed a positive duty on an insured to contact the Hotline. Failure to do so could result in the declination of a claim. However, the policy wallet’s wording did not give C the same impression.

It was arguable that, even if C had seen a copy of the policy, he would not have been aware that the angiogram and angioplasty would be “private medical treatment” rather than “public treatment”, and excluded under the policy.

loop as to what is going on. In this way, delays will be understood and more readily accepted. How difficult is it to lift the telephone and explain what is happening. Unfortunately, in many cases I have seen, the overuse of email did not provide the same “warm fuzzy” effect, simply because of the impersonal nature of the email communication and failure to pay attention to detail.

If there are likely to be delays with the progress of the claim – set the scene by telling the claimant. People just want to know what is going on with their claim.

A quote from a recent complainant’s letter to ISO.

*“Firstly, let us thank you for the very good communication with us. People don’t mind if things take time, it’s when one doesn’t know what’s happening, that frustration arises.”*

**Remember: Claims are like chess – the most important part of the play is the first move.**

(Acknowledgement to The Claims Faculty of the Chartered Insurance Institute for their research on claims.)

## Fair and Reasonable principle

The ISO’s jurisdiction is set out in Rules and Terms of Reference (“the TOR”), as agreed by the industry Board.

Under paragraph 5.7 of the ISO’s TOR, the ISO is required to make decisions “*by reference to what is, in his/her opinion, fair and reasonable in all the circumstances*” and, under paragraph 5.8, “*shall have regard to ... any applicable rule of law ...*”.

The fair and reasonable principle is the key to an ombudsman being more able to provide redress for consumers, than the strictly legal approach offered by the courts.

In 2008, in accordance with its Rules, the ISO Commission’s public review of the ISO Scheme targeted 2 areas – efficiency and fairness. The Reviewers commented that they were satisfied the ISO Scheme meets the Benchmark of fairness and made some very helpful recommendations to “*fine tune its processes and its settings in the interests of enhancing the fairness of outcomes*”. It was acknowledged by the Reviewers that the ISO is “*taking into account all the criteria for decision-making*” and “*the outcomes of the complaints [they] saw were overwhelmingly fair*”.

The Reviewers also commented that the fair and reasonable principle is “*an essential aspect of the ISO’s identity as an alternative dispute resolution forum – the scheme is different, and should be different, from a court of law*”.

The ISO makes decisions having regard to the law, in order to ensure those decisions are substantially fair and reasonable. This is illustrated in complaints about the non-disclosure of material information, where the current law has very harsh consequences for consumers. However, while harsh consequences result from a strict application of the current law on non-disclosure, a fair and reasonable approach requires the application of broader legal principles. The following are examples of what is required by the ISO:

- The ISO requires the insurer to ask specific questions on an application for insurance and, if it has not done so, has waived the right to avoid a policy on the basis the information not disclosed was material (109454 – 2002).
- The ISO requires the insurer to show that it was induced to enter the contract by the non-disclosure (111996 - 2007).
- The ISO will consider whether the Complainant had any knowledge of the information not disclosed (109445 - 2001).
- The ISO may look at a proportional approach, depending entirely on the circumstances of the case (112206 - 2008).

This was because C was referred by his doctor in the UK to the cardiology department of the hospital, which was part of the publicly funded National Health Service. While the angiogram and angioplasty might technically have been “*private medical treatment*” under the policy, a reasonable person in C’s circumstances could have understood the angiogram and angioplasty to have been “*public treatment*”, because they were carried out at a hospital which was part of the publicly funded National Health Service in the UK.

On an application of paragraph 5.7 of the ISO’s Terms of Reference, the Case Manager did not believe it was fair or reasonable in all the circumstances for P to rely on the policy’s terms and conditions to decline the claim. This was because C was not provided with the policy and the policy wallet he was given did not clearly set out his obligation to contact the Hotline. P was in control of the systems and procedures which should ensure that a policy was provided to an insured. The Case Manager did not believe P had fairly or reasonably applied the terms and conditions of the policy to the claim.

*Complaint upheld*

### Case Study 2

In April 2007, C arranged insurance with P for his business. In the application for insurance, C allocated the total sum insured of \$85,000 under the category of “*Stock*”.

In December 2007, the business premises were broken into and various items stolen including: employees’ effects, stock/consumable items, tools and office equipment, in the sum of about \$14,000 (without any deductions for excess, depreciation etc.) C made a claim to P for the loss.

In its investigation, P established that “*... the stolen plant and office equipment [was] not covered under the policy.*” Also, “*the directors personal belongings and personal cash [were] not covered under this policy and may have been insured elsewhere under a domestic cover*”.

P advised C that, under the terms and conditions of the policy, C was only insured for items of “*Stock*”. However, P had also taken into account C’s intention “*to include Contents as well as Stock when taking out this cover*”. P provided C with a claim payment, which included a payment for the employees’ effects (not covered under the policy), stock and an ex-gratia payment for the tools and equipment included in the claim.

The claim payment was in the sum of about \$7000 and C accepted this as partial payment.

- The ISO requires the insurer to provide proof of the non-disclosure (111960 - 2007).
- The ISO requires the insurer to apply any remedies set out in the policy. If remedies for non-disclosure are in the contract, those remedies will override the common law and the insurer cannot then attempt to rely on its common law rights (110710 - 2004).
- The ISO requires the insurer to follow any applicable code of practice in accordance with paragraph 5.8 of the TOR (111878 - 2006).
- The ISO obtains independent underwriting opinions from senior underwriters to assist with a decision about whether the information not disclosed is material and the insurer is following good industry practice. It is ultimately the ISO's decision based on the evidence obtained (111805 - 2007).
- An insurer cannot go on a "fishing expedition" to find material information on which to avoid a policy (109658 - 2002).

In a very recent decision of the English Court of Appeal (*R (on the application of Heather Moore v Edgecomb Ltd) v Financial Ombudsman Service* [2008] EWCA Civ 642), it was held that the Financial Ombudsman Service in the UK is not required to apply the law, given the statutory requirement for it to determine a complaint on a fair and reasonable basis. An ombudsman is required to take into account relevant law, but can depart from it giving reasons why - subject to judicial review.

Fairness, as a guiding principle in decision-making, is fairer to both parties when relevant and applicable legal principles are taken into account.

## Updating our records

Over the next few months, we will be contacting all of our Participants to ask for up-to-date information about their internal complaints processes and contact personnel.

We did this several years ago to identify where we could help Participants to provide their customers with a better complaints service. We welcome opportunities to assist with training about complaints handling and the role of the ISO. We are also very pleased to provide feedback about the way in which Participants deal with complaints, from our experience dealing with the complaints files and talking to Complainants. From the information gathering exercise, we hope to provide Participants with useful information which may improve their complaints handling in the future.

## Legislation

The Financial Advisers Act 2008 and the Financial Service Providers (Registration and Disputes Resolution) Act 2008 ("Disputes Resolution Act") were enacted at the end of September 2008. The government is also required to set up a reserve EDR scheme under the Disputes Resolution Act and the existing schemes must be approved. There is no implementation date yet, but we understand it is scheduled for 2010. The Financial Advisers Act 2008 and the Financial Service Providers (Registration and Disputes Resolution) Act 2008 can be accessed at:

[http://www.legislation.govt.nz/act/public/2008/0091/latest/DLM1584202.html?search=ts\\_a ct\\_FINANCIAL+ADVISERS&sr=1](http://www.legislation.govt.nz/act/public/2008/0091/latest/DLM1584202.html?search=ts_a ct_FINANCIAL+ADVISERS&sr=1) and

[http://www.legislation.govt.nz/act/public/2008/0097/latest/DLM1109427.html?search=ts\\_a ct\\_FINANCIAL+SERVICE+PROVIDERS&sr=1](http://www.legislation.govt.nz/act/public/2008/0097/latest/DLM1109427.html?search=ts_a ct_FINANCIAL+SERVICE+PROVIDERS&sr=1)

## Christmas Hours

The ISO Office will close at 5 pm on Tuesday, 23 December 2008 and re-open at 8.30am on Monday, 12 January 2009.

On behalf of us all at the ISO Office, we wish you all a

***Merry Christmas and a Happy New Year.***



### Assessment

C stated that the \$85,000 total sum insured was intended to cover \$40,000 consumables and \$45,000 trade tools and office equipment. C believed that "Stock", in ordinary usage, could also include tools and equipment, as well as goods for sale. This was supported by various dictionary definitions.

The Case Manager confirmed with several insurers that, when "Stock" is used within the insurance industry, it refers to only goods, consumables or the raw materials for sale ("the industry standard"). C believed the definition of "Stock" in the policy included tools and equipment. However, the Case Manager believed the definition of "Stock" could also be read in line with P's view and the industry standard, as "stock and materials in trade".

C said "Contents" are limited to furnishings in a building and do not include tools or equipment. However, the Case Manager believed the dictionary also broadly defined "Contents" to include tools and equipment on the premises. The Case Manager did not believe it was fair or reasonable to give a limited meaning to one word and a wide meaning to another, to suit a particular argument, as this led to an inconsistency of approach. To prevent words being misinterpreted and taken out of context, they are defined by the relevant industry. Therefore, the ISO relied on the industry standard, which was consistent with "Stock" being defined as "stock and materials in trade".

Accordingly, the Case Manager did not believe that the responsibility should have been placed on P to make sure that C's property was all correctly insured. The Case Manager believed C's broker had a responsibility to check the proposal with C, to ensure that he was correctly insuring the property.

In the Case Manager's discussion with P, P agreed to offer C \$2,000 (in addition to the claim payment) as full and final settlement of the claim. However, C was adamant that he would not accept any "charity" from P and he did not accept P's latest offer, because he believed P was still liable for the whole claim.

In the circumstances, C was only insured for items of "Stock", having regard to the policy and the industry standard. P had offered a total settlement of about \$9,000 and the Case Manager believed that P had been fair and reasonable in all the circumstances, in accordance with paragraph 5.7 of ISO's TOR.

*Complaint not upheld*