Heading:

Decision concerning Insurance Company Communications and transparency – Complaint upheld

A v B [2012] FDRS Feb 2012

1. Issue

This complaint relates to a dispute over an insurance application, entered into between [Complainant names] ("the Applicants") and [Scheme Member name] ("the Scheme Member").

The Applicants have identified a number of broad grounds in their complaint to FDR, which I will set out in more detail below. However, those complaints relate to what they consider to be an undertaking to reimburse premiums, and also in relation to communications and transparency.

2. Jurisdiction

I find that Financial Dispute Resolution ("FDR") holds jurisdiction to consider this complaint.

As indicated above, the subject matter of this dispute centres on an insurance product, and dealings in relation to that product.

Section 5 of the Financial Service Providers (Registration and Dispute Resolution) Act 2008 ("FSP(RDR) Act") defines the meaning of 'financial services' as including acting in a broking service. On the information available, the Scheme Member in this case appears to have been acting as an insurance broker as would be defined in the legislation. Therefore, by virtue of section 7 of that Act, this complaint will fall within the jurisdiction of the FSP(RDR) Act.

Part 3 of the FSP(RDR) Act relates to dispute resolution, and requires that a financial service provider be a member of an approved dispute resolution scheme or the Reserve Scheme. In this case, [Scheme Member name] is a member of Financial Dispute Resolution (FDR), being the Reserve Dispute Resolution Scheme.

Section 49F of the FSP(RDR) Act, holds that Members of the Scheme "must comply with the rules of the scheme". The rules which apply are the Financial Service Providers (Dispute Resolution-Reserve Scheme) Rules 2010 ("the Rules").

An insurance product is a Category 2 product in terms of the Financial Advisors Act 2008, and therefore the protections available to the Applicant under that legislation must also be applied.

For completeness, the Scheme Member acknowledges there is jurisdiction for FDR to consider this complaint. However, the Scheme Member provides a limitation to that consent, that:

> *"[FDR] may not be able to properly make a judgment on the Underwriting decisions of the [Underwriter] in regards to the Applicant's hospital insurance policies"*

I do not disagree with that exception, on the basis that the underwriter is not a Scheme Member, and therefore their actions fall outside my jurisdiction to consider.

[…]

3. Background

As I understand matters, the applicants entered into a number of insurance contracts with the Scheme Member in September 2009, being life and accident policies.

In more recent times however, on 18 April 2011, the Customers applied to the Scheme Member for a 'hospital indemnity policy'. That application was made via an Agent for the Scheme Member, [Agents name].

Unfortunately I have not been provided with a copy of the application form completed by the Applicants, only a blank form. I understand however, that the completed form was then forwarded to the Insurer', to be considered by it's underwriting department. The Insurer being [name].

It is common ground between the parties that the Applicant paid premiums for that policy, and that those amounts were received and banked by the Scheme Member.

Unfortunately Mr [Customer name] was hospitalised between 24 and 28 April 2011 with a pneumonia and fever.

On 6 May 2011, the applicant made a claim via the Scheme Member, with respect to that hospitalisation.

As noted above, the policy application was subsequently reviewed by the Insurer's underwriting department, who determined that the Applicants' premiums needed to be higher than originally advised due to 'heart and diabetes' issues revealed on what was stated to be the GP's medical records. On that basis a 'modification' form was generated, which sought to increase the premium for the hospital policy. Heart and Diabetes conditions were expressly stated as the reason for that modification on the form. That 'modification' form was presented to the Applicants to sign via the Scheme Member, thereby agreeing to the premium increases.

A dispute subsequently arose between the parties relating to that rate increase, with the Applicants refusing to consent to increased premiums, on the basis that they considered that Mr [Customer name] did not have any pre-existing health problems, as alleged by the Scheme Member.

Two medical certificates were provided by the Applicants to the Scheme Member, one dated 21 June 2011, and second 22 June 2011. The 21 June 2011 certificate from [Doctor's name] states:

> *"This is to certify that I have examined the above patient and found his 'glucose tolerance test' is normal. The test report is attached."*

The 22 June 2011 certificate from [Doctor's name] states:

> *"We would like to advise that we have no clear record to suggest that Mr [Customer name] had any heart disease or angina. He is not on any medications for heart disease and has not had any chest pains.*
>
> *If you have any questions please do not hesitate to contact me."*

Those medical certificates were forwarded to the Insurer, which advised that the underwriter maintained its position, although it gave no reasons to support that view.

The dispute was subsequently managed by [Manager's name], a senior manager for the Scheme Member. I understand that sometime around July 2011, [Manager's name], advised the Customers that if they were to cancel their policies, they would receive a full refund of the premiums paid. The extent of the undertaking to refund premiums is a matter in dispute.

On 27 July 2011, the Customers wrote to the Scheme Member as discussed, seeking cancellation of their policy, in anticipation of the proposed refund.

The Applicants subsequently received cheques from the Scheme Member for various amounts of $29.50, $31.13, $30.00, $9.25, $43.38, $23.54, and $2.50.

Complaint

On 9 December 2011, [Solicitor's name], a Staff Solicitor for the [Location] Neighbourhood Law Office acting for the Applicants, wrote to FDR, confirming the response from the Scheme Member in relation to the dispute was rejected, and confirming the Applicants' position.

In his letter from 9 December 2011, [Solicitor's name] set out the complaint as follows:

> *"We are advised that from the beginning of their engagement with the Company [The Customer's] felt the Company acted with little transparency, did not coherently communicate with the clients the necessary details regarding their policies and pricing and often made administrative errors."*

[Solicitor's name] advised that the customer was seeking a full refund of all monies paid to the Scheme Member. Payments made by Mr [Customer name] totalled $1,355.98, and Mrs [Customer name] $1,364.99. Those amounts are primarily comprised of premiums paid for insurance products written over the years not including the hospital policy.

4. Position of the Parties

Scheme Member's position

I understand the Scheme Member's position to be that the Applicants' application for hospital cover would only to be accepted following approval from the Insurer's The Insurer advised that a premium loading was required due to alleged pre-existing health problems for Mr [Customer name], being heart and diabetes conditions.

On the basis that the Applicants had declined to agree to the premium 'modification', the Scheme Member agreed that any premiums paid must be reimbursed, and has accordingly done so.

With respect to the communication difficulties, I take the Scheme Member to consider that some of the difficulties have resulted from the Applicants not having reliable telephone communications, and also difficulties with language, as Mr [Customer name] does not speak English.

Applicants' position

I have not received any evidence or statement from the Applicants, only communications from their representative, [Solicitor's name]. The representative wrote to FDR on 9 December 2011 confirming that the Applicant did not accept the Scheme Member's response in relation to the complaint at level 1 of the FDR process. [Solicitor's name] advised the applicant's position as being:

- No explanation has been provided as to why the original claim was not accepted, and disclosure of information has been substandard.
- There have been minimal communications from the Scheme Member to the applicants. [Solicitor's name] states that the communications would typically be from the Applicants to the Scheme Member, and at times the Scheme Member would be difficult to contact.
- It is disputed that there was any heart condition present, which is the purported reason for the delay in accepting the claim.

I also take it from the original complaint, that the applicant is seeking reimbursement of all premiums paid over the years on all [Scheme Member name] policies.

For completeness, I do not interpret the Applicants' position to be that any insurance agreement with respect to Mr [Customer name]'s hospital admission should be honoured.

5. Proposed Decision

I set out my proposed decision as follows. I would emphasise that both the Applicant and the Scheme Member may provide comments on this proposed decision which may materially change the decision proposed, or the reasoning given. After the parties have an opportunity to provide further comments to FDR, I will issue a final decision.

As indicated above under the heading 'Applicants' Position', I have interpreted this complaint to be made on 4 broad grounds. I will consider each broad ground separately.

1. Refund of entire historical premiums.

I take the Applicants' position to be that [Manager's name] made an undertaking that if the Applicants were to cancel the policies, that a full refund of all premiums paid over the years would be made.

However, I take the Scheme Member to believe the intention was only to reimburse the premiums paid for the hospital policy, not the other non-hospital policies.

One of the difficulties faced in considering this complaint, is that there is a significant lack of contemporaneous documentation provided to FDR. Not only has the original policy application not been provided to FDR, but neither has any document relating to an offer of the reimbursement of premiums on cancellation. I am presuming that is because any offer was only made orally and not recorded in writing. However, I would have expected that such an offer in a dispute such as this, would have been crystallised in

writing, or at the very least recorded in a file note. No such documentation has been provided to FDR.

Furthermore, I have not received any evidence directly from the Applicants as to the nature of the offer. Taking a technical approach to considering this complaint, the onus does sit with the Applicant to make out their complaint.

From a practical perspective, it would in my view make little sense for the Scheme Member to make an offer to reimburse the entire historical premiums. That is because the Applicants had the benefit of that cover over the previous years, and also that there is no dispute with respect to the non-hospital cover provided.

Furthermore, the Scheme Member, as I understand matters, is acting as a broker. Therefore, it is most unlikely the Broker would have authority to have premiums that had been paid to the Insurer, reimbursed without the Insurer's authority to do so.

I find there is insufficient evidence to establish that the Scheme Member's Agent did in fact made an offer to reimburse the entire historical premiums paid. This aspect of the Applicants' complaint is unlikely to be upheld.

2. No explanation as to why the original claim has not been accepted, and insufficient disclosure.

I have had difficulty in establishing whether in fact any policy had been agreed upon between the[Customer name]and the with respect to the hospital policy. That is because it seems that the Applicants had paid premiums to the Scheme Member, which it had accepted and banked. In my view, a reasonable trader would not have accepted the Applicants' money (premiums) unless the policy had in fact been accepted.

Furthermore, it makes little sense that the would seek to 'modify' the premiums due, or request that the applicant 'cancel' the policy, unless a policy was in fact in place. I note also that the 'modification' form states that:

> *"I hereby agree that these changes shall be an amendment to and form a part of the original application and of the policy issued thereunder and that they shall be binding on any person who shall have or claim under any interest under such policy."*
>
> [Adjudicator's emphasis]

Given the clear wording of that clause, it would seem to be that the intention of the modification would be to apply to an issued policy, and not simply advise of an amendment to a quoted premium rate.

I take the Applicants' position to be that after the claim was made against the policy (on 6 May 2011 following the hospitalization), that the Scheme Member failed to provide an explanation as to why that claim was not accepted.

Without first determining whether a policy had been entered into, it is impossible to decide this aspect of the complaint.

The Scheme Member's position seems to be that the hospital policy had not been agreed upon (issued), and therefore no claim could be accepted against that policy. If that were the case, then I would find the Scheme Member had made a proper explanation as to why the claim had not been accepted. That is that the claim was not accepted, as no policy was in place.

However, if I were to find that a policy had been entered into between the parties, then the Applicant could rely on that policy, and could rightly expect any benefit which might apply under that policy be provided. In such a case, the Scheme Member must provide a sufficient explanation, in my view in writing, as to why the customer's subsequent claim was declined. At the end of the day, the Scheme Member (Broker) is the intermediary of communications between the Customer and the Insurer. If the Insurer did not provide an adequate explanation as to why the claim was declined, I consider the Scheme Member (Broker) has an onus to take steps to ensure a proper explanation is obtained and provided to the customer.

A third possibility is that the Scheme Member had erroneously indicated to the Customers that hospital cover was in place from the time the premiums had been paid and accepted by the Scheme Member. If that were the case, and if the Scheme Member's Agent

did not have authority to give such an indication, then clearly the Scheme Member given the principle of agency, must accept responsibility for providing misleading information from [Scheme Members Agent].

I would like to receive further comments from both parties with respect to the issue of whether a policy had been agreed upon at the time the claim was made on 6 May 2011. The final decision will likely be based on an approach indicated in the above three paragraphs, depending on the further comment provided.

3. Inadequate communications from the Scheme Member to the Applicants.

There is disagreement between the parties regarding the direction of communications. Both parties maintain that the communications came primarily from themselves to the other party.

I accept the statement from the Scheme Member that it had considerable difficulties in communicating with the Applicant, as there were problems with the Applicants' telephone. That is a mitigating factor which will go some way to fairly explain why the majority of telephone communication came from the Applicant rather than the Scheme Member.

I also understand the Scheme Member found verbal communications to be difficult, as Mr [Customer name] had become heated regarding the issues over the policy. In such a case, in my view a reasonable provider would have made alternate efforts to contact its customer, and particularly in writing.

There is also the issue of Mr [Customer name]'s limited grasp of English. In that regard, I note the undated and unsigned statement from [Manager's name] that:

> *"When I made contact with Mr* [Customer name] *his English was limited and difficult to understand, and he had many frustrations of trying to explain his point of view. At this point his wife (name] would be the interpreter of our many conversations that were to follows."*

The Scheme Member, via it's agent [Agents name], must have known of Mr [Customer name]'s difficulty with English when the application was made. That lends further support for a potential finding that the Scheme Member should have taken additional steps to ensure adequate communications, and that Mr [Customer name] understood what was being communicated to him, and the terms of any policy which may arise.

To that extent, my provisional view is that this aspect of the complaint has likely been established, and will likely find the appropriate remedy would be for the Scheme Member to provide a written apology to the Applicants for failure to provide adequate communications.

4. Pre-existing medical condition disputed.

The position taken by the Applicant is that he did not have any pre-existing medical condition as was proposed by the Scheme Member after the 6 May 2011 claim had been made. The Applicant has provided clear medical evidence from the General Practitioner, strongly supporting that position.

No alternate medical evidence has been presented to FDR from the Scheme Member, suggesting that Mr [Customer name] did in fact have any medical condition as proposed by the Insurer's underwriting department. In a reply to FDR dated 18 October 2011, [Scheme Member Representative] from the Scheme Member, states the premium rating was applied "due to medical conditions that were outlined in the medical records received from their GP". However, those 'medical records' have not been presented to FDR.

On the evidence available, I would make a finding of fact Mr [Customer name] did not have any medical condition proposed by the Insurer.

However, I do not have jurisdiction to consider the Insurer's decision making in this case – as they are not Scheme Members, and nor is the complaint to FDR against them.

Notwithstanding that fact, given the available medical evidence strongly favours that Mr [Customer name] did not have the medical conditions proposed, as I have indicated above, I consider that the Scheme Member (Broker) should have done more to ensure the Insurer had properly considered the new medical certificates provided.

Unless the Scheme Member can produce sufficient evidence disputing the accuracy of the medical certificates provided, the proposed decision will likely be a finding of fact mentioned above, and a direction that the Scheme Member provide a written apology to the Customer in relation to wrongly stating there was a relevant medical condition present.

Systemic Issues

Rule 50 of the Reserve Scheme Rules relates to what the Reserve Scheme must do regarding 'systemic issues'. That provision holds:

> *(1) The reserve scheme must report any systemic issue that is identifies, in the course of considering a complaint, to the advisor body, the member concerned, and other members (as the reserve scheme considers appropriate).*
> *(2) In these rules, a systemic issue is an issue that has material implications, beyond the parties to the particular complaint, relating to either-*
> *a. the systems or conduct of the member complained about; or*
> *b. …*
> (3) *Examples of systemic issues include poor disclosure or communication processes, information technology problems, administrative or technical errors, flaws in the design of financial products or other financial services, or inaccurate interpretation by a member or members of standard terms and conditions.*

On the face of the information provided in this case, I have serious concerns regarding disclosure and communication, as well as internal processes applied. Those concerns include:

- A policy document (accepting I have only been provided with a blank document), which is far from plain English. That document includes, particularly on page 1, very technical information requests, which would make no sense to an

ordinary customer. Presumably it is intended that the agent complete that form, but nevertheless, that form in its entirety is executed by the customer, who must be entitled to know what they are signing.

- Unless documentation has not been provided to FDR, there is a complete lack of written communication with the customer setting out what had been agreed, and the expectations on the parties. In my view, a reasonable insurer would confirm communications in writing, or at the very least maintain appropriate file notes confirming oral undertakings made, such as for example, the offer to reimburse premiums paid, to settle the dispute.

- One of the contracting parties (Mr [Customer name]) does not speak English. Given the policy document as mentioned above would be difficult for a person with skills in English to understand, it would simply be unrealistic to expect a non-English skilled customer would understand what they were contracting to. I would like to receive further comment from the Scheme Member advising of what steps it took to ensure Mr[Customer name], a Tongan speaker, properly understood what it was selling to him.

  [...]

Given the above concerns, FDR may decide to forward these concerns to the appropriate advisory body, as well as the Scheme Member concerned.

6. Final Decision

In the sections above, I have recorded the proposed decision provided to the parties. Following receipt of that proposed decision, both parties have provided further comments. I note that both the Applicant, and the Scheme Member, have accepted the proposed decision. I record the final decision below, including further comments from the parties.

1. Refund of entire historical premiums.

I find it has not been established that the Scheme Member made an undertaking to the Customer, that it would reimburse all historical

premiums paid. It does seem likely that the undertaking was only to reimburse premiums paid for the hospital policy, which I understand has occurred.

For that reason, I find this aspect of the Customers complaint is not upheld.

2. No explanation provided as to why the original claim has not been accepted, and insufficient disclosure.

In response to the proposed decision, the Customers representative states that Mr [Customer name]'s position is that the policy had been approved. Mr [Solicitor's name] states that on 18 March 2010, the Customer and the Scheme Member's representative, [name], entered into an agreement. Mr [Solicitor's name] also provided a receipt from the Scheme Member's representative recording payment of $25.75 for the "hospital plan", also from 18 March 2010.

In the Scheme Members response, the Scheme Member's representative advised:

> *"To clarify, a Hospital policy was issued on 4th May, 2011, with an offer of the policy with premium loading for the health concerns of NZ$46.75.*
>
> *At this time, Mr [Customer name] refused to accept the modification to the issued policy, and therefore coverage never began on the Hospital policy and the policy was never placed."*

Unfortunately, the further information provided by the parties following the proposed decision, has not assisted in clarifying matters, rather it has made the state of the evidence more confusing.

The Scheme Member advised that the Customer applied for the hospital policy in April 2011. That is entirely consistent with the limited documentation available, and the response from the underwriter.

However, the response from the Customer, is that he entered into an agreement with another sales agent [name] on 18 March 2010 (that is one year earlier), and a receipt has been presented, of that same date, supporting a payment had been made.

It makes no sense to me why a payment would be made to [sales agent name] for a "hospital plan", when the application was not made until over one year later.

While I regret to make this finding, I must conclude that the state of the evidence is so unclear, that I am simply unable to reach a view as to whether the Scheme Member had advised that hospital policy cover was in place, nor the date that would apply from. I therefore decline to make a finding as to this aspect of the complaint.

3. Inadequate communications from the Scheme Member to the Applicant.

As mentioned in the proposed decision, there is disagreement between the parties regarding the direction of communications.

Following consideration of the parties replies, I confirm the proposed decision. For the reasons set out in the proposed decision, I find that aspect of the complaint has been established. I direct that the Scheme Member provide a written apology to the Customer for failure to provide adequate communications.

4. Pre-existing medical condition disputed.

A reply to the proposed decision has been received from the Insurer, and in particular [name], dated 1 February 2012. [name] advised that the decision regarding pre-existing heart and diabetes issues, was made on the basis of information provided in an earlier application for cover. [name] states that a report had been received from General Practitioner [Doctor's name], which indicated there were issues with non-insulin dependent diabetes, and angina.

However, [name] states that given the more recent medical information, that the Insurer now accepts there is no pre-existing history of diabetes.

With respect to the angina (heart pain), [name]fairly in my view, stated that the insurer would be prepared to accept there were was no risk with angina, if either [Doctors name] retracted his earlier report, or the Customer underwent testing to exclude that condition.

While that outcome has been reached in the context of the complaint to FDR, it seems reasonable to assume that such an outcome could also have been reached if the Scheme Member (broker), had undertaken fuller and more effective communications between the Insurer and the Applicant, when the dispute originally arose.

On the basis of the evidence currently available, I find that Mr [Customer name] is unlikely to suffer a diabetes condition. However, I also find there is insufficient evidence to exclude Mr [Customer name] suffering a heart condition.

As indicated in the proposed decision, I consider that the Scheme Member, acting as a broker, should have done more to settle the dispute regarding the existence or otherwise, of the two proposed medical conditions. For that reason, I direct that the Scheme Member provide an apology to Mr[Customer name], for failing to clarify the issues in relation to pre-existing conditions, earlier.

Systemic Issues

In the proposed decision, I raised concerns regarding potential systemic issues.

Again I note Rule 50 of the Reserve Scheme Rules, which sets out what the Reserve Scheme must do regarding 'systemic issues'. That provision holds:

1. *The reserve scheme must report any systemic issue that is identifies, in the course of considering a complaint, to the advisor body, the member concerned, and other members (as the reserve scheme considers appropriate).*

2. *In these rules, a systemic issue is an issue that has material implications, beyond the parties to the particular complaint, relating to either-*
   a. the systems or conduct of the member complained about;
   or
   b.…

3. *Examples of systemic issues include poor disclosure or communication processes, information technology problems, administrative or technical errors, flaws in the design of financial products or other financial services, or inaccurate interpretation by a member or members of standard terms and conditions.*

Following consideration of the Scheme Member's reply, I find that aspects of this complaint do warrant referral as a systemic issue. Those relate to:

- The policy document – I find the form of the document is overly technical, and it seems unrealistic to accept that an ordinary customer would understand what information was being sought, or what they were signing against.

- Written communication and records – In their written response, the Scheme Member has acknowledged a lack of written records. As indicated in my proposed decision, there should have been a better record of communications in writing, both to the Customer and in file note form. I have no reason to assume this is an isolated case, and therefore it is appropriate this be raised as a systemic issue.

- […]

I find these concerns should be notified to the Scheme Member itself [Scheme Member name] and the advisory body. However, as an advisory body has not been appointed, pursuant to Rule 52, the notification must be made to the Minister.

Mr R Woodhouse

FDR Scheme Adjudicator

February 2012