INSURANCE OMBUDSMAN SERVICE

1 July 2007 – 30 June 2008 Annual Review

The Insurance Ombudsman Service:

- Our service is free to consumers and an efficient and cost effective alternative to legal action.
- Our dispute resolution process is completely independent and administered by an expert team of insurance professionals and lawyers.
- We can make determinations (binding on participating insurance providers but not on consumers) of up to $280,000.
- We deal with disputes over the following types of insurance cover:
    - Home building and contents
    - Motor vehicle
    - Travel
    - Sickness and accident
    - Consumer credit
    - Pleasure craft
    - Personal and domestic property insurance
    - Medical indemnity insurance
    - Residential strata title
    - Some small business policies
    - Third party vehicle disputes if you are uninsured, where property damage is under $3,000

The Insurance Ombudsman Service (IOS) is an independent, national body offering external dispute resolution to the insurance industry and consumers. The IOS offers an information service for consumers on general insurance issues as well as providing free dispute resolution to consumers who have disputes with their general insurance providers.

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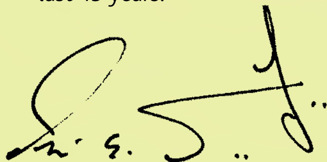
Message from the Chairman

On behalf of the Board of the Insurance Ombudsman Service, it is with great pleasure I present the final IOS Annual Review.

This Annual Review details IOS operations from 1 July 2007 – 30 June 2008. On 1 July 2008 IOS merged with the Banking and Financial Services Ombudsman and the Financial Industry Complaints Service to create the Financial Ombudsman Service.

I would like to thank the Board, the Ombudsman and all IOS staff for their unstinting hard work and dedication during the last 15 years.



Peter E. Daly AM
Chair of the IOS Board

1 July 2007 to 30 June 2008

Highlights

Calls to the IOS information hotline were up 9%, to 122,605 calls, from 112,442 in the previous year.

The IOS formally resolved 2,038 disputes, 12% more than the previous year.

32% of disputes related to motor vehicle policies, 28% to home building policies and 16.5% to travel insurance policies.

IOS ran eight Open Forums around the country, consulting more than 500 stakeholders on a range of issues relating to IOS determinations.

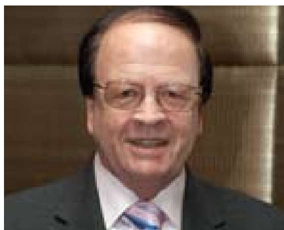
IOS participated in outreach to community organisations, consumers and legal and consumer affairs advisors throughout the year, including presentations to Centrelink, a national forum of consumer representatives, and many community organisations following flooding in New South Wales and Queensland.

About the

IOS Board

The Board is comprised of seven directors: an independent Chair, three industry representatives and three consumer representatives.

Board of Directors at 30 June 2008



Peter E. Daly AM

(Chair)

Mr Daly was appointed a director of IOS in December 1993 and the Chair in January 1997. He came to Australia in 1980 from South Africa and was appointed the Chief Executive and Managing Director of Norwich Winterthur Group in 1983.

Mr Daly has held a number of directorships since then, was the President of the Insurance Council of Australia 1986 -1987 and Chief Executive Officer from 1991–1997. He was the Deputy Chairman of the Zoological Parks and Gardens Board and is also the Chair of Financial Industry Complaints Service Limited.

On 14 March 2004, Mr Daly was awarded the Order of Australia for services to the insurance industry and to the community, particularly through the advancement of alternative dispute resolution and consumer protection.

Karen Chalmers-Scott

FAICD

Ms Scott was appointed a director of IOS in August 2006 as a consumer representative. She works as an independent public affairs/consumer affairs practitioner.

Ms Scott has extensive experience as a senior executive across the regulatory, commercial, dispute resolution and not-for-profit sectors, and her previous roles include General Manager, Customer Affairs for the Office of the Regulator General, Victoria; Customer Advocate within Bank of Melbourne/Westpac; and Assistant State Director for the Institute of Chartered Accountants, Queensland.

Ms. Scott is a Fellow of the Australian Institute of Company Directors. She also serves on the Surveyors Board of Queensland, the Commonwealth Consumer Affairs Advisory Council, and a number of other advisory committees.

David Coorey

BA LLB (UNSW)

Mr Coorey was appointed a director of IOS in July 2006 as a consumer representative.

In 2002 he joined the Consumer Law team of the Civil Litigation section of the Legal Aid Commission of NSW. He previously worked with the law firm Freehills over three years, including a one year pro bono secondment to Kingsford Legal Centre.

Mr Coorey has worked in a variety of areas of civil law, including insurance, credit, consumer and trade practices litigation as well as human rights and discrimination law. Since commencing with the Legal Aid Commission, he has been actively involved in policy work in consumer law, with particular interest in policy issues that affect consumers of insurance products.

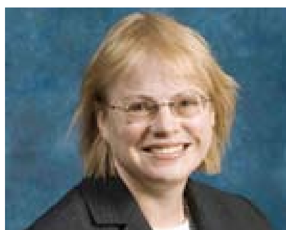
Kerrie Kelly

CLE

Ms Kelly was appointed a director of IOS in April 2006 as an industry representative. Ms Kelly joined the Insurance Council of Australia as Executive Director and CEO in April 2006. She is a lawyer who has held senior executive positions in the public and private sectors working in the fields of banking and finance, manufacturing and transport. She has considerable experience in strategic and operational planning, resource allocation, policy development and implementation, strategic alliance development, as well as product and services development and management.

Ms Kelly was previously Chief Executive Officer of the Financial Planning Association of Australia. Ms Kelly is also a Member of the Australian Government's Financial Literacy Foundation Advisory Board and Director of the Finance Industry Council of Australia Ltd.

Board of Directors at 30 June 2008



Dr Elizabeth Lanyon

LL M (Melb) 1986, LLB (Hons) (Melb) 1980, BA (Hons) (Melb)

Appointed a director of IOS in November 2002 as a consumer representative, Dr. Lanyon is currently senior policy advisor to the Director of Consumer Affairs Victoria. She is an Honorary Associate Professor in the Law School at Monash University.

Dr Lanyon is a member of the Law Council Financial Services Committee and co-author of the two major texts on consumer credit law in Australia.

John Peberdy

ANZIIF (Snr Assoc), CIP

Mr Peberdy was appointed a director of IOS in August 2006 as an industry representative. He is the Chief Executive Officer of Ansvar Insurance and is responsible for the Australian and New Zealand companies of the Ecclesiastical Insurance Group.

Mr Peberdy joined Ansvar Insurance in 1973 in Adelaide and was transferred to Melbourne in 1985. He has since been involved in a range of management roles and was appointed CEO in May 1999. He is a Senior Associate of the Australian and New Zealand Institute of Insurance and Finance and a CIP. He is also a director of the Insurance Council of Australia.

Mr Peberdy is particularly interested in the issue of reduction of loss and injury from preventable causes within the community service sector.

John Rogers

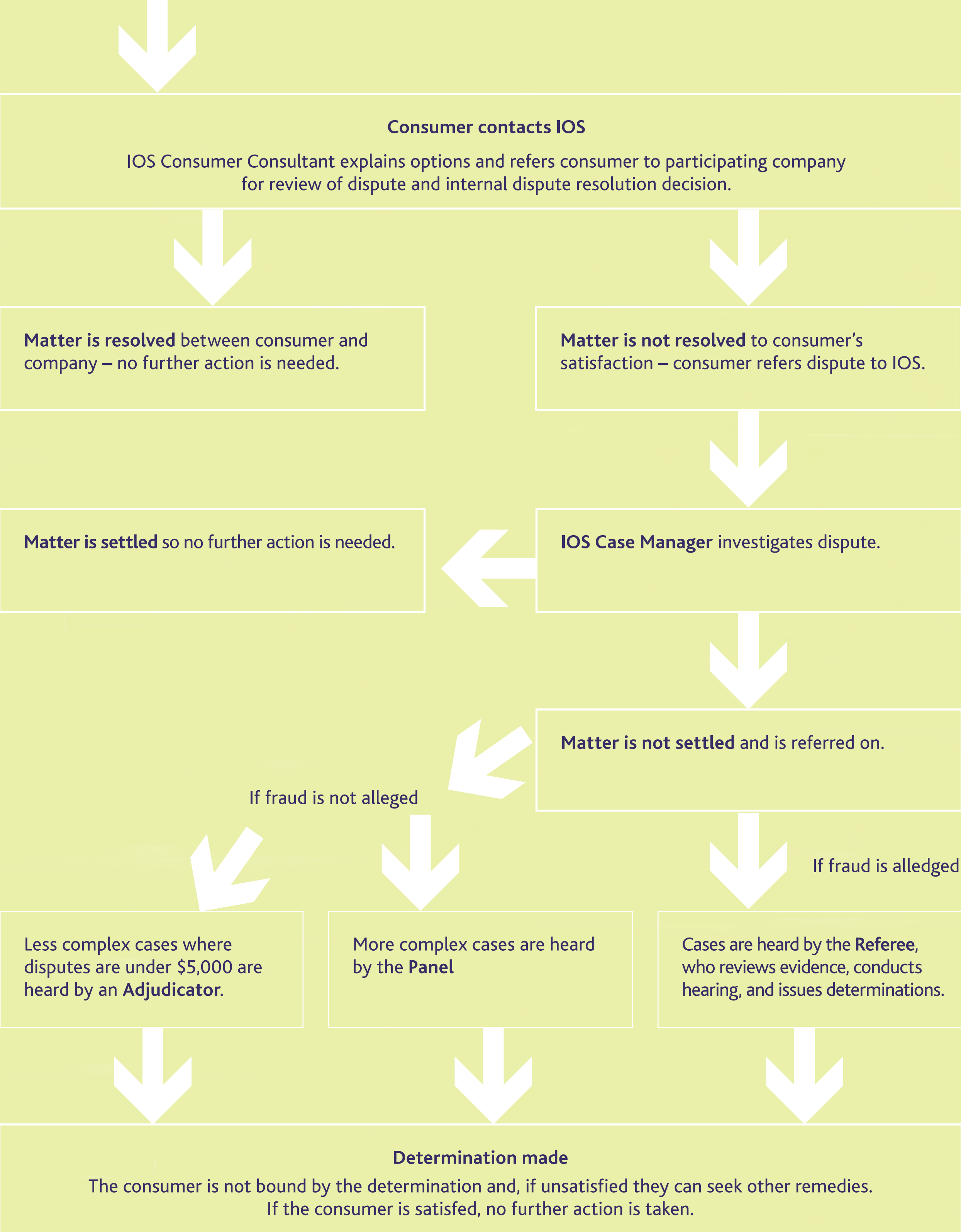
BJuris, LLB

Mr Rogers was appointed director of IOS in June 2007. He was in a private legal practice for 10 years, the last three as a Partner at Phillips Fox, Perth, before moving into the insurance industry in 1991. He initially worked in insurance broking and risk consultancy.

In 1997 Mr Rogers joined GIO, later purchased by Suncorp. He has been the General Manager of Suncorp Commercial Customer Development for the past five years. Mr Rogers is responsible for the end-to-end customer experience which includes the sales, underwriting and claims processes. He sits on Suncorp's General Insurance Licensee Compliance Committee which provides a detailed overview of internal and external dispute resolution across all of Suncorp's GI products.

Mr Rogers is ultimately responsible for the IDR process within Commercial Insurance.

Dispute Resolution



Sam Parrino

Ombudsman's Report

Sam Parrino
Ombudsman – General Insurance
Financial Ombudsman Service

The Financial Ombudsman Service

Writing as the General Insurance Ombudsman with the new Financial Ombudsman Service, let me say that the creation of the Financial Ombudsman Service has been major part of our focus through 2007 – 2008. The rapid and efficient implementation of the merger between the three major EDR schemes in the financial services sector, the Insurance Ombudsman Service (IOS), the Banking and Financial Ombudsman Service (BFSO) and the Financial Industry Complaints Service (FICS) is a testament to the high level of team-work and dedication within these organisations.

The Financial Ombudsman Service will provide a streamlined, effective and specialised dispute resolution service to well over 80% of all stakeholders in the financial services market-place. We aim to develop the pre-eminent source of external dispute resolution for financial services in Australia, to the benefit of the industry and its customers.

The input received from insurance stakeholders during the extensive consultation period regarding the new Terms of Reference (TOR) and processes for the Financial Ombudsman Service has been of great value to us and, rest assured, we will do our utmost to create the TOR to underpin the effective and efficient delivery of external dispute resolution for the financial services industry.

The Financial Ombudsman Service structure also provides for the appointment of a General Insurance Issues Advisory Committee. The Committee will assist the Board to address matters impacting on consumers and financial service providers in relation to general insurance, including, in a broad sense, jurisdictional issues, complaints processes and case costs / levies. The Committee will be chaired by a Financial Ombudsman Service Board Director and may comprise of one to three representatives of the industry and an equal number of consumer representatives.

The work of the former IOS Board Consumer Committee, which has focused on key issues impacting on consumer accessibility to IOS, will contribute to the new processes and procedures for the Financial Ombudsman Service. I look forward to working with the Chief Ombudsman, Colin Neave, and my colleagues Alison Maynard (Investments, Life Insurance and Superannuation) and Philip Field (Banking) to create the benchmark for external dispute resolution in Australia.

IOS Independent Review

Under the terms of ASIC approval of IOS, an independent review of the scheme is required every three years which has coincided with the current Financial Ombudsman Service Project. In light of the concurrent merger, we have commissioned the 2008 Review to focus on the dispute resolution processes used by IOS and the sufficiency of the jurisdiction and financial limits. Specifically, the Review will address these aspects of IOS operation against the following criteria:

- Decisions are in keeping with the Terms of Reference
- The Service observes the principles of procedural fairness
- The Service provides adequate reasons for decisions
- There is consistency in how consumers and members are dealt with and
- The effectiveness of the dispute resolution processes

The Independent Review is being conducted by the Navigator Company Pty Ltd and the results will be available December 2008. We expect that many of the recommendations arising from the Independent Review will be considered in the formulation of the new TOR and processes for the Financial Ombudsman Service.

The year at IOS

This has been a typically busy year at IOS with total referrals up 12.6% to 2,170 compared to 1,927 in 2006-2007. A substantial portion of this increase came from New South Wales and Queensland in the aftermath of the significant weather events in those States. This can be seen from the number of home building disputes dealt with during the year which rose nearly 50%, with 604 disputes compared to 403 in the previous year. Home building disputes made up 28% of the total number of disputes at IOS in 2007-2008 compared with just 21% in the previous year.

Interestingly, 79% of the home building disputes which came to IOS in 2007-2008 concerned 'exclusions or conditions' in policies, compared with just 49% in the previous year. Moreover, of the 538 home building disputes determined by the end of the 2007-2008 financial year, 60% were decided in favour of the insurer, with 26% in favour of the consumer and 12% settled. These statistics highlight once again how crucial it is that consumers read the policy document and that insurers clearly communicate in that document what is and is not covered.

Flood events continue to be a source of disputation and we support the endeavours of the industry to seek new ways of clarifying and expanding the extent of cover provided to customers so as to alleviate the need for an independent third party such as FOS to adjudicate on disputes.

Once again, the largest category of disputes received by IOS was motor vehicle, with 703 disputes or 32% of the total number of disputes, in the 2007-2008 year. In the previous year, however, motor vehicle disputes made up 35% of the total number of disputes at IOS.

Whilst there was a slight rise in the total number of travel disputes dealt with during the year, up 2.8% to 360, travel insurance disputes decreased to 16.5% of the total number of disputes received, compared with 18% in the previous year. This is an encouraging sign that the industry is perhaps dealing more effectively with these disputes at the IDR stage.

Nearly 44% of cases referred involved amounts of less than $5,000, a reduction of 3% on last year while 59% were for less than $10,000, also 3% less than in the prior year. IOS saw 33 disputes involving amounts of more than $150,000 this year compared to 20 the previous year, an increase of 65%, which confirms the need for the monetary jurisdiction of the Service to reflect the increased property values within the community.

General Insurance Code of Practice

Due to the combined nature of the Financial Ombudsman Service annual reporting this year, we will be publishing the report of the independent Code Compliance Committee and the statistics resulting from the IOS role as monitor of the Code in a separate publication.

All stakeholders will receive a copy of this Code publication and we look forward to launching it before the end of the year.

Thank you

This final annual review from the Insurance Ombudsman Service (IOS) is the culmination of 15 years of hard work and dedication from all involved with the Service. I would like to take the opportunity to thank the IOS Board, particularly the Chair, Peter E. Daly AM, the directors past and present, the independent decision makers, my management team and the staff who have dedicated themselves to creating a premier EDR scheme for the insurance industry and its customers.

Sam Parrino

Ombudsman – General Insurance
Financial Ombudsman Service

Peter Hardham

Panel Chair's Report

Peter Hardham

Panel Chair

Climate change

The first thing Panel members do each day is listen to the weather report to check whether there has been a major storm, downpour, earthquake, earth tremor, hailstorm, bushfire, flood or other significant climate event. News of the breaking of the drought would be welcome. Unsurprisingly, there is a clear link between major weather events and the number of referrals which come to IOS. Climate change and global warming are thus of vital interest to IOS decision makers.

Long term drought can have a significant effect on soils and, consequently houses. Large insurance claims follow. Climate change-related disputes also arise from storms, which are usually accompanied by wind, rain or hail and may result in flood, erosion, subsidence and various forms of inundation and damage. The most commonly argued issues are whether damage to an insured property was storm damage or flood, whether it was the rain water run-off, erosion or subsidence, or whether the weather event revealed a lack of maintenance, rusted roof guttering or poor drainage from which the property suffered serious damage.

The issue for determination in these disputes relates to whether the damage was caused by storm or by a separate cause or phenomenon that arose independently of the storm, such as rainwater seeping into the ground causing earth movement. In this regard it is important to make a distinction between cause and effect, that is, if the storm produced the rain which caused the earth to wash away from the foundations which in turn led to the damage to the foundations and the collapse of the home. In these circumstances, it may be fair to argue that the proximate cause of the loss was the storm and the other events occurred directly from there, namely erosion, subsidence and damage.

However, if there is an event to disrupt the cause and effect phenomenon, then the excluded cause may prevail e.g. earth movement may be deemed to be the approximate cause, if a significant period of time occurred between the storm, the water seeping into the ground, the movement of the earth and the damage. The storm water/flood water dichotomy has already been the subject of analysis in Panel reports in previous years. It is for these reasons that we decision makers are interested in the impact of climate change and the impact it is having on the insurance industry and the manner in which it is formulating its policies.

The politics of climate change

Politicians like insurance companies to pay claims, especially those arising from storms. After the major storms in the Hunter Valley in June 2007, members of the NSW Government offered free legal opinions that, following the flooding of many properties, the proximate cause was the storm and the flooding which occurred to many properties was a direct result thereof. Unfortunately certainly for us decision makers, the law does not function that simply. Damage proximately caused by the storm i.e. water that comes from the roads and gutters is classed as stormwater. If it finds its way into a creek or watercourse and then enters the property from that source, it is classed as a separate proximate cause, namely flood, which is excluded from many, but not all insurance policies.

Many local authorities have allowed people to build on flood plains which immediately creates a problem politically. As Moss Cass MP, the former relevant Federal Minister, pointed out during the 1974 Brisbane floods, 'Flood plains are for floods." To what extent are the State politicians, especially the Minister for Local Government, responsible for flood minimisation and prevention, particularly in circumstances where the flood minimisation process results in both protection for some residents and an increase in risk for others? For example, during a recent inspection by the Panel following the Newcastle/Hunter Valley floods of June 2007, we were shown how a levee bank

constructed in one township provided the majority of residents with protection from the water overflowing from the river which circumnavigated the town, but resulted in the inevitability that the remaining properties would be flooded and, of course, rendered their insurance policies useless to protect them from the devastating consequences of these events.

The problem that manifested in one case was compounded because the insurance company that insured the applicants' buildings decided to treat the claim as storm whereas the insurer of the contents denied the claim.

When the Panel met the policy holder on site, he told us that he believed the property was damaged by storm, not so much on the topographical merits of the case, but because the politicians told him it was storm, and the building insurer told him the same thing. In these circumstances it was with some embarrassment that the Panel had to inform him that as a result of the levee bank facilitating the inevitability of the river flooding his property, it could not support his claim. Unsurprisingly he changed his insurance company and no doubt sought disaster relief from the State or Federal Governments.

Notwithstanding that the number of flood-related disputes coming to IOS has reduced over the past five years, the disputes that we do receive are becoming more complex due to unusual factual scenarios, more complex definitional issues, and increasingly convoluted and longer policies.

An example of the problem is the highly distressing and not unusual situation where, due to the pressure of flood water in the general area, sewage enters through the various orifices in the bathroom and causes noisome damage to the premises. These claims are usually denied on the basis that the proximate cause of the damage is the presence of floodwater in the vicinity, although no floodwater actually enters the property. Many definitions of flood require the water referred to in the excluded peril to actually enter the property as distinct from the presence of water in the area causing noisome sewage to backflow.

The Panel is aware of a New Zealand case, which largely supports the proposition that, not withstanding this, the flood exclusion actually prevails. We ask rhetorically, is this fair, because on a literal interpretation of the policy exclusion, the claim should be paid because the noisome sewage causing the damage did not emanate from a water course?

Domestic violence

Domestic violence, like storms, fires and floods seems to be on the increase, in terms of disputes that come to the Panel. We have commented on this issue in previous Annual Reviews in the context of one of the parties to the relationship burning down the matrimonial home. In these earlier Review contributions we have analysed the issue as to whether the nature of the respective policy holder's interests in the damaged property is joint or composite, that is, whether the innocent party's interest can be severed and separated from the perpetrator of the violence to the property. In some instances, depending upon the circumstances, the Panel has found that it can separate the proprietorial interests of the parties with a result that the innocent party has been paid in part, and in some cases all, of the damage.

However, different considerations may apply to moveable items such as jointly owned furniture, motor vehicles, caravans, boats and trailers. For example, in one case recently considered by IOS, the motor vehicle was jointly owned at the time of policy inception but, by the time the policy was renewed, the husband with a history of violence had left the property, although the motor vehicle remained in the possession of the wife. The wife had in the meantime obtained a restraining order against the husband, prohibiting him from entering the property. The wife wanted to change the policy in relation to the motor car to her name, but the insurer, justifiably in one sense, refused to allow her to do so without the husband's consent. The husband, not surprisingly, refused, no doubt due to his overall philosophy that the matrimonial home, the furniture, the motor car, and the wife were chattels. In the circumstances the motor vehicle policy remained in joint names.

In the early hours of the morning, the husband in defiance of the orders of the

court, entered the former matrimonial property and destroyed the motor car. Initially the claim was accepted, the insurer for some reason being unaware of how the vehicle was damaged, but after the husband rang the insurer and proudly told him he was responsible for the damage, the insurer 'unauthorised' the repairs to the car on the grounds that the policy holder had intentionally damaged the property. As a result the claim was denied and the vehicle remained with the repairer, because the wife could not afford to repair the vehicle herself. We ask rhetorically, without stating the result of the case, is this fair?

The Panel has previously encouraged insurance companies to advise their policy holders who own jointly insured property, and change their relationship, either by way of separation or divorce, to inform them of these events. Such matters can be established either by court documents, mutual agreement or other means, and it will have the result that insurance companies are aware as to who is in possession of the property, and no doubt it would be of interest to the underwriter as to whether the property is the subject of a domestic violence order.

Travel insurance

The Panel admires the creativity of the travel insurance industry in developing a multitude of ways in which travel insurance is sold, either directly through the member, via its army of travel agents, the telephone, airline companies, tour operators, travel organisations that organise group tours, and more importantly via the internet.

Internet generated policies have provided us with some interesting disputes, in relation to whether the policy holder has successfully run the online gauntlet of advising the insurer of pre-existing medical conditions, usually via a multi-step underwriting process. We never cease to be amazed by the generosity of some underwriters.

In one dispute the policy holder wanted the travel insurance policy to cover him during a trip to the United States during which he planned to go skiing. He had previously experienced significant lower back problems, and had undertaken investigations and treatment over a period of time for this condition. The member had introduced a process for requiring persons to apply for cover for such conditions, but only if the person with the history of back and spinal problems was attending a pain relief specialist. The applicant had undergone treatment from various medical and health practitioners, but had not undertaken care by a pain relief specialist.

When the inevitable happened and he aggravated his back condition due to a skiing incident, the member denied the claim on the basis that the claim arose as a result of a pre-existing medical condition, an allegation with which the Panel agreed. The applicant was successful in the dispute because it was not the type of pre-existing medical condition which was excluded by its internet generated step-by-step underwriting procedures, because there was no evidence that the applicant had been receiving treatment from a pain relief specialist.

The Panel has also encountered many disputes in which the critical issue is whether the applicant was clearly informed of the policy terms and exclusions. This can be difficult to prove with internet generated policies unless there is some evidence that the policy holder has downloaded the policy. The industry has tried to overcome this problem by requiring prospective policy holders to tick a box which confirms that the policy holder has "read and fully understood the policy terms". In one case the particular policy was in excess of forty pages in length, was in small print, lacked a coherent index, and contained policy exclusions and limitations in six different parts of the policy. The Panel decided that this acknowledgement was of little evidentiary value.

The educational role

As we have stated in previous Reviews the educational role of the Panel is equally as important as its decision making. This role is achieved by articles decision makers provide to insurance journals; the Industry Forum process; our conferences; and by visits to member companies and addressing consumer groups. On one occasion a senior claims officer from a large insurer spent two weeks at the Service observing how we operate.

It is also important for our case managers to receive ongoing training and we have an educational program operating at the moment instructing all case managers on the provisions of the *Insurance Contracts Act*.

The educational program was in evidence at the recent *IOS Annual Conference* at which a series of workshops were conducted. These workshops dealt with issues relating to non-disclosure, fraud, the application of difficult policy terms, the duty of both parties to act with utmost good faith and the impact of the *Insurance Contracts Act* on decision making. They were successful both for the participants and the decision makers who facilitated the workshops.

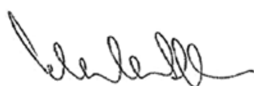
There is no doubt the existence of a body of decisions is a great asset not only for IOS, but to all the stakeholders. These decisions can impact on issues much wider than the issues in dispute such as the effectiveness of the policy in terms of clear communication, the layout of key documents such as policy renewals and certificates, and the impact of product disclosure statements. This, in our opinion, is one of the strengths of the decision making system of IOS in providing a good educational resource for all of the stakeholders.

As stated in our last Review, we have had two Panels operating since April of 2007 and, because of an upsurge in referrals, we have even had recourse to a third Panel under the chairmanship of John Price who also operates as Referee and Adjudicator.

The other Panel Chairs, Peter Hardham and Ron Beazley, also act as Adjudicators with the able assistance of Christine McCarthy. With three Panel Chairs and Adjudicators, and a Referee, all decision makers need to be alert to the growing pressure for consistency in decision making.

In conclusion, we wish to acknowledge the tremendous contribution that the case managers make to our decision making process and note that their excellent and well considered drafts are adopted by the decision makers approximately ninety per cent of the time. We also wish to acknowledge the vital contribution of our secretarial staff who until recently consisted of Pamela Roche, Sue Horley and Gina Vasquez, with the recent addition of Laura Fahey.

The year ahead will be a time of great change and challenge as the merger between the three ombudsman schemes consolidates. Our aim is to embrace that change without in any way compromising the quality and time involved in our decision making processes.



Peter Hardham

Panel Chair

John Price

Referee's Report

John Price
Referee

What an interesting 12 months it has been. There has been an increase in the number of fraud related referrals (123 during 2007-2008) and I have had to deal with my role as Alternate Panel Chair, at various times chairing Panel One, Panel Two, and Panel Three, as well as being an Adjudicator. It has been not only challenging, but interesting and rewarding.

I have learned to increasingly appreciate the role and input of the industry and consumer representatives on the Panel when dealing with complex matters – their participation can be invaluable. I have also seen the importance of the oral hearing/examination as part of the inquisitorial process in decision-making while dealing with allegations of fraudulent conduct.

Oral hearings and use of interpreters

Perhaps the best illustration of the benefit of the oral hearings came during a determination involving a disputed theft of a truck. Central to the insurance company's allegation in this matter were inconsistencies contained in the consumer's initial claim and subsequent statements. On the face of it, those inconsistencies appeared significant. What became apparent, however, was that at no stage in the investigation of the claim had the consumer been offered the assistance of an interpreter. The assistance of an interpreter was not offered by the insurer's call operator, investigator nor by the dispute resolution officer. Despite the obvious inconsistencies, nobody thought the consumer might have needed some assistance. The consumer requested an interpreter attend the oral examination. As the oral examination proceeded, it became apparent the consumer had very little comprehension of English. The interpreter, in fact, commented to me that he believed the consumer had little understanding of his native language. I was informed the consumer had at some stage prior to the alleged theft, suffered a significant brain injury, which may well have contributed to his confused state. This explanation was not apparent from the material exchanged. The oral examination provided the consumer an opportunity to clarify numerous issues and resolve much of the dispute.

By coincidence, on the same day, during the course of another oral examination where the insurer had relied upon inconsistencies in the evidence of the consumer and his two witnesses, it again became apparent that interpreters were not offered to the consumer or his witnesses when the statements were being taken by the investigator. Inconsistencies related to dates, times and places and, on reading the transcripts of the interviews, were significant. Close reading of the transcripts, however, indicated some confusion amongst the witnesses. The consumer and witnesses attended the oral examination, but it was immediately apparent they had limited comprehension of English. Again, as a result of the oral examination, a number of the inconsistencies were able to be clarified and, more importantly, the consumer and his witnesses were able, through the assistance of interpreters, to comprehend the nature of the allegations made and provide appropriate responses.

These two simple but not uncommon examples highlight not only the benefits of the oral examination process in clarifying issues, but also give rise for concern as to the investigation processes adopted by insurers when dealing with consumers from non-English-speaking backgrounds. I find it disappointing that an investigator would not offer the services of an appropriately qualified interpreter when it becomes obvious that person has difficulty in comprehending the matters which are being put to them. I find this particularly disturbing when these statements are subsequently relied upon and the inconsistencies highlighted as part of an allegation of fraudulent conduct.

I have subsequently had discussions with investigators about their normal procedures in these circumstances. Most advised that if they believe an interpreter is required they would suspend the interview and arrange a new interview with an interpreter after seeking instructions from the insurance company client.

A couple suggested they would proceed with the interview, in particular if the factual matters were not in dispute. They advised, however, they would notify the insurer in the event that there was any concern as to the information contained in the statement that the consumer required an interpreter in any future interviews. Both processes seem to be sound practice and it caused me some concern, therefore, to find the allegations of fraud made in matters where clearly interpreters were required but not used. This has not been isolated to these two I have referred to, and has occurred in other matters throughout the year but perhaps in less dramatic circumstances.

Those insurers I have spoken to advise me they have a process that requires an investigator to notify them immediately the investigator believes an interpreter is required. Again a sound practice but given my experience clearly there has been a breakdown in that practice.

I would strongly recommend to all insurers that they audit their guidelines for the use of interpreters, in particular where statements taken by investigators are to be used to highlight inconsistencies and form the basis of an allegation of fraudulent conduct. Ensuring they have a robust process for determining the use of interpreters should help resolve a number of 'inconsistencies' to the benefit of all parties.

New Referee powers in the Terms of Reference

The year was also significant as it was the first year in which all the matters which came before me were addressed under the Terms of Reference that came into operation on 1 January 2007.

It was the first year in which the Terms of Reference gave me power to determine the dispute, that is, if the allegation was one of fraud or false and misleading statements, to actually determine whether the insurer has satisfied the appropriate test, or in the alternative, to exercise the powers under Clause 8.7(b) of the Terms of Reference to determine there were substantial issues of fact in dispute.

Some may recall there was concern with this amendment of the Terms of Reference, in particular as to the difficulties that would be faced by insurers. As I have always believed the amended Terms of Reference, whilst providing a fairer process, has not led to any significant change in the determinations. As in the past, I have applied the Briginshaw test as the principal test in determining these matters.

Of the 123 fraud related matters during 2007-2008, approximately 40% were determined in favour of the consumer, 45% in favour of the insurer and 15% on the basis of Clause 8.7(b). I have been reluctant to use 8.7(b) as I would prefer in most cases to try to resolve the dispute within the powers available to me.

I find, however, that Clause 8.7(b) is very useful, in particular where, despite thorough investigation, the investigation process is thwarted by a lack of co-operation in providing information by either the consumer or persons with whom the consumer is associated. If I am satisfied the lack of co-operation is part of a deliberate process to impede the investigation and potentially mislead the insurer, then consideration needs to be given to the application of 8.7(b) of the Terms of Reference. This discretion will not be exercised lightly, however. An insurer needs to establish quite strong evidence to prove the lack of co-operation or deliberate obstruction of the investigation process.

Thank you

Finally, it would be remiss of me not to acknowledge the considerable assistance I have received during the year from the principal Case Managers, John Davey, Keith Atkins and Chris Liamos and from my assistant Sue Horley.

I should also acknowledge the considerable assistance, input and robust debate provided by the consumer and industry representatives of Panel One, Panel Two and Panel Three during my time as Panel Chair of those Panels. It has been most enjoyable.

The close of the financial year saw the merging of the various industry dispute resolution services into the Financial Ombudsman Service.

It is an exciting time for all and an opportunity to hopefully improve our decision making processes further for the benefit of both consumers and financial service providers. I look forward to seeing the progress and development of the new Terms of Reference.

John Price
Referee

Ron Beazley

Adjudicator's Report

Ron Beazley

Adjudicator

Statistics

In previous years I have referred to annual statistics, the bane of many annual reporters, and in particular, to the win/loss ratios affecting adjudications.

In those reports I have observed and noted a steady win/loss ratio of 2:1 (66%) in favour of insurers and I have suggested insurers should endeavour not to fall below that benchmark.

During the past year, excluding non-claim disputes (273), IOS made 1,897 determinations of which some 893 (47%) were adjudications. In my view, it is significant that 74% of the adjudications favoured the insurer, a ratio of approximately 3:1. Thus, at least in the past year, the ratio has increased with significantly improved performance by insurers. The challenge for insurers in future years will be to use that ratio as its new benchmark for measurement of decision making.

It is interesting to note that, when fraud related matters are excluded, the Panel outcomes in favour of insurers fall to 62%, 12% less than adjudications.

Under recent administrative arrangements each of the Panel Chair, Referee and Adjudicator also sit as Panel Chair and Adjudicator, so the difference cannot be simply explained by reference to different approaches by the respective decision makers. While one cannot know the precise reasons for the higher level of determinations in favour of applicants in Panel matters, it may be explained at least partly by two factors.

First, one suspects that smaller dollar disputes may be resolved in favour of the consumer at claim level for commercial reasons or customer loyalty or goodwill. Secondly, Panel determinations involve three decision makers including consumer and insurer selectees. Each of those decision makers brings special and important nuances to the process which by its nature is more rigorous and dynamic than that of a single decision maker.

The make-up of the membership of the insurer's internal review committees is a matter for individual insurers but I suggest those committees might be strengthened by inclusion of some external or consumer oriented persons.

The dangers of paraphrasing

At recent forums and the annual conference mention has been made of the need to exercise great care in drafting policy documents. In particular, mention has been made of the form of words that must be used in the Notices of Disclosure required by S.22 (1) of the *Insurance Contracts Act*.

For general insurance products the Notices are set out Parts 1 and 3 of Schedule 1 of the Regulations. Some insurers seek to paraphrase those Notices and therein exists a potential trap for insurers. Because the Notices are required by legislation, the observance of the Duty requires strict compliance and failure to so comply may involve loss of the protection of the Act. Whilst it may not be seen to be practicable to repeat the Statutory Notices 'word for word' great care must be taken to ensure the respective Notice complies with the form set out in the Schedule. It is suggested that the attention of professional draftspersons be drawn to this important requirement.

Ron Beazley

Adjudicator

1 July 2007 – 30 June 2008

Statistics

Table 1: IOS phone calls

	IOS	FOS
2003 - 2004	67,545	149,710
2004 - 2005	64,563	148,148
2005 - 2006	64,568	162,405
2006 - 2007	112,442	208,383
2007 - 2008	122,605	222,801
TOTAL	431,723	891,447

Table 2: Origin of referrals by State

	No.	%
New South Wales	844	39
Victoria	590	27
Queensland	358	16
South Australia	145	7
Western Australia	145	7
Australian Capital Territory	41	2
Tasmania	38	2
Northern Territory	9	0
TOTAL	2,170	100

Table 3: Reasons member denied liability

	Cancellation of insurance contract	Disclosure issues	Exclusion/condition	Failure to offer insutance	Fraudulent claim	GI product advice	No policy contract	No proof of loss	Non-disclosure on proposal	Not covered by policy	Other	Premium & no claims bonus changes	Quantum	Sales & marketing	Service/handling of complaint	Third party	Total	2007 - 2008 (%)	2006 - 2007 (%)
Risks	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	2	0	1
Caravan/Campervan	0	0	6	0	0	0	0	0	0	0	0	0	3	0	0	0	9	0.4	0
Consumer Credit	0	0	8	0	0	0	0	0	0	0	0	0	0	0	1	0	9	0.4	1
Home Buildings	5	1	476	1	5	0	11	0	7	38	0	2	54	1	3	0	604	28	21
Home Contents	0	0	148	1	8	0	2	1	5	24	0	0	31	0	1	0	221	10	12
Marine-Pleasurecraft	0	1	9	1	0	0	0	0	1	0	0	0	0	0	0	0	12	0.6	1
Medical Indemnity	2	0	2	0	0	0	0	0	0	0	0	2	0	0	0	0	6	0	0
Motor Vehicle	5	9	324	4	101	1	59	0	82	8	0	8	88	2	12	0	703	32	35
Motor Vehicle TP	0	0	2	0	0	0	0	0	0	0	0	0	3	0	1	35	41	2	2
Other	0	0	8	0	0	0	0	0	0	0	0	2	1	0	0	0	11	0.5	0
Personal Accident/Sickness	0	1	75	0	0	0	1	0	2	2	0	0	1	2	0	0	84	4	4
Small Business	1	1	62	0	0	0	1	0	1	4	0	0	11	0	0	0	81	4	3
Strata Title	0	0	25	0	0	1	0	0	0	0	0	0	1	0	0	0	27	1	2
Travel	0	0	335	3	4	0	4	0	0	3	1	1	7	0	2	0	360	16.5	18
TOTAL:	13	13	1,481	10	119	2	78	1	98	79	1	15	200	5	20	35	2,170	100	100
Percentage:	1%	1%	68%	0%	5%	0%	4%	0%	5%	4%	0%	1%	9%	0%	1%	2%	100%		

Table 4: Value of disputes

Value range	No. of disputes	Average value
No Value	273	$0.00
1 to 3,000	716	$ 1,450.04
3,001 to 5,000	251	$ 4,173.58
5,001 to 10,000	329	$ 7,591.32
10,001 to 15,000	161	$ 12,668.88
15,001 to 20,000	119	$ 18,069.27
20,001 to 25,000	70	$ 23,072.26
25,001 to 30,000	55	$ 28,291.73
30,001 to 35,000	32	$ 33,304.03
35,001 to 40,000	25	$ 38,386.22
40,001 to 45,000	10	$ 43,032.31
45,001 to 50,000	22	$ 48,829.74
50,001 to 100,000	55	$ 68,348.79
100,001 to 120,000	6	$ 113,403.01
120,001 to 150,000	13	$ 140,570.75
150,001 to 200,000	15	$ 171,272.39
200,001 to 250,000	8	$ 225,238.13
250,001 to 290,000	6	$ 279,166.67
290,001 to 500,000	3	$ 418,000.00
500,001 +	1	$ 550,000.00
TOTAL	2,170	

Table 5: Summary of outcomes by policy type

	In favour of applicant		In favour of member		Settled		Rejected		Withdrawn by applicant		Supp det. cases		Total
All Risks	0	0%	1	50%	0	0%	1	50%	0	0%	0	0%	2
Caravan/Campervan	2	33%	4	66%	0	0%	0	0%	0	0%	0	0%	6
Consumer Credit	1	9%	8	72%	2	18%	0	0%	0	0%	0	0%	11
Home Buildings	140	26%	324	60%	68	12%	2	0%	0	0%	4	0%	538
HomeContents	40	18%	138	65%	29	13%	3	1%	1	0%	0	0%	211
Marine-Pleasurecraft	2	16%	8	66%	2	16%	0	0%	0	0%	0	0%	12
Medical Indemnity	1	50%	1	50%	0	0%	0	0%	0	0%	0	0%	2
Motor Vehicle	192	28%	379	55%	93	13%	17	2%	2	0%	0	0%	683
Motor Vehicle TP	14	36%	20	52%	4	10%	0	0%	0	0%	0	0%	38
Other	3	20%	9	60%	3	20%	0	0%	0	0%	0	0%	15
Personal Accident/Sickness	32	41%	30	38%	15	19%	0	0%	0	0%	0	0%	77
Small Business	24	34%	39	55%	6	8%	0	0%	0	0%	1	1%	70
Strata Title	7	35%	8	40%	5	25%	0	0%	0	0%	0	0%	20
Travel	77	21%	217	61%	57	16%	2	0%	0	0%	0	0%	353
TOTAL	535	26%	1,186	58%	284	13%	25	1%	3	0%	5	0%	2,038

Table 6: Total referral outcomes July 2005 - June 2008

	Determined								Other resolutions				
	Applicant favour		Member favour		Unsuitable for resolution		Total		Settled		Withdrawn		Completed
July 2005 - June 2006	500	24.4%	1,204	58.7%	78	3.8%	1,782	86.9%	252	12.3%	17	0.8%	2,051
July 2006 - June 2007	466	25.7%	1,026	56.6%	98	5.4%	1,590	87.7%	220	12.1%	3	0.2%	1,813
July 2007 - June 2008	540	26.3%	1,184	58.3%	26	1.2%	1,750	85.9%	285	14.0%	3	0.1%	2,038
TOTALS/AVERAGE	1,506	25.5%	3,414	57.9%	202	3.5%	5,122	86.8%	757	12.8%	23	0.4%	5,902

Table 7: Referee outcomes July 2005 - June 2008

	Determined						Other resolutions				
	Applicant favour		Member favour		Unsuitable for resolution		Settled		Withdrawn		Completed
July 2005 - June 2006	43	37.4%	16	13.9%	56	48.7%	0	0.0%	0	0.0%	115
July 2006 - June 2007	50	39.1%	6	4.7%	71	55.5%	0	0.0%	1	0.8%	128
July 2007 - June 2008	35	38.0%	44	48.0%	12	13.0%	0	0.0%	0	0.0%	91
TOTALS/AVERAGE	128	38.3%	66	19.7%	139	41.6%	0	0.0%	1	0.0%	334

Table 8: Adjudicator outcomes July 2005 - June 2008

	Determined						Other resolutions				
	Applicant favour		Member favour		Unsuitable for resolution		Settled		Withdrawn		Completed
July 2005 - June 2006	197	21.7%	701	77.4%	8	0.9%	0	0.0%	0	0.0%	906
July 2006 - June 2007	159	20.9%	598	78.5%	4	0.5%	1	0.1%	0	0.0%	762
July 2007 - June 2008	227	25.4%	662	74.1%	2	0.0%	2	0.0%	0	0.0%	893
TOTALS/AVERAGE	583	22.7%	1,961	76.6%	14	0.5%	3	0.0%	0	0.0%	2,561

Table 9: Panel outcomes July 2005 - June 2008

	Determined						Other resolutions				
	Applicant favour		Member favour		Unsuitable for resolution		Settled		Withdrawn		Completed
July 2005 - June 2006	260	34.0%	487	63.7%	13	1.7%	5	0.7%	0	0.0%	765
July 2006 - June 2007	250	36.0%	419	60.3%	22	3.2%	4	0.6%	0	0.0%	695
July 2007 - June 2008	269	35.4%	477	62.8%	11	1.4%	2	0.0%	0	0.0%	759
TOTALS/AVERAGE	779	35.0%	1,383	62.3%	46	2.0%	11	0.5%	0	0.0%	2,219

Table 10: Analysis of complaints resolution times July 2004 - June 2008

Adjudicator	1-30 days	31-60 days	61-90 days	91-120 days	120 days+	
July 2004 - June 2005	1%	2%	31%	50%	0%	
July 2005 - June 2006	1%	17%	65%	83%	17%	
July 2006 - June 2007	0%	12%	79%	97%	3%	
July 2007 - June 2008	0%	7%	67%	21%	5%	

Referee	1-30 days	31-60 days	61-90 days	91-120 days	120 days+	
July 2004 - June 2005	1%	2%	31%	50%	0%	
July 2005 - June 2006	8%	11%	20%	56%	44%	
July 2006 - June 2007	0%	0%	13%	52%	48%	
July 2007 - June 2008	1%	0%	13%	37%	48%	

Panel	1-30 days	31-60 days	61-90 days	91-120 days	120 days+	
July 2004 - June 2005	1%	2%	31%	50%	0%	
July 2005 - June 2006	7%	20%	54%	75%	26%	
July 2006 - June 2007	0%	4%	53%	83%	17%	
July 2007 - June 2008	0%	4%	47%	30%	17%	

Total	1-30 days	31-60 days	61-90 days	91-120 days	120 days+	
July 2004 - June 2005	1%	2%	31%	50%	0%	
July 2005 - June 2006	7%	19%	52%	73%	27%	
July 2006 - June 2007	0%	8%	62%	87%	13%	
July 2007 - June 2008	0%	5%	55%	26%	12%	100%

* There were an additional 284 matters settled without the need for determination.

Table 11: Summary of Insurers' Annual Returns 2007[1]

Insurer	Total Policies	Total Claims	% Claims to Policies	Number of Disputes	% IDR Disputes to Claims	Number of Referrals to IOS	% IDR Disputes Referred to IOS	In Favour of Consumer	% IOS Referrals in Consumer Favour
IAL (NRMA, SGIC, SGIO)	4,060,410	427,460	10.5%	5,454	1.3%	234	4.3%	55	23.5%
AAMI	3,900,234	390,744	10.0%	1,502	0.4%	255	17.0%	59	23.1%
ALLIANZ **	3,704,846	256,289	6.9%	1,708	0.7%	200	11.7%	51	25.5%
QBE (TRAVEL, WESTERN QBE)	2,050,656	223,128	10.9%	734	0.3%	110	15.0%	28	25.5%
GIO	1,839,324	206,987	11.3%	1,380	0.7%	224	16.2%	59	26.3%
AAI	1,679,207	156,590	9.3%	522	0.3%	76	14.6%	28	36.8%
IMA (RACV)	1,578,361	144,345	9.1%	2,051	1.4%	72	3.5%	19	26.4%
CGU	1,528,527	303,056	19.8%	541	0.2%	98	18.1%	21	21.4%
SUNCORP	1,499,610	204,643	13.6%	932	0.5%	114	12.2%	25	21.9%
VERO	1,229,933	89,078	7.2%	636	0.7%	100	15.7%	17	17.0%
RACQI	1,099,130	105,858	9.6%	269	0.3%	77	28.6%	20	26.0%
WESTPAC	902,613	32,697	3.6%	136	0.4%	24	17.6%	2	8.3%
COMMONWEALTH	817,400	55,131	6.7%	536	1.0%	87	16.2%	28	32.2%
RAC	663,141	91,674	13.8%	97	0.1%	9	9.3%	3	33.3%
WESFARMERS	491,452	29,352	6.0%	23	0.1%	3	13.0%	2	66.7%
AMERICAN HOME*	406,575	85,024	20.9%	276	0.3%	73	26.4%	19	26.0%
RAA	394,427	32,179	8.2%	93	0.3%	22	23.7%	6	27.3%
ELDERS	353,901	38,627	10.9%	208	0.5%	58	27.9%	29	50.0%
AUTO & GENERAL	347,481	32,564	9.4%	224	0.7%	39	17.4%	8	20.5%
SWANN INSURANCE	328,273	31,334	9.5%	171	0.5%	15	8.8%	5	33.3%
COMBINED	269,554	24,729	9.2%	32	0.1%	11	34.4%	6	54.5%
HBF	262,071	36,576	14.0%	56	0.2%	7	12.5%	2	28.6%
CALLIDEN (AUST. UNITY, ARGIS)	243,905	11,974	4.9%	46	0.4%	17	37.0%	6	35.3%
CUMIS (CUNA Mutual)	215,739	20,656	9.6%	28	0.1%	9	32.1%	5	55.6%
RACT	210,990	21,282	10.1%	6	0.0%	2	33.3%	2	100.0%
ING	202,338	738	0.4%	6	0.8%	1	16.7%	0	0.0%
ANSVAR	128,919	9,863	7.7%	3	0.0%	3	100.0%	1	33.3%
LUMLEY*	100,470	17,077	17.0%	15	0.1%	13	86.7%	4	30.8%
MUTUAL COMMUNITY	96,006	12,790	13.3%	24	0.2%	6	25.0%	1	16.7%
LLOYD'S	91,858	10,127	11.0%	67	0.7%	15	22.4%	9	60.0%
GE (HALLMARK)	90,000	3,657	4.1%	16	0.4%	1	6.3%	1	100.0%
DEFENCE	82,993	10,814	13.0%	14	0.1%	2	14.3%	0	0.0%
TIO	71,348	7,478	10.5%	1	0.0%	0	0.0%	0	0.0%
ZURICH*(ASSOC MARINE)	51,764	20,888	40.4%	113	0.5%	33	29.2%	1	3.0%
AIOI	48,065	3,934	8.2%	10	0.3%	1	10.0%	1	100.0%
ST ANDREW'S	39,768	1,087	2.7%	11	1.0%	3	27.3%	0	0.0%
GUILD	34,468	4,429	12.8%	9	0.2%	0	0.0%	0	0.0%
MTA	30,150	593	2.0%	3	0.5%	0	0.0%	0	0.0%
VIRGINIA	29,714	6,443	21.7%	9	0.1%	3	33.3%	1	33.3%
CATHOLIC	26,380	1,523	5.8%	3	0.2%	1	33.3%	0	0.0%
FORTRON	23,651	2,623	11.1%	5	0.2%	0	0.0%	0	0.0%
CHUBB*	18,700	1,048	5.6%	1	0.1%	1	100.0%	0	0.0%
CREDICORP	13,382	213	1.6%	0	0.0%	0	0.0%	0	0.0%
TOKIO*	446	29	6.5%	1	3.4%	0	0.0%	0	0.0%
MITSUI-SUMITOMO	292	44	15.1%	1	2.3%	0	0.0%	0	0.0%
SOMPO	214	19	8.9%	0	0.0%	0	0.0%	0	0.0%
SUNDERLAND MARINE	203	35	17.2%	0	0.0%	0	0.0%	0	0.0%
NIPPONKOA	129	10	7.8%	0	0.0%	0	0.0%	0	0.0%
LIONHEART - IN RUNOFF						1		1	100.0%
ACE +						11		1	9.1%
HOLLARD +						12		5	41.7%
NTI***						1		0	0.0%
SPORTSCOVER +						2		2	100.0%
TOTAL	31,259,018	3,167,439	10.1%	17,973	0.6%	2,046	11.4%	533	26.1%
Medical Indemnity Insurers									
AVANT						2		1	50.0%
GRAND TOTAL							2048		534

* High claims incidence is due to product mix which include group policies for travel, group personal accident or motor fleet contacts ie one policy covering many persons or vehicles

** Figures include Club Marine and Mondial Assistance

*** NTI are unable to provide policy and claims details as their contracts are Trucks and fleets which may contain a directors car or utility but cannot be identified for statistical purposes

\+ Not Code members - no statistics provided

++ Statistics not provided

1 Please note these statistics are for personal lines contracts only

CONTACTING US

On 1 July 2008 IOS merged with the Banking and Financial Services Ombudsman and the Financial Industry Complaints Service to form the Financial Ombudsman Service, with the following contact details:

Telephone	1300 78 08 08
Fax	(03) 9613 6399
Web	www.fos.org.au
Email	info@fos.org.au
Mail	GPO Box 3, Melbourne Vic 3001