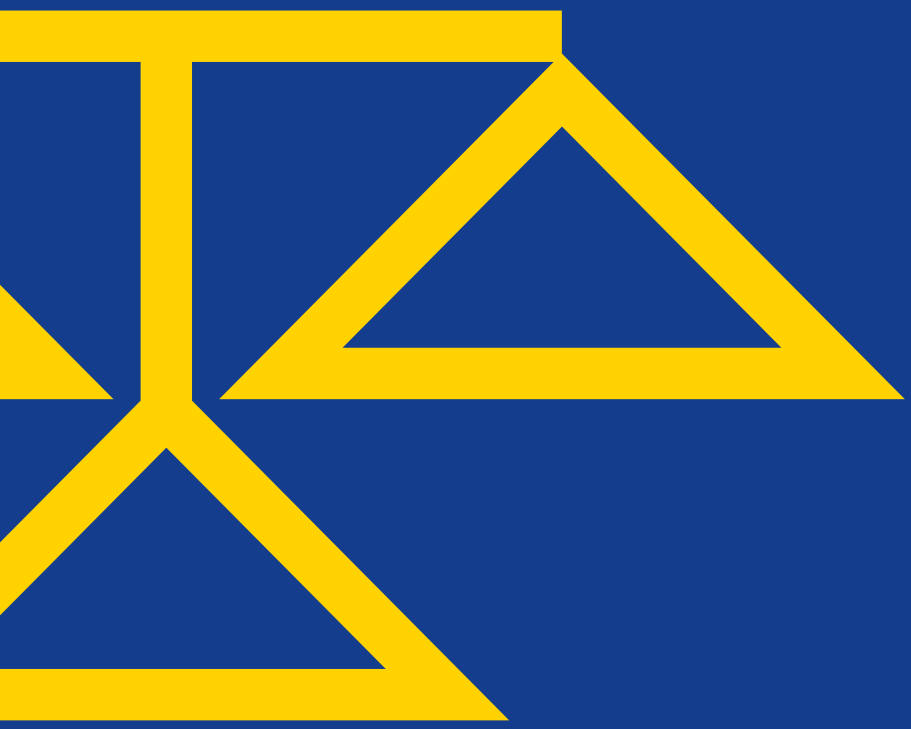
Annual Review **2005**

INSURANCE OMBUDSMAN SERVICE LIMITED



Annual Review

Pursuant to the Terms of Reference of the Insurance Ombudsman Service Limited the following is the Annual Review for the period ending June 30, 2005

On behalf of the IOS Board it is with pleasure I release this Review as a public document.

Peter E Daly, AM, Chair of the Board

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Chair's Foreword

The general insurance industry deserves congratulation for the continuing excellent results it has achieved in the past year, with a decline in the number of disputes referred to the Service.

As Chair of the Service, it's always my pleasure to note the progress that has been made year by year. Changes to the Insurance Ombudsman Service are made at irregular intervals to keep the Service in step with the needs of the industry and community, and we have travelled an enormously long way since the first tentative steps taken by the original General Insurance Claims Review Panel Scheme.

The highlight of the year was the Independent Review conducted by the Allen Consulting Group, which has given us much to discuss. The Review was commissioned to consider the accessibility, independence and effectiveness of the Service. I was very pleased with the outcome; it supported our view that IOS is in good technical shape, but could be even more effective with a relatively small number of achievable improvements.

The Review (which can be downloaded from the IOS website) has brought into sharper focus some areas that deserve greater consideration by the Ombudsman and his managerial team. These include such aspects as the way the Service is promoted to the community and new ways to increase access to the Service.

As the Service moves over the next year to implement the recommendations of the independent Review, it will also be adapting to the role of monitoring and helping to ensure the smooth implementation of the new General Insurance Code of Practice, which comes into force on 18 July 2006. Compliance with the old Code has been a significant role for the Service. The role under the new regime will be even more challenging.

The new Code of Practice embraces most classes of general insurance business, both personal lines and commercial lines, and participation will now extend to any organisation which provides an insurance service.

The industry's leaders – and particularly the Insurance Council of Australia (ICA) – deserve congratulations for devising a code which is more comprehensive than any other in the world. It is a fitting "world's first" that demonstrates yet again the Australian general insurance industry is maintaining its focus on consumer-focused initiatives.

Challenge is a constant in an organisation as flexible as IOS. Even as the recommendations flowing from the independent Review present us with new challenges, they also give us great satisfaction. The Review has not found anything fundamentally flawed in the way the Service is formed or in the way it goes about its role. Its recommendations are, for the most part, complementary to the direction in which the Service has been heading, and provide added encouragement that we are, indeed, steering in the right direction.

That "direction" is very important to the entire general insurance sector. Over the years the Service has provided invaluable support to the industry by identifying practices and potential systemic problems that require attention if they are to stay in alignment with changing community perceptions.

Each of the reports in this Annual review – from the Chair of the Panel and Referee in particular – show clearly just how valuable this Service is to its stakeholders.

The statement is often made that IOS is one of the few organisations which measures its success by the continuing downward trend of disputes handled. There is some truth in that comment, and this year's results continue that downward trend. IOS can indeed demonstrate remarkable success in a significantly lower number of disputes referred to it, and in the number of determinations that have been found against the insurer.

Chair's Foreword

Peter E Daly
Chair of the Board

There is little doubt that the determinations made by the Panel are increasingly complex and far-reaching. The reason for this is obvious: insurers now have in place sophisticated review systems that resolve internally all but the most complex and contentious disputes.

I would like to thank the members of the Board for their dedication and interest over the past year. Graeme Adams, Fiona Guthrie, Raymond Jones, Elizabeth Lanyon, Alan Mason and Denis Nelthorpe have provided wise counsel and clear focus throughout the year.

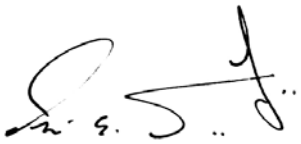
It would be difficult not to be impressed by the work of the Code Compliance Committee chaired by Michael Gill. He is very ably assisted by Robert Drummond and Denis Nelthorpe, with secretarial support provided by Rose-Marie Galea.

During the year the Insurance Council of Australia commissioned an independent review of the role of the General Insurance Information Privacy Code, which was conducted by Ms Wendy Machin. As a result, the Council decided to withdraw the Privacy Code, which had attracted only 23 industry signatories.

Throughout this unsettling period the Committee's Chair, Richard Viney, and Committee members Nigel Waters and Robert Drummond have maintained close liaison with the member companies, and I thank them for their dedication.

My thanks also to the Panel Chair, Peter Hardham, and his tireless team of decision-makers – Ron Beazley, the Adjudicator and Alternate Panel Chair and Alternate Referee; Alternates Matt Walsh and Richard Viney; and Panel members Brendan Pentony, Denis Trafford, Geoffrey Peacock and Brian Marshall. In particular thanks to John Price, our Referee, who has shown his mettle in his first full year in what has become a very important and central role. Their work lies at the very core of IOS, and the issues they tackle so willingly are not getting any less complex as time goes by. Their contribution to the Service's continuing success is gratefully acknowledged by the Board.

Lastly, my personal appreciation is extended to the Ombudsman, Sam Parrino, and his management team. They and their staff make a complex and demanding support role seem that much easier.



Peter E Daly, AM
Chair of the Board

About the Board

The Board is comprised of seven directors, an independent Chair (appointed by the Insurance Council of Australia), three industry representatives (one of whom is the Executive Director of ICA) and three consumer representatives (appointed by the Board).

The Chair is appointed for two years or any other period determined by ICA. Two industry directors are appointed at the annual general meetings of IOS Ltd; the incumbent Executive Director of ICA is a director. The three consumer directors are appointed for a period of two years and are eligible for reappointment. Directors may appoint alternate directors. Members are:

P E Daly, AM (Chair) Appointed a director of the Company 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. He 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 Ltd.

G Adams BE, MBA Appointed a director of the Company in March 2001 as an industry representative. He is the General Manager, Product & Underwriting of Insurance Manufacturers of Australia Pty Ltd. Graeme has over 20 years' experience in general insurance. He is a fellow of the Australian Institute of Company Directors. He has been a director of numerous IAG subsidiary companies and a director of an insurance company in Thailand.

F Guthrie BA (Psychology), MBA (Finance), Fellow AICD Appointed a director of the Company in August 2002 as a consumer representative. Fiona is the Deputy Chair of the Consumers' Federation of Australia, a member of the Commonwealth Consumers' Affairs Advisory Council and the Chair of the Centre for Credit and Consumer Law at Griffith University. She was recently the consumer representative on the Standards Australia committee that developed the corporate governance suite of standards. Fiona is also on the Board of Energex Retail Pty Ltd. In her work life she runs her own consultancy business, specialising in policy development, organisational evaluation and workshop facilitation.

R L Jones AFAMI Appointed a director of the Company in March 1998 as an industry representative. He is Managing Director of QBE Insurance (Australia) Limited. Raymond joined the insurance industry in 1984 as General Manager of Citicorp Insurance. He has a Marketing Diploma from the University of New South Wales and was a graduate of the Harvard Business School Advanced Management Program in 1998. He is President of the Australian Insurance Association, a director of the Insurance Council of Australia and Chairman of QBE Mercantile Mutual.

Dr E Lanyon LLM (Melb) 1986, LLB (Hons) (Melb) 1980, BA (Hons) (Melb) Appointed a director of the Company in November 2002. Dr Lanyon is currently a legal consultant to Mallesons Stephen Jacques Financial Services Group in Melbourne. She is an Honorary Associate Professor in the Law School at Monash University. In 2003 she was appointed to the Board of the International Consumer Law Association. Elizabeth is national Chair of the Law Council Financial Services Committee and co-author of the two major textson consumer credit law in Australia. She is also a frequent consultant to government on consumer credit matters.

A J Mason BA (Hons), FCII Appointed a director of the Company in January 1997. He is the Executive Director of the Insurance Council of Australia. He has over 30 years' insurance experience, mainly in Australia and also in the United Kingdom and South Africa. He is a director of Finsuper.

D Nelthorpe B Juris, LLB Appointed a director of the Company in March 1999 and is a member of the Code Compliance Committee of the Board. Denis is a former director of Energy Industry Ombudsman Ltd and currently a consulting lawyer working with a wide range of government, industry and community organisations. He is a past president of the Consumers' Federation of Australia. He was the past Chief Executive Officer of the Consumer Credit Legal Service from 1986-91 and the Consumer Law Centre Victoria from 1983-98.

Responsibilities of the Board

Overseeing and monitoring the activity of the Service and ensuring the independence of the dispute resolution process.

Effecting changes to the Terms of Reference following consultation with its members, ICA, ASIC and such consumer groups as the Board considers appropriate.

Appointing the Chair of the Panels, the Referee(s) and the Adjudicator.

Ensuring that the Panels, the Referee(s) and the Adjudicator adhere to the Terms of Reference, but in so doing the Board shall have no power to overturn any decision of those review bodies.

Analysing statistical information on the Service.

Analysing an Annual Review of the Service from the Chief Executive and making its own comments therein as appropriate.

Satisfying itself that the promotional programs/projects of the Service are adequately funded.

Commissioning an independent review of the Service's operations and procedures at least once every three years.

Consulting with ASIC about the terms of the independent review and the appointment of the independent reviewer.

Making the results of the independent review publicly available.

Ensuring that IOS has procedures in place for dealing with systemic issues and serious misconduct.

Consulting with ASIC in relation to changes to the IOS procedures for dealing with systemic issues and serious misconduct.

Ombudsman's Report

The Insurance Ombudsman Service continues to evolve in line with the needs of the industry and community it serves. In 13 years the Service has undergone two name changes, taken on new tasks and developed innovative solutions to contentious issues.

Throughout this period, the Service has always kept its focus on its major role: to provide a credible, efficient and independent source of review for insurance company customers. We have also acted as a critical sounding-board for the general insurance industry. The information and experience we have gained from working in external dispute resolution (EDR) – information that is made freely available – is a powerful tool.

The members of this Service take great pride in the fact that our work over the years has influenced the direction of claims and dispute resolution in general insurance. Suggestions that once seemed unlikely and perhaps even ridiculous are today commonplace industry wisdom.

Name change to Insurance Ombudsman Services

After 13 years operating firstly as the General Insurance Claims Review Panel Scheme and then as the General Insurance Enquiries and Complaints Scheme, the Service changed its name during the year to better identify the crucial role we play in the general insurance industry.

The name "Insurance Ombudsman Service" was adopted primarily to ensure the best possible level of community recognition. Research has shown wide public acceptance of the word "ombudsman" as providing a measure of justice to people who feel they have been treated unfairly. The name change has had little impact on the actual day-to-day running of the Service, but it does highlight some aspects that are not easily recognised.

First, the Insurance Ombudsman Service is not one person. While I have the honour to have the title bestowed upon my position as the former Chief Executive of the Service, the "ombudsman" is in fact everyone involved in the process of providing assistance to the public.

This is a wide group covering many specialised skills: the consumer consultants, the case managers, the management team, the administrative officers, the secretarial staff and especially the independent decision-makers.

The Insurance Ombudsman holds responsibility for the management of both the Insurance Ombudsman Service and the company IOS Limited, and is the official spokesperson for both organisations.

There is no change to titles or responsibilities of the decision-makers. The tripartite Panel will continue to focus on the more important and complex disputes referred for resolution and the roles of the Panel Chair, Referee and Adjudicator continue as before.

However, we accept that the word "ombudsman" focuses public expectation on the Service in a way that may not have previously been the case. The level of service expected of an independent industry-based ombudsman system also requires that we carefully examine the way that we work and the ways in which we relate to the community.

Through the transition to new approaches and attitudes, the Insurance Ombudsman Service has continued to emphasise adherence to the fundamentals of alternate dispute resolution – that is, "speedy, economical and equitable".

Similarly, the Terms of Reference and the requirements of the Australian Securities and Investments Commission's (ASIC) Policy Statement 139 (PS139) setting out the requirements of an external dispute system must also be considered when shaping the nature and focus of the Insurance Ombudsman Service.

The Service has forged its reputation both within and outside the general insurance industry on its adherence to the principles of what is "fair and reasonable in all the circumstances", as well as having regard to good insurance practice, the terms of the policy and established legal principle. These criteria continue to drive the dispute resolution function as exercised by the various independent decision-makers – the Panel, the Referee and the Adjudicator.

Ombudsman's Report

Sam Parrino
Insurance Ombudsman

Change is not only inevitable, it's desirable

The independent Review into the operations and performance of the Insurance Ombudsman Service, which was a requirement of ASIC Policy Statement 139, was completed during the year. The Review will help shape the future role and jurisdiction of the Service.

The independent Review is designed to ensure the Service continues to satisfy the requirements of PS139 and therefore retain its status as an approved external disputes resolution scheme for the general insurance industry. The independent reviewer, the Allen Consulting Group, attracted 21 submissions. Its report was presented to the IOS Board of Directors in October for its evaluation.

Not surprisingly, the Review found that individual parties' satisfaction with the Service correlated with the outcome of the dispute. Perceptions of inconsistency in determinations were, in the main, just that.

Such views appeared to the independent reviewer to be based on an incomplete understanding of the criteria that must be considered by the decision-maker, and of developments in the law.

However, despite these considerations, a great deal of positive material has been gathered from the independent Review. An implementation plan has been developed which will see a number of significant changes take place. This will include changes to the Service's jurisdiction as well as to its procedures.

Under the plan, the management of the Insurance Ombudsman Service has the task of implementing such changes as:

- Adopting a wider public profile and making more selective use of the media;
- Monitoring the use of the Service by various disadvantaged groups;
- Developing systems to improve tracking and analysis of the time taken to resolve disputes;
- Raising the monetary limit from $150,000 to $280,000 with the limit adjusted every three years;
- A quality review process to discuss and emphasise the educational and more significant aspects of a determination without altering the binding nature of the determination on the insurer involved.

Each of these changes requires considerable discussion and planning to ensure implementation is efficient, economical and widely supported by all stakeholders. New approaches are invariably more effective if they are planned carefully, and over the next year the Service will be communicating our new approaches. Some will be immediately obvious and others will be more subtle; but all will be implemented in a spirit of openness.

The new Code of Practice

The Insurance Ombudsman Service currently administers and monitors compliance with the General Insurance Code of Practice, which was introduced in 1995. During the past year the Code was extensively updated, with significant new features that will provide new challenges to the Service in its vital supporting role. I see this as part of our evolution, and it is pleasing to see increasing attention and resources being allocated to this important but less visible role.

The new Code is truly innovative in its coverage of the needs of both individual consumers and business customers, all of whom will benefit from the improved definitions of standards of service delivery. They will also benefit from the enhanced levels of information policyholders will receive when purchasing insurance, when making a claim and in their dealings with insurers and their representatives.

The use of the Code of Practice as a driver of industry change is to be applauded. However, by themselves they are of limited impact. An independent body armed with the task of monitoring compliance is essential to ensure that members of the Code are meeting the relevant standards and benchmarks. That is where the Insurance Ombudsman Service plays a valuable ancillary role.

One method employed by the Service to review compliance by each member on an annual basis is through the conduct of audits. This involves the inspection of files to ensure the requirements of the Code have been adhered to. Any instances of non-compliance are immediately brought to the attention of management and corrective action implemented. Instances of material breach of the Code or of an unsatisfactory response to identified non-compliance are referred to the Code Compliance Committee.

Ombudsman's Report

Once financial services providers affected by the new Code formally adopt it, the Insurance Ombudsman Service will review each provider to ensure compliance is both genuine and complete.

The community is entitled to expect greater openness in the way insurers and their representatives communicate with them, and to this end the new Code will prove to be an important development in the drive for greater transparency.

Data on insurer performance

As the political and regulatory landscape continues to evolve, so have the expectations of stakeholders. They have clear ideas of what the Insurance Ombudsman Service should be.

The issue of transparency and openness, highlighted under the Financial Services Reform Act, has application to individual companies' performance. It is firmly on the agenda of this organisation.

There are several reasons for this Service taking a deeper interest in this aspect of contemporary financial services oversight:

- The regulatory focus on disclosure and transparency is moving into the area of industry-based alternative dispute resolution (ADR) schemes.
- When a request for performance details about individual companies is denied, it draws the criticism of interested bodies such as the media, community support groups, the consumer movement and the regulator.
- Withholding such information contributes to a community perception that the industry has something to hide.
- Companies that perform well in a dispute should be able to publicise that fact.
- There is nothing new in reporting member performance. Other major industry-based alternative dispute resolution schemes already do this.

This Service believes that the publication of statistical data disclosing a member's results in a manner that does not create a false or misleading picture about the member's performance is highly desirable. It will also bring credit on the industry by providing a much greater level of openness.

The publication of statistics will commence from 1st January 2006. The extent and nature of the published reports will be reviewed after 12 months. At that point the Service will invite feedback from member companies and other interested parties. The data collected will remain the property of the Insurance Ombudsman Service and use by a member company or other organisations will require the permission of the Service.

As a former Insurance and Superannuation Commissioner, George Pooley, commented several years ago:

"The greater the degree of transparency and accountability in the industry, the less need there is for prescriptive and commercially intrusive regulatory rules."

In summary

The Insurance Ombudsman Service has had an unusual, but not extraordinary, 2006. The effectiveness of the Service is obvious to those who work alongside it, whether the interests represented are industry or community-based.

The external Review has given us a valuable insight into our work, and a keener sense of purpose to sharpen our communications activities and adopt a more responsive profile within the community.

We have invaluable functions to fulfill within the industry, and we will, as always, do all we can to help the community and the general insurance industry along the path to a strong, co-operative and positive relationship.

Sam Parrino
Insurance Ombudsman


The members of this Service take great pride in the fact that our work over the years has influenced the direction of claims and dispute resolution in general insurance.

Panel Chair's Report

This has been a year of contraries, or what the high-minded might describe as the tension of opposites.

Take for example, the significant drop in the number of disputes that have come to IOS. Many people, mainly within the industry, view this as a positive because it demonstrates, so the argument goes, the internal dispute resolution (IDR) system is working. On the other hand, representatives of the consumer movement highlight the statistic that only three out of 10 people whose claims are rejected at IDR take the dispute further. This, so the argument goes, is proof that policyholders are intimidated by the dispute resolution process and cannot see the advantage of going to an "industry-run" external dispute resolution scheme.

Of course, no-one will know the answer to that question unless the seven out of 10 are polled; and who is going to do that, unless the individual member companies co-operate in the process? Never ask a question unless you know the answer.

There are however indicators that might support the former view. My subjective observation is that a lot more care is taken by members in drafting the final letter of denial. Frequently detailed and well constructed reasons are provided to the policyholder, which may or may not persuade them to move on to something else. Secondly, there is a greater exchange of information, encouraged by IOS and of course the IDR process, which offers greater transparency in the decision-making process. Thirdly, more insurers have much more sophisticated internal dispute resolution processes than previously, when the claims officer might discuss the dispute with the claims superintendent over a quiet beer at the office watering hole. I would still like to know about the other seven, however.

In the meantime, the Panel has fewer disputes to determine, although 90% of the ones we do receive are complex or borderline, which is what we are here for.

On that subject, I would suggest the role of the Panel is continuing to evolve. We have the opportunity to offer advice to stakeholders on a variety of subjects and IOS is becoming, in my opinion, just as important as an educational institution as it is as a decision-making institution. After all, we are in a unique position in that we have considered thousands of disputes and have hopefully learned something on which we can offer some insight.

Many Panel decisions deal with more than the facts in dispute, as they also reveal flaws in the process of communication between the parties, and address wider concerns which I will be referring to in this report. This includes the role of the expert and difficult provisions of the Insurance Contracts Act and the manner in which the concept of utmost good faith should function in the claims process.

I fully support the educative role of IOS, which is embraced by many sections of the insurance community, particularly the Insurance Council of Australia, the Australian and New Zealand Institute of Insurance and Finance (ANZIIF), the consumer movement and the Australian Securities and Investments Commission. It is also ignored by a small minority who are convinced we are, at best, a necessary evil – or perhaps even that the word "necessary" is unnecessary.

I recently received a letter from one member's solicitor, who in complaining about his client being denied procedural fairness by IOS, then went on to state, without providing any material in support, that this was yet another example of IOS treating his member client unfairly.

I suppose you get out what you put in. I would suggest those members who avail themselves of what we have to offer might be more satisfied with what we do (or to at least put the necessary back in "necessary evil") than those who constantly challenge the advice we have to offer, which is offered to be helpful and perhaps save the industry the odd million or ten.

The Panel has had to make some difficult decisions in the review period, which I propose to outline.

Section 54, Insurance Contracts Act 1984

In Determination No 19025, the Panel was persuaded to reassess the manner in which it believed section 54 of the Insurance Contracts Act impacted on circumstances where a member was able to successfully establish it was entitled to deny the claim. The Panel's enquiries, aided

Peter Hardham
Chair, Claims Review Panel

by comprehensive legal submissions from both the applicant's solicitor and the member, established that, following a number of decisions of the New South Wales Court of Appeal and the High Court, it had been eventually made clear that irrespective as to whether a policy term was an insuring clause or a policy exclusion/limitation, once an insurer had established the policy did not cover the event giving rise to the claim the insurer still had to prove, where the event giving rise to the claim occurred after the policy was entered into, that it had suffered prejudice as described in sub-section (1) of the section; or alternatively, the event giving rise to the claim was capable of causing or contributing to the loss.

Several people have stated they do not understand how we could have come to that decision because neither the Panel nor the court can rewrite the policy, and the policy terms – particularly an insuring clause – are sacrosanct. However, it should be pointed out it is well established that many sections of the Act do permit a court, and unfortunately the Panel, to rewrite the insurance contract in certain circumstances (see sections 14, 35, 37, 46 and 47 of the Act).

In my opinion it is crucially important these matters are understood, particularly by the industry, because a very large sum may ultimately go in the direction in which it was not intended, that is, away from the pockets of shareholders if these issues are not addressed. The impact of section 54 can be minimised by the appropriate construction of policy terms, by understanding what is required to establish prejudice, and by accepting for better or worse the full implications of the legislation. In any event, it is worth repeating what the High Court said in a 2001 decision of *FAI Insurance v Australian Hospital Care*, in which three judges said:

"No distinction can be made, for the purposes of section 54, between provisions of a contract which define the scope of cover and those provisions which are conditions affecting an entitlement to claim."

One eminent judge stated that interpreting section 54 in the manner that has evolved with the High Court would in some instances produce "absurd" results. Whether this is a fair statement or not, the important lesson to be understood is that IOS decision-makers are obliged to apply the law and there have been several instances when we have done so that have produced unfair results both to consumers and members.

An insurer's obligations before denying a claim

In Determination No 20675, the fundamental issue for consideration was whether an insurer had complied with its obligations to act with utmost good faith towards its policyholder when, in the context of a consumer credit policy, it denied a claim for disablement benefits payable under the policy on the grounds the disablement arose from a pre-existing condition.

The relevant facts were as follows. The applicant took out a consumer credit policy with respect to payments he was obliged to make for a motor vehicle. He made a claim for benefits based on a condition which he described as reactive anxiety, stress and depression by way of a claim which reached the member on 29/30 January 2001. Approximately two days later, the member denied the claim and the applicant was admitted to a psychiatric institution following which the motor vehicle was repossessed and the applicant sustained what he said were substantial losses totalling approximately $20,000.

The Panel found the claim form indicated the applicant was claiming for a new illness notwithstanding some years previously suffering from a similar condition. The claim form was accompanied by a medical certificate from the applicant's doctor, who was asked if there were "any connection of prior illness with this particular illness", to which the doctor replied "not really – coped well. Was discharged from Navy" (which was when the earlier illness arose). In these circumstances, the Panel concluded with respect to the doctor's statements:

"In the Panel's opinion, this information should have removed any remaining doubt about the matter and persuaded a reasonably objective and diligent claims officer that the illness giving rise to the claim was a new illness. However, if contrary to expectation, the claims officer was unduly and perhaps unreasonably still unconvinced of these matters, at the very least the claims officer should have sought additional information from the doctor, or obtained his own medical counsel."

The Panel then went on to find the member unreasonably denied the claim and

"…failed in its obligations to act with utmost good faith towards the applicant, because it did not apply the principles of scrupulous fairness to the process referred to above (that being the basis of

Panel Chair's Report

utmost good faith) and by so doing, ought to have known of the distinct likelihood the vehicle may be repossessed".

The Panel also determined in that case the member pay the applicant's legal costs because it found the applicant required the assistance of a solicitor to present his case in what were very complex and difficult circumstances. In doing so, the Panel indicated it would be the exception rather than the rule to require a member to pay legal costs in a dispute dealt with by IOS; but it did so in this case, because in the Panel's opinion it was necessary for the applicant to obtain legal assistance to present his case. The determination in relation to legal costs was made in accordance with the provisions of clause 10.2(b)(vii) of the Terms of Reference.

Expert reports

This is one of those ongoing problems faced by both the courts and IOS decision-makers. At various times, the Panel has expressed considerable concerns about the methodology followed by doctors, engineers (of many descriptions), hydrologists (who may also be engineers), pharmacologists, forensic scientists, psychologists, rehabilitation experts, jewellers, valuers and last but by no means least, members of the legal profession (barristers and solicitors alike). How can the Panel purport to be so omnipotent? I shall confine my remarks to the subjects of alcohol and drugs.

Insurers are now much more democratic in allegations they make about their policyholders (and their friends) in their endeavours to achieve an altered state of consciousness before they engage in driving escapades. Driving in such a state is no longer the province of middle-aged, red-faced, overweight males. It now extends across the whole community to young sophisticated women, ladies of maturity, testosterone-charged bucks, and elderly gentlemen. However, we are all different shapes and sizes, and as the judges have repeatedly stated, alcohol and drugs affect our bodies in different ways.

Oh for the days when we all drank beer, and pretty much out of the same size glasses (standard or pots). Now we have imported boutique beers from Belgium, Holland, Italy, Indonesia, Malaysia and Mexico, some of which is light, some of which is heavy, some of which is in-between. Now we have the choice to take our mind-altering substances out of different sized glasses, stubbies, schooners, middies, pints, pots or cans. We have different sized bottles, cans, flasks, and (it would appear) it is now fashionable to carry flasks of brandy or rum in the glovebox for a nerve soother after the driver has run into a pole. You will of course note I have not even started on wines and champagnes and spirits. And the altered state of consciousness people now reach does not seem to help them recall how much they have actually had to drink.

Then, of course, there are the drugs, the marijuana, speed, ecstasy, benzodiazepines, cocaine and various mixtures thereof which are now receiving much more common usage, except in the case of red-faced, middle-aged, overweight males.

In Determination No 18587, the member relied on a pharmacologist's report to prove the applicant was under the influence of alcohol. The expert concluded as follows:

"He had been drinking fairly heavily many hours earlier and his BAC when the crash occurred was probably about 0.088g, his legal limit as a 'P' driver being 0.02g. His driving was most likely to have been impaired by the alcohol he had consumed and he would have been under the influence of alcohol at that time. Alcohol must be regarded as the likely contributor to the cause of the crash..."

The Panel ultimately rejected that opinion because the expert made a number of crucial assumptions without supporting evidence. Firstly, the expert assumed the applicant consumed four or five cans of Bourbon and Coke whereas there was no material to indicate whether they were glasses or cans. It was also assumed the applicant had been "drinking fairly heavily" the previous evening without stating why that assumption had been made.

Another assumption was that the breath test was taken 45 minutes after the accident, but nobody bothered to ask when it was actually taken. It was also opined the applicant was under the influence of alcohol whereas the uncontradicted evidence, apart from the breath test, was that he consumed four or five drinks in the period of six hours prior to the accident.

While the Panel had some doubts about the accuracy of that statement, no representative of the insurer had established the applicant had given

an inaccurate or untrue account of his alcohol consumption. Most importantly, no representative of the insurer had bothered to interview the police which, in the Panel's opinion, was a major omission.

Other problems we have experienced with expert reports are medical opinions where the doctor has not examined the applicant, legal opinions which lack balance, and reports from engineers who have not conducted adequate inspections of the relevant areas. In this regard, I remind all persons reading this report, the role of an expert is to express an independent opinion based on transparent reasoning, irrespective of whom, ultimately is paying for it.

Last year's Annual Review

It is of great encouragement to me to note many people not only read these reports but act upon them. For example, there has been a great deal of interest shown on the subject of illusory cover, which was the feature of the Panel report in the 2003 Annual Review. This is of course a subject which is under constant monitoring by the Panel and is again relevant to the issues explored in the Panel report in this Review. In 2004, the Panel expressed concerns on issues such as the unoccupancy provisions of a policy, landlord's insurance and wrongful and inappropriate cancellation of insurance policies. We have also raised awareness of difficulties in the marketing and interpretation of travel insurance policies. All these matters have been the subject of consideration by various members, ICA and other bodies.

I am pleased to state that many member companies are now specifically offering landlord's insurance rather than attempting to include it in home buildings insurance. Some insurers have clarified their definitions of "unoccupancy", and others are reviewing their procedures for policy cancellation. A group of travel insurers also met to consider issues raised by the Panel in our reviews and determinations.

I should also like to record the significant opportunities ICA and ANZIIF have given me to publicise my concerns in various forums which are, of course, offered for the benefit of all the stakeholders.

We are also dealing with the impact of changes to legislation particularly as a result of the Financial Services Reform Act, case law, and possibly further changes if amendments are made to the Insurance Contracts Act following the review of that legislation. I have no doubt other changes will ensue following the independent Review of the Service.

These are just some of the issues we have had to squarely face in the past 12 months, and demonstrate the multiple challenges which face the Panel. In dealing with these disputes we have been ably assisted by our loyal and multi-skilled case managers who firstly have to interpret the material they receive from the parties and separate the relevant, the irrelevant and the partially relevant. It is then their function to seek additional material where necessary and to prepare a draft determination for consideration by the Panel.

The Adjudicator and Alternate Panel Chair, Ron Beazley, also deserves a very special mention as the number of matters requiring his adjudication now exceed the disputes determined by the Panel. This means the tripartite system is now used in a minority cases which, in my opinion, is as it should be. However, it is interesting to reflect on why such a high percentage of disputes that come to IOS involve amounts of under $5,000.

I would also like to commend the valuable contribution made by the Referee, John Price, who, as well as dealing with all fraud-related disputes has acted as Alternate Adjudicator in order to manage the increasing workflow in this area. John has already made a significant positive impact on the IOS decision-making process.

I would also like to acknowledge the invaluable support I and the Panel receive from the Panel Secretaries and the IOS Secretariat, as it is a combined effort that goes to produce the determinations that are so important to the community and the stakeholders and involve on an annual basis, disputes totalling approximately $10 million.

Without contraries, there is no progression.

Peter Hardham,
Chair, Claims Review Panel

Privacy Compliance Committee Chair's Report

As previewed last year, the Insurance Council made arrangements in early 2005 for an independent review of the General Insurance Information Privacy Code (the Privacy Code) in accordance with Section 1.24 of the Privacy Code. Wendy Machin of Machin Consulting was appointed to conduct the review.

The Board of IOS received notification at its meeting on 16 September 2005 of the resolution of the Board of ICA to withdraw the Privacy Code. This followed the main recommendation made in the Machin Review of the Privacy Code. The Committee understands that ICA, in consultation with the Federal Privacy Commissioner, is preparing a transition plan designed to allow all 23 companies to make an orderly exit from the Privacy Code. It is unlikely that this matter will be resolved prior to 2006 and as a result, subscribing members will be informed of developments as they arise.

Complaints received

During the period 1 July 2004 to 30 June 2005 the Privacy Compliance Committee received seven complaints under the General Insurance Information Privacy Code (the Privacy Code) from individuals who were dissatisfied with the manner in which the relevant organisations handled their privacy complaints.

The complaints received during this period involved the following sections of the Privacy Code:

- General Insurance Information Privacy Principle 1.1: Collection: An organisation must not collect personal information unless this information is necessary for one or more of its functions or activities.
- General Insurance Information Privacy Principle 1.3: Collection: We will tell you who we are and what we intend to do with information about you.
- General Insurance Information Privacy Principle 2.1: Use or Disclosure: An organisation must only use or disclose personal information for the primary purpose for which it was collected.
- General Insurance Information Privacy Principle 6.1: Access and correction: If an organisation holds personal information about an individual, it must provide the individual with access to the information on request.

One complaint was resolved by way of a written determination issued by the Committee. Four complaints were resolved to the satisfaction of both parties without the need for a formal determination. The remaining two complaints were unresolved as at 30 June 2005 and remain outstanding. During the same period the Committee finalised two complaints carried over from the previous period by issuing written determinations.

Systemic issues

Several of the complaints considered by the Committee during the course of this period arose in relation to one organisation in particular. In the course of the Committee's investigation of these matters it was found that either the organisation and/or its authorised representative failed to recognise the individual's complaint as a privacy complaint.

This meant that the organisation did not inform the individual concerned about the availability of its internal privacy complaints procedure. The organisation recognised the failure to advise individuals about its internal privacy complaint procedure as a training issue and has taken a number of steps to address this matter as follows:

- All staff underwent refresher training in privacy awareness, including in relation to the Privacy Code and the organisation's complaints handling procedure;
- Product disclosure statements and policy wordings were reviewed to ensure that the required information about the complaint handling procedure was being provided;
- Development of a process by which beneficiaries (as opposed to the insured) under a policy may be provided with information about the complaint handling procedure;
- Working to develop a more effective way of highlighting the need to identify and correctly deal with privacy complaints that arise during the claims handling process.

Privacy Compliance Committee Chair's Report

Richard Viney
Chair Privacy Compliance Committee

Compliance reviews

During this period all organisations reviewed this year demonstrated compliance with the Privacy Code.

Number of subscribing organisations

During November 2004 RACT Insurance Pty Ltd withdrew from the Privacy Code. This means that there are 23 companies currently subject to the Privacy Code. A list of the subscribers can be viewed on the IOS web site at www.insuranceombudsman.com.au.

Internal complaint handling by subscribing organisations

Under the Privacy Code, each subscribing organisation is required to provide statistics to IOS of complaints dealt with by its internal privacy complaints handling procedure. The attached table has been prepared by aggregating the statistics forwarded by individual organisations.

Results of organisations' internal privacy complaints handling procedure for the period 1 July 2004 to 30 June 2005

Privacy Principles	Brought Forward	Number of Complaints	Settled for Consumer	Settled for Insurer	Outstanding
1. Collection	1	2	0	2	0
2. Use and Disclosure	5	13	6	6	1
3. Data Quality	0	5	4	1	0
4. Data Security	1	10	9	1	0
5. Openness	2	0	0	0	0
6. Access and Correction	1	7	1	0	6
7. Identifiers	0	0	0	0	0
8. Anonymity	0	0	0	0	0
9. Transborder flows	0	0	0	0	0
10. Sensitive Information	0	0	0	0	0
11. Other Code complaints	0	0	0	0	0
Total for all Classes	10	37	20	10	7

Procedures to ensure that the Service is accessible to complainants

Each staff member of the Insurance Ombudsman Service has been trained in the Privacy Code. Each IOS staff member who may be required to handle a privacy enquiry/complaint is required to record details of such enquiry/complaint. This is lodged with the Committee and Secretariat for further action.

In the event of a privacy complaint, directions are given to the individual to refer the matter to the organisation's internal privacy complaint procedure before it will be investigated by the Committee. Those individuals making enquiries/complaints which do not fall within the Privacy Code will be advised to refer these matters to the Privacy Commissioner.

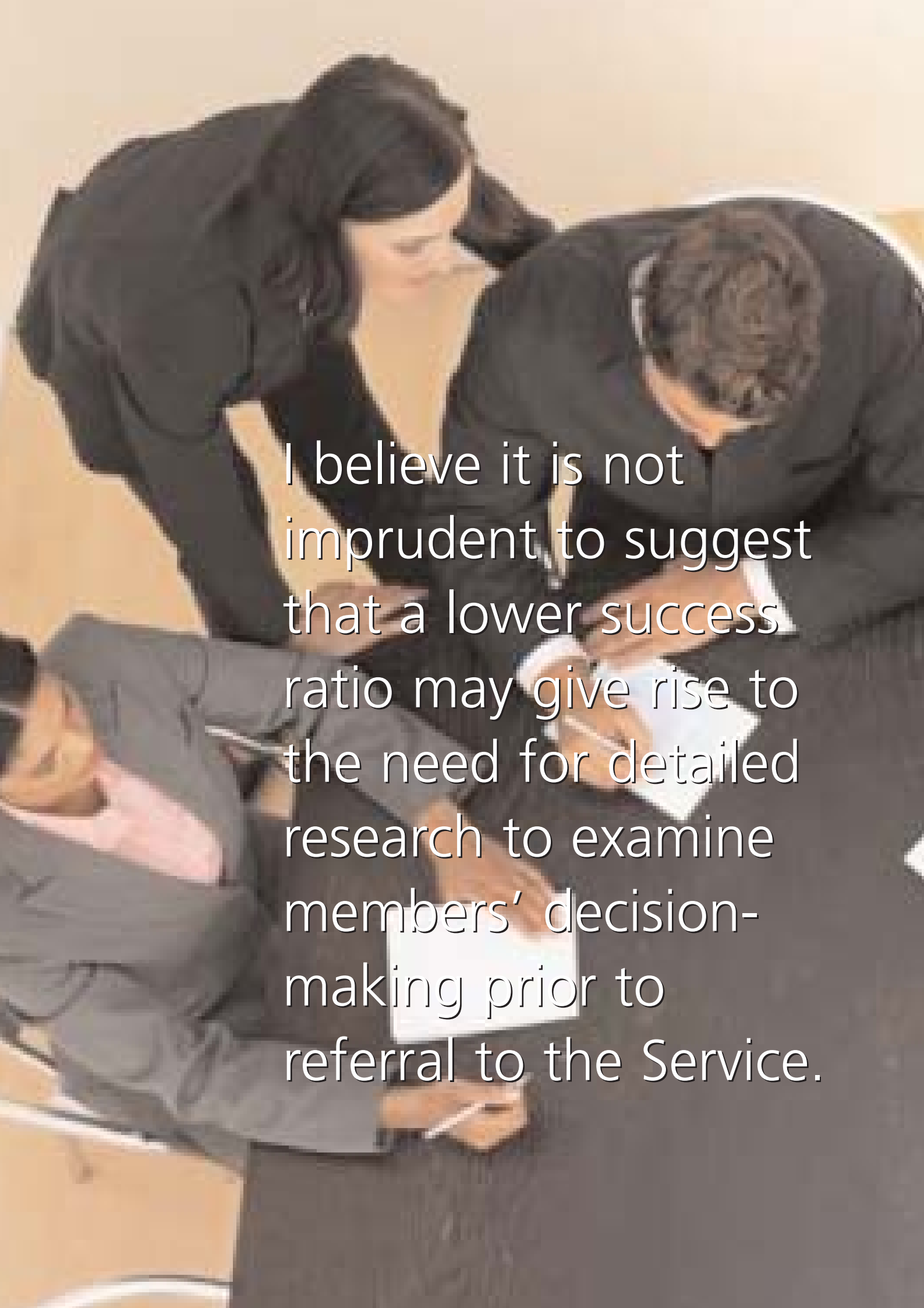
Written enquiries/complaints, which are of a non-Privacy Code nature, will be considered by IOS, which will seek the individual's agreement to refer the matter to the Federal Privacy Commissioner.

In the event of an enquiry/complaint falling within the ambit of the Privacy Code the Secretariat will explain to the individual the Committee's procedures and assist the individual to prepare the complaint in written form addressing the required minimum information.

The Secretariat will acknowledge receipt of the claim in writing and keep the complainant advised of the progress of the Committee in the matter.

The Committee wishes to acknowledge the willing assistance provided to it by the Secretariat.

Richard Viney
Chair, Privacy Compliance Committee



I believe it is not imprudent to suggest that a lower success ratio may give rise to the need for detailed research to examine members' decision-making prior to referral to the Service.

Adjudicator's Report

Ron Beazley
Adjudicator

It is my practice in September of each year to peruse statistical information in respect of the 12 month period ended 30 June. I do not examine or consider such information at any other time during the relevant 12 month period. Usually, I compare the information of the previous 12 month period.

For the period ended 30 June 2005 670 matters were determined with the Adjudicator's jurisdiction. Approximately 17.5% were resolved at Case Manager level and less than 2% were withdrawn or determined to be unsuitable for resolution.

During the previous 12 month period a very similar percentage of cases were withdrawn or otherwise resolved. In 2004-05 548 matters were determined by the Adjudicator, compared with 469 determinations for the previous year. I refer to the relevant tables on page 40.

Three significant facts emerge from the statistics.

First, there is a remarkable consistency each year respectively in the percentage that are determined by the Adjudicator or settled or withdrawn.

Secondly, there is an increase in the total numbers of Adjudicator determinations to 30 June 2005 that reflects the increase in the Adjudicator's jurisdiction to the sum of $5,000.

Thirdly, and I think most significantly, there is close conformity each year in the percentage of determinations in favour of the member (approximately 60%) and in favour of the applicant (approximately 20%).

In dealing with raw numbers it is not appropriate to do more than speculate as to why the determinations favour members by a ratio of 3:1. Having said that, one would expect the members should have expertise in preparing submissions and in decision-making that should produce at least a 3:1 success rate.

I believe it is not imprudent to suggest that a lower success ratio may give rise to the need for detailed research to examine members' decision-making prior to referral to the Service. This is a matter that in my opinion is highly relevant to the member's reputational risk.

I do not examine, nor do I consider it would be appropriate to examine, statistics in respect of individual members' success rates. But I am happy to throw down the gauntlet to members to analyse carefully their success rates against the 3:1 ratio and to monitor future decisions using that ratio as a benchmark.

Ron Beazley
Adjudicator

Referee's Report

Having joined the Insurance Ombudsman Service as Referee in August 2004, after spending over 26 years as a litigator and partner of Maurice Blackburn Cashman, it has certainly been a bit of a culture shock, but an enjoyable one.

I cannot help but be impressed by the professionalism shown by all members of the IOS team, in particular the Case Managers in their preparation and presentation of material. Their contribution to the success and efficiency of IOS cannot be under-estimated. I am also very grateful for the support of the Chairman, Peter Daly, the Ombudsman, Sam Parrino, the Panel Chair, Peter Hardham, and alternate Referees, Ron Beazley and Dick Viney. It has been most appreciated.

Since commencing as Referee, I have had to adjust from spending a lifetime as a plaintiff's advocate in the adversarial system to that of an independent, impartial decision-maker. While I would be lying to say that at times I have been tempted to adopt the role of advocate during some oral examinations, I have found the change not as difficult as I first anticipated.

As this is my first report as Referee, it is appropriate that I give you an insight into how I see the role and the issues that arise.

Referee's procedures

The Terms of Reference envisage that the Referee will function as informally as possible and with the minimum of legal form and technicality. It is an inquisitorial process rather than adversarial. In my short time as Referee, I have read many submissions by insurers arguing that the procedures of the Referee are not appropriate to deal with a matter where fraud is alleged. The argument runs along the line that where an allegation of fraud is made, they should have the opportunity to test the evidence by way of an adversarial process and cross-examination.

Such submissions in my view fail to understand either the purpose of an alternate dispute resolution process, the function of the Referee or the efficiency of an inquisitorial process as opposed to the complex and expensive nature of a court-based adversarial system. Fundamental to the success of IOS is the requirement for full exchange of material relied upon by either party to the dispute.

While some may argue this gives the other party an opportunity to tailor the evidence to the allegations made, it allows all parties an opportunity to understand the basis of an allegation made. The full exchange of material is an increasingly important part of legal process throughout the country. In legislation, such as the Accident Compensation Act in Victoria, it is enshrined as part of the pre litigation process and has proved very successful in the resolution of matters, without the need for litigation.

In my mind, the early exchange of material is a very important factor in leading to the early resolution of disputes. The flow-on is a significant saving in terms of legal cost to all parties concerned. I am pleased to say, from my experience so far, the majority of insurers have embraced this process although the quality of the material exchanged does vary greatly. Many consumers however do not fully understand the process and are disadvantaged by the lack of material supplied to support their claim.

While most members have been educated as to the process, I feel we could do more to educate consumers as to our procedures and processes to help level the playing field.

Referee's Report

John Price
Referee

Oral examination

As I grow into the Referee's role, the importance of an oral examination conducted openly and informally becomes more and more obvious. Ron Beazley commented on the oral examination process in his Referee's Report in 2004. I fully endorse his comments. The oral examination gives the parties to the dispute the opportunity to explain their position, clarify uncertainties, and understand the evidence that has been presented and allegations made.

Wherever possible, I encourage participation of all parties to the dispute in the oral examination process. Prior to the oral examination, I thoroughly examine the material exchanged. I like to use the oral examination process as an opportunity to enquire of the insurer as to the basis of their submission, clarify anomalies in the presentation of their material or comment on what I see as unsubstantiated allegations. This affords the insurer an opportunity to explain their position and if I have misinterpreted the material to persuade me otherwise. I hope that insurers benefit from this process by way of improved internal decision and policy-making in future.

The consumer is given the opportunity to understand the allegations made and the evidence relied upon, present their response and through questioning, explain inconsistencies that may appear in statements. Issues dealing with opportunity, motive and credibility can be discussed and explained. The informal nature of the oral examination is a wonderful tool.

Wherever possible, the insurer's representative attending the oral examination should have a full understanding of the material relied upon. Without fully understanding the material, their position is compromised and contribution to the oral examination significantly reduced. I am pleased to say, in most instances, the insurers' representatives have been very well prepared and extremely co-operative.

In certain circumstances, and in accordance with the Terms of Reference, an insured may request that an insurer not be present or an insurer may elect not to attend an oral examination. The absence of either party to a dispute, in my view, compromises the effectiveness of the oral examination. I endorse the approach adopted by previous Referees and support the position that both parties should attend the Referee's oral examination. Attendance embraces the more human side of the process and affords the opportunity to understand the views expressed by the other parties.

While it is only natural there will be a degree of animosity exhibited by an aggrieved party in a dispute, I am pleased to say at this stage, everyone has been on their best behavior during all oral examinations.

If an insured has requested the member not be present, it is my practice, if there are issues I require clarified, to contact the insurer prior to the oral examination. The insurer is invited to forward particulars of any issues or questions they wish me to put to the insured. This is a valuable opportunity for an insurer to highlight the major areas of their argument.

It is my process to notify the insured at the oral examination, in the event that the insurer is not present, that I will be informing the insurer of the particulars of the oral examination and information obtained. This is explained as being important to the process of procedural fairness. The Referee is obliged to bring to the attention of non-attending parties new information that is provided or elicited at the interview to enable the other party to rebut or respond to that material. The necessity to do this inevitably leads to a delay in the decision-making process.

Some insurers routinely elect not to attend the oral examination, in some instances without informing IOS of their decision. I strongly encourage them to re-think their position and embrace the oral examination process.

The onus of proof

There often appears confusion in the eyes of the insured and insurer as to who has the onus of proof in a fraud matter and no doubt, at times, the line can appear quite blurred.

Simply stated, the initial onus is on the applicant (insured) to prove on the balance of probabilities that the event/loss occurred comes within the terms of the policy and to establish a prima facie claim.

Once the insured has established a prima facie claim, then the onus

Referee's Report

shifts to the insurer who must establish that there are reasonable grounds to have the view that:

Clause 9.4

" (a) A claim may be fraudulent; or
(b) On the inception of or renewal of the insurance a fraudulent misrepresentation or non-disclosure was made to the member…"

In my determinations, I refer to a case of *Hammoud Brothers Pty Ltd v Insurance Australia Ltd*. I find the case offers a clear explanation of the process that occurs when considering a fraud matter. I recommend, to those interested, that they take the opportunity of reading this case.

It is important that where such serious allegation of fraud is made that the insurer satisfy me on the balance of probabilities, but bearing in mind the Briginshaw test, that they have reasonable grounds to form the view that the claim may be fraudulent. In the event of fraudulent non-disclosure/misrepresentation then the insurer must show that there was a fraudulent misrepresentation or non-disclosure.

Ron Beazley in his report of 2004, referred to the words of the High Court in *Neat Holdings Pty Ltd v Carajan Holdings Pty Ltd* and in particular reference to Briginshaw standard:

"… should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a Court should not likely make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct".

As I have said frequently in the course of oral examinations, and when discussing the issue of onus of proof with insurers, I adopt the view that fundamentally, most persons are law abiding and honest. To do otherwise would be a failure to apply established legal principles. As such, evidence that is inexact, unsubstantiated or speculative will not meet the required standard.

While I appreciate in most instances of fraud it is rare there is direct evidence of fraud, the presentation of the evidence to me needs to be well considered and persuasive. Justice Dixon in *Morrison and Anor v Jenkins and Anor* said:

"With claims of circumstantial evidence the chances of error in the conclusion arise first from the chances of error in each fact or consideration forming the steps and second from the chance of error in reasoning to the conclusion from the whole of those facts and considerations. It is therefore wrong to take each fact or consideration separately, to assess the possibilities of error in finding it is established and then if you think it should be found afterwards to treat it as a certainty and pass to the next fact or consideration and so on to the conclusion. The possibilities of error at all points must be combined and assessed together. "

They are powerful words when considering the approach to be taken by a Referee in considering an allegation of fraud. With this in mind, I thought I would briefly highlight a number of issues:

Material Exchange

Insurers are still presenting submissions where there is a substantial lack of documentation to support the allegations made.

Recently in a matter involving an allegation of fraudulent non-disclosure, the insurer presented a submission based entirely on an investigator's report, a driving history and a policy renewal document. The allegations concerned non-disclosure at inception of the policy some five years prior to the renewal and on each renewal of the policy after that time. No material to support the allegation of non-disclosure on inception of the policy was supplied. There was no copy of the original application or any documents. In the oral examination (the insurer elected not to attend), it became apparent that policy inception was 11 years prior to the loss and not five years as alleged. The insured maintained that at no stage had he been asked the questions claimed by the insurer.

The insurer was invited to provide a copy of the original application and subsequent renewals while the insured was asked to supply copies of any documents held by him. The insurer conceded that the policy had in fact been incepted 11 years prior to the event and advised that they could not produce any record relating to the alleged non-disclosure at inception. They continued however to maintain their arguments that there was a failure to disclose relevant driving history at inception and on renewal of the policy. The insured produced a renewal document for the years 2000 to 2001, two years prior to the loss. That document did not contain any of the questions alleged by the insurer to have been asked on renewal.

Further, in this particular matter, the renewal document forwarded to the insured in 2003 was in fact a new contract of insurance with the insurer having taken over the policy from a prior insurer as part of a portfolio transfer. As a new policy, the insurer was obliged to comply with the provisions of Section 21A of the Insurance Contracts Act. No evidence was produced to show they had complied with Section 21A. The insurer was not successful in that matter. It was a dispute which I believe would not have come before the Referee if the insurer had looked closely at what evidence it actually had and what it could exchange.

Material that arises after the exchange of documentation

On occasions, either party to a dispute will not have all of its material to exchange when filing either the Notice of Referral or Notice of Response.

It is my practice not to exclude additional material being provided at or prior to the oral examination. Naturally I encourage all parties to exchange the material as early as possible as the late exchange of material will inevitably cause delays in the decision-making process. I will not allow a party to be ambushed by the late supply of material that was in existence and available at the time of referral or response. As a matter of procedural fairness, all parties are given the opportunity to respond to new material.

Occasionally, I will request further material or information be provided or in particular, where there are allegations of misrepresentation or non-disclosure, an explanation from the insurer of its procedures and processing, I have found insurers are very co-operative in this respect.

Once the oral hearing has been conducted and I have signed off on my determination, then under the Terms of Reference there is little opportunity to revisit the determination no matter how persuasive some new evidence may be.

This issue has been raised at meetings with industry representatives and in meetings between the decision-makers and is likely to be subject to further discussion. While an insured has the opportunity of presenting further material and seeking a further determination of a dispute in accordance with Clause 6.2(d) of the Terms of Reference, there does not appear to be the same facility open to the insurer. The insurer of course, where it has significant new evidence of fraud, may bring civil action against the applicant to recover monies paid.

In any decision-making process, there must be a sign-off date. It is fundamental to the success of any decision-making process, be it a court or an ADR. To allow determinations to be reopened some time after they are signed and distributed would be to compromise the process.

Hearsay

In many instances, I am asked to rely on statements attributed to persons by an investigator without either a signed statement from the person or a transcript of the statement of the person. In these cases, the evidence is hearsay and of little evidentiary worth. While it is not appropriate to apply strict rules of evidence in the decision-making process, it is important, given the seriousness of the allegation of fraud, that the insurer provides the best possible evidence to support its position. Wherever possible a party to a dispute who seeks to rely on statements attributed to other persons should obtain signed written statements or at the very least a transcript from a taped statement.

Referee's Report

Investigation reports

I read with interest the comments made by Ron Beazley in his report of 2004 on the issues of perceived bias of an investigator. Unfortunately there remains amongst some investigators adherence to *"a strongly adversary method of interviewing claimants and their witnesses"*. This approach does not assist the decision-making process.

I recently had cause to determine a matter in which the insurer relied, in part, on a breach of Section 13 of the Act, the duty of utmost good faith. The insured, on the face of it, was not fully co-operative. At the oral hearing, the insured advised that the investigator had made numerous accusations to him. The investigator had been extremely aggressive and according to the insured abusive towards him when providing his statement. Examination of the transcript showed the investigator making numerous accusations against the insured as to his honesty and integrity. The investigator accused the insured of having provided false information as to his employer, providing false names and details of witnesses and impersonating his employer when the investigator had telephoned. None of the accusations were substantiated in any way. To the contrary, the evidence pointed to the insured having provided accurate information. The interview appeared to be very acrimonious. The investigator's comments did not assist the process.

In another matter, the insureds were subjected to over eight hours of interview. The investigator, in reporting to the insurer, believed the claim might be fraudulent, due to inconsistencies in statements as to the use of keys to the vehicle. Close examination of the statements however, show that when the insureds had provided the keys to the investigator that supported their position, the investigator quickly moved on from that line of questioning. The investigator's approach and reasoning did not make any sense to me.

Fortunately, I can report, that in the majority of the reports I have read, the message from Ron Beazley's appears to have sunk in. I can only repeat Ron's message: *"The old adage 'drop the epithets and personal comments' will assist an investigator in the production of a measured and objective report."*

New policies, renewal and technology

My recollection from when I was young is that life was pretty simple. Initially there were only two TV channels to choose from. Football was played every Saturday on a home-and-away basis and a crystal radio set was very simple and effective means of listening to the cricket late at night when Australia played overseas. Later when I purchased my first car it was easy to find out where to put the oil, change the spark plugs and do your own maintenance. I could even crank-start it if necessary. Insurance was conducted in person. The application completed by hand and if you did not know anything you could ask the person sitting in front of you.

Today however, the demands of modern society, the wonderful advances of technology and communication have changed things. Cricket can be viewed from many angles on one of the 98 channels offered by pay TV with instant replay, freeze action, stump cam, etc. To look under the bonnet of a modern motor vehicle requires advance engineering and computer technology degrees and you can forget about doing virtually anything other than changing a flat tyre. The insurance industry has more than kept pace with the change and demands of society. Increasingly transactions are done over the telephone or the internet. The opportunity for personal contact is limited as the demands for efficiency, convenience, price, premium, competitiveness and profitability increase. With these developments, inevitably issues of misrepresentation and non-disclosure will arise. Without a paper trail questions as to admissible evidence involving allegations of misrepresentation/non-disclosure will also arise.

If you consider motor vehicle insurance and the myriad of different policies that are available and differing underwriting guidelines that apply, it is clear that the insurer must be vigilant in its efforts to fully inform an insured of specific disclosure requirements. The Panel recommendations with respect to Sections 21 and 21A may further complicate the requirements on the insurer.

With policy inception and renewal being via the telephone or the internet, it may be difficult to establish just what an insured person understood was to be disclosed.

Expert evidence

Over recent times, the courts have made considerable comment as to the use of expert evidence and independence of experts.

In matters that come before the Referee, the "expert evidence" is often central to the member's argument. While the requirements and presentation of expert evidence have been discussed in papers and determinations presented by previous Referees, recent matters that have come before me have given cause for concern about the presentation of expert evidence.

Courts have consistently warned as to the need for any decision-making body to be very careful in blindly accepting the views or opinions of "experts".

In the recent decision of *ASIC v Rich*, Justice Austin of the New South Wales Supreme Court, made the following comments as to the considerations going to the admissibility or discretionary exclusion of expert evidence:

(a) The evidence, if not admissible as evidence of fact, must be evidence expressing the expert's opinion;

(b) The person put forward as an expert, must possess specialised knowledge based on training, study or experience;

(c) The expert's opinion must be wholly or substantially based on his or her specialised knowledge;

(d) The expert's report must distinguish between the opinions and the facts on which they are based;

(e) The expert must set out his or her reasoning for each opinion expressed;

(f) Where it is pertinent to do so, the expert's report must set out the reasoning by which certain information was considered and rejected or discounted for the purpose of the report;

(g) The expert's opinion must not be wholly or substantially based on facts that can be proved only by inadmissible evidence;

(h) The expert's opinion and reasoning must be his or her own, and not simply the adoption of the work of someone else; and

(i) Although the expert need not be independent of the litigants, he or she must be in a position to exclude from consideration everything except the matter identified as the facts upon which his or her opinion are based.

While acknowledging the risk in placing emphasis on formal matters, Justice Austin noted that the fundamental question to be addressed is whether the trier of fact (decision-maker), has been supplied with criteria in enabling it to evaluate the validity of the expert's opinions. This is an appropriate approach to be adopted by any decision-making body.

The most glaring error in the presentation of expert evidence before the Referee is the failure to identify the expert's field of specialised knowledge or experience. The High Court in *HG v The Queen* noted that the expert's field must be sufficiently organised or recognised to be accepted as a reliable body of knowledge or experience.

In order for a decision-making body to be satisfied of the specialised knowledge of the "expert" it is necessary that the expert witness clearly identify the level of his or her expertise in a field of specialised knowledge or experience. As noted by Justice Austin in *ASIC v Rich*, this can be done in the body of the expert's report or an appendix to the report. The expert evidence must be confined to evidence, which is wholly or substantially based on the expert's specialised knowledge. Where the expert's reasoning is not dependant on his or her specialised knowledge and is a process that could have been undertaken by the decision-making body, without the expert's assistance, it is not admissible as expert opinion evidence.

In general, the expert opinion must be based on facts either proven by the expert or otherwise by admissible evidence. As Justice Austin noted in *ASIC v Rich*, if the expert fails to identify and articulate the assumed, accepted and observed facts upon which he or she proceeded, the Court may well be unable to identify those facts with consequences of several kinds. Firstly, it may be unable to comprehend the opinion so as to decide how much or what probative value to give to it. Secondly, it maybe unable to determine whether the facts assumed to be accepted by the experts correspond to the

Referee Report

facts provided or admitted at the hearing. Thirdly, in extreme cases, the consequence of failure to articulate the factual basis may even be inadmissibility for irrelevancy. He referred to the case of *Quick v Stoland* in which Justice Branson remarked that a bare expression of opinion which does not disclose its factual basis, will be incapable of affecting the assessment of the probability of the existence of any fact in issue in the proceeding and will therefore be irrelevant under Section 56(2).

In a recent determination, evidence of a number of "experts" was presented in a form of a "Summary of Conclusions and Reasoning" prepared by the member's legal adviser. Statutory declarations were then prepared for the "experts" by the member's legal provider after several discussions with the experts. The statutory declarations purported to adopt the conclusions and reasoning of the summary. At no time was evidence presented of the training study or experience of the "experts". At no time was evidence presented to distinguish between the opinion and the facts on which those opinions were based. The opinions were not identified as being wholly or substantially based on the particular individual's specialised knowledge. The evidence presented in this manner was of little evidentiary value. In other matters that have come before me, the evidence has been presented in a comprehensive report however, no evidence has been presented to establish a particular level of expertise or the area of specialised knowledge of the proposed expert. This creates significant difficulty in assessing what weight should be placed on the evidence.

I am pleased to say that in the majority of matters in which expert evidence has been presented to me, it has been presented in an appropriate fashion. It is important however to reinforce to all parties the necessary requirements and to avoid unpleasant surprises that may result where the expert evidence is not presented in the appropriate fashion.

Conclusion

The Insurance Contract Act 1984 like any piece of legislation is complex and invites debate and argument. The issues involving fraud that are dealt with under the Act by their very nature continue to invite debate and argument. Given the seriousness of an allegation of fraud and its impact on the individuals concerned the more open and comprehensive the debate, the more issues are likely to be resolved. This is in the interests of all parties to the Service. Frequently the words of Justice Tidwell in the *Transport Industries Insurance Company v Longmuir* are referred to and I quote:

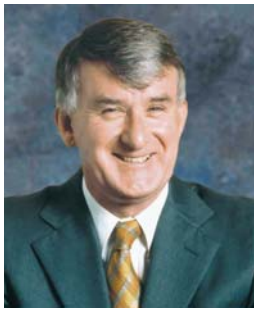
"The overall effect of the detailed picture can sometimes be best appreciated by standing back and viewing it from a distance, making an informed, considered and qualitative appreciation of the whole. The overall effect of the details is not necessarily the same as the sum total of the individual details."

John Price
Referee

Insurers are still presenting submissions where there is a substantial lack of documentation to support the allegations made.

Code Compliance Committee Chair's Report

Michael Gill
Chair, Code Compliance Committee



The uncertainty about the future of the Code ended with the launch of the Insurance Council of Australia's General Insurance Code of Practice on 18 July 2005.

As previewed last year, the new Code focuses on claims handling, an area that has been left untouched by the financial services regulatory framework introduced under the Corporations Act 2001. The new Code now extends to all general insurance products, that is, both personal and commercial lines, except for statutory classes of insurance, medical indemnity insurance, reinsurance and life and health products issued by life insurers or registered health insurers. In addition to ICA members the new Code may be adopted by all other industry participants and service providers.

Annual reviews by the Secretariat continue to identify instances of non-compliance by insurers and their intermediaries. The number of instances of non-compliance reported in relation to employee familiarisation has risen sharply and it is disappointing to observe a lack of improvement in the number of instances of non-compliance reported in relation to agent training.

While there has been a significant reduction in the number of instances of non-compliance overall and in particular in relation to agent record-keeping, the Committee is very disappointed about the reviews of compliance by the underwriting agencies and coverholders. Consequently, the Secretariat will sharpen its focus on insurer intermediaries during the next 12 months. As the new Code will cover more coverholders and underwriting agencies, it is important that steps be taken to ensure their compliance. The Committee met on four occasions during the year and it is pleasing to observe that there were no new matters reported to the Committee for investigation.

Following the Committee's concerns about travel insurance disputes, IOS initiated discussions with key travel insurers which led to the drafting of a "tips and hints" brochure for consumers. It is hoped that the draft brochure will be finalised later this year following further consultation and discussion with the insurers involved, IOS and IOS decision-makers.

My thanks once again to the Code Secretariat led by Rose-Marie Galea with enormous support from Peter Daly and Sam Parrino of IOS. Stan Spanner has continued to conduct company reviews. The Committee, as usual, is much aided by Stan's work.

Finally to my fellow Committee members Denis Nelthorpe and Robert Drummond, my acknowledgement of the significant role which each plays in the work of the Committee and in all matters relevant to the Code.

Michael Gill
Chair, Code Compliance Committee


The Secretariat will sharpen its focus on insurer intermediaries during the next 12 months.

Code Of Practice

On 18 July the Insurance Council of Australia launched the new General Insurance Code of Practice following an intense and lengthy period of consultation with IOS, the industry, consumer groups and other stakeholders. IOS will continue to have responsibility for monitoring members' compliance under the new Code.

The new Code is significant in that for the first time it extends to all classes of general insurance business – both personal lines and commercial lines – except for compulsory third party insurance, workers' compensation, reinsurance, marine insurance (under the Marine Insurance Act 1909), life and health insurance and medical indemnity insurance. In addition, membership of the new Code has been extended beyond general insurers so that any participant who provides an insurance service, including authorised representatives, brokers acting on behalf of insurers, and other service providers, will be eligible to join the new Code provided specified criteria are met. The new Code will come into effect on 18 July 2006 and it is expected that all members of the existing Code who adopt the new Code will do so by the effective date.

There are many challenges facing IOS during the transition period including continuing to monitor compliance with the existing Code while members work toward achieving compliance with the new Code; ensuring members who are ready to adopt the new Code have achieved compliance with the new Code; completing a revision of all Code documentation to accommodate the requirements of the new Code; and development and implementation of a new database for the new Code. The Code Secretariat will continue to work closely with all insurers and it will make itself available to assist them, and prospective participants, in completing a successful transition to the new Code.

Reviews

During the period 1 July 2004 to 30 June 2005, IOS conducted 51 reviews of insurers' compliance with the General Insurance Code of Practice. IOS also reviewed compliance of 24 insurer intermediaries, consisting of underwriting agents and external claims handlers. These reviews required insurers and their intermediaries to provide IOS with access to their files, records, and procedures to ascertain whether insurers and their intermediaries were satisfying their obligations under the Code.

There has been a significant fall in instances of non-compliance this year when 84 instances of non-compliance were found (compared to 114 instances during the previous year). Overall, 53% (27) of insurers were found to be compliant with the Code while a disappointing 29% (7) of insurer intermediaries were found to be compliant during this period. The low level of compliance found among insurer intermediaries is a matter which will receive a heightened focus during the transition from the existing Code to the new Code and in the ensuing period.

All insurers involved have addressed areas of non-compliance by implementing appropriate procedures to remedy the non-compliance and prevent any recurrence. In addition, the Code Secretariat circulated Code review outcomes to all Code members during this period on a quarterly basis to assist members identify emerging trends. The Secretariat has continued to work closely with insurers and their intermediaries and has made itself available to them. Many insurers continue to make use of the resources offered by the Secretariat.

Code of Practice Statistics – Breach results (Table 10)

It is pleasing to note a significant fall in the number of possible breaches this year compared to the previous year. This year there were 243 possible breaches, a fall of 39% compared to last year. The number of established breaches has also fallen to 125, a fall of 22%. Of the 243 possible breaches recorded during the year, 159 were identified either from enquiries to the first tier of the Service or through disputes referred for resolution, which means that the Service continues to be the main source of possible breaches, as noted in the past.

As mentioned earlier, 84 instances of non-compliance arose directly from the reviews of 51 insurers and 24 insurer intermediaries. Once again there has been a marked improvement seen in relation to agent record-keeping. There has also been a significant improvement seen in relation to the supervision of investigators, assessors and loss adjusters; advisory brochures on internal dispute resolution; and advice on external disputes resolution and written response.

Compliance in relation to agent and employee training (six instances this year compared with five last year) and approval of investigators (17 instances this year compared with 16 last year) remain relatively unchanged. However, it is disappointing that there have been three times as many instances of non-compliance recorded in relation to employee familiarisation (15) when compared to last year (5). Most of these matters arose from reviews of insurer intermediaries and as noted above, insurer intermediaries will receive further attention from IOS during the next 12 months.

When non-compliance is established, insurers are required to implement appropriate procedures to remedy the area of non-compliance, and to prevent its recurrence, within the time frame set down by the Code Compliance Committee. This process is monitored by IOS to ensure that insurers achieve and maintain compliance with the Code.

Code of Practice Statistics – Internal Disputes Resolution (Table 11)

There has been only a minor (2%) increase in the number of disputes recorded at IDR level from 12,480 during the previous period to 12,723 disputes in this period. Of the total number of disputes, 7,953 disputes, or 62%, were claims-related. The remaining 4,770 disputes, or 38%, represent non-claims related disputes. When compared with last year, the number of claims-related disputes has increased 12%, with an equivalent fall in the number of non-claims related disputes this year.

There has been only a 5% increase in the number of claims reported this year when compared with last year, with only a 2% increase in total policy numbers across all classes of business subject to the Code. The number of disputes settled in favour of consumers for this period was 3,798, representing 30% of all disputes, slightly less than the previous period when 35% were settled in favour of the consumer.

Statistics

Table 1
IOS Enquiries

A decrease of 3000 telephone enquiries from the previous year is largely attributable to the efficient operations of the Joint Call Centre, which efficiently directs the caller to the appropriate financial service EDR scheme. The numbers of contacts confirms the need for an information service able to answer consumers' questions about financial service products. The Joint Call Centre is operated by the partnership of IOS, the Banking and Financial Services Ombudsman Service (BFSO), the Financial Industry Complaints Service (FICS), Insurance Brokers Disputes (IBD), the Credit Union Disputes Resolution Centre (CUDRAC), the Superannuation Complaints Tribunal (SCT) and the Credit Ombudsman Service (COS, formerly the Mortgage Industry Ombudsman Service).

Year	Number of Enquiries
2000-01	68,252
2001-02	75,487
2002-03	63,231
2003-04	67,545
2004-05	64,563
TOTAL	339,078

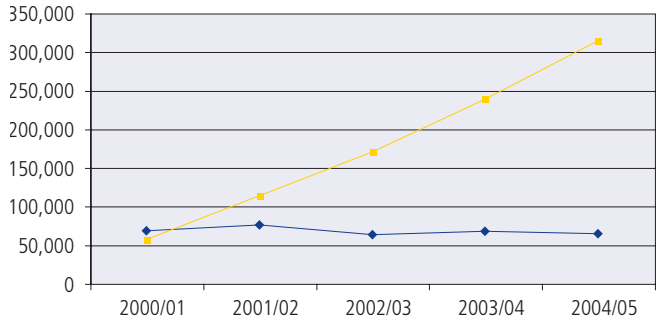


Table 2
Origin of Referrals by State (July 2004 – June 2005)

Number of Referrals				
		2004-05		2003-04
New South Wales	601	36%	583	34%
Victoria	506	30%	520	30%
Queensland	252	15%	265	15%
South Australia	136	8%	129	7%
Western Australia	110	7%	150	9%
Tasmania	26	2%	40	2%
Australian Capital Territory	29	2%	41	2%
Northern Territory	7	0%	6	0%
TOTAL	1667	100%	1734	100%

Referrals from New South Wales and Victoria constitute two-thirds of all referrals to IOS, which is consistent with those two states' market share.

Table 3
Reasons Members Denied Liability (July 2004 – June 2005)

	Fraud	Not covered by policy	Cond./Excl.	Non-disclosure	No policy contract	No proof of loss	Quantum dispute	Third party	Other	TOTAL	2004-05	2003-04
Motor Vehicle	88	13	237	111	54	1	65	0	17	586	35%	36%
Motor Vehicle Third Party	0	0	0	0	0	0	4	15	0	19	1%	1%
Home Building	8	49	227	2	6	0	20	0	1	313	19%	18%
Travel	5	14	261	2	1	2	9	0	2	296	18%	15%
Home Contents	22	31	105	12	3	4	20	0	1	198	12%	15%
Consumer Credit	0	0	9	2	0	0	0	0	3	14	1%	1%
Pleasure Craft	2	4	15	0	2	0	2	0	0	25	1%	1%
Personal Accident/Sickness	1	9	70	6	3	0	3	0	2	94	6%	7%
Caravan	0	0	1	0	0	0	0	0	0	1	0%	0%
All Risks & Other	1	1	26	1	0	0	0	0	3	32	2%	1%
Small Business	4	10	45	3	2	0	7	0	2	73	4%	3%
Strata Title	0	2	12	0	0	0	2	0	0	16	1%	1%
TOTAL	131	133	1,008	139	71	7	132	15	31	1667		
	8%	8%	60%	8%	4%	0%	8%	1%	2%		100%	
2003-04	10%	10%	56%	12%	4%	0%	6%	1%	0%			

Most of the disputes arise from motor vehicle, home building and home contents policies; these constitute 66% of all referrals. However, the continuing rise in the number of travel insurance disputes raises questions. IOS and representatives of the major travel insurers are looking at the causes and ways of addressing them. The falling reliance on an allegation of alleged fraudulent behaviour reflects greater awareness by insurers of the importance of ensuring the evidence available supports such a serious allegation.

Statistics

Table 4
Values of Disputes

	2004-05		2003-04	
	Number of Disputes	%	Number of Disputes	%
Value unknown	86	5%	92	5%
Up to $3000	583	35%	594	34%
$3001-$5000	253	15%	200	12%
$5001-$10,000	256	15%	305	18%
$10,001-$15,000	141	8%	161	9%
$15,001-$20,000	88	5%	108	6%
$20,001-$25,000	58	3%	70	4%
$25,001-$30,000	44	3%	52	3%
$30,001-$35,000	14	1%	20	1%
$35,001-$40,000	26	2%	21	1%
$40,001-$45,000	13	1%	16	1%
$45,000-$50,000	17	1%	11	1%
$50,001-$100,000	53	3%	50	3%
$100,001-$120,000	7	0%	16	1%
$120,001-$150,000	12	1%	7	0%
$150,001-$200,000	8	0%	5	0%
$200,001-$290,000	7	0%	5	0%
$290,001+	1	0%	1	0%
TOTAL	1667	100%	1734	100%

The recent trend for the number of referrals to fall on a year-by-year basis may have eased for now, with the difference in yearly totals now being less than 4%. However, the percentage of low-value disputes (less than $5000) reached 55%, with disputes of less than $10,000 totalling 70%. What is disappointing is the fact that 16 matters exceeded the increasingly inadequate financial limit of $150,000.

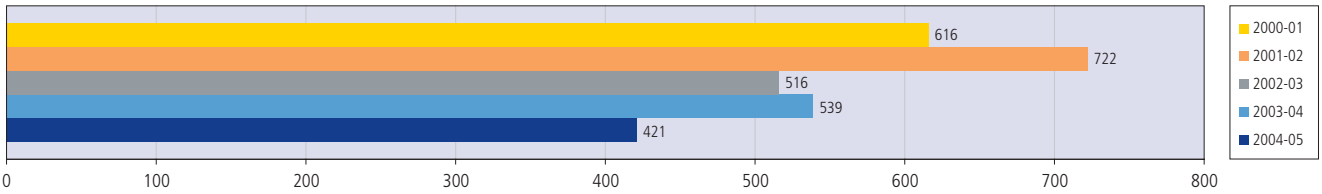
Table 5
Total Referral Outcomes (July 2000 – June 2005)

	Number of referrals	Determined				Unsuitable for resolution		TOTAL		Other Resolutions				Completed
		Applicant favour		Member favour						Settled		Withdrawn		
July 2000-June 2001	2543	616	24.5%	1249	49.6%	207	8.2%	2072	82.4%	417	16.6%	27	1.1%	2516
July 2001-June 2002	2557	722	28.3%	1110	43.5%	168	6.6%	2000	78.4%	519	20.3%	32	1.3%	2551
July 2002-June 2003	2046	516	23.7%	1055	48.5%	180	8.3%	1751	80.5%	404	18.6%	19	0.9%	2174
July 2003-June 2004	1734	539	29.8%	888	49.1%	111	6.1%	1538	85.0%	253	14.0%	19	1.0%	1810
July 2004-June 2005	1667	421	28.1%	762	50.9%	109	7.3%	1292	86.4%	191	12.8%	13	0.9%	1496
TOTAL	10547	2814	26.7%	5064	48.0%	775	7.3%	8653	82.0%	1784	16.9%	110	1.0%	10547

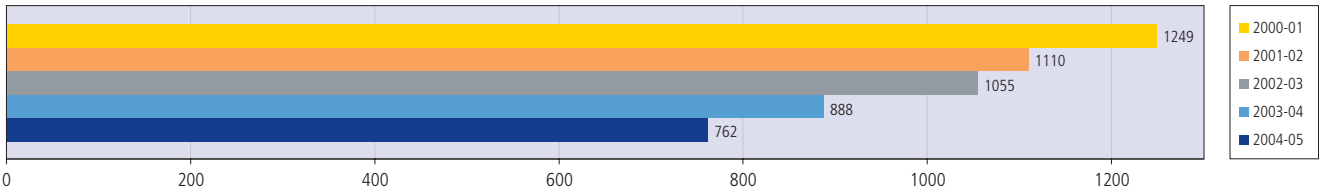
There is a continuing trend of fewer disputes settling at the Service, which is largely due to more robust internal dispute resolution (IDR) processes and companies being satisfied with their IDR decisions. Member performance at the Service also continues to improve.

Statistics

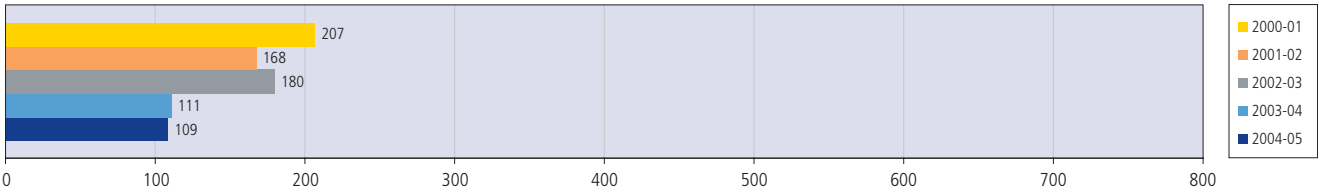
Applicant Favour



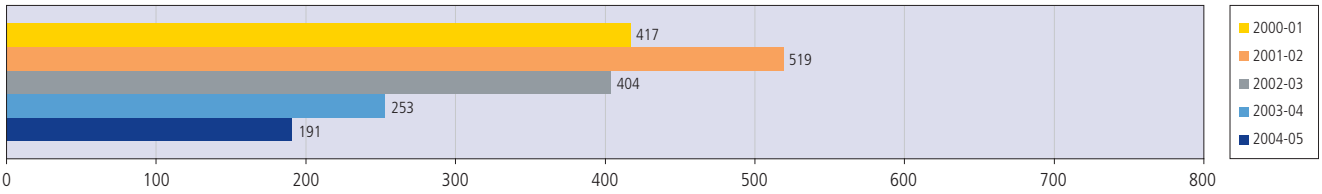
Member Favour



Unsuitable for Resolution



Settled



Withdrawn

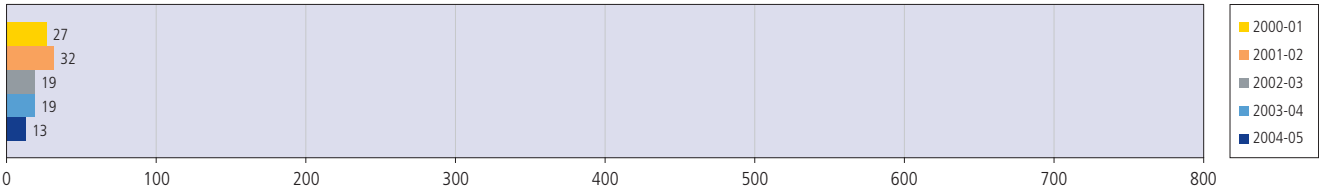


Table 6
Summary of Outcomes by Policy Type (July 2004 – June 2005)

Policy Type	TOTAL	Applicant favour	Member favour	Settled	Unsuitable for resolution	Withdrawn Consumer /insurer	%
Consumer Credit	15	47%	40%	13%	0%	0%	100%
Home Buildings	269	25%	60%	9%	5%	1%	100%
Home Contents	187	28%	45%	14%	12%	1%	100%
Marine – Pleasurecraft	18	17%	44%	33%	6%	0%	100%
Motor Vehicle	561	29%	43%	15%	11%	1%	100%
Motor Vehicle Third Party	19	26%	47%	11%	16%	0%	100%
Personal Accident/Sickness	87	36%	47%	16%	0%	1%	100%
Travel	240	23%	66%	9%	1%	0%	100%
Caravan/Campervan	1	0%	100%	0%	0%	0%	100%
All Risks	2	0%	50%	50%	0%	0%	100%
Other	32	44%	41%	13%	3%	0%	100%
Small Business	51	33%	53%	10%	4%	0%	100%
Strata Title	14	43%	57%	0%	0%	0%	100%
TOTAL	1496						

The increase in travel insurance disputes and the fact that travel insurers are successful 66% of the time – the highest success rate of all classes of business – suggest that the product may not be meeting the level of expectation consumers held at the time of purchase.

Statistics

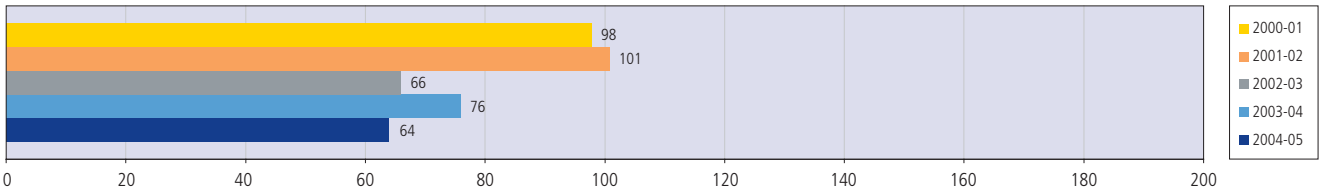
Table 7
Referee Outcomes (July 2000 – June 2005)

	Applicant favour		Member favour		Unsuitable for resolution		Settled		Withdrawn		Completed
July 2000 – June 2001	98	33.3%	22	7.5%	172	58.5%	1	0.3%	1	0.3%	294
July 2001 – June 2002	101	42.4%	7	2.9%	127	53.4%	2	0.8%	1	0.4%	238
July 2002 – June 2003	66	23.9%	16	5.8%	155	56.2%	37	13.4%	2	0.7%	276
July 2003 – June 2004	76	40.6%	10	5.3%	80	42.8%	20	10.7%	1	0.5%	187
July 2004 – June 2005	64	43.0%	12	8.1%	63	42.3%	7	4.7%	3	2.0%	149
TOTAL	405	35.4%	67	5.9%	597	52.2%	67	5.9%	8	0.7%	1144

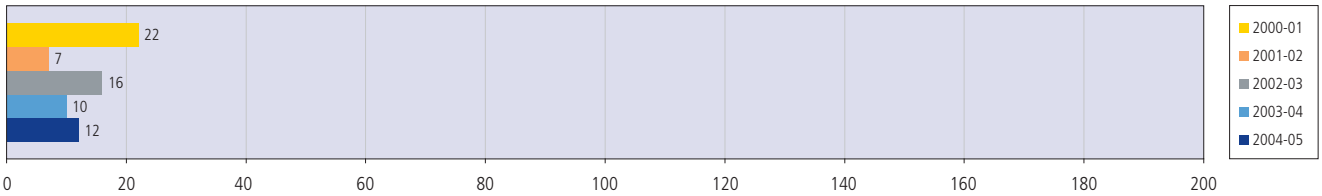
There is a continuing downward trend in referrals where fraud is alleged. Fewer disputes are found to be "unsuitable for determination". This is largely attributable to the requirement of a full exchange of information between the parties.

Statistics

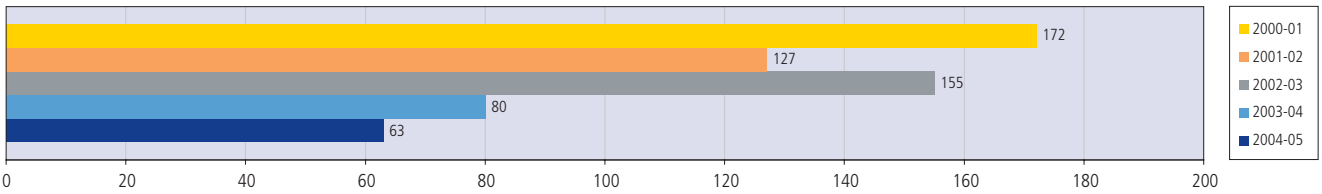
Applicant Favour



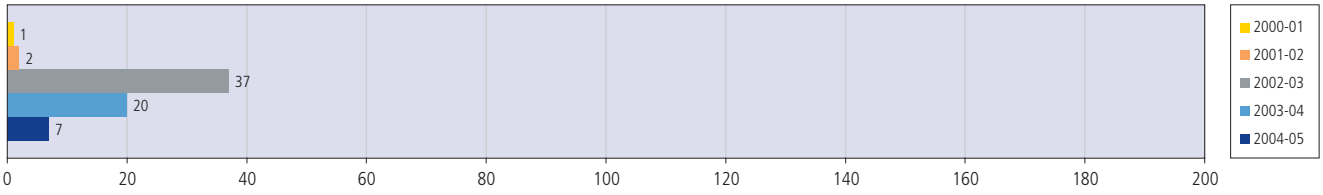
Member Favour



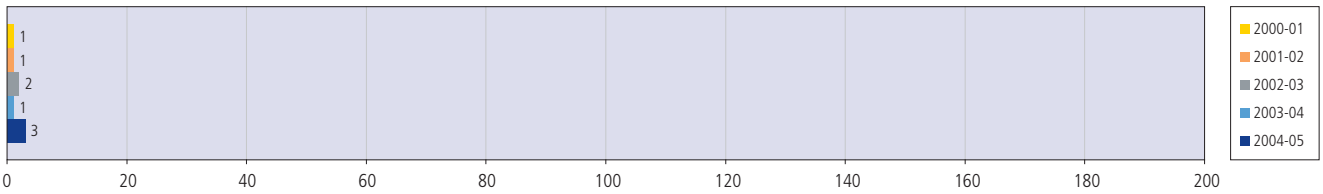
Unsuitable for Resolution



Settled



Withdrawn



Statistics

Table 8
Adjudicator Outcomes (July 2003 – June 2005)

	Determined by adjudicator				Unsuitable for resolution		TOTAL		Other resolutions				Completed
	Applicant favour		Member favour						Settled		Withdrawn		
July 2003 – June 2004	123	21.0%	346	58.9%	0	0.0%	469	79.9%	108	18.4%	10	1.7%	587
July 2004 – June 2005	136	20.3%	410	61.2%	2	0.3%	548	81.8%	116	17.3%	6	0.9%	370
TOTAL	259	20.6%	756	60.1%	2	0.2%	1017	80.9%	224	17.8%	16	1.3%	1257

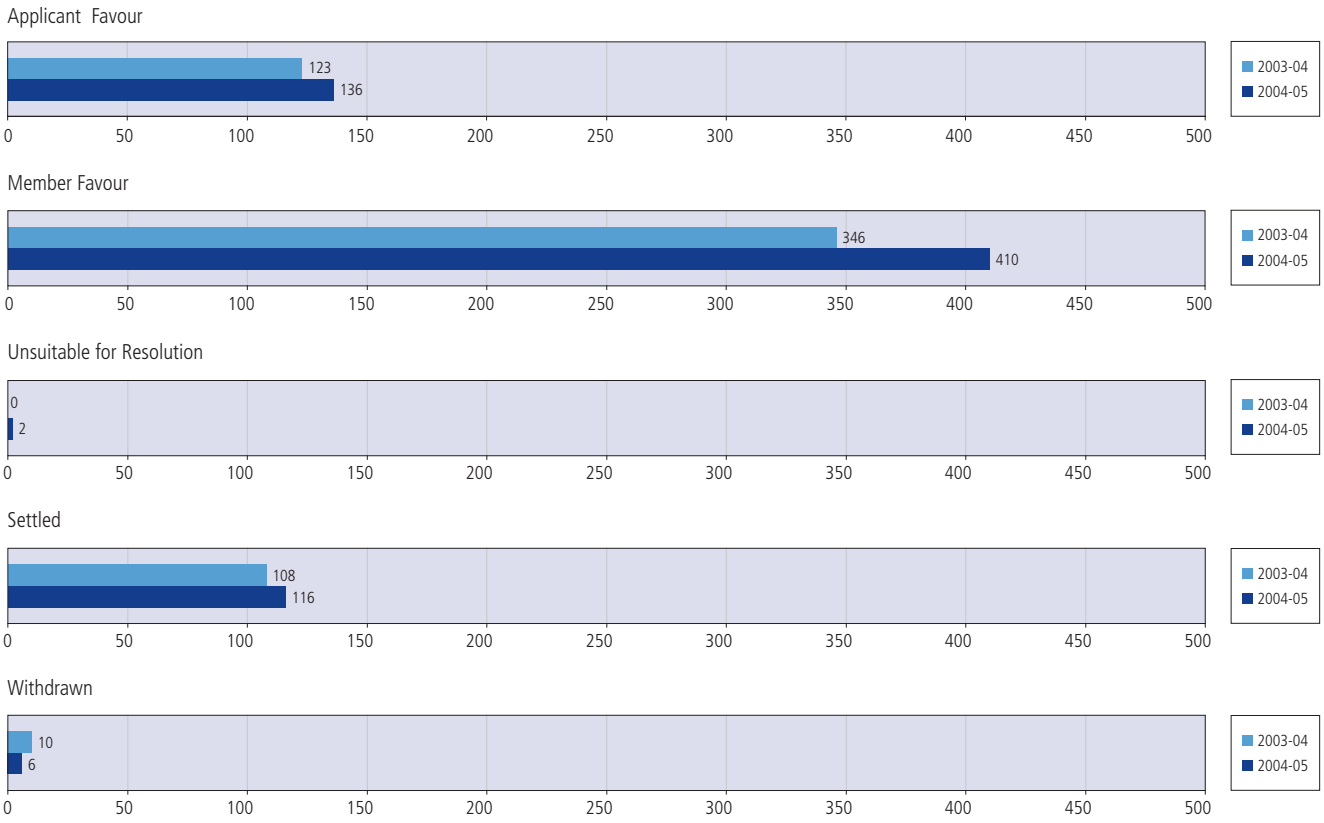


Table 9
Analysis of Complaints Resolution Times (July 2002 – June 2005)

Adjudicator

	1-30 Days	31-60 Days	61-90 Days	91-120 Days
1 July 2002 – 30 June 2003	0%	5%	55%	92%
1 July 2003 – 30 June 2004	1%	6%	52%	95%
1 July 2004 – 30 June 2005	1%	2%	31%	50%

Referee

	1-30 Days	31-60 Days	61-90 Days	91-120 Days
1 July 2002 – 30 June 2003	0%	0%	6%	31%
1 July 2003 – 30 June 2004	0%	0%	3%	29%
1 July 2004 – 30 June 2005	0%	0%	4%	26%

Panel

	1-30 Days	31-60 Days	61-90 Days	91-120 Days
1 July 2002 – 30 June 2003	0%	1%	33%	71%
1 July 2003 – 30 June 2004	0%	0%	14%	72%
1 July 2004 – 30 June 2005	0%	0%	16%	54%

Total

	1-30 Days	31-60 Days	61-90 Days	91-120 Days
1 July 2002 – 30 June 2003	6%	16%	46%	77%
1 July 2003 – 30 June 2004	5%	14%	35%	77%
1 July 2004 – 30 June 2005	5%	12%	30%	55%

Staff resources have been increased and processes reviewed to help reduce the time taken to resolve disputes by IOS. Clearly, the need for a full exchange of information between the parties has increased the time taken to resolve matters. With extra resources, improved processes and improved tracking of timelines, IOS is looking to a reduction in the time taken to resolve disputes.

Statistics

Table 10
Code of Practice Statistics – Breach results (July 2004 – June 2005)

Section	Type of Breach	Number of Alleged Breaches	Non-compliance found to exist
Agent Skills	3.1(a)	0	0
Agents Informing Consumer	3.1(b)	0	0
Agent Authority	3.2	3	2
Agent Training	3.3	7	6
Agent Record-Keeping	3.4	5	5
Provision of Advice	3.6	0	0
Employee Familiarisation	3.5(a)	28	15
Employee Training	3.5(b)	12	6
Plain Language Documentation	4.1(a)	3	3
Availability of Policy	4.1(b)	4	2
Documentation prior to Renewal	4.1(c)	2	1
Information with Policy	4.1(d)	8	5
Identify Proposal Requirement	4.2(a)	1	1
Duty of Disclosure	4.2(b)	3	3
Adequate Space Provided	4.2(d)	0	0
Consumer Information Brochure	4.4	0	0
Declined Cover	4.3	1	0
Assistance and Information to Claimant	5.1(a)	27	6
Prompt Consideration of Claim	5.1(c)	5	0
Keeping Claimant Informed	5.1(d)	18	4
Advice on Acceptance or Rejection	5.1(e)	14	1
Require further Information	5.1(f)	8	1
Rejection Advice and Reason	5.1(g)	11	6
Non-Disclosure of Information	5.1(h)	0	0
Supervision of Investigators, Assessors and Loss Adjusters	5.2	14	8
Approval of Investigators	5.3	18	17
Approval of Assessors, Loss Adjusters and Collection Agents	5.4	0	0
IDR Fair and Timely	6.1	15	9
Advisory Brochures on IDR	6.2	11	9
Advice on EDR and Written Response	6.3	18	8
Failure to Promptly Remedy Non-compliance	7.2(a)	0	0
Participate in Scheme	6.4	0	0
Failure to Submit Annual Report	7.1(b)	0	0
Appropriate Systems for Compliance with Code	7.1(a)	4	4
Publication of Code	1.8	1	1
Use of Plain Language	4.2(c)	2	2
Plain Language Forms	5.1(b)	0	0
Monitors Disputes with Consumers and Compliance with Code	7.1(c)	0	0
IDR Oral Request	6.3	0	0
TOTAL		243	125

When non-compliance is established, insurers are required to implement appropriate procedures to remedy the area of non-compliance, and to prevent its recurrence, within the time frame set down by the Code Compliance Committee. This process is monitored by IOS to ensure that insurers achieve and maintain compliance with the Code.

It is pleasing to note a significant reduction in the number of possible breaches compared to the previous year. This year's total of 243 possible breaches is a fall of 39% compared to last year. Significantly, the number of established breaches has also fallen to 125, a fall of 22%. Of the 243 possible breaches recorded during this period, 159 were identified either from enquiries to the consumer consultants of IOS or through disputes referred for resolution.

In addition, 84 instances of non-compliance arose directly from the reviews of 51 insurers and 24 insurer intermediaries. The statistics confirm continued improvement in relation to agent record-keeping, the supervision of investigators, assessors and loss adjusters, information brochures about the IDR process, the provision of advice about the availability of EDR and the provision of a written response to claimants.

However, it is disappointing that there have been three times as many instances of non-compliance recorded in relation to employee familiarisation (15) when compared to last year (5). Most involve intermediaries and as noted above, insurer intermediaries will receive closer attention from IOS during the next 12 months.

Statistics

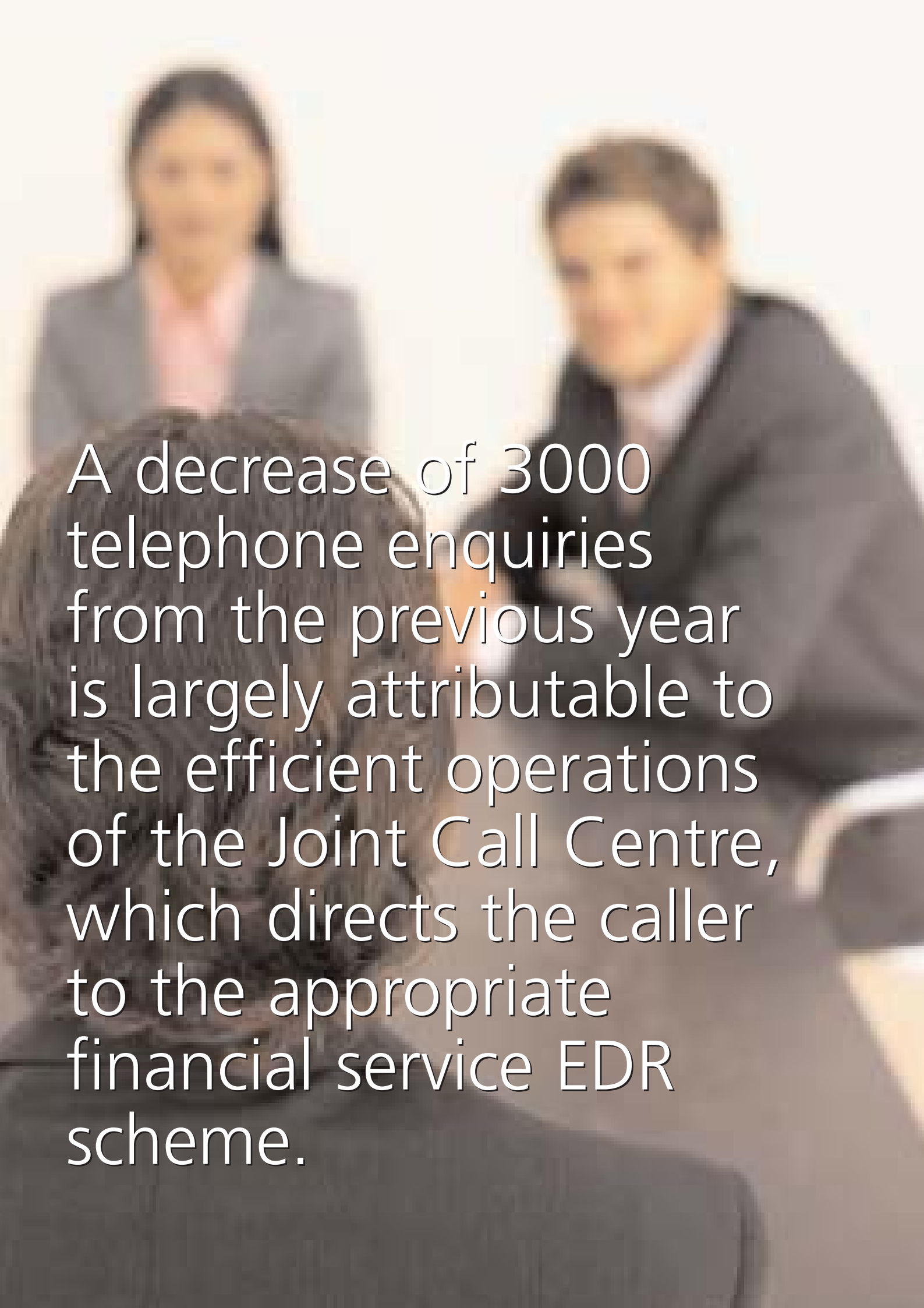
Table 11
Code of Practice Statistics – Internal Dispute Resolution

	All classes	Motor	Home contents	Home building	Travel	Consumer credit	Sick & acc.?	Valuables	Marine	Caravans	Mobile phones	Other classes
Policies (including renewal)	26,545,814	10,301,950	5,734,310	5,558,842	1,975,325	610,966	506,269	348,329	291,491	259,435	185,495	773,402
Claims	2,837,190	1,515,836	375,270	544,705	144,203	14,219	48,752	23,405	9480	9420	25,100	126,800
Claims Rejected	43,082	3251	9201	13,112	5003	1379	1419	1612	45	74	2055	5931
Disputes												
Agents	20	12	5	1	0	1	0	0	0	0	0	1
Employees	644	419	171	53	0	0	0	0	1	0	0	0
Policy Documentation	307	200	21	36	9	12	15	1	4	1	0	8
Claims	7953	3261	963	1277	1304	48	339	156	126	23	291	165
Others	3799	2937	449	356	19	0	6	9	14	3	0	6
TOTAL	12,723	6829	1609	1723	1332	61	360	166	145	27	291	180
Dispute settled in:												
Favour of Consumer	3798	1838	467	465	445	30	125	68	66	15	227	52
Favour of Insurer	8659	4868	1118	1232	805	31	232	99	77	12	68	117
Outstanding	929	511	74	100	171	10	17	0	19	6	5	16

There were 12,723 disputes recorded at the insurer's IDR level compared to 12,480 previously. Of that total 7,953, or 62%, were claims-related. The remaining 4,770 disputes, (38%), represent non-claims related disputes. Compared with last year, claims disputes increased 12%, with an equivalent fall in non-claims related disputes.

It is worth noting that out of about 2.8 million claims, only 43,000 were rejected. This constitutes a mere 1.5% of all claims and confirms the business of insurance is paying genuine claims. Of the 12,723 claims that went to IDR, only 1667 or 13.6% were referred by the claimant to IOS for independent resolution.

The number of disputes settled at the IDR level in favour of consumers (i.e. the insurer overturned its own initial rejection of the claim) was 3,798, representing 30% of such disputes, slightly less than the previous year. The number of disputes confirmed in favour of insurers during this period was 8,659 or 68%. Last year, 64% of disputes were confirmed in favour of insurers with the balance representing disputes that had not been finalised at the time of reporting.



A decrease of 3000 telephone enquiries from the previous year is largely attributable to the efficient operations of the Joint Call Centre, which directs the caller to the appropriate financial service EDR scheme.

Member Companies

Participating members of the Service and Code signatories can be found on the website

www.iosombudsman.com.au

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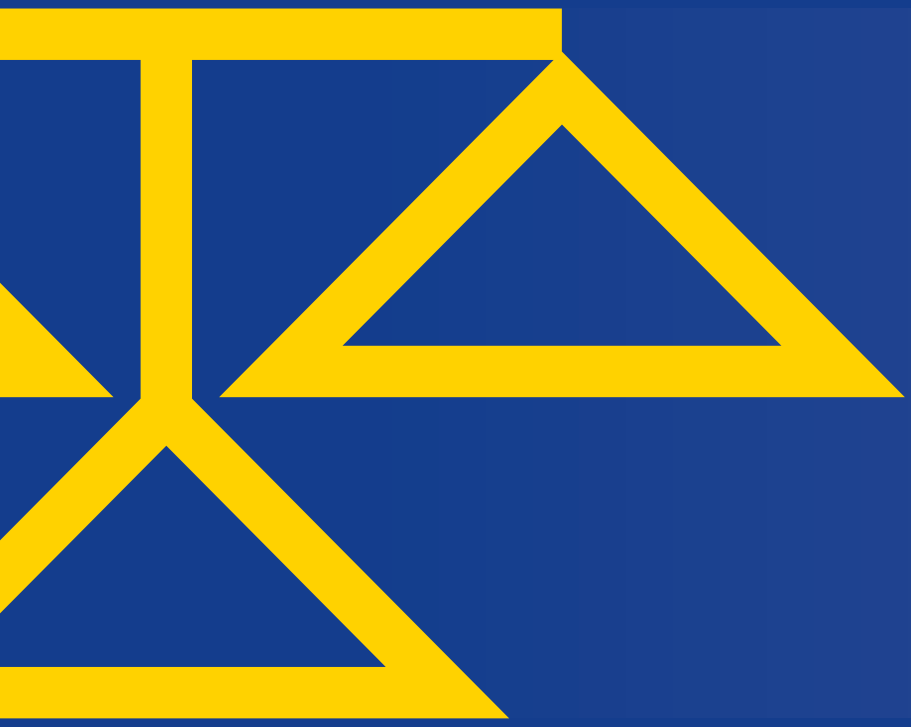
Annual Review **2005**

INSURANCE OMBUDSMAN SERVICE LIMITED

Addendum



This addendum contains further informative commentary and data on the operations of the Insurance Ombudsman Service that should be read in conjunction with our recently published Annual Review. It includes an article from the Chair of the Claims Review Panel, Peter Hardham, on:

- The wordings of various insurance policies;
- Statistical data on the operations of the Panel during 2005;
- It also includes a summary of the claims performance of all IOS Participating Companies; and
- News of upcoming conferences.

I believe the information contained in this addendum will assist in providing a wider review of the operations of the service.

Sam Parrino
Insurance Ombudsman

Panel Report

Insurance policies come in various shapes and sizes and they all need improvement. Insurance Ombudsman Service (IOS) Panel staff recently examined a range of typical policies, and this is what we found.

The first policy booklet we looked at was called "Home Insurance". It was 62 pages. The second was 53 pages and it was called "Home and Contents Insurance". The third was a "Home and Contents" policy and it was 64 pages. The fourth one was called a "Car" insurance policy (25 pages), which was extremely small and would easily fit in your hip pocket. The fifth was called a "Motor Vehicle" insurance policy (38 pages). The sixth and last of the policies featured in this analysis simply announced "Help, to protect your pride and joy" which, on close inspection, revealed it was a "Motor Vehicle" insurance policy.

The Product Disclosure Statement

Each policy features a "Product Disclosure Statement" (PDS) which is often referred to as a separate part of the booklet. In the first policy document, we noted it was 15 pages and it was said to contain "significant benefits and risks associated with this product". It was a very comprehensive document. The next policy document we looked at also contained a product disclosure statement 15 pages and included a summary of what was described as important terms. It was however, somewhat hard to tell where it began and finished. Another policy described the index as the PDS. Many of the PDSs we read bravely attempted to summarise the policy benefits in a way which must result in the policyholder not then wanting to read the policy document. In some cases, the PDS has apparently overtaken the policy document altogether.

PDSs have had mixed reviews. In some instances they have received the "too much information" tag. Many commentators have expressed doubts about the effectiveness of these documents as they certainly add to the length of the policy booklet. It must be quite a challenge for the draftsmen of these documents in trying to summarise, even to 15 pages, the contents of the 50 or 60 pages that follow. What would the Claims Review Panel do if you left something out?

We wonder whether they could be confined to three or four pages because, in our opinion, the manner in which product disclosure statements are drafted has the tendency to defeat the purpose of explaining in concise terms the major benefits and limits provided by the policy. Fifteen pages is too long, and to simply refer to the policy index is somewhat cheeky. We would suggest much work needs to be done to improve this part of the policy documentation.

The Disclosure Statement

Next comes the Disclosure Statement, which is quite different conceptually to the Product Disclosure Statement. When we came to read Duty of Disclosure Statements, we all felt bored and perplexed. Bored because the words are complex and vacuous, and perplexed because, even for us, it was hard to understand what they mean.

The obligation on the insured is to disclose to the insurer what a "reasonable person" believes it wants to know, even if you do not know about it, provided that a reasonable person whomever that may be, does. The reviewing of the Insurance Contracts Act reached the conclusion that an insurer should direct specific questions at policyholders at most times when they want disclosure – that is, at inception and renewal. The Panel supports that reform. At present, the requirement only applies at policy inception and in relation to "eligible contracts", which does not, for example, include commercial or business policies.

If this change was introduced, reading the disclosure section of the policy would be a much more satisfying process because it would be confined to warning prospective policyholders they should answer specific questions accurately.

The Index

Most, but unfortunately not all, policies have an index. An index gives the reader a chance to find the relevant policy term. During the era of multiple flood disputes, the Panel ran a competition

Peter Hardham
Panel Chair

amongst IOS case managers called "Find the Flood Exclusion" (if there was one). The record was five minutes but it took one case manager 50 minutes to find the exclusion buried in the definition of "home buildings".

In our opinion, a policy that does not have an index is flawed.

The Definition Section

Many policies have "definition sections" where all sorts of words are given all sorts of meanings. Some policy draftspersons use the definition section of the policy to set out the policy terms such as including a definition of "flood" under the definition of "home buildings". Another device is to use this section of the policy to call an apple an orange. We have encountered many policies which define goods as being in the open air, if they are situated in an unlocked building, which is, of course, enclosed. We have seen the term "unattended luggage" defined as leaving the goods "in a position where they can be snatched" so that the very act of the goods being taken means they are, in effect, unattended. This is contrary to the legal definition of this term which means that the goods have been left in a position where the policyholder is not capable of keeping them under observation.

We have also observed that the term "you" is defined in many instances to mean "all the persons named on the policy schedule", which is fair enough, but some policies go on to specifically state the act of one policyholder will bind another, which can have devastating consequences in a domestic arson scenario.

In our opinion, it is permissible for a term to be artificially defined i.e. to call an apple an orange, providing this process is clearly highlighted and facilitated by means of cross-referencing. In other words, where the broad unattended luggage exclusion is set out, a reference should be made to the fact, that the term is artificially defined in the definition section of the policy.

In terms of the layout of a policy, it is of interest to refer to Determination No. 20661, which arose from a travel claim. This policy was sold to the applicant by a travel agent who was fully aware of the nature of the trip the applicant and his wife were undertaking. The policy did not have an index and purported to provide multiple options rolled into one policy. In other words, it described itself as "tailored". It was in a print which gave us all eyestrain and it contained an exclusion of gargantuan effect. The tailored policy chosen by the travel agent for the applicant was called a "VFR" which was shorthand for "Visiting Friends and Relatives" travel, something the policyholder had no intention to do. The exclusion relevant to the dispute provided as follows: "If you take Plan M your luggage is only covered whilst in the custody of a carrier i.e. airline, coach or train".

This particular policy exclusion was No. 7 of the policy benefits. It was, of course, not a benefit but an exclusion. The Panel took the view the policyholder had no hope of discovering the relevant exclusion.

The Policy Terms

Now we come to the substantive terms of the policy, many of which are not in the policy document. For example, they may be found in the policy schedule or the policy certificate or in a separate letter providing special policy terms, or in a brochure or a PDS, which may or may not be part of the actual policy, or in a derogation notice (which, sadly, we do not see many of these days).

In some instances, part of the policy term might be in the policy, and another part may be in the schedule or the certificate. In these circumstances, it is important the documents speak to one another.

This problem arose in Determination No. 20276 when the Panel had to consider whether the insurer had met its obligations to clearly convey a crucial limitation of cover – namely that it only covered drivers 30 years and over. The applicant brought a claim for damage to her motor vehicle when it was involved in an accident while being driven by her 20-year-old daughter. At the time when she took out the policy, there were no persons likely to drive the vehicle who were under the age of 30. However, subsequent to that time, her daughter obtained her licence and the applicant allowed her to drive the vehicle on the day of the

accident. The policy schedule provided by the insurer at the time of policy inception included the following:

"Comprehensive cover – provides cover for:

- Certain optional covers (where agreed) such as rental or loan car following an accident, removal of basic excess for windscreen claims, protected no claim bonus and restricted driver cover.

Note that the restricted driver option provides a discounted premium, but limits the drivers who are covered under the policy."

It then set out a number of policy excesses including:

"Inexperienced Driver Excess	$600
Undeclared Young Driver Excess	$900"

The inexperienced driver excess was said to apply to drivers over the age of 25 who had held their Australian driver licence for less than two years and the undeclared young driver's excess applied to drivers under the age of 25 years not listed on the policy schedule.

The applicant, not surprisingly, on reading this document thought her daughter was covered although she expected to pay an additional excess.

However, the policy document provided something else which the applicant said she did not expect. On page 11 of the policy, under the heading "Restricted Drivers", the following appeared:

"When the current schedule shows that the restricted driver option applies, we will not cover any accidental loss, damage or liability, which results in a claim, when the driver of your vehicle was a person under 30 years of age."

The product disclosure statement contained in the introduction to the policy document provided no such exclusion, although it did state:

> *"Note that the restricted driver option provides a discounted premium, but limits the drivers who are covered under the policy."*

The policy contained an index which includes "Words with Special Meanings" on page 4, and while there were two types of driver descriptions in this section of the policy and a special meaning was given to them, there was no definition therein of the word "restricted driver". In the course of its determination, the Panel made the following comments:

> *"… an insurer must take great care to make sure its procedures for selling the policy and the documentation it produces thereafter is expressed in the clearest possible terms. After all, the obligation is to act with the utmost good faith, not simply good faith, which is a heavy onus in this context on an insurer;"*

The fundamental principle relevant to all insurance disputation on which all parties agree is that no-one ever reads the policy before a claim is made. This is always how it has been and probably will be. Most people read mortgage documents, loan agreements, leases, contracts for the purchase of motor vehicles, even rate notices, but they will not, or maybe cannot, read an insurance policy.

Let us now turn to a brief analysis of the policies we examined initially. The terms of cover are contained in four sections: Home Building insurance, Home Contents insurance, Accidental Damage cover and Personal Property insurance. They are all separate and the policy is appropriately indexed. Randomly, the Panel turned to section 3, i.e. the Accidental Damage cover in which it was stated it was not available without section 2. It said the policy was made up of the policy schedule, the introduction and information section of the booklet, section 2 of the policy as well as section 1 and that it was important for the policyholder to note there were limits to the amounts which the member would pay, there were exclusions to the policy, there were conditions – that is, things which the policyholder must do – and that the schedule "may set out special limits, exclusions or conditions applying to your policy" and there were also certain terms "which we have specially defined".

This was a perfectly proper and normal policy presentation but may we suggest, even to a Panel member, it was a formidable challenge to understand each and every aspect of cover, and all the various component parts of the insurance contract. On the other hand, we have also seen several policies which have all the events that are included on one page, and all the exclusions opposite. What a great idea!

At the other end of the scale was the policy which we considered in Determination No. 20661, where the policy had multiple options, no index, small print, exclusions mixed into benefits, and multiple sections.

The point we are making in this analysis is that it requires considerable effort, intelligence and tenacity on the part of the average policyholder to find out, in advance, what is covered and what is not covered, and whether there are limitations to cover. All these matters are the essential ingredients of a contract which has the potential benefit to a policyholder of tens of thousands if not hundreds of thousands of dollars, but which might result in tragic consequences to their lives if they do not understand critical exclusions. Underpinning everything is the possibility the contract may be worthless should the policyholder fail to disclose information which goes to the heart of the contract. This may occur notwithstanding he/she was unaware of its significance in situations where it is determined that a reasonable person would have been so aware.

In the review of the Insurance Contracts Act, the reviewers recommended the Act should be amended so that the obligation that should rest on the insurer is to communicate the policy terms in a "clear, concise and effective" manner; otherwise the term on which the insurer relies to deny a claim may not be available to it in a similar manner that applies at present with respect to sections 14, 35 and 37 of the Act.

We would suggest the obligation proposed will be a far greater obligation than presently exists to clearly inform a policyholder of relevant terms because of the addition of the words "concise and effective". We say this because if the policyholder, for better or for worse, did not understand or even know of the policy term, then it would be difficult to accept that it has been communicated to him effectively, and if the policy is 100 pages long, and if the crucial policy term is at page 66, it will be hard to describe the policy document as "concise". We must also not overlook the requirements of the Corporations Act and other legislation.

In any event, whether the present law is or is not altered, we are of the opinion that there is considerable improvement required for much policy documentation to pass minimum legal requirements. The problem has been compounded by Financial Services Reform Act legislation which puts obligations on the providers of financial services who offer advice which has the effect that they do not offer advice. We offer the following contribution to what we believe is a crucial debate.

1. Assuming it is necessary to have multiple policy documents, it is crucial they speak to one another. In Determination No. 20276, it would have made all the difference if the policy schedule simply stated that under-30 drivers were not covered. The PDS should accordingly mirror and realistically summarise the key policy benefits in a concise and effective form.

2. Is it possible to standardise the terms of basic items requiring cover, for example, with flood? At a recent seminar, I was advised some insurers provide no flood cover, some provide it for a price, some provide it to everyone, some provide "flash flood cover" (whatever that means) and some provide it in some locations and not others.

We know the industry is working on this issue, but surely flood cover should be available to anyone who wants it, provided there is a suitable adjustment of premium for an individual who persuades a local council (which we must say is not too difficult in some places) to allow them to build on the edge of a fast-flowing river.

We also ask the question rhetorically, in terms of home building, contents and like policies, as to whether it is possible to provide accidental damage cover on a wide and possibly universally acceptable basis, where once again, for a suitable premium, an insurer offers to cover all accidental damage which would, of course, exclude deliberate damage, or damage occasioned by neglect. Our limited enquiries reveal that an additional premium of $200 or slightly more, might result in such cover which would then, no doubt, bring about a reduction in policy size from 50 pages to five, provided the lawyers who participate in the drafting process, are not paid by the word.

This concept might conceivably be translated into other areas where, for example, a motor car policy provides cover in all circumstances except where the driver has engaged in wilful or serious misconduct, such as driving while in an altered state of consciousness or an unsafe vehicle, or on the wrong side of a freeway while in an altered state of consciousness.

3. If all this is too hard, what about putting all the exclusions in one place, doing away with general exclusions, specific exclusions and exclusions that apply to policy A and not to policy Z, or that apply to travel policies such as that described in Determination No. 20661?

4. Eradicate policies that are unclear in terms of typography and design.

5. Find a way of overcoming underinsurance or over-insurance. Are replacement policies out of the question? Can we do away with the concept of "Sum Insured"? Can the policy limitation process be simplified e.g. what is or is not a "collection"? What constitutes "reasonable care"? What does "Legally responsible" mean in terms of the cover provided for contents? These are existential dilemmas that have, in effect, the potential to fry our brains!

In other words, we propose the need to re-examine the concept of insurance and insurance documentation and ask whether simplicity can be introduced (or reintroduced), even if the cost is a small premium increase to the community, which, in turn, may well be counterbalanced by the reduction in cost of legal and claims fees.

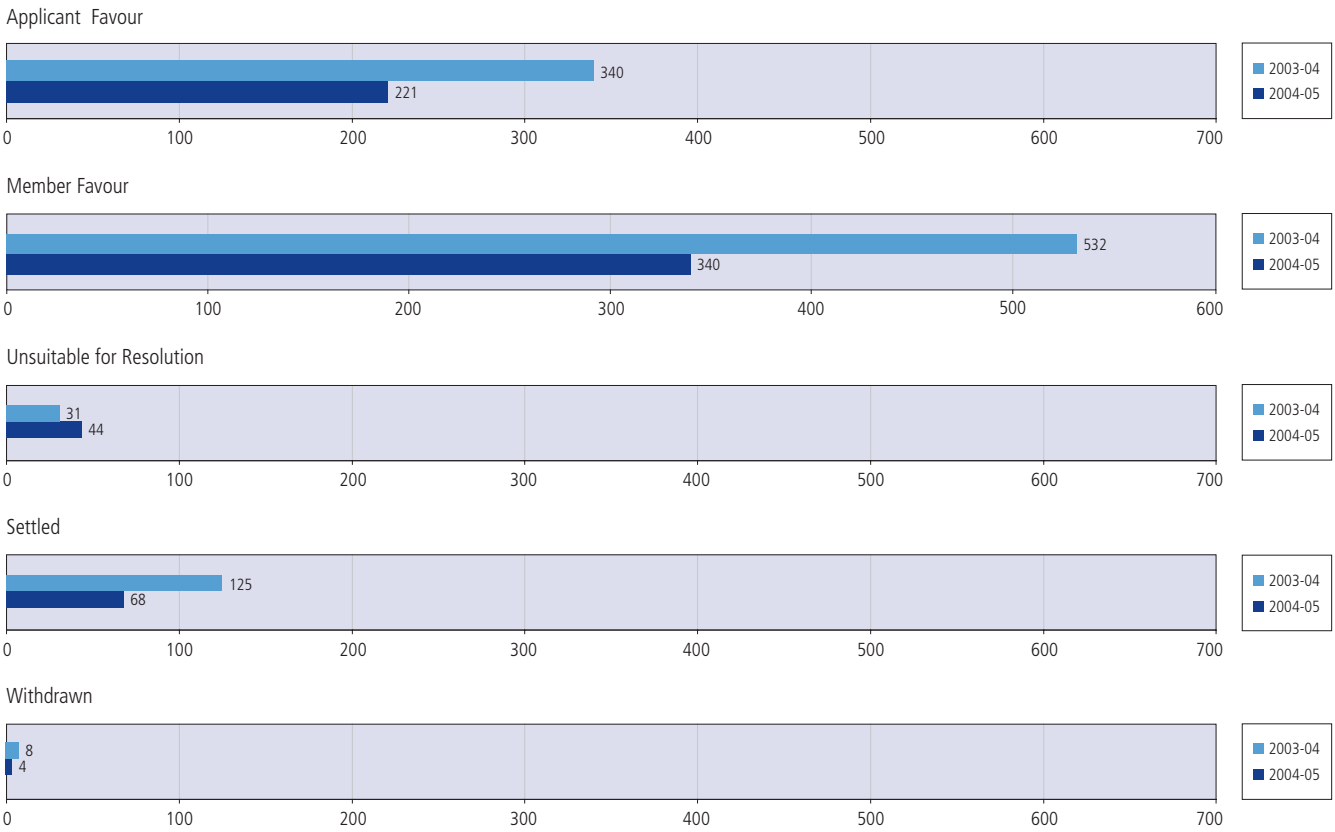
In any event, the issues raised by the Panel in this review may be prophetic, because we suggest if nothing is done, there will be more disputation (possibly being resolved against the industry) more legal and claims fees, more criticism, more IOS panels and bad publicity for an industry which deserves much more positive publicity than it receives.

Peter Hardham,
Panel Chair

Statistics

Table 1
Panel Outcomes (July 2003 – June 2005)

	Determined by Panel				Unsuitable for resolution		TOTAL		Other Resolutions				Completed
	Applicant favour		Member favour						Settled		Withdrawn		
July 2003 – June 2004	340	32.8%	532	51.4%	31	3.0%	903	87.2%	125	12.1%	8	0.8%	1036
July 2004 – June 2005	221	32.6%	340	50.2%	44	6.5%	605	89.4%	68	10.0%	4	0.6%	677
TOTAL/AVERAGE	561	32.7%	872	50.9%	75	4.4%	1508	88.0%	193	11.3%	12	0.7%	1713



Conferences 2006

National Conference
26 June 2006

The Insurance Ombudsman Service is holding its 2006 National Conference on Monday June 26 at the Park Hyatt in Melbourne. Themed "Doing it better", the one-day conference is designed around three workshops with a strong focus on fraud. Speeches from industry experts will also feature. To express interest, please contact Malcolm Heath on 02 9252 3574 or email mheath@conferenceworld.com.au.

International Conference
28-31 August 2006

The Insurance Ombudsman Service, together with the Financial Industry Complaints Service and the Banking and Financial Services Ombudsman, will this year host the international external dispute resolution conference.

"ADR '06 in Oz" will be held at the Sanctuary Cove Park Hyatt on the Gold Coast from August 28-31, providing an excellent opportunity for industry experts around the world to meet and share thoughts on best practices.

With the imminent launch of "Shared Services", a scheme combining the three hosts, a strong focus will be on joining forces to create a consistent approach to the dispute resolution process. For more information, please contact Malcolm Heath on 02 9252 3574 or email mheath@conferenceworld.com.au.

How Insurers Perform With Disputes

The Insurance Ombudsman Service (IOS) has for the first time released details of the number of disputes between insurance companies and consumers, and how they were resolved.

The information, which covers the year ended 30 June 2005, is an important step in the industry's continuing drive to introduce greater transparency to the insurance process.

But because insurers have vastly different market shares, the public has been warned not to try to extrapolate too much from the data. For example, the top five insurers hold more than 80% of the market, so the percentage of claims in which an insurer is involved has to be regarded against that figure.

Some insurers have relatively tiny market shares, so that even one or two disputes can see its performance in relation to claims disputes feature at the top of the list.

It is not commercially feasible to publish the number of policies held by each insurance company. While it would make interpretation of the figures easier, it could also provide commercially sensitive information in a market that is highly competitive.

The figures should nevertheless give a clear indication of the relative claims performance of each insurer.

The data shows that of the 55 insurance companies which are participants of the IOS scheme, five companies had no disputed claims at all during the period. In some cases this is because the company involved is in run-off – that is, it is not selling any new policies and is only administering existing claims. (These companies are indicated by an *.)

TABLE 1: The percentage of total claims made against individual companies compared to the number of policies they issue. The industry average is 9.91%, the highest is 40.88%, and the lowest is 1.13%.

TABLE 2: The percentage of total disputes referred to internal disputes resolution (IDR) processes within insurance companies, compared to the number of claims. If a claim settlement proposed by the insurer is disputed by the consumer, it must be referred in the first instance to a company's IDR committee, which is usually made up of senior executives.

The average number is 1.77% of policies; the highest is 69.23% (relating to a company in run-off, which for part of the period had no IDR process – the second-highest is 4.26%); the lowest is 0.03%. Eight companies reported no disputes at all.

TABLE 3: The percentage of disputes referred to IOS, compared with the total disputes referred to the companies' IDR processes. In other words, these are the percentage of disputes that consumers refer to IOS for a binding decision on the insurer following that insurer's IDR process.

Again, the highest figure of 166.7% relates to an insurer in run-off, which referred all disputed returns to IOS. The next-highest figure is 100%; the average is 22.2%; and the lowest (achieved by 14 insurers) is zero.

TABLE 4: The percentage of disputes referred to IOS that were found in favour of the consumer. Of the 55 companies involved, the highest percentage is 100%; the average is 35.04; and the lowest is 0 (achieved by 14 insurers).

Table 1
Percentage of Claims compared to Policies, per member, 2004/05

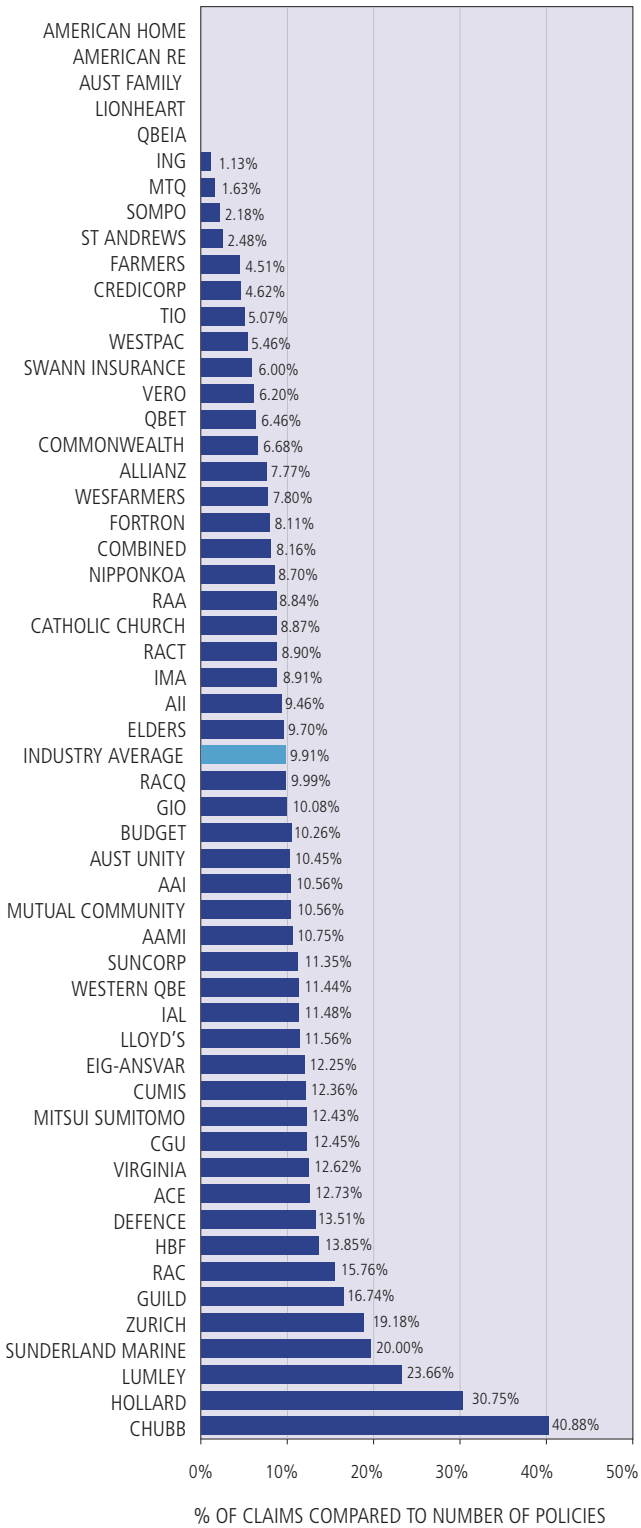
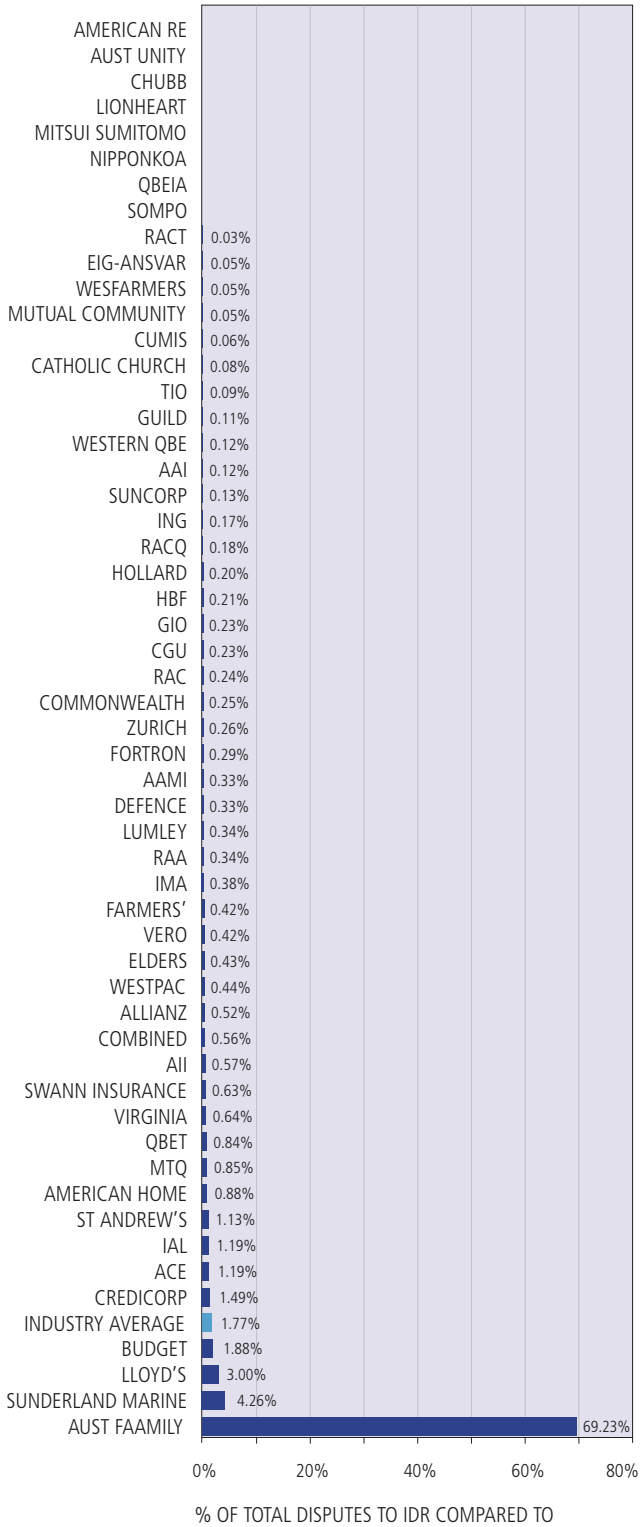
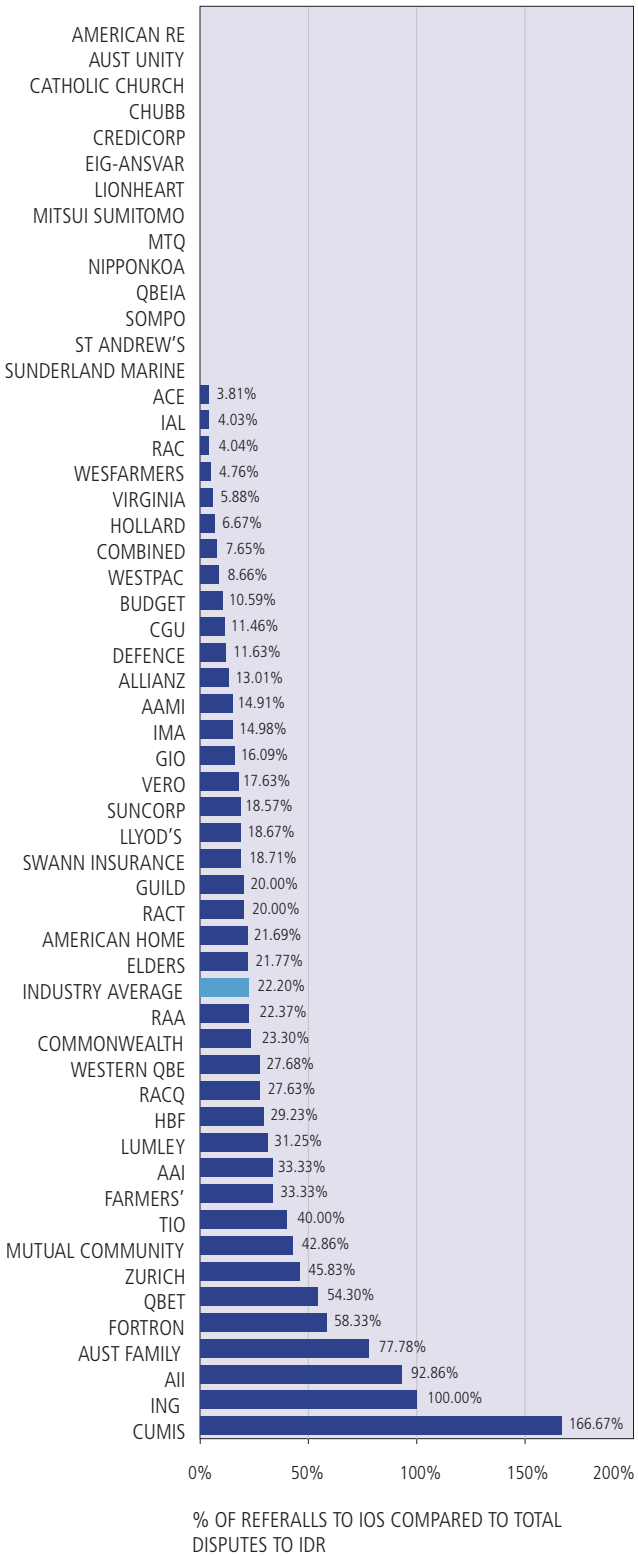


Table 2
Percentage of Claims referred to IDR, per Insurer, 2004/05



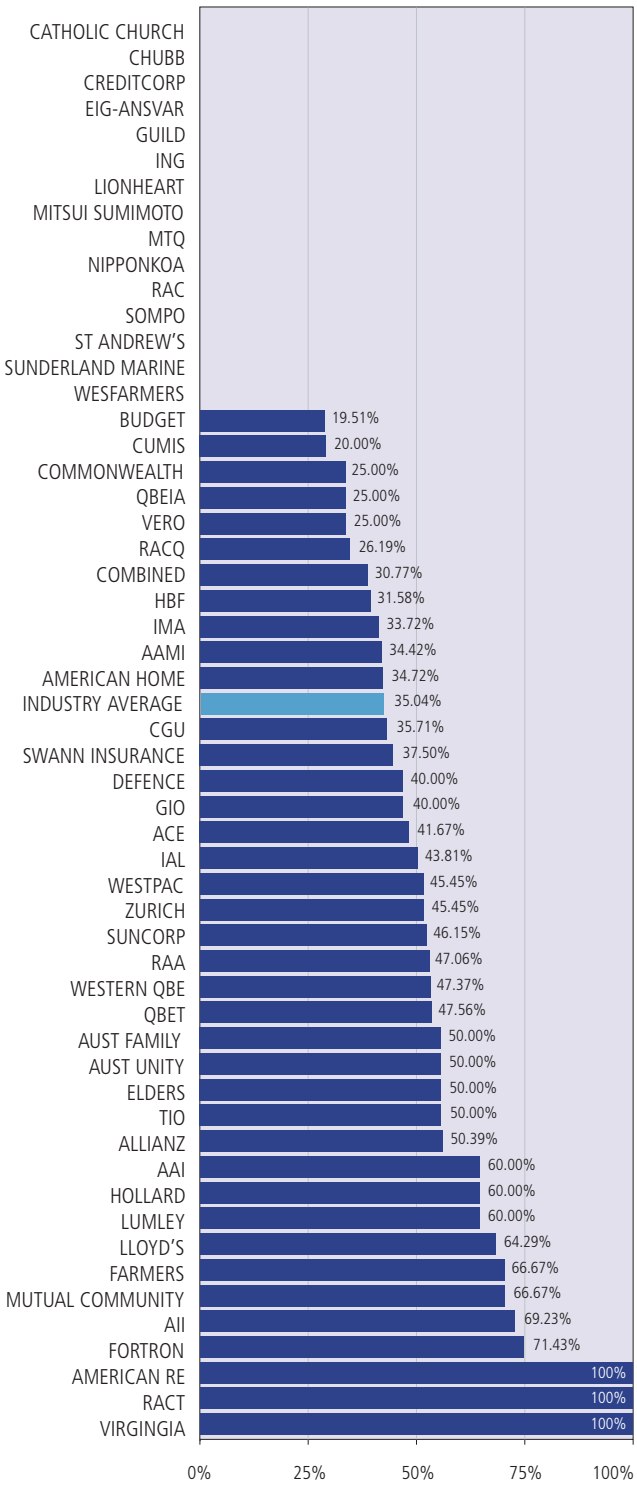
Statistics

Table 3
Percentage of IDR decisions, per Insurer, referred to IOS 2004/05



% OF REFERALLS TO IOS COMPARED TO TOTAL DISPUTES TO IDR

Table 4
Percentage of EDR decisions, per Insurer, found in favour of consumer 2004/05



% OF DISPUTES IN FAVOUR OF APPLICANT COMPARED TO REFERRALS TO IOS

Legend

Company	Abbreviation
Australian Alliance Insurance Company Limited	AAI
Australian Associated Motor Insurers Limited	AAMI
Ace Insurance Limited	ACE
Australian International Insurance Limited	AII
Allianz Australia Insurance Limited	ALLIANZ
American Home Assurance Company	AMERICAN HOME
American International Assurance Company (Australia) Limited	AMERICAN RE
Australian Family Assurance Limited	AUST FAMILY
Australian Unity General Insurance Limited	AUST UNITY
Budget Insurance Company Limited	BUDGET
Catholic Church Insurances Limited	CATHOLIC CHURCH
CGU Insurance Limited	CGU
Chubb Insurance Company of Australia Limited	CHUBB
Combined Insurance Company of Australia	COMBINED
Commonwealth Insurance Limted	COMMONWEALTH
Credicorp Insurance Pty Ltd	CREDICORP
Cumis Insurance Society Inc	CUMIS
Defence Services Homes Insurance Scheme	DEFENCE
EIG – Ansvar Limited	EIG-ANSVAR
Elders Insurance Limited	ELDERS
Farmers Mutual Insurance Limited	FARMERS'
Fortron Insurance Group Limited	FORTRON
GIO General Limited	GIO
Guild Insurance Limited	GUILD
HBF Insurance Pty Ltd	HBF
Hollard Insurance Company Pty Ltd (The)	HOLLARD
Insurance Australia Limited	IAL
Insurance Manufacturers of Australia pty Limited (RACV Insurance)	IMA
ING General	ING
Lionheart Insurance Pty Ltd	LIONHEART
Lloyd's Australia Limited	LLOYD'S
Lumley General Insurance Limited	LUMLEY
Mitsui Sumitomo Insurance Company Limited	MITSUI SUMITOMO
MTQ Insurance Limited	MTQ
Mutual Community General Insurance Pty Ltd	MUTUAL COMMUNITY
NIPPONKOA Insurance Company Limited	NIPPONKOA
QBE Insurance (Australia) Limited	QBEIA
QBE Travel	QBET
RAA Insurance Limited	RAA
RAC Insurance Proprietary Limited	RAC
RACQ Insurance Limited	RACQ
RACT Insurance Pty Ltd	RACT
Sompo Japan Insurance Inc.	SOMPO
St Andrew's Insurance (Australia) Pty Ltd	ST ANDREW'S
Suncorp Metway Insurance Limited	SUNCORP
Sunderland Marine Mutual Insurance Company Limited	SUNDERLAND MARINE
Swann Insurance (Aust) Pty Ltd	SWANN INSURANCE
Territory Insurance Office	TIO
Vero Insurance Limited	VERO
Virginia Surety Company, Inc.	VIRGINIA
Wesfarmers Federation Insurance Limited	WESFARMERS
Western QBE Insurance Limited	WESTERN QBE
Westpac General Insurance Limited	WESTPAC
Zurich Australian Insurance Limited	ZURICH

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