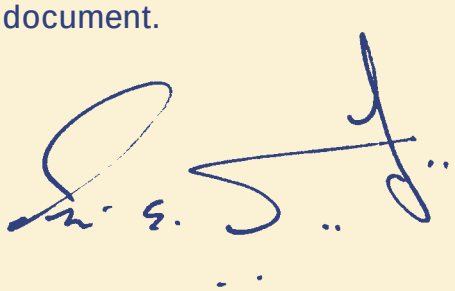
INSURANCE OMBUDSMAN SERVICE LIMITED

IOS Annual Review 2006

Annual Review

Pursuant to the Terms of Reference of the Insurance Ombudsman Service Limited, the following is the Annual Review for the period ending 30 June 2006.

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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Peter E. Daly AM
Chair of the Board

The Impetus to Accessibility

The past year has seen some important developments in the evolution of the Insurance Ombudsman Service. It has been a year of challenges and, with our response to the Independent Review, has given impetus to the maturation of the IOS into a more accessible organisation, increasingly ready to deal with issues simply because they affect the relationship between insurer and consumer rather than because the jurisdiction or the Terms of Reference (TOR) cover such situations. This follows the approach already adopted by the industry through the expanded use of its internal dispute resolution (IDR) services to deal with disputes and solve issues not necessarily covered by the TOR.

The IDR has great potential to solve problems for the insurer quickly and cost-effectively, similarly, IOS has the potential to resolve problem issues expeditiously and to the mutual benefit of all. It is more than a simple dispute resolution service. It has an important role to play in helping the industry to raise its standards of customer service and claims handling.

During the year, the IOS has focused on developing its communication strategy and in dealing with accessibility issues. In line with the Allen Consulting Group's recommendations following the Independent Review, the IOS conducted two surveys to assess a sample of consumers and their ability to access the service. The findings were positive in terms of accessibility for non-English speakers and highlighted other demographic areas where the IOS will focus future attention. IOS will continue to monitor awareness and usage among disadvantaged groups in the community next year and will be formulating a communications plan in response to these findings.

Another IOS initiative, designed to help improve industry performance, is the IOS Code Working Party on travel insurance, which will help to raise levels of consumer awareness about pitfalls in relation to travel insurance and, at the same time, raise levels of accessibility to the IOS. The working party has been busy during the year looking at issues affecting consumers of travel insurance. Industry and consumer representatives have worked closely with IOS to develop an informative document to educate travellers with hints and warnings so as to better manage their expectations of travel insurance products.

Greater Access for the Financially and Socially Disadvantaged

As a corollary of this transition to a more embracing organisation, there is an increasing expectation from many stakeholders that, as a benefit and an obligation for a continuing degree of industry ownership and a co-regulatory approach to dispute resolution, IOS will adequately deal with the special needs of the financially and socially disadvantaged sections of society.

IOS has been researching this issue throughout the year and next year we hope to improve access to justice for all consumers with issues relating to general insurance and to raise awareness amongst industry of the need to encourage the uninsured and socially disadvantaged to access new and more relevant insurance products.
The IOS Board has established a special committee to examine many of these issues during the coming year.

Many industry members are already advanced in their thinking in relation to these issues and have taken steps to tackle some of the perceived barriers to entry for the uninsured. We would like to congratulate these members on their forward thinking and encourage all of our members to take this issue on board.

IOS Easing the Burden on Courts

Having reached almost 25,000 determinations since inception, IOS has gone a long way to easing the burden on the courts as an arbiter of disputes for general insurance. Our published decisions, available on the IOS website, are a vital source of information for all interested in insurance. This means that all involved with general insurance underwriting and claims need a good working knowledge of the principles and standards applied by the IOS. To assist in achieving this aim, we are increasing the opportunity for regular liaison with interested parties and are also developing a regular programme of meetings

"Having reached almost 25,000 determinations since inception, IOS has gone a long way to easing the burden on the courts as an arbiter of disputes for general insurance."

where stakeholders can meet with the IOS team including the independent decision-makers and discuss, question and seek clarification of determinations.

Ground-breaking Work

These developments see IOS and the general insurance industry in the vanguard of ADR services to consumers. During the year, the IOS jointly hosted the International Ombudsman Conference in Queensland, enabling us to compare our system with those of other countries. Across such issues as procedural fairness, consistency, relationships with stakeholders, independence and the manner in which decision-making occurs there can be little doubt that Australia is particularly advanced. I would like to thank the Ombudsman for his hard work in jointly presenting this highly successful international event.

Board Update

This year has been a particularly busy one for the Board. With four new members appointed in the year to 31 August 2006, we have a new team ready to encourage and energise IOS during the coming year. I would like to welcome Kerrie Kelly and John Peberdy, as the new industry representatives, and Karen Chalmers-Scott and David Coorey as new consumer representatives.

On behalf of the Board and the executive, I would like to take this opportunity to thank the departing Board members whose commitment and enthusiasm over an extended period has made my role a comparatively easy one. They have been productive contributors to the development of IOS and the performance of its many duties under both the TOR and the Code of Practice. Graeme Adams, Raymond Jones, Denis Nelthorpe, Fiona Guthrie and Alan Mason have all made invaluable contributions to the success of the Board and the Board committees.

A Busy Year for IOS Team

The IOS team has driven two major projects through to completion during the year – preparations for the introduction of the new Code of Practice on 18 July 2006 and the IOS' implementation of the recommendations of the independent review undertaken by the Allen Consulting Group.

I would like to thank all at IOS for their efficient response to these challenges. With the help of the industry, the Code team has successfully put in place the systems and procedures required to effectively monitor compliance with the new Code.

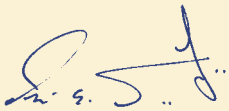
The changes made in response to the independent review have been undertaken in consultation with members, consumer representatives and regulators and they should go a long way to ensuring we continue to meet our obligations under PS 139. Moreover, the challenges set by the review have rejuvenated our focus on creating a broader, more accessible organisation better positioned to help all stakeholders.

Each of the reports which follow in this annual review highlights the increasingly complex nature of the work undertaken by the independent decision-makers and how valuable that work is to all stakeholders. With the increase in the number of disputes referred to IOS this year, the Chair of the Panel, the Adjudicator and the Referee have been busier than ever. The increase in the number of claims denied by insurers, as recorded in the IDR statistics, has helped fuel this increased workload. The IOS focus on education is designed to ensure that the decisions made by industry at the claims stage are the correct ones and thus avoid the need for the matter to become a dispute referred to IOS for resolution.

I would like to offer my thanks to Panel Chair, Peter Hardham and his Panel Members: Brendan Pentony, Denis Trafford, Geoffrey Peacock and Brian Marshall, as well as to Ron Beazley, the Adjudicator and John Price, the Referee, for their fine work this year in resolving an increasing number of matters – 2051 disputes have been resolved during the year.

I would also like to acknowledge Michael Gill for his hard work as Chair of the Code Compliance Committee during the transition to the new Code of Practice and congratulate him on his appointment as Chair of the new Code Compliance Committee. Congratulations are also deserved for the appointment of Denis Nelthorpe to this Committee as consumer representative and to John Driscoll as industry representative.

Last, but certainly not least, I would like to thank the Ombudsman, Sam Parrino, and his management team for their smooth management of the service through a challenging year. I look forward to working with all of the team at IOS as we continue to offer an accessible, efficient and cost effective service to all of our stakeholders.



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 the Insurance Council of Australia) and three consumer representatives (appointed by the Board).

The Chair is appointed for two years. Two industry directors are appointed at the annual general meetings of IOS Limited; the incumbent Executive Director of the Insurance Council of Australia 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.

Current Directors (at 31 August 2006) are:

P. E. Daly, AM (Chair)

Mr Daly was 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. Mr Daly has held a number of directorships since then, was the President of the Insurance Council of Australia 1986-1987 and Chief Executive Officer from 1991-1997. He was the Deputy Chairman of the Zoological Parks and Gardens Board and is also the Chair of Financial Industry Complaints Service Limited. On 14 March 2004, Mr Daly was awarded the Order of Australia for services to the insurance industry and to the community, particularly through the advancement of alternative dispute resolution and consumer protection.

G. Adams, BE, MBA

Mr Adams was appointed a director of the Company in March 2001 as an industry representative. He is Head of Personal Insurance, Product & Underwriting at Insurance Manufacturers of Australia Pty Ltd. Mr Adams has over 20 years' experience in general insurance and 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.

K. Chalmers-Scott, FAICD

Ms Scott was appointed a director of the Company in August 2006 as a consumer representative. Holding qualifications in education and business administration, she works as an independent public affairs / consumer affairs practitioner. Ms Scott has extensive experience as a senior executive, across the regulatory, commercial, dispute resolution and not-for-profit sectors. Her previous roles include General Manager Customer Affairs for the Office of the Regulator General, Victoria; Customer Advocate within Bank of Melbourne/Westpac; and Assistant State Director for the Institute of Chartered Accountants, Queensland. Ms Scott is a Fellow of the Australian Institute of Company Directors. She also serves on the Surveyors Board of Queensland, the Commonwealth Consumer Affairs Advisory Council, and a number of other advisory committees.

D. Coorey, BA LLB (UNSW)

Mr Coorey was appointed a director of the company in July 2006 as a consumer representative. In 2002 he joined the Consumer Law team of the Civil Litigation section of the Legal Aid Commission of NSW. He previously worked with the law firm Freehills for over three years, including a one year pro bono secondment to Kingsford Legal Centre.

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

K. Kelly, CLE

Ms Kelly was appointed a director of the Company in April 2006 as an industry representative. Ms Kelly joined the Insurance Council of Australia as Executive Director and CEO in April 2006. She is a lawyer who has held senior executive positions in the public and private sectors working in the fields of banking and finance, manufacturing and transport, and has considerable experience in strategic and operational planning, resource allocation, policy development and implementation, strategic alliance development, and product and services development and management. Ms Kelly was previously Chief Executive Officer of the Financial Planning Association of Australia.
Ms Kelly is also a Member of the Australian Government's Financial Literacy Foundation Advisory Board and Director of Finance Industry Council of Australia Ltd.

Dr E. Lanyon, LL M (Melb) 1986, LLB (Hons) (Melb) 1980, BA (Hons) (Melb)

Appointed a director of the Company in November 2002 as a consumer representative, Dr. Lanyon is currently senior policy advisor to the Director of Consumer Affairs Victoria. She is an Honorary Associate Professor in the Law School at Monash University. Elizabeth is a member of the Law Council Financial Services Committee and co-author of the two major texts on consumer credit law in Australia.

J. Peberdy, ANZIIF (Snr Assoc), CIP

Mr Peberdy was appointed a director of the Company in August 2006 as an industry representative. He is the Chief Executive Officer of EIG-Ansvar Ltd and is responsible for the Australian and New Zealand companies of the Ecclesiastical Insurance Group. Mr Peberdy joined Ansvar Insurance in 1973 in Adelaide and was transferred to Melbourne in 1985. He has since been involved in a range of management roles and was appointed CEO in May 1999. He is a Senior Associate of the Australian and New Zealand Institute of Insurance and Finance and a CIP. He is also a director of the Insurance Council of Australia. Mr Peberdy is particularly interested in the issue of reduction of loss and injury from preventable causes within the community service sector.

About the Board

Retired Directors

The IOS Board and executive would like to offer our thanks to the following Board members who resigned before 31 August 2006:

F. H. Guthrie, B.A, M.B.A., F.A.I.C.D.

Appointed a director of the Company in August 2002 as a consumer representative, Ms Guthrie resigned as a director and also as a member of the audit committee in March 2006. Ms Guthrie was the Deputy Chair of the Consumers' Federation of Australia, the Chair of the Centre for Credit and Consumer Law at Griffith University and the Chair of the Consumer Advisory Panel of the Australian Securities and Investments Commission.

D. Nelthorpe, B. Juris, L.L.B.

Mr Nelthorpe was appointed a director of the Company in March 1999 as a consumer representative and was a member of the old Code Compliance Committee, a committee of the Board. He resigned as a director on 16 July 2006 as a result of his appointment by the Board of IOS as the independent consumer representative of the General Insurance Code of Practice Compliance Committee.
Mr Nelthorpe is currently a consulting lawyer working with a wide range of government, industry and community organisations. He is Chair of the Consumer Credit Fund (Victoria) and a member of the National Advocacy Panel of NECA. He is a past president of the Consumers' Federation of Australia. He was the past Chief Executive Officer of the Consumer Credit Legal Service 1986-91 and the Consumer Law Centre Victoria 1993-98.

A. J. Mason, B.A. (Hons), FCII, ANZIIF (Fellow), FAICD

Mr Mason was appointed a director of the Company in January 1997 as an industry representative and resigned from the Board in March 2006. He was the Executive Director of the Insurance Council of Australia Limited and has over 35 years experience in the insurance industry, mainly in Australia and also in the United Kingdom and South Africa. Mr Mason was also a director of the Finance Industry Council of Australia.

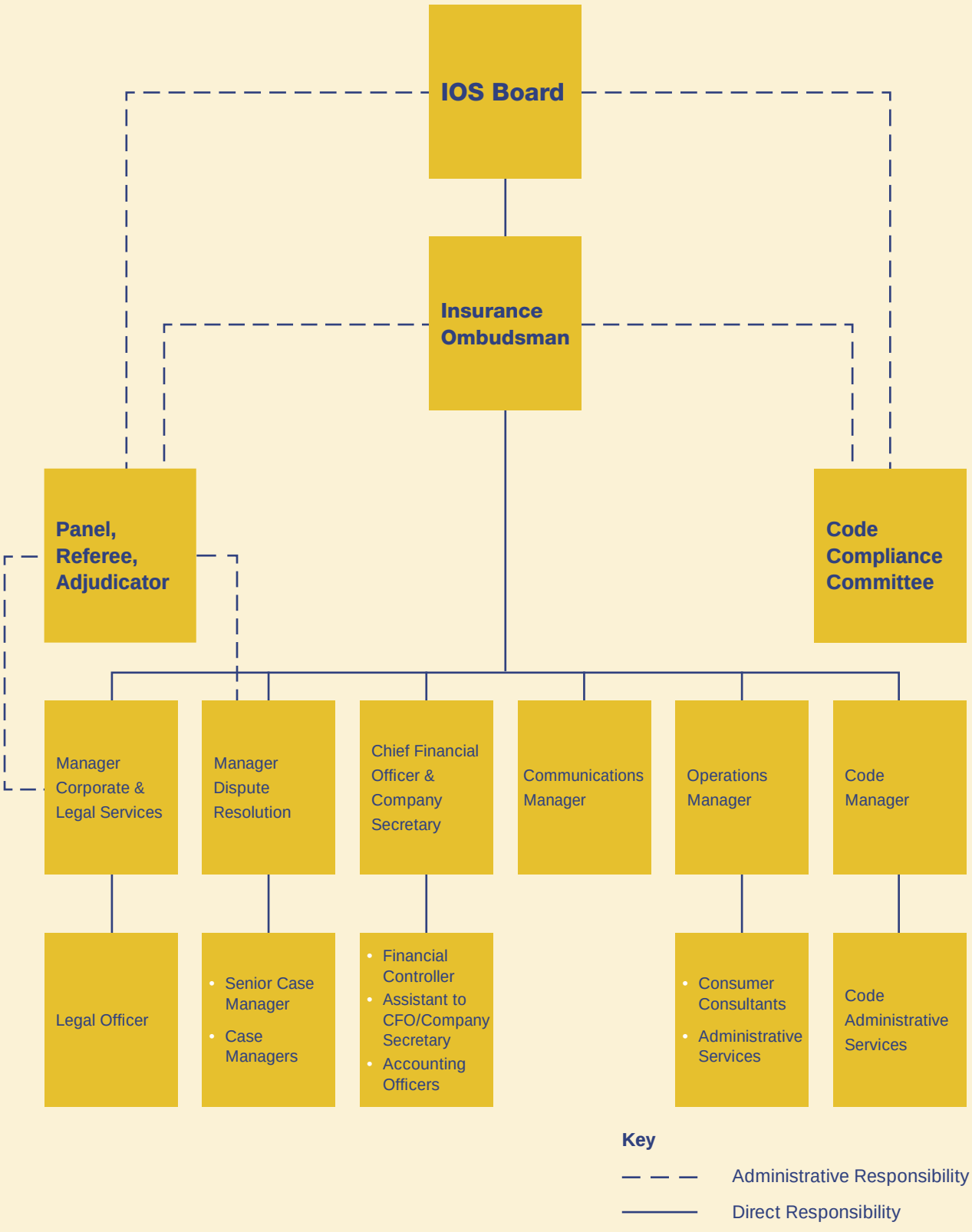
R. L. Jones, AFAMI

Appointed a director of the Company on 27 March 1998 as a member representative, Mr Jones resigned from the Board in August 2006. He was Director of Business Development for QBE Insurance (Australia) Ltd and QBE Insurance (International) Ltd, Director of the Insurance Council of Australia Limited, and President of the Australian Insurance Association. He has 22 years of experience in senior positions in the insurance industry, including 5 years overseas.

C. Wolthuizen, BA (Hons), LL.B

Ms Wolthuizen was appointed a director of the company in March 2006 and resigned in June 2006. Ms Wolthuizen was the Executive Director of the Consumer Law Centre Victoria and Chair of the Consumers' Federation of Australia. She previously worked as Senior Policy Officer at the Australian Consumers' Association and as Senior Policy Officer at the UK National Consumer Council.
She was a member of the ACCC's Consumer Consultative Committee, the Consumer Affairs Victoria Working Together Forum and a range of consultative and advisory committees to government and industry. She has been a columnist on consumer issues for various newspapers. Prior to working in the consumer sector, Catherine worked as a journalist with the ABC and as a senior political adviser.

Organisation Chart



Ombudsman's Report

Sam Parrino
Insurance
Ombudsman

Taking the Initiative – IOS as Educator

This has been an extremely busy year for IOS with significant resources and focus placed on implementing the many changes arising out of the Independent Review by the Allen Consulting Group, as well as readying our systems and procedures for the introduction of the new Code of Practice. As the Chair of the Board has noted in his overview, IOS is placing increasing emphasis on accessibility to the service for all in the community as a key initiative for both now and the future.

To achieve this we are striving to reduce perceived and actual barriers that may exist for special groups within the community. It is with this objective that IOS has distributed several communications and undertaken related outreach and research-based projects, which are examined later. We have also been in discussion with community groups about the plight of the uninsured and the underinsured with a view to finding possible solutions to this problem. Recent Insurance Council of Australia statistics showing that 1.8 million Australian households are uninsured, including 65% of renters, highlight the need to reach out to this group.

In conjunction with the industry and consumer bodies, IOS has an important role to play in addressing this issue.

Research reinforces the need for IOS to be an educator, taking a pre-emptive role in helping to ensure that disputes between consumers and industry are minimised or avoided. There is a growing need to tackle issues with the potential to result in conflict before the conflict arises. Educating consumers about IOS, industry IDR processes and ADR in general, as well as increasing awareness of trends in disputes, will benefit all stakeholders. Education will lead to better understanding of the Insurance Contracts Act, policy interpretation and policy drafting and will reduce consumer angst and industry costs. Furthermore, consumers' expectations of insurance will be more realistic and an informed consumer is a more satisfied customer.

The IOS Response to the Independent Review

I would like to thank the Board, all at IOS, as well as industry and consumer groups for their assistance in achieving such a rapid and effective implementation of changes arising out of the Review.

As you are aware, this review was required to assess IOS compliance with the requirements of PS 139, an integral part of the ASIC approval process for industry based EDR schemes. The majority of the recommendations made by the Allen Consulting Group related to operational issues, with significant emphasis on improving the outreach and consultation processes of IOS. The Allen Group commented, "Overall, we believe that the IOS is performing well relative to the benchmark criteria…".

Following are some of the highlights of the IOS response to the review recommendations. After consultation with stakeholders and Board endorsement, the resulting amendments to the Terms of Reference will take effect from 1 January 2007.

- IOS will increase monetary jurisdiction for binding determinations from $150,000 to $280,000.
- IOS will abolish the $150 fee for **uninsured** applicants in third party motor vehicle disputes. This amendment will be reviewed after 12 months of operation.
- The definition of 'small business' in the TOR will encompass businesses with turnover of $1 million, with no limitation on the number of employees. This amendment will be reviewed after 12 months operation.
- It will be the role of the Board to appoint the independent decision-makers. The Insurance Council of Australia will cease performing this function which will now be the responsibility of the IOS Board.
- Improved promotion of IOS
  - Established a more interactive website
  - Introduced monthly bulletins for wide distribution and easy electronic access
  - Instigated closer liaison with consumer advocacy groups

"IOS is placing increasing emphasis on accessibility to the Service for all in the community . . ."

- Distributed nationally brochures about IOS in six languages
- Appointed a Communications Manager to develop a more integrated and proactive communications programme

- To better monitor access to IOS by disadvantaged groups we will continue to conduct surveys of consumers to gauge levels of accessibility. During the past year, IOS conducted two surveys: (1) A survey of consumers who contacted our consumer consultants on the national toll-free number for information and assistance; and (2) A survey of those who chose not to proceed to the IOS with their dispute following the insurer's IDR.

  The results showed that 99% of callers found the service very helpful and highly satisfactory. It was also found that 99% of consumers at the dispute stage stated that the insurer did advise them of the availability of IOS and its services.

  The second survey showed that the young (18-24) and seniors (65 years and older) are under-represented among those contacting IOS. This study also showed that language does not seem to be a barrier to those contacting IOS – non-English speakers were represented at the same levels as English speakers. While these results are encouraging, the IOS will seek to assess levels of consumer engagement with the service during the next year and verify whether these findings still hold true.

  A more worrying finding of the second survey into why consumers chose not to proceed to IOS was that 30% claimed they were not advised about the IOS by their insurer. This indicates that consumers are missing the reference to IOS provided as part of the IDR advice and this is something which IOS and the industry must address. Monitoring by IOS has found high levels of compliance among insurers of their notification requirements, so it appears a problem of presentation not omission.

  Moreover, the fact that the other main reason given for not contacting IOS was that the consumer had "had enough" or "could not be bothered" taking their dispute further at the conclusion of IDR indicates that perhaps some insurer IDR processes are not consumer friendly, so they decline to continue. IOS is researching this issue further as we believe this process can be made more expeditious and effective.

- To ensure the staff is adequately trained to provide the required assistance and develop systems to allow improved tracking of dispute time frames and develop benchmark time frames. IOS has reviewed its training programme and identified areas for further development. We also have introduced new systems to improve tracking of time frames and developed new benchmarks against which to assess our performance. These time frames will be publicised and updated regularly on the IOS website.

Financial Ombudsman Service (FOS)

The national call centre conducted under the banner of "The Financial Ombudsman Service" (FOS) has, since 2002, played an important part in the Shared Services Project undertaken by IOS in conjunction with the Banking and Financial Services Ombudsman (BFSO) and the Financial Industry Complaints Service (FICS). This service, in which a caller in relation to any financial services product is immediately connected to an individual rather than a voice recording, has facilitated easier contact with a dispute service by allowing consumers to call one national and toll-free hotline number for help. This initiative has minimised any potential confusion about which EDR service to contact and has streamlined the enquiry process. The FOS call centre received 99,510 calls during the first seven months of the year, with an average 45% of these calls involving general insurance and therefore expeditiously and seamlessly coming to IOS.

The IT initiative has continued apace this year as the three major organisations seek to merge and simplify their back-office support networks. The first phase of this IT project, to consolidate rental agreements for all three organisations and implement a single technology platform, was completed at the end of May 2006.

An ADR Service you can be Proud of

At the risk of sounding self-congratulatory on behalf of IOS and the industry generally, it is useful to highlight some of the advantages inherent in the regulatory structure which governs the Australian insurance industry and its dispute resolution processes. As Co-Chair of the 2006 International Ombudsman Conference held in Australia in August, I was able to compare our system with those of other jurisdictions and learned that the following issues are crucial in the successful functioning of our system:

"...our timelines have surpassed even the new benchmarks set during the year...In the last quarter of the year we averaged 90% of disputes being settled in under 120 days."

Value of Cases

In terms of the value of cases referred to us, 51% were under $5,000, while 66% were under $10,000. These are comparable to the values of the cases referred to us last year. It will be of interest to see if the increase in monetary jurisdiction, due to take effect on 1 January 2007, and the major increases in property values these past few years, will have an impact on the value of cases we deal with in coming years.

Resolution Timelines

Whilst coping with this 12% increase in referrals, the IOS team has done a great job in reducing the time frames within which those disputes are resolved. Having established tougher benchmark time frames, the IOS surpassed these benchmarks during the latter stages of the year.

At the first tier level, the IOS has been increasingly busy through the year. For the first seven months of 2006 the joint call centre, run under the banner of Financial Ombudsman Service, received 99,510 calls compared to 90,304 for the same period last year, an increase of around 9%. General insurance has consistently received the majority of calls with around 48%, however, since the addition of more EDR Schemes as participants, general insurance calls now constitute 45% of total calls. This confirms the fact that consumers need more user-friendly information about the products sold by the industry.

In the same period our own first tier Consumer Consultants handled 43,711 contacts compared to 36,096 last year, an increase of around 20%. The complexity of calls is growing, with direct correspondence and email communication more than doubling for the same period.

The New Code of Practice

The new Code came into operation on 18 July 2006. IOS spent this year assisting our members in the implementation of the systems and processes required to meet the new standards through a range of measures including:

- One-on-one meetings with individual insurers to discuss modification of existing systems to accommodate the new requirements;
- The development of new documentation for monitoring compliance with the new Code;
- Holding meetings with Code Compliance Managers to discuss issues arising from implementation of the new Code;
- A programme of national educational outreach to members to outline IOS obligations and expectations.

The IOS would like to thank the industry for its responsiveness and cooperation which has meant a smooth transition to the new Code on 18 July 2006.

Cyclone Larry

Cyclone Larry in March 2006 further highlighted the importance of IOS involvement in emergencies in conjunction with the industry. As part of an integrated industry, governmental and community response, overseen by General Peter Cosgrove (Ret.), IOS has helped consumers deal with the myriad of problems caused by the nightmarish conditions after the cyclone. With an IOS representative permanently stationed and on call in Cairns since 18 April 2006, as at 30 September 2006 IOS has undertaken 391 individual consultations with residents of the area with 20% requiring referral to the insurer. The IOS intends to continue to be proactive during domestic emergency situations and in educating consumers in their expectations of the industry at such times with a view to benefiting all stakeholders during trying times.

In Conclusion

I would like to thank every member of the team at IOS for their unstinting application in carrying forward our work during a challenging year. The independent decision-makers and all the staff have dealt with increased workloads and a rapidly changing environment through a focus on hard work and commitment. Supported by a Board which is united and focused on the success of IOS in the performance of its duties and in the need for it to respond to the ever-changing order of things, I am excited for the future as we try to create a more accessible service, representing the best of the insurance industry and seeking to provide real access to justice for all consumers with complaints relating to general insurance.

Sam Parrino
Insurance Ombudsman

Dispute Flow Chart

Consumer

Complaints

- Telephone, or
- In writing

IOS Consumer Consultant

Explains options and refers consumer to participating company for review of dispute and Internal Dispute Resolution decision.

Consumer

If dispute is not resolved, to consumer's satisfaction, consumer can refer dispute to IOS.

IOS Case Manager

Investigates dispute. If dispute is not settled, refers to Panel, Referee or Adjudicator.

Adjudicator

Less complex cases, where $5000 or less is in dispute and no fraud is alleged. Determination, binding on participating company, not binding on consumer.

All disputes where **fraud is not alleged**

If the matter is considered complex, it is referred to the Panel

The Panel

Reviews evidence, conducts hearing if necessary. Issues Determinations, binding on participating company, not binding on consumer.

All disputes where **fraud is alleged**

Referee

Reviews evidence, conducts hearing. Issues Determinations, binding on participating company, not binding on consumer.

Determination

Consumer

Not bound by Determination. Can seek other remedies elsewhere. If consumer accepts Determination, no further action.

Panel Chair's Report

Peter Hardham
Panel Chair

Is the Panel too similar to a Court?

During a recent conference, a speaker stated that the Panel has become too formal and legalistic in its decision-making, taking it away from its original role as an informal decision-making body, operating with a minimum of legal formality. The comment was also made that, as we align ourselves with the formal decision-making process, we are attracting growing involvement with the legal profession which would, in turn, accelerate the Panel on its path to becoming similar to a quasi-court which may add to the cost of Panel decision-making.

I would like to respond as follows:

- We have seen an increasing number of complex disputes which leads to more applicants seeking legal assistance. I suggest it is beyond the capacity of most individuals to adequately present their case in a dispute involving allegations of non-disclosure, complex medico/legal issues, or in cases involving domestic arson. Some of these disputes might involve claims of up to $280,000, which is the new jurisdictional limit for the Panel as from 1 January 2007.
- Unlike other international jurisdictions, we need to respond to the challenges of the Insurance Contracts Act which has now been with us for 22 years. When the Act is further amended, following the recommendations of the Cameron Review, we will be faced with further changes and consequent complexity.
- As the Panel has produced a large body of determinations over the past 15 years, parties are increasingly using those decisions in support of their arguments in new disputes so that a body of "our own case law" has developed. Whilst previous determinations are not binding, in order to ensure consistency, we try to ensure our decision-making is consistent. In this way, a degree of formality has slowly evolved. Provided the standard of decision-making is constantly being improved and refined and is in keeping with criteria established in our terms of reference, I do not believe this is a retrograde development.

Visit to the UK Ombudsman

Last August, I travelled to London and I spoke with Peter Hinchcliffe of the UK Insurance Ombudsman Scheme about a number of matters, including the degree to which our respective organisations act as educators or even regulators in the sense that some of our decisions have far-reaching implications in terms of the operations of the insurance industry. His comment was that his Scheme is wary of the line between decision-making, education and regulation and if there were concerns, e.g. as to the lack of clarity in insurance documentation, this was a matter for the regulator and not his organisation. I wonder if this is the case in Australia and whether, having signed approximately 10,000 determinations in my time at IOS, I and my colleagues are in a unique position to draw the stakeholders' attention to flaws in the processes of marketing, drafting and interpreting insurance policies.

We also discussed the need for consistency in decision-making relationships with stakeholders over specific issues such as the interpretation of terms such as "reasonable care", "unattended luggage" and the manner in which we deal with allegations of fraud, domestic arson and time frames. I was impressed with the commonality of problems with which we deal, and the consistency of our approach, which is not surprising in view of the fact that the Australian common law is very strongly based on United Kingdom law and many UK decisions are still important in our decision-making. I considered we compared favourably in time frames in resolving disputes.

Panel Chair's Report

International Ombudsman's Conference

I was privileged to be invited to attend the International Ombudsman Conference held in Queensland in August, which was attended by 114 delegates from many different countries including Pakistan, Canada, the US, Trinidad and Tobago, many European countries, South Africa and PNG. The conference was hosted by the three major schemes in Australia, namely IOS, FICS and BFSO and was an outstanding opportunity to explore such issues as procedural fairness, time frames, consistency, relationships with stakeholders, administration, funding and issues such as independence, the relationship with Government and the manner in which decision-making occurs. I was very proud of IOS as I think it compares favourably with all the other schemes in terms of speedy, efficient and effective decision-making. Some points worth highlighting in the context of this report are as follows:

- There is no equivalent of the Insurance Contracts Act in other countries and most countries are operating within the structure of ancient legislation or the common law. In many instances, the Insurance Contracts Act is the envy of other schemes who are advocating legislative reform based on the Act. When the amendments are made to our Act, we will be further advanced along the path of legislative reform.
- There is no equivalent to the General Insurance Code of Practice and the new Code, which came into full operation on 18 July 2006, is something we should regard with considerable pride. It has the potential to improve the process of claims-handling and relationships between the industry and its customers. I expect it may also result in a continued reduction of disputes being referred to IOS, unless our jurisdiction is expanded to bring it into closer harmony with the range of products covered by the Code.
- The laws in relation to non-disclosure in Australia are much more favourable to the consumer than in the UK, New Zealand and South Africa, because in many instances in these countries, the non-disclosure or misrepresentation itself, will be enough for the insurer to avoid the policy from inception, irrespective of the insurer's attitude to the application for insurance if the failure to disclose or misrepresentation did not occur. In other words, there appears to be no statutory or common law equivalent for the provisions of section 28(3) of our Insurance Contracts Act.
- The resolution timelines in many schemes are much longer than with our Service. This may be partially due to the fact that many schemes issue "preliminary determinations" on which the parties can comment and respond before the determination is final.
- Negotiation and conciliation is employed more frequently than our Service.
- The relationship between the IOS and the industry is very strong and positively compares with the majority of other schemes.

Conciliation and Mediation

In my opinion, the conciliation and mediation role of IOS could be further utilised and understood, especially as it is employed effectively in other schemes. I am aware that in the great majority of cases that come to the Service, both parties are looking for a decision, as the dispute has already been considered by the member's claims staff, the insurer's own IDR process and the IOS case manager, and the material on which the parties rely has been fully exchanged. However, I believe there are a significant number of disputes where complex factual and legal issues interplay to the extent that a win for either party would be unjust and unfair e.g. in many medico/legal disputes, domestic arson, non-disclosure - in such cases, the fairest result is a compromise. In the court process, a judge, having heard part of the evidence, may indicate privately or publicly to the parties they should try to resolve the dispute. This is exactly the process I believe should be employed when the Panel recommends this course and I hope the parties will listen. We only do this in a minority of cases but a matter resolved by negotiation is more than likely to result in an ongoing relationship between the parties.

Travel Insurance

I note the issue of travel insurance has been occupying a great deal of our attention over the past several years, and the Panel has devoted a significant part of its report to this issue. Travel insurance occupies more of our time because more people travel, the process of travel has become more complex, and at times stressful, and there are many problems we encounter which are unique to the travel insurance sector.

"The new Code, which came into full operation on 18 July 2006, . . . has the potential to improve the process of claims-handling and relationships between the industry and its customers."

In an endeavour to pro-actively deal with these problems, an IOS Travel Insurance Group has been formed which has already met on a number of occasions to deal with such issues as policy wording, controversial decisions, the quality and quantity of medico/legal evidence and the process of selling insurance e.g. the role of the travel agent. In my opinion, this is a very worthwhile forum and has the potential to achieve more progress in these areas rather than relying on determinations as the sole educative tool. Meetings with individual insurers have also occurred to discuss more specific cases.

Medical Indemnity

I should also acknowledge the addition to the Service of the medical indemnity insurers who insure doctors and health professionals. The Panel has already dealt with a small but challenging number of disputes involving the terms and conditions imposed by the members on doctors' insurance obligations, disputes involving non-disclosure and sometimes ethical disputes. The Panel had to consider one dispute where a health professional was refused indemnity for his defence to disciplinary proceedings for allegedly wrongfully disclosing confidential information about a patient in respect to factual matters that were conveyed to him. Many of these disputes take us into interesting new territory.

Education

I have also experienced many opportunities during the past 12 months to attend conferences, seminars, meetings and communicate with all sections of the industry including claims managers, underwriters, loss adjusters and assessors, investigators and brokers. I would like to thank ANZIIF, the Insurance Council of Australia and the legal and insurance professional associations for providing me with these opportunities because it makes my role easier if it is more generally understood. Not everybody agrees with what I say, however, in my opinion, debate and discussion breed better understanding.

A growing number of complex medico/legal disputes encouraged me to initiate a training session for IOS staff (including case managers and decision-makers) which was led by a very competent and experienced medical practitioner, Dr John Stanton. He was generous enough to provide a very comprehensive presentation on a range of important subjects such as coronary artery disease, musculo-skeletal injuries and psychological illness such as depression, anxiety and more severe psychotic illnesses. He also made a valuable contribution to our National Conference in similar areas. I believe it would be helpful to further develop this process so that it involved members of the industry, the consumer movement and all persons who are required to grapple with these problems.

I have also become passionate on the whole subject of financial literacy as many people do not understand the complexities of insurance, financial planning and banking. In terms of insurance, which is my specialty, I would like to explore ways in which the advantages and pitfalls of insurance could be conveyed to young people in their final years at school, during tertiary studies and beyond. I would also like consumer and community groups to have these opportunities as I have seen many people financially stricken by an unsuccessful insurance claim that might have been determined against them on the basis of legal, medical or engineering technicality e.g. a failure to disclose a minor speeding offence, a medical condition occurring many years beforehand or an unknown engineering fault affecting the stability of a home, or simply misunderstanding the limits of an insurance policy. This, I believe, is a priority for all stakeholders to embrace.

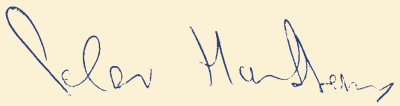
The Support of Other People

I would like to conclude by paying tribute to many people who help the Panel operate effectively. We are blessed to have the support of ten case managers who are responsible for the presentation of all disputes to the Panel in a comprehensive and intelligible form. In many instances, this can be very challenging especially if the applicant policyholder lacks the necessary skills to do so or the member simply sends in its claim file without any real attempt to analyse the issues in dispute. Their function is to create a level playing field in terms of the exchange of documentation and ensuring the necessary material is provided. They also provide decision-makers with an analysis of the factual and legal issues which is presented in the form of a draft determination. This work is vital to the effective functioning of the Panel, and other decision-makers, and the speedy resolution of disputes.

Panel Chair's Report

I would also like to acknowledge the support of the Ombudsman, Sam Parrino, and his staff for creating a positive and harmonious environment in which we can operate and function to the best of our abilities. Mr Parrino and I work together as partners, notwithstanding that we operate in different areas and with separate functions. I have also had the full support of the IOS Board which is very interested in our work and provide me with regular opportunities to meet with them and outline topics of mutual interest and concern. I would be rendered useless without the ever present support of my administrative and secretarial staff - Pamela Roche, Lucy Cannizarro and Sue Horley.

I hope this report will stimulate useful debate and discussion.



Peter Hardham
Panel Chair

Panel Report – 15 years on … how far have we progressed?

IOS has been operating for 15 years and this report will analyse the journey we have undertaken in conjunction with all stakeholders. This Review will examine the principal areas of difficulty featured in previous Annual Reviews to assess whether our message is being heard and why the same issues recur.

1. Non-Disclosure

In September 1997, the Panel issued a series of Practice Notes which are being updated at the moment. Many of them have stood the test of time reasonably well, including the Practice Note setting out the Panel's requirements when an insurer is denying a claim, based on non-disclosure or misrepresentation by the policyholder. We should say we issued these Practice Notes mainly for the assistance of the industry because we did not want undeserving applicants to have their claims paid purely on the basis of legal technicality. We would be very interested to know how many claims officers are aware of these Practice Notes, or keep a copy in their pocket.

Two years later, partially as a result of the Panel's advocacy, section 21A of the Insurance Contracts Act was introduced. This section requires insurance companies to ask specific questions of respective insureds at policy inception and requires a disclosure notice to be given which reflects that duty, rather than the broader duty imposed by section 21. In the Panel's opinion, this major change in the Act is still not widely appreciated because we continue to receive a significant number of disputes where member companies are asserting insured persons were asked to disclose their traffic, driving and licence history, but they do not tell us what question was actually asked of the policyholder. In our experience, insurance companies will variously ask prospective insureds to inform them of offences, convictions, infringements, on the spot fines, licence cancellations, suspensions, disqualifications or instances where persons have lost their licences only to recover them on appeal.

The issues involved in Determination No. 23339 amply illustrated how important it is to ask questions that are specific and are reasonably capable of being understood.

In this case, the applicant disputed the member's refusal of the claim based on non-disclosure. In particular, the member said the applicant did not disclose a licence suspension.

The Panel observed that section 21A of the Act requires the member to ask specific questions about matters which are relevant to its decision to offer insurance. The Panel noted however, neither the member's application form nor its renewal invitation have a specific question in respect to licence suspension or cancellation although the application does contain questions in relation to other matters relevant to driving history.

In its determination, the Panel stated as follows:

> *"…. in the Panel's opinion a reasonable person would assume an insurance company is not interested in a matter in respect of which it does not ask a question. If an insurance company were interested in the person's licence suspensions, then in the Panel's opinion, in accordance with law, it is obliged to ask a question to that effect of the prospective policyholder. By failing to ask the applicant at policy inception about licence suspensions, in the Panel's opinion the member cannot then complain that the applicant did not disclose this information."*

It was in our Annual Review of 1999 that the Panel Chair raised the issue of insurance companies cancelling insurance policies retrospectively after an allegation of innocent non-disclosure or misrepresentation was made. The Panel Chair report stated as follows:

> *"It is noted with some concern that in an unacceptable number of cases insurers are still making very basic mistakes such as 'avoiding' policies in cases where innocent misrepresentation or non-disclosure is alleged, failing to properly consider the effect of various provisions of the Insurance Contracts Act, particularly Sections 13 and 14 (utmost good faith), Sections 46 and 47 (unknown defects and medical conditions), and Section 54 (breach of policy term) and purporting to cancel policies retrospectively contrary to Sections 59 and 60 of the Act."*

Since then, the Code of Practice Secretariat has written to every member company explaining to their staff that they cannot retrospectively cancel policies except in cases of fraud. We have continued to comment, sometimes stridently, in numerous determinations that this procedure is illegal and yet it still happens occasionally. An insurance policy can only be avoided in cases of fraudulent non-disclosure or misrepresentation.

Panel Report – 15 years on … how far have we progressed?

A wrongful notification of retrograde cancellation will make it impossible for the hapless recipient to obtain insurance in the future. An insurance policy can only be cancelled in accordance with the provisions of sections 59 and 60 of the Act, which requires prospective cancellation. If this process continues, it may have systemic issues implications.

We note from perusing many different underwriting guidelines that, frequently, underwriters have a discretion as to whether to accept a risk or not, particularly in the context of persons with a criminal history. In our Practice Notes, we have stated:

> *"Where the insurer's underwriting guidelines require a matter to be referred to the underwriter (rather than declined), additional proof is required, because if the matter had been referred, the risk may still have been accepted with certain conditions, or upon payment of additional premium. This additional proof may take the form of a statutory declaration and/or the provision of details of previous declinatures."*

Member companies are still having difficulty in understanding that retrospective underwriting is a precarious activity, and the wider the discretion, the more persuasive the reasons will need to be as to why a risk would not have been accepted if the non-disclosure or misrepresentation had not been made.

2. Insurance and the Telephone

In the Annual Review of 2001 we provided a detailed commentary on the problems associated with telephone-induced insurance contracts and the difficulties in establishing what transpired between the policyholder and the insurer's representative during that process.

We acknowledge that since that time insurance companies have greatly improved their capacity to capture information provided by telephone by sending documents to their policyholders confirming the material disclosed, and in many instances, by actually recording the conversations, a most commendable practice. A minority of companies still continue to rely on a series of hieroglyphics colloquially described as "screendumps". The problems can also be increased when the policy is sold via an agent such as a bank. The Panel has encountered a growing number of disputes which feature misunderstandings as to the nature and extent of jewellery cover and the introduction of such terms as "Valuables", "Special valuables", "Special contents" "Unspecified valuables" and "Specified special valuables". Sometimes these terms are sprinkled throughout the policy in difficult to find locations. Many insurance companies, in the end, only provide jewellery cover for less than $2,000 for all items of jewellery not otherwise specified.

There are many other words that may cause confusion in the mind of policyholders, such as the difference between a driving "offence" and "conviction", what is constituted by a "criminal conviction" and whether minor offences should be disclosed. Problems also arise in explaining the policyholders' disclosure obligations.

Frequently policyholders allege the telephone operator did not understand their employer's or their principal's product or gave false or misleading information. The problem of clear communication is compounded by the impact of the Financial Services Reform Act (FSRA) and the constraints on giving advice imposed on insurance companies and their agents. The class of agents who sell policies include banks, building societies, credit unions, travel agents, brokers who operate with the underwriting authority of companies (not necessarily binders) car dealers and estate agents.

Determination No. 24702 illustrates the problem.

In this case, the applicant stated the bank's telephone operator (the bank was the member's agent) informed her that jewellery was covered except any items of over $5,000 value which was contrary to the policy terms. The applicant alleged the member's representative admitted there were problems with this agent. As the Panel said:

> *"These are serious allegations to make and the Panel would expect them to be dealt with specifically by the member's representative. Whilst the member's representative did state in part of the member's submission 'no evidence of a staff error could be found', the Panel would have expected him to admit or deny the statement attributed to him by the applicant to have set out the enquiries that were made; and to have dealt specifically with the allegation made by the applicant that the agent informed her, full cover applied to jewellery valued at $5,000 or less."*

"A wrongful notification of retrograde cancellation will make it impossible for the hapless recipient to obtain insurance in the future."

In any event, the Panel noted the policy itself was difficult to follow. The Panel then went on to state:

> *"The Panel thus observes the policy includes concepts such as 'Valuable items", "Special contents" and "Special valuable items" and of more concern is the reference to "Special valuable items" which does not appear until one reads the section "Paying claims".*
>
> *In the Panel's opinion what the member should have done to have complied with section 35 of the Act was the following:*
>
> 1. *It should have included significant reference in the product disclosure statement to the fact that valuable items were not in fact covered except to a sum of $2,000 or $1,250 for any one item.*
> 2. *It is important to place all these limitations in the one part of the policy and the Panel cannot understand why reference was not made to all the limitations in cover at say pages 23 and/or 24 of the policy. As stated above, it is only when the reader refers to the section of "Paying claims", the reader has ascertained there is the option of obtaining "Special valuables" cover. It would have been a very simple matter for the section of the policy contained at page 36, to which the Panel has made reference, to be placed immediately alongside the limitation of cover for valuable items contained at page 23 of the policy.*
> 3. *The Panel believes it is unnecessary to have a multiplicity of terms to cover valuable items and the use of the term "Valuables", "Special valuables" and "Special Contents", particularly when they are spread over different parts of the policy, makes reading of the policy more difficult."*

In the circumstances, the Panel determined the dispute in favour of the applicant.

The communication problem we have identified makes it necessary for insurance companies to ensure agents are trained to keep policy concepts simple, especially where policy limitations apply. They should either record telephone conversations or ensure the operators keep records of conversations. They should make sure that policies are drafted clearly because jewellery limitations are not contained in the statutory cover.

3. Policy Documentation

We published major articles on this important but neglected subject in our Annual Reviews of 1999 "The Insurance Policy – an Exercise in Communication", 2001 "The Challenge of Clear Communication", 2003 "The Illusory Nature of Cover", and 2005 "Analysing the Insurance Policy".

It is disappointing that we have not received significant response to these articles. Some companies, however, have responded to our representations by issuing separate landlord policies, as distinct from combined home buildings and landlord policies, and by ensuring policy documents are provided to insured parties on a regular basis. We are pleased that, in a significant number of cases, companies have changed policy terms which the Panel or the Adjudicator have adjudged as ambiguous or not conveying the intent of the policy draftsperson. However, the danger of insurance policies failing to meet the requirement for clear communication are increased by the marketing of larger and more convoluted policy documents. The requirement for clear communication is also emphasised in the Corporations Act, which requires an insurance company to communicate a policy term in a "clear, concise and effective" manner which, in our opinion, is a higher standard than that imposed by the Insurance Contracts Act where the requirement is to "clearly inform".

The illustration following will demonstrate how drafting errors can occur. In Determination No. 24239, the applicant's vehicle was involved in an accident whilst the driver was attempting to avoid a random breath test. The member denied liability relying on a policy exclusion which entitled it to do so when:

> *"your vehicle was being driven in a manner which resulted in a deliberate exposure to exceptional danger, or any wilful or reckless act."*

The member was successful in this case because it established the applicant drove in a dangerous and reckless manner. This result is to be contrasted with Determination No. 24004 when the applicant's son lost control of the vehicle he was driving and hit a power pole and two parked vehicles. The member denied liability to meet this claim on the grounds the collision was caused:

> *"whilst the vehicle was being driven in a manner which resulted in a deliberate exposure to any wilful or reckless act, or exceptional danger."*

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In the police proceedings arising from the accident, the son admitted he had driven recklessly and dangerously. However, the Panel found extreme difficulty in understanding the nature and scope of the policy exclusion and in the course of the determination made the following comment:

> *"It appears the exclusion requires proof of a deliberate act on the part of the driver as distinct from an error of judgement, even a significant error of judgement. It also appears this deliberate act must involve exposure to "exceptional danger". The Panel has great difficulty in understanding the phrase "deliberate exposure to any wilful or reckless act". The Panel cannot understand why, if the member wanted to refuse cover in circumstances where the driver of the vehicle drove recklessly, it did not, similar to other insurers, simply set out an exclusion in those terms. In the Panel's opinion the use of the language referred to above, is convoluted and almost meaningless. The terms "deliberate exposure", "exceptional danger" or "wilful or reckless act", are not defined in the policy. In the Panel's opinion, it is impossible to give meaning to the term, and in any event, it falls well short of the standard to clearly inform a policyholder of relevant terms not contained in standard cover as set out in section 35 of the Act."*

It will be observed from a careful perusal of the two policy terms the insertion of the words "any wilful or reckless act" appears to have been put in the wrong place. In the latter dispute, this drafting process made a significant impact on the result of the determination.

A related subject deals with the dichotomy between the aspirations of the marketing department and the more sober, turgid function of the policy draftsperson. This issue was raised in our Annual Review of 2000 and was revisited in Determination No. 23969. This dispute arose following a claim for a lump sum payment under a personal accident policy. The policy provided limited benefits as it only made provision for lump sum benefits payable for very serious injuries such as a 100% loss of use of a limb, paraplegia etc. The applicant claimed relief under section 35 of the Insurance Contracts Act and the Trade Practices Act on the basis the policy was misrepresented to her.

Shortly before policy inception, the applicant received a brochure outlining the policy benefits and the brochure referred to the following outline of cover:

> *"…. The good news is that from as little as 23 cents a day you can have complete peace of mind. Knowing that if the unexpected should occur, you'll receive a cash payment of up to $100,000 to help ease the pain of your injury. And this can be doubled to $200,000, for less than double the premium."*

The applicant also received documentation which stated:

> *"This Plan will pay you up to $200,000 if you are injured in an accident".*

Approximately a week after the policy had been taken out, the applicant received a copy of the policy. The letter accompanying the brochure made the following statement:

> *"….. With the [company] accident protection Plan you can relax, knowing that if you are ever unlucky enough to have a specified accident, you can receive a financial payment."*

In considering the applicant's submission that she had been misled as to the policy benefits, the Panel took into account the member's submission that a distinction has to be made between marketing material and policy documentation and in terms of marketing, an insurance company should be given more scope in the presentation of material to a prospective policyholder. Dealing with these responses, the Panel made the following statement:

> *"The Panel accepts the member's arguments that in the case of marketing materials, there will be some "puffery" in order to attract customers, such is the nature of marketing. This is particularly so in the case of advertising material which is of an introductory or preliminary nature. However, in this instance, the member was marketing a policy which did not include standard cover and the brochure was intended not to whet the appetite of the individual but rather to explain the policy benefits. In other words, it was a direct offer to purchase insurance rather than a preliminary advertisement. A distinction can be drawn between inflating the benefits of a policy and misleading a customer about what the actual terms of that policy are.*
>
> *In failing to specifically identify in the original letter and brochure that the policy only covered specified events, a customer might easily be lead to believe that the cover was more comprehensive than it was. In other words, the introductory letter and the*

"The requirement for clear communication is also emphasised in the Corporations Act."

brochure had the effect of reasonably creating in the applicant's mind that she had substantial cover in the event of her suffering a significant accident, and whilst she was invited to read the policy which she received at least a week after she had entered into the insurance contract, the policy did not clearly alert her to the fact that cover under the policy was very limited indeed compared with, for example, the cover provided in the statutory policy."

The Panel found the documents presented to the applicant did not satisfy the provisions of section 35 of the Act and therefore the policy provided to the applicant was replaced by the statutory policy which provided cover in the circumstances within the applicant's claim.

In our opinion it would be an important step forward for industry representatives with policy drafting experience to meet with the Panel to discuss these issues. Such a process has the potential to save the industry tens of millions of dollars in disputed claims, disgruntled or lost customers, reduced claims and improvement of the industry's image.

4. Travel Insurance

We first raised issues in relation to this segment of the industry many years ago. Travel insurance has been the subject of comment in our Annual Reviews in 2002 and 2003. The number of travel-related disputes is disproportionate to the percentage of policies issued. In our view there are a number of reasons for this phenomenon.

1. Travel insurance is sold without any consistent underwriting processes. It appears to us the only underwriting that occurs is that individuals may be asked if they have any pre-existing medical condition, the definitions of which vary considerably from policy to policy.
2. The insurance policies are sold in the circumstances where the policyholders' preoccupations are in other directions as they have just collected their hotel vouchers and airline tickets and the concept of insurance, is more of an irritation to be endured, rather than a significant contract of enormous potential.
3. Many travel policies are not well designed or user-friendly and may contain surprising or devastating exclusions in unlikely places e.g. unattended luggage exclusions which, in many instances, exclude cover unless the luggage is strapped to your arms or legs or both.
4. The drafting of many travel insurance policies in our view is mediocre. The definitions of pre-existing medical conditions are a catalyst for a rich amount of debate and analysis by IOS decision-makers which the following example reveals.

In Determination No. 23662, the dispute contained a claim for benefits under a travel policy brought by an 83-year-old man when his overseas trip was cancelled after he was informed in May 2005, he required coronary by-pass surgery. The member denied the claim on the basis that it arose out of a pre-existing medical condition. The Panel noted particularly the policy was specifically designed for persons aged between 70 and 84. The applicant's medical history revealed that 19 years previously i.e. in 1986, he saw a cardiologist and subsequently an angioplasty was performed on 3 June 1986. Regular tests were conducted until January 1989 when the applicant again underwent angioplasty. For the next 16 years, the applicant had no heart symptoms despite regular medical checking although he had been taking preventative medication to decrease the potential for blood clotting and to keep his blood pressure low. He had apparently led an active and healthy life over this period. The member relied on a policy exclusion for a pre-existing medical condition which was relevantly defined as "any chronic or ongoing medical condition".

In the circumstances, the Panel concluded the member had not established the policy exclusion. The Panel stated:

"In the Panel's opinion, it would be well known to the member's underwriters, as it is to the majority of members of the public, that the great majority of persons aged between 70 and 84 years, and certainly aged 83 years and eight months, would be in less than perfect health. When an insurer chooses to provide travel insurance to the "mature-aged traveller", it must inevitably follow, that the member's underwriters are dealing with a section of the population, that are less likely to be in excellent health than persons 40 or 50 years younger. This view is reinforced by the definition of "existing medical condition" contained in the policy which makes specific reference to the fact "hypertension alone, controlled by medication is not considered an existing health disorder" (see page 8 of the policy.)"

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The Panel went on to say:

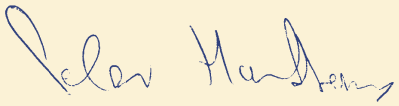
> *"In the Panel's opinion, the commercial purpose of this insurance contract was to insure mature age travellers, in this case an 83-year-old man whom the member knew, or ought to have known, was not in the same medical condition as a much younger person.*
>
> *Considering the applicant's medical history in this context, the Panel is not satisfied he suffered from a pre-existing medical condition as defined by the policy and there was no evidence the condition had been chronic or ongoing in the period prior to policy inception."*

In Determination No. 24409, the Panel followed a similar approach in determining that the applicant's heart surgery in 1987 was not related to treatment incurred in May 2005 for congestive heart failure which caused cancellation of the journey. The relevant part of the policy exclusion defined "pre-existing medical condition" as "any medical condition … that you are aware, or could reasonably be expected to be aware before we issue the policy."

The Panel stated:

> *"In this case, the applicant is 74 years of age, and in the Panel's opinion, it would be inequitable and contrary to the principles of utmost good faith to interpret the policy exclusion as including any condition of which the applicant had been aware during the 74 years of her life, albeit of a minor or major nature. In the Panel's opinion, to interpret this broad clause within the context of the commercial purpose of the policy, the member would need to prove that, at the time the applicant took out the policy, she could be expected to be aware of a medical condition, which might impact on the circumstances of her journey and/or might translate into relevant terms in the context of an insurance policy to cover travel contingencies."*
>
> *In the Panel's opinion, for the member to simply assert that 18 years prior to policy inception, the applicant had experienced significant coronary artery disease and therefore, this was a pre-existing medical condition, is nowhere near sufficient to establish the burden of proving the complex elements of the policy exclusion, …"*

As the foregoing examples indicate, the Panel expects a reasonably high standard of drafting and communication of the policy terms. The Panel believes it is entitled to insist on that standard because the Corporations Act and the Insurance Contracts Act require that standard, the former requiring the policy terms to be communicated clearly, concisely and effectively and the latter imposing a requirement to clearly inform. The Panel is in the unique position to outline these standards and is hopeful that, in doing so, the level of significant insurance disputation will be further reduced.



Peter Hardham
Panel Chair

Referee's Report

John Price
Referee

In reflecting on the past twelve months, it is appropriate to thank the staff of the Insurance Ombudsman Service, in particular, case managers, John Davey and Keith Atkins who prepare the cases and my assistant Lucy.
Their calm, balanced approach assists enormously in helping stakeholders understand the process ahead.

I also acknowledge the opportunity I have been given, at a professional level to attend both consumer and industry based conferences. Discussion, information and exchange of views are important as part of any continued professional development in understanding issues within the insurance industry. In addressing these forums, I hope I have been able to give an insight into the process of the Referee and an opportunity for stakeholders to raise issues for general discussion.

The matters that come before the Referee fall within a very small percentage of total disputes referred to IOS. IOS statistics show that of 2051 matters referred to IOS for determination in 2005/2006, only 115 involved an allegation of fraud.
These figures are contrary to popular media commentary that would see fraud rampant in the insurance industry. The statistics simply do not support this and the insurance industry and the consumers are poorly served by such commentary. However, some sections of the industry would argue that we only see the tip of the iceberg.

Although the number of disputes before the Referee is relatively small, their nature and complexity should not be under estimated. In the past twelve months disputes have varied from home arson to avoidance of an age related excess. There have been disputes as to malicious damage in the course of an eviction and claims for excessive medical and dental costs incurred overseas.

Not everybody had his or her vehicle stolen or house burgled.

Whilst the circumstance of each claim varies enormously, they do carry with them one consistent allegation, the allegation of fraudulent conduct. As I regularly state in determinations, the allegation of fraud is a very serious allegation. It is effectively an allegation of criminal conduct in a civil matter and carries with it considerable impact on an individual, in particular the ability to obtain insurance and in many circumstances, finance.

Given the seriousness of the allegation, the evidence in support must be clear and cogent. In exact proof, indirect testimony or speculation is not sufficient.

Of the 115 fraud related matters determined in 2005/2006, 43 were in favour of the insured. That is nearly 38% of disputes where the allegations were more likely based on speculation rather than acceptable evidence. Compelling evidence as to motive, opportunity or evidence attacking character or credibility was missing. In many, the oral interview played an important role in clarifying these issues and determining the dispute.

The benefit of the oral interview process is highlighted in the following two examples:

Example A

"A's" vehicle was stolen from the front of her house between 9.30pm 30 September 2005 and 8.30am 1 October 2005.

The claim was denied with the insurer alleging fraudulent conduct based on inconsistencies in witness statements, in particular "A's" statements as to the sale of the vehicle and movements on the evening of the 30 September 2005.

On receipt of the transcript of her statement, "A" advised it contained numerous errors, did not properly reflect her statement to the investigator and requested a copy of the tape of the interview.

The insurer provided the tape of interview after the oral interview despite "A" making her allegations on receipt of the Notice of Response. The insurer admitted at the oral interview they had relied on the accuracy of the transcript and disputed "A's" allegations as to its accuracy. They had not listened to the tape. At the oral interview, "A" covered those parts of the transcript she disputed, in particular the time she said she arrived home and the number of times the vehicle was advertised for sale.

Referee's Report

The tape confirmed "A's" allegations as to the inaccuracies in the transcript. The tape confirmed "A's" original statement to the investigator was consistent with statements from other witnesses and did not contain misleading information. In the absence of the inconsistencies, there was no evidence as to character, credibility or opportunity. Contrary to the insurer's allegations, the tape confirmed "A" was open and frank in her discussion with the investigator. The matter was determined in favour of the applicant.

Example B

"B" insured a motor vehicle with his son "S" as a nominated driver. As "S" was under 25 the excess applicable to him increased from $450 to $1000.

On 1 September 2005, "B" lodged a claim with the insurer claiming he was the driver of the vehicle when it collided with a stationary vehicle.

There was no dispute that the collision occurred or that the damage to both vehicles was relatively minor.
At the time of referral to IOS, "B" had not made a claim for damage to his vehicle. Damage to the third party vehicle was approximately $1200.

The insurer denied the claim on the basis that "B" and "S" made false statements in support of the claim and there were reasonable grounds to believe the claim may be fraudulent. The denial followed information received from the third party driver "TP" and other witnesses to the effect that "S" and not "B" was driving the vehicle. "TP" provided a statutory declaration in support of her statement.

"B" maintained at the oral interview that he was the driver of the vehicle. "B" and "S" provided inconsistent statements as to events leading to and following the accident. "B" also claimed the transcript was inaccurate and did not reflect his statement to the investigator.
A review of the tape of transcript did not reveal any significant inconsistencies. The evidence was strongly in favour of the insurer, however, the claim raised a further issue of the application of section 56(2) of the Insurance Contracts Act 1984.

Minimal and Insignificant Fraud and the role of mediation

As the amount involved in the claim was minor (effectively $550, being the age related excess) an issue of the use of section 56(2) of the Insurance Contracts Act 1984, considered alongside the Terms of Reference, arose.

There was no dispute the accident occurred or the accident was the fault of the driver of the insured vehicle. Prior to the referral to IOS, the insurer offered to resolve the claim, with an increased premium and excess on the basis "S" was the driver. "B" rejected this and strongly maintained he was the driver. Despite clear statements from "TP" and witnesses placing "S" driving the vehicle, "B" maintained he was the driver at the oral interview. The amount involved in the claim was relatively small, and the question became whether the fraud was an insignificant or minimal part of the claim? Did the fraud taint the whole claim?

In view of the actions of "B" and "S" and witness statements I was satisfied the insurer had established reasonable grounds to have the view the claim may be fraudulent. On balance I was satisfied "B" and "S" had made a deliberate attempt to avoid the age related excess. Their actions were not a minor or insignificant part of the claim but went to the claim as a whole. I felt compelled in the circumstances to determine the dispute pursuant to clause 8.7(b) of the Terms of Reference.

As the dispute reached the oral interview stage, I was not in a position to resolve it through mediation, which in the circumstances I believe, would have been preferable. It brings to the fore an issue that arises from time-to-time in matters before me. What is the role, if any, of the Referee or the Service as a mediator?

The Terms of Reference under Clause 10.1 provide that an objective of the IOS is to facilitate settlement or withdrawal of disputes. IOS will attempt to promote conciliation as a means of resolving a dispute. Where this is not practicable, the matter will go to a decision-maker for determination. There is no reference to mediation.

In recent discussion with a prominent plaintiff lawyer, he suggested legal advisers often bypassed the Insurance Ombudsman Service and other industry EDR schemes, to proceed directly to court. Courts have embraced the concept of court sponsored mediation. Before the matter proceeds to trial, the parties are required to attend mediation before an independent mediator in the hope of resolution.

"What is the role, if any, of the Referee or the Service as a mediator?"

From my own experience, and from discussions I have had, many matters resolve through mediation. The resolution of matters prior to litigation can be seen as a positive in the process, however, the cost involved to both parties is far greater than before the IOS, given the process is free to the insured.

Maybe it is time to consider whether the Service could improve its process by offering a form of mediation. If evidence does point to a trend in litigation, with resolution through mediation, then I am of the view all stakeholders would benefit by considering a mediation role for IOS. This needs to be debated as part of the emerging issue of financial literacy and understanding the impact of an allegation of fraud, discussed later in this review.

Emerging Issues

Travel Insurance

The number of disputes under travel insurance policies appears to be on the rise. During 2005/2006, six travel related disputes came before me and the trend has continued into 2006/2007. In the past these disputes were virtually non-existent.

The tyranny of distance, despite the Internet can lead to difficult problems for an insured in proving their claim. The remoteness of some locations, local custom, and the cash economy can conspire to make it difficult even for the most seasoned traveller to provide proof of ownership, proof of purchase/ treatment or the validity of receipts.

Even where receipts are provided, the content can be barely legible or not bear a full description of the items. Dates do not always correspond with the claimed date of purchase. It is possible the mistake is an innocent mistake made by a vendor not used to supplying receipts. It does not necessarily mean the claim is fraudulent.

Excessive medical and dental expenses may well reflect an opportunistic approach by the local medical or dental provider rather than an attempt to deceive. They may well reflect local custom and attitudes, in particular where the provider is aware of the patient's ability to claim through insurance. Where the medical or dental treatment is emergency treatment, then the patient has little choice but to pay the excessive amount. Such medical or dental providers are unlikely to cooperate with any investigation of the charges.

The member is placed in a difficult position when investigating such claims and providing evidence on which to base an allegation of fraud. Contacting the provider of the goods or services or investigating the claim properly can be an expensive and frustrating task. In one matter, an overseas investigator, appointed to investigate the provider of certain goods and services, provided a very brief report based largely on hearsay. The investigator claimed he was intimidated by the provider and did not want his details disclosed for fear of reprisals against him and his family from the persons investigated. The insurer could not substantiate his claims.

I can appreciate the difficulties all parties face in these matters. However, where the allegation made is one of fraudulent conduct then the evidence in support should be clear and cogent. The same test applies to the standard of evidence, regardless of the amount involved or location of the loss. The allegation still carries with it a significant impact on an insured person.

Privacy Legislation

The absence of information in material exchanged is often attributed to the application of the privacy laws. Whilst the privacy laws prevent unwarranted enquiry into a person's affairs, the provision of appropriate authorities should allow access to relevant information. To overcome the problem, consideration needs to be given to the development of industry standard authorities and/or requests. As part of the process, it is important the individual be reminded of his or her rights and obligations. It is a sensitive issue and stakeholders of IOS should consider whether appropriate standard form documentation could be used to further improve the exchange of information.

Understanding the implication of an allegation of fraud/financial literacy

From my experience, many people do not understand that having a claim rejected because of false or misleading statements is effectively an allegation of fraud. Many do not realise the allegation impacts not only on the relationship with the particular insurer or policy but on all other policies they may have and on inception or renewal of any future insurance. Many do not understand that they will find it extremely difficult to obtain insurance or possibly finance in the future if the allegation is maintained.

Referee's Report

I suspect many rejections are not disputed due to the limited value of the claim or lack of understanding of the allegations. Some sections of society may be intimidated by what they see as "authority figures" and accept decisions in ignorance of the implications. This is not the fault of the insurer. Clearly, IDR and the notification of rights to pursue a dispute before the Service are significant steps in the right direction. However, in my view where rejection is based on fraudulent conduct or false and misleading statements then the broader implication of that allegation needs to be spelt out.

How far the insurance industry should go in improving the financial literacy of its customers needs debating and all stakeholders should be involved. In my view where an allegation of fraud is made it is most important there is a clear understanding of the implication of that allegation. By understanding the implications, the insured is able to make an educated and informed decision as to the appropriate course of action. The current notice of rejection does not go that far.

Conclusion

I look forward to my continued involvement with IOS and the continued interaction with the stakeholders. I hope my observations serve to provoke debate amongst all stakeholders as a means of promoting the continued evolution of the industry and IOS in dealing with disputes.

John Price
Referee

Adjudicator's Report

Ron Beazley
Adjudicator

During the year 2005-2006 2,051 matters were determined by the IOS, of which 252 matters were settled and 17 were withdrawn. All of the settled matters were disputes for more than $5000, i.e. they were not matters referred to the Adjudicator.

The Adjudicator dealt with 906 matters, approximately 50% of all determinations. Of these 701 matters were decided in favour of the member (77%) and 197 (23%) in favour of the applicant. By comparison of the matters referred to the Panel 64% were decided in favour of the member and 36% in favour of the applicant.

One must be very cautious in drawing conclusions on the basis of raw statistics but some observations may assist. First, there has been an increase this year in the total number of matters referred to the IOS and in the number of determinations. Secondly, there has been an increase in the number of matters settled and all of the settlements, except 5 before the Panel, were effected with the involvement of the case managers.

In a substantial number of those cases settlements occurred because new information came to light that was not known to the member at the time of denial of the claim or its internal dispute resolution process.

Whilst it is desirable that the member should obtain all information before denying a claim, from a decision-maker's perspective, it is pleasing to acknowledge the flexibility of members in considering settlement of a claim rather than simply allowing the matter to be determined by the IOS.

It is also pleasing and appropriate to acknowledge the excellent work generally undertaken by the case managers and in particular in respect of the work done to achieve resolution of disputes. I am sure my fellow decision-makers will agree that settlement of a dispute is a preferable option to a decision, however well it is prepared and written, and that by definition must leave one party disappointed and perhaps disenchanted with the process. This may particularly be so for members who are locked into the decision without recourse to litigation save for limited resort to judicial review.

Although the Panel decides a slightly higher number of matters in favour of the applicant than does the Adjudicator any difference might be explained by a number of unknown factors that may include the willingness of the member to resolve smaller disputes in favour of the applicant without recourse to the IOS. The members' reasons for so doing may be commercial and or to preserve and engender goodwill.

One further factor may be the large number of "excess" disputes arising in motor vehicle disputes that find their way to the Adjudicator. Although the dollar value of the "excess" may not justify referral on a purely commercial basis many members hold hard to the view it is important to maintain the integrity of their decision-making rather than to simply roll over and avoid the cost of referral. Although I am not aware of the percentage of "excess" disputes decided in favour of applicants I suggest it is important to the industry to nurture and preserve the integrity of members' decisions.

I sincerely thank the administrative staff, the case managers, the executive management and my fellow decision-makers for allowing me to enjoy a satisfying and rewarding year.

Ron Beazley
Adjudicator

Code of Practice Overview

New Code

The standards of the new General Insurance Code of Practice were implemented by the general insurance industry on 18 July 2006, following a 12 month transition period. IOS used the transition period to assist the general insurance industry with various aspects of the new Code, including IOS' monitoring role, working with companies to achieve compliance under the new Code, and conducting an extensive review of its Code monitoring systems and processes.

Board Code of Practice Committee

Under the former Code, the Code Compliance Committee was a subcommittee of, and reported directly to, the Board of IOS. The new Committee is no longer a Board subcommittee and has been granted independent status under the new Code. As a result and with a view to maintaining a close eye on developments in relation to the new Code, the Board of IOS decided earlier this year to establish its own Board Code of Practice Committee to oversee IOS monitoring responsibilities under the new Code.

Code Education

As part of the Insurance Council of Australia Code Awareness Seminars programme during July, August and September 2005, IOS presented a paper on its monitoring role under the new Code in Sydney, Melbourne, Canberra, Brisbane, Adelaide, Perth and Hobart. IOS also spoke on aspects of transition to the new Code during May 2006 at the Insurance Council of Australia's 11th Queensland Annual Conference.

Meetings to discuss the new Code were held with member company Code Compliance Managers in Melbourne, Sydney, Brisbane and Perth during March and April 2006.

During the last 12 months, IOS has responded to queries on transition, interpretation of the new Code, compliance issues under the new Code, the proposed pre-Code adoption self-assessment process, the checklist document and the Code Review document.

Code Review Document

IOS drafted and circulated to Code Compliance Managers a new Code Review document reflecting the compliance requirements of the new Code. This document has been used since April 2006 to review Code members' compliance with the new Code. Feedback from Code members is being used to refine the Code Review document.

Compliance Checklist document

IOS developed and circulated to Code Compliance Managers a compliance checklist document based on the Insurance Council of Australia's transition aid document. The checklist operates as a compliance guide for Code Compliance Managers, highlighting various ways in which compliance may be achieved, and various matters which could be considered or reviewed.

Pre-Code Adoption Assessment of Compliance

IOS drafted and circulated to Code Compliance Managers a pre-Code adoption self-assessment document. Companies were requested to complete and return the document to IOS prior to implementation of the new Code's standards on 18 July 2006. The responses were used to determine whether companies had a capacity to fulfil their obligations under the new Code at the time of adoption, and to identify any deficiencies in systems and processes prior to a full review of compliance.

Reviews of Compliance under the New Code

As a number of companies elected to implement the standards of the new Code prior to 18 July 2006, IOS began its programme of compliance reviews in April 2006. To June 2006 IOS reviewed four companies under the new Code with one review identifying several compliance issues which were promptly remedied by the relevant company.

New Code Compliance Monitoring Database

Development of a new compliance monitoring database for the new Code is underway with a key innovation being a facility allowing member companies to directly enter into the database statistical data relating to complaints, disputes, policies and claims on a class by class basis.

Annual Compliance Report

Development of a new Annual Compliance Report to accommodate the expanded jurisdiction of the new Code and its requirements is also presently underway.

As in the past, IOS will continue to work closely with companies to achieve and maintain compliance with the new Code. IOS will also continue to make itself available as a resource to member companies and offer assistance to intending Code participants.

"IOS will be closely monitoring the progress of companies over the first 12 months of the new Code's operation, as companies put into play the new Code's requirements."

Reviews under the Former Code

During the period 1 July 2005 to 30 June 2006, IOS conducted 44 reviews of insurers' compliance with the former Code of Practice as well as reviewing compliance of 21 insurer intermediaries. These reviews require subjects to provide IOS with access to their files, records, and procedures to ascertain whether insurers and their intermediaries are satisfying their obligations under the Code.

Given this report relates to the final year of operation for the former Code, it is pleasing to see that there has been a significant fall in instances of non-compliance this year. Only 20 instances of non-compliance were found this year compared to 84 instances the previous year. This means that 85% of companies reviewed were found to be fully compliant with the Code. All companies with outstanding matters have promptly addressed non-compliance by implementing procedures to remedy and prevent any recurrence.

With the introduction of the new Code, IOS and the general insurance industry will be confronted with new challenges. These challenges flow from the Code's higher standards, particularly for insurance claims and complaints handling, and the participation of companies who have not previously been exposed to a code of practice. Further challenges will arise from the extension of the new Code's jurisdiction to commercial products, which means that business customers are now covered by the Code, an innovation within the insurance industry. As a consequence, IOS will be closely monitoring the progress of companies over the first 12 months of the new Code's operation, as companies put into play the new Code's requirements.

Former Code Statistics

Breach Results – 2005 to 2006 (See Statistics Table 11)

There has been a fall in the number of potential breaches this year compared to the previous year. This year there were 172 potential breaches compared to 243. The number of established breaches has also fallen to 79, compared to 125. With the majority (88%) of possible breaches referred to IOS either from enquiries to our consumer consultants through disputes referred for resolution or through matters that have been referred to the Service for resolution by the decision-makers, IOS continues to be the main source of identifying potential breaches.

As noted earlier, 20 instances of non-compliance arose directly from the reviews of 44 insurers and 21 insurer intermediaries. This highlights a marked improvement in the level of compliance overall, particularly in the areas relating to agent authority, agent training, agent record keeping, rejection advice and reason, approval of investigators, advisory brochures on IDR and advice on EDR and written response.

However, one notes an increase in breaches in relation to the supervision of investigators, assessors and loss adjusters (11 instances compared to 8 instances), and fairness and timeliness of IDR (14 instances compared to 9 instances). These matters will continue to be monitored closely by IOS as part of its review process.

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 a defined time frame. This process is monitored by IOS to ensure that members achieve and maintain compliance with the Code.

Revocation of the General Insurance Privacy Information Code (the Privacy Code)

Following the Insurance Council of Australia's request to the Federal Privacy Commissioner to revoke the Privacy Code, and to ensure a smooth transition for Privacy Code members from the Privacy Code to the National Privacy Principles under the Federal Privacy Act, the Office of the Federal Privacy Commissioner (OFPC) agreed to accept privacy complaints relating to Privacy Code members from 1 February 2006.

The Federal Privacy Commissioner subsequently executed a legislative instrument formally revoking the Privacy Code with effect on 30 April 2006. This meant that on 30 April 2006 the Privacy Code ended, the Privacy Compliance Committee was dissolved and IOS' monitoring role ceased.

Sam Parrino
Insurance Ombudsman

Code Compliance Committee Chair's Report

Michael Gill
Chair, Code Compliance Committee

The general insurance industry undertook an extensive transition programme during the last 12 months to implement the service standards of the Insurance Council of Australia's new General Insurance Code of Practice (the New Code) which came into effect on 18 July 2006. The former General Insurance Code of Practice (the Former Code) continues to apply to pre-18 July 2006 claims. As a consequence, this is my final report under the terms of the Former Code.

The Committee met on five occasions during the year and I am pleased to report that no new matters were reported to the Committee for further investigation. Annual reviews by the Secretariat continue to identify instances of non-compliance by insurers and their intermediaries. However, there has been significant improvement in the level of compliance observed during the reporting period. The instances of non-compliance reported in relation to employee familiarisation has fallen and it is pleasing to observe that no instances of non-compliance in relation to agent training were recorded.

Compliance failure by underwriting agents continued to concern the Committee. The broader range of policies covered by the New Code means that underwriting agents face significantly greater compliance obligations and the challenges of meeting them.

Following a report of three Code breaches based on inappropriate policy cancellation, the Committee asked IOS to investigate whether companies were complying with the Code and the Insurance Contracts Act when cancelling policies. A survey conducted by IOS found that companies were complying with the Code and the Insurance Contracts Act when cancelling policies. The three companies which were in breach as a result of their cancellation procedures implemented changes which satisfied IOS. The breaches were not material.

The Committee also asked IOS to investigate the adequacy of internal company training, the Committee having received reports that internal training may have been inadequate when compared with external training. The IOS survey of this issue established that the training was satisfactory and members were Code compliant.

Once again, there has been a welcome reduction in the number of instances of non-compliance overall when compared with the period ending 30 June 2005. However, we have observed a significant rise in the number of instances of non-compliance recorded in relation to the fairness and timeliness of IDR and supervision of investigators, assessors and loss adjusters. As highlighted last year, the New Code will bring new compliance challenges for the industry given its new and higher standards, an extension of the scope of the New Code to commercial products and to a greater number of intermediaries.

Members of the Committee continued to assist with document and communication improvement for travel insurance and also played a significant role in assisting with the implementation issues for the New Code.

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 I wish to acknowledge the significant role played by my colleagues, Robert Drummond and Denis Nelthorpe. In particular I wish to extend my warmest wishes to Robert for his future endeavours following his departure from the Committee in July this year.

Michael Gill
Chair, Code Compliance Committee

Statistics

Table 1 IOS 1st Tier Statistics

(July 2005 – June 2006)

	Number of Enquiries IOS	Number of Enquiries FOS
2001 - 2002	75,487	
2002 - 2003	63,231	142,921
2003 - 2004	67,545	149,710
2004 - 2005	64,563	148,148
2005 - 2006	64,568	162,405
Total	**335,394**	**603,184**

Table 2 Origin of Referrals by State

Number of Referrals	2005 - 2006		2004 - 2005	
New South Wales	676	36%	601	36%
Victoria	568	30%	506	30%
Queensland	326	17%	252	15%
South Australia	117	6%	136	8%
Western Australia	122	7%	110	7%
Tasmania	26	2%	26	2%
Australian Capital Territory	29	2%	29	2%
Northern Territory	6	0%	7	0%
Total	**1,870**	**100%**	**1,667**	**100%**

Statistics

Table 3 Reasons Members Denied Liability

(July 2005 – June 2006)

	Fraud	Not covered by policy	Exclusion / Condition	Non-Disclosure on proposal	No policy contract	No proof of loss	Quantum	Third Party	Cancellation of insurance	Failure to offer insurance	Premium & No Claims Bonus	Sales & Marketing	Service/Handling of complaints	Other	Total	2005-2006	2004-2005
All Risks & Other	0	1	12	0	2	0	1	0	1	0	0	0	0	0	**17**	1%	1%
Caravan/Campervan	0	1	4	0	0	0	0	0	0	0	0	0	0	0	**5**	0%	0%
Consumer Credit	0	0	7	0	2	0	1	0	0	0	0	0	0	0	**10**	1%	1%
Home Buildings	6	57	283	4	5	2	25	0	1	0	3	0	1	1	**388**	21%	19%
Home Contents	13	30	159	3	4	3	17	0	0	0	2	0	1	0	**232**	12%	15%
Marine - Pleasurecraft	1	1	4	0	1	0	5	0	1	0	0	0	0	0	**13**	1%	1%
Medical Indemnity	0	0	1	0	1	0	0	0	0	2	0	0	0	0	**4**	0%	N/A
Motor Vehicle	108	7	290	93	63	0	56	0	0	3	6	0	1	4	**631**	34%	36%
Motor Vehicle Third Party	0	0	0	0	0	0	6	17	0	0	0	0	0	0	**23**	1%	1%
Personal Accident/ Sickness	1	4	53	4	6	0	4	0	0	0	0	2	0	0	**74**	4%	7%
Small Business	2	7	45	0	1	0	8	0	0	0	2	1	0	0	**66**	4%	3%
Strata Title	0	1	22	0	0	0	2	0	0	0	0	0	0	0	**25**	1%	1%
Travel	5	7	352	3	1	0	14	0	0	0	0	0	0	0	**382**	20%	15%
Total	**136**	**116**	**1,232**	**107**	**86**	**5**	**139**	**20**	**3**	**0**	**15**	**3**	**3**	**5**	**1,870**		
2005-2006 (%)	7%	6%	66%	6%	5%	0%	8%	1%	0%	0%	1%	0%	0%	0%		100%	
2004-2005 (%)	8%	8%	60%	8%	4%	0%	8%	1%	n/a	n/a	n/a	n/a	n/a	2%			

Statistics

Table 5 Summary of Outcomes by Policy Type

(July 2005 – June 2006)

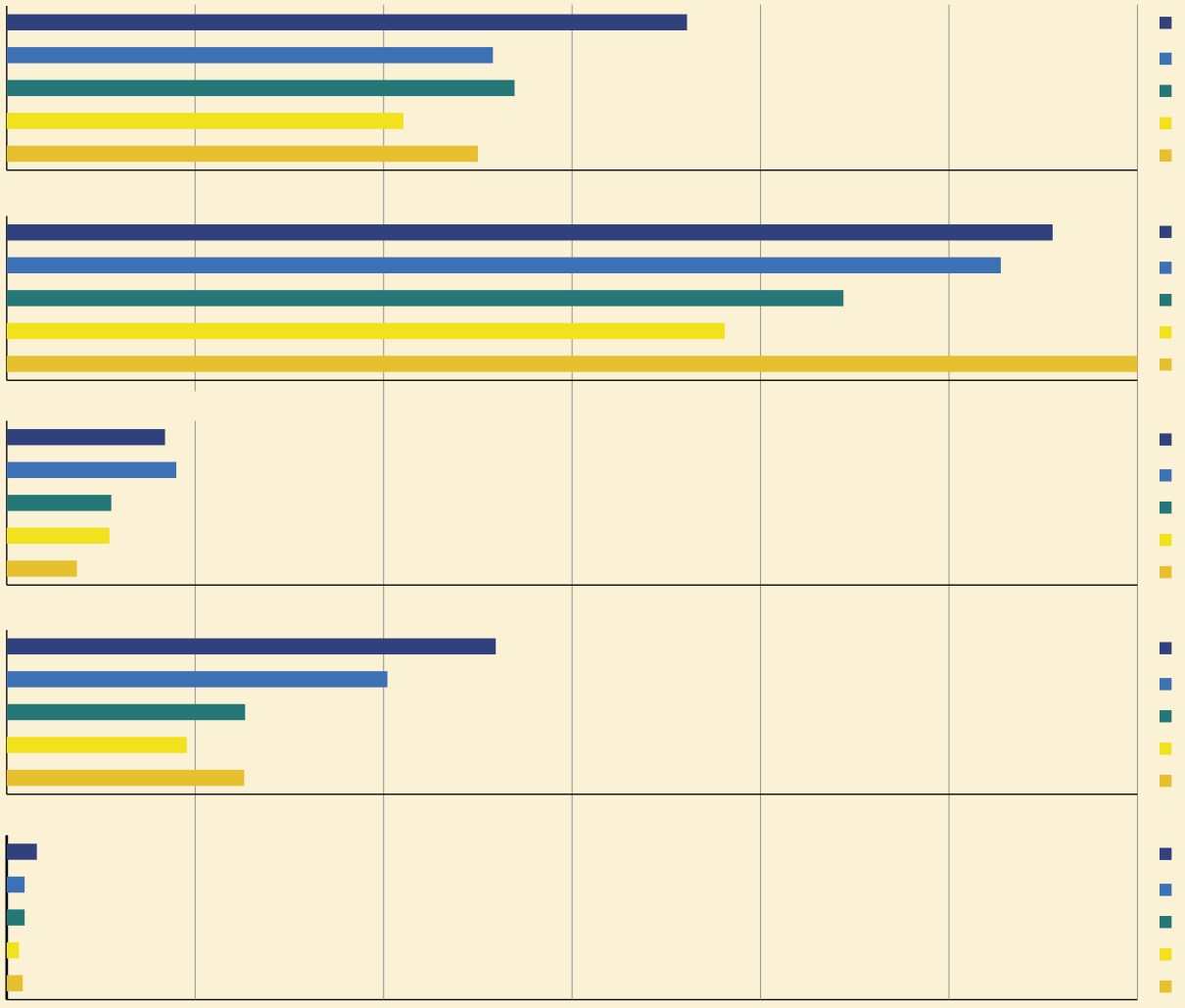
Policy Type	In favour of Applicant	In favour of Member	Settled	Rejected	Withdrawn	Total
All Risks	1 25%	3 75%	0 0%	0 0%	0 0%	4 100%
Caravan / Campervan	2 33%	4 66%	0 0%	0 0%	0 0%	6 100%
Consumer Credit	4 26%	10 66%	1 6%	0 0%	0 0%	15 100%
Home Buildings	116 27%	250 59%	50 11%	5 1%	2 0%	423 100%
Home Contents	66 26%	143 57%	27 10%	10 4%	4 1%	250 100%
Marine- Pleasurecraft	5 29%	7 41%	4 23%	1 5%	0 0%	17 100%
Medical Indemnity	0 0%	4 80%	0 0%	1 20%	0 0%	5 100%
Motor Vehicle	139 20%	397 58%	79 11%	61 8%	5 0%	681 100%
Motor Vehicle TP	9 36%	12 48%	3 12%	0 0%	1 4%	25 100%
Other	1 7%	8 57%	4 28%	1 7%	0 0%	14 100%
Personal Accident / Sickness	28 30%	47 51%	13 14%	1 1%	2 2%	91 100%
Small Business	25 29%	46 54%	10 11%	3 3%	0 0%	84 100%
Strata Title	4 15%	18 69%	4 15%	0 0%	0 0%	26 100%
Travel	100 24%	248 60%	57 13%	2 0%	3 0%	410 100%
Total	**500** **24%**	**1,197** **58%**	**252** **12%**	**85** **4%**	**17** **0%**	**2,051** **100%**

Statistics

Table 6 Total Referral Outcomes

(July 2001 – June 2006)

	Determined				Unsuitable for resolution		Total		Other resolutions				Completed
	Applicant favour		Member favour						Settled		Withdrawn		
July 2001 - June 2002	722	28%	1,110	44%	168	7%	2,000	78%	519	20%	32	1%	2,551
July 2002 - June 2003	516	24%	1,055	49%	180	8%	1,751	81%	404	19%	19	1%	2,174
July 2003 - June 2004	539	30%	888	49%	111	0%	1,538	85%	256	14%	19	1%	1,810
July 2004 - June 2005	421	28%	762	51%	109	7%	1,292	86%	191	13%	13	1%	1,496
July 2005 - June 2006	500	24%	1,197	58%	85	4%	1,782	87%	252	12%	17	0%	2,051

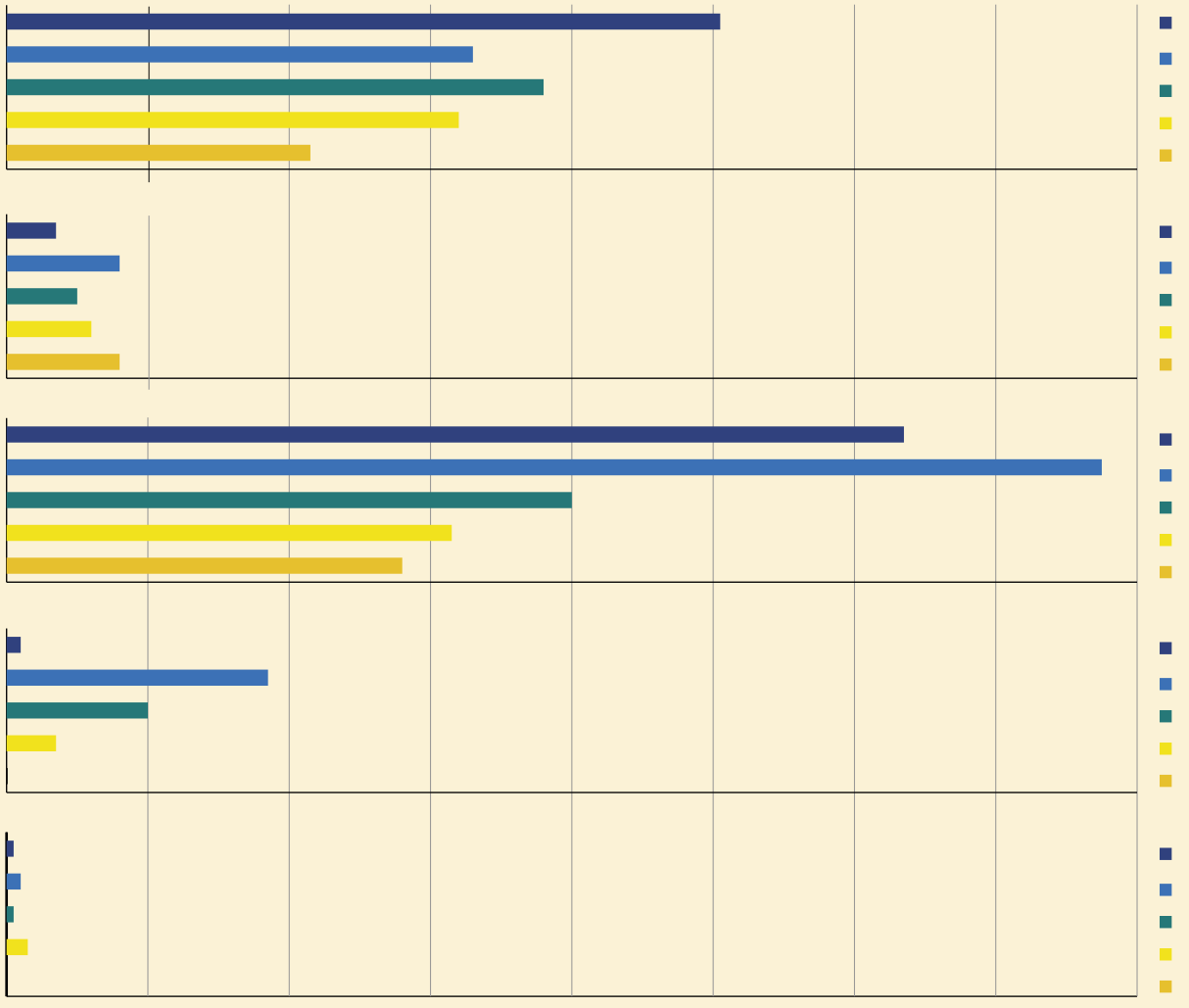


Statistics

Table 7 Referee Outcomes

(July 2001 – June 2006)

	Determined				Unsuitable for resolution		Other resolutions				Completed
	Applicant favour		Member favour				Settled		Withdrawn		
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
July 2005 - June 2006	43	37.4%	16	13.9%	56	48.7%	0	0.0%	0	0.0%	115

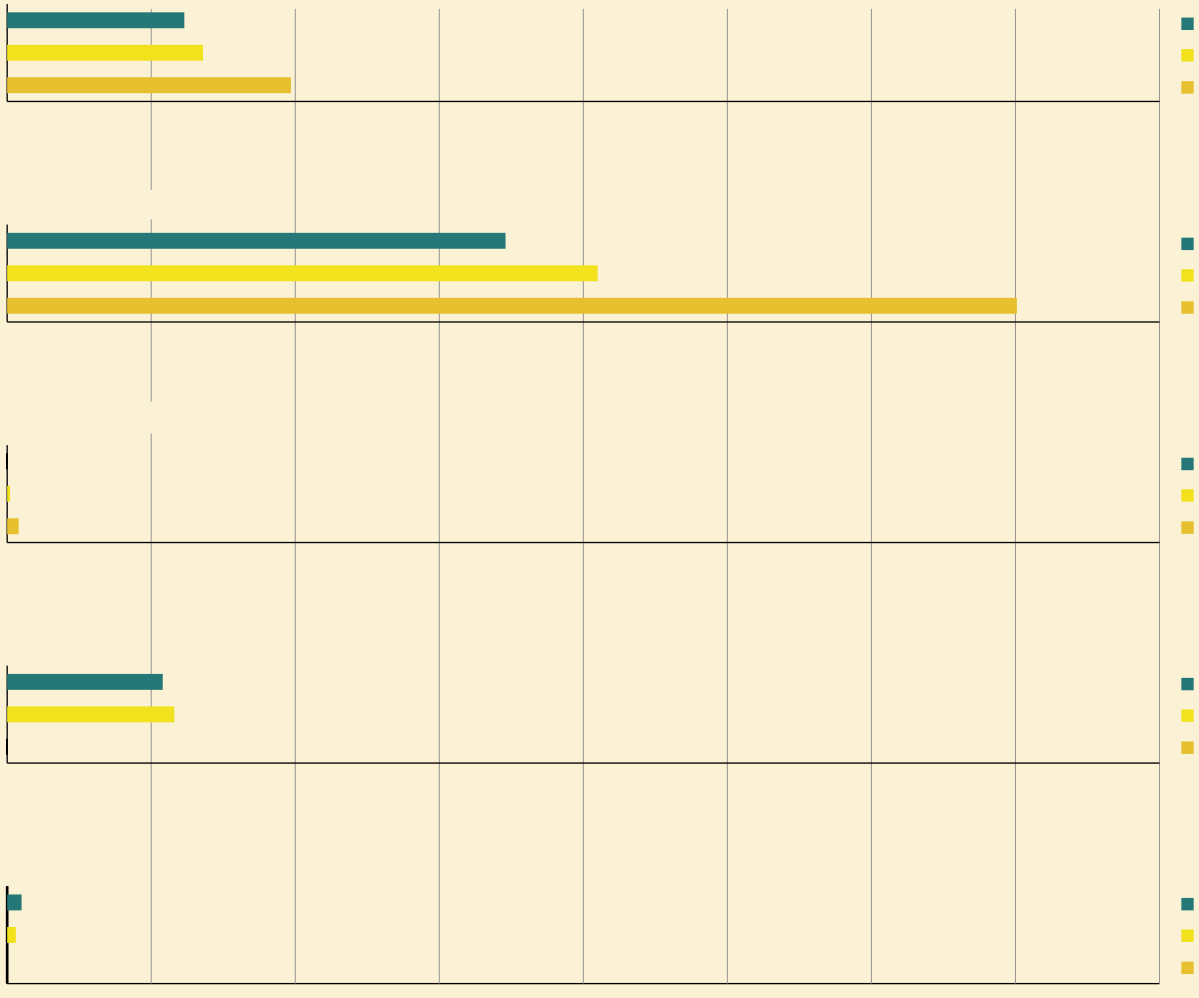


Statistics

Table 8 Adjudicator Outcomes

(July 2003 – June 2006)

	Determined				Unsuitable for resolution		Other resolutions				Completed
	Applicant favour		Member favour				Settled		Withdrawn		
July 2003 - June 2004	123	21.0%	346	58.9%	0	0.0%	108	18.4%	10	1.7%	587
July 2004 - June 2005	136	20.3%	410	61.2%	2	0.3%	116	17.3%	6	0.9%	670
July 2005 - June 2006	197	21.7%	701	77.4%	8	0.9%	0	0.0%	0	0.0%	906

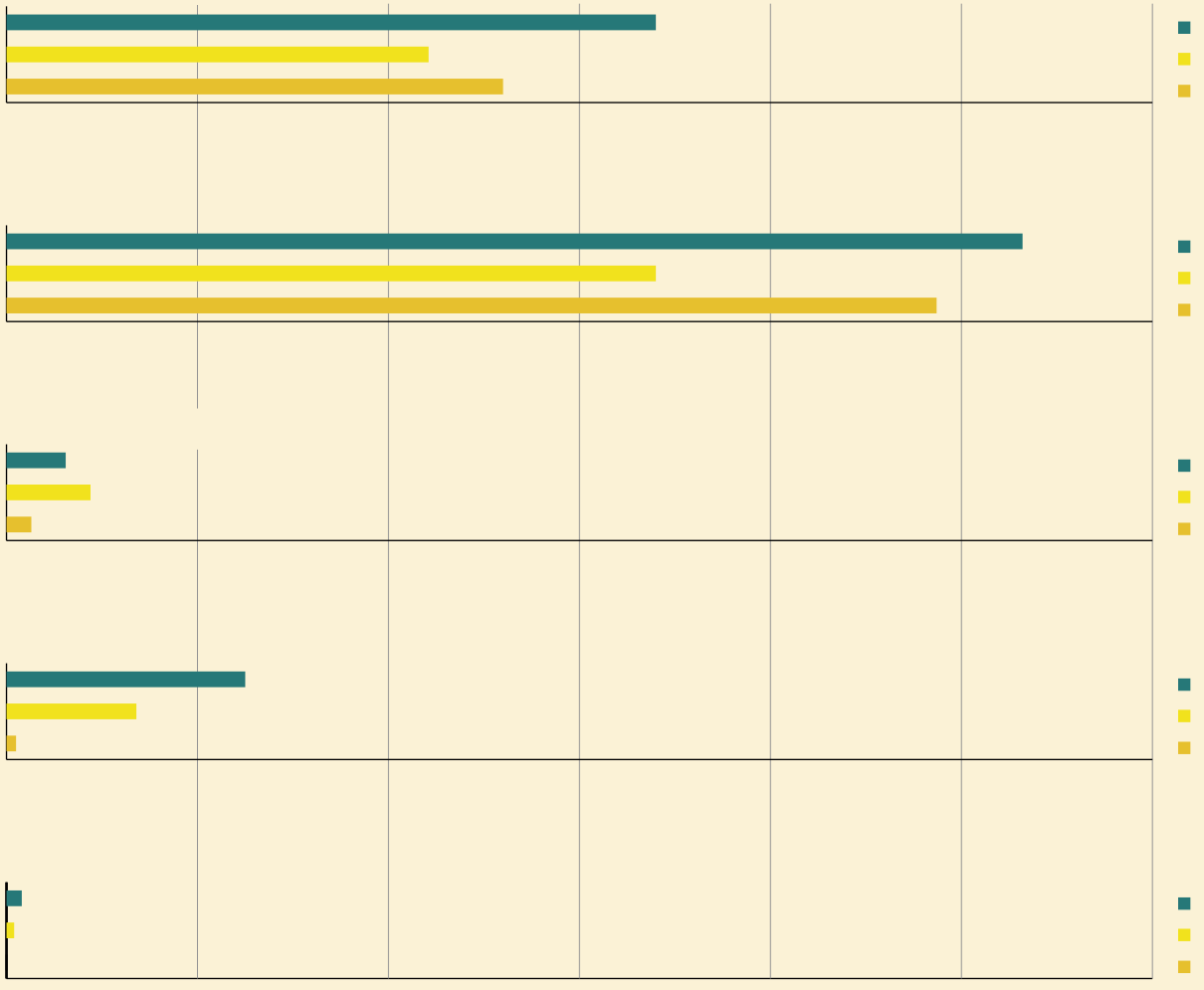


Statistics

Table 9 Panel Outcomes

(July 2003 – June 2006)

	Determined				Unsuitable for resolution		Other resolutions				Completed
	Applicant favour		Member favour				Settled		Withdrawn		
July 2003 - June 2004	340	32.8%	532	51.4%	31	3.0%	125	12.1%	8	0.8%	1,036
July 2004 - June 2005	221	32.6%	340	50.2%	44	6.5%	68	10.0%	4	0.6%	677
July 2005 - June 2006	260	34.0%	487	63.7%	13	1.7%	5	0.7%	0	0.0%	765



Statistics

Table 10 Analysis of Complaints Resolution Times

(July 2002 – June 2006)

		1–30 days	31–60 days	61–90 days	91–120 days
Adjudicator	July 2003 - June 2004	1%	6%	52%	95%
	July 2004 - June 2005	1%	2%	31%	50%
	July 2005 - June 2006	1%	17%	47%	19%
Referee	July 2003 - June 2004	0%	0%	3%	29%
	July 2004 - June 2005	0%	0%	4%	26%
	July 2005 - June 2006	8%	4%	9%	36%
Panel	July 2003 - June 2004	0%	0%	14%	72%
	July 2004 - June 2005	0%	0%	16%	54%
	July 2005 - June 2006	7%	13%	34%	21%
Total	July 2003 - June 2004	5%	14%	35%	77%
	July 2004 - June 2005	5%	12%	30%	55%
	July 2005 - June 2006	7%	12%	32%	22%

Explanatory Notes for Table 10:

During the year, IOS implemented new benchmarks for each jurisdiction. Under the new benchmarks, 90% of the adjudicator's files should reach completion within 90 days, while 90% of the Panel's files should be completed within 120 days. During June 2006, the Adjudicator achieved 95% of files completed within 90 days and the Panel achieved 85% of cases completed within 120 days. The time frame commences from the date IOS receives the referral notice, through the exchange of information process, until the determination is completed and the file is closed.

Statistics

Table 11 Code of Practice – Breach Results

(July 2005 – June 2006)

Section	Type of Breach	No. of Alleged Breaches	Non-compliance found to exist
1.8	Publication of Code	0	0
3.1(a)	Agent Skills	0	0
3.1(b)	Agents Informing Consumer	1	1
3.2	Agent Authority	0	0
3.3	Agent Training	3	0
3.4	Agent Record Keeping	1	1
3.5(a)	Employee Familiarisation	19	11
3.5(b)	Employee Training	10	6
3.6	Provision of Advice	0	0
4.1(a)	Plain Language Documentation	1	0
4.1(b)	Availability of Policy	0	0
4.1(c)	Documentation prior to Renewal	1	1
4.1(d)	Information with Policy	6	5
4.2(a)	Identify Proposal Requirement	4	3
4.2(b)	Duty of Disclosure	0	0
4.2(c)	Use of Plain Language	0	0
4.2(d)	Adequate Space Provided	1	1
4.3	Declined Cover	0	0
4.4	Consumer Information Brochure	0	0
5.1(a)	Assistance & Information to Claimant	12	3
5.1(b)	Plain Language Forms	0	0
5.1(c)	Prompt Consideration of Claim	6	1
5.1(d)	Keeping Claimant Informed	15	3
5.1(e)	Advice on Acceptance or Rejection	11	3
5.1(f)	Require further Information	7	2
5.1(g)	Rejection Advice and Reason	9	1
5.1(h)	Non Disclosure of Information	0	0
5.2	Supervision of Investigators, Assessors & Loss Adjusters	22	11
5.3	Approval of Investigators	4	3
5.4	Approval of Assessors, Loss Adjusters & Collection Agents	1	0
6.1	IDR Fair & Timely	22	14
6.2	Advisory Brochures on IDR	2	2
6.3	Advice on EDR & Written Response	10	4
6.3	IDR Oral Request	1	0
6.4	Participate in Scheme	0	0
7.1(a)	Appropriate Systems for Compliance with Code	3	3
7.1(b)	Failure to Submit Annual Report	0	0
7.1(c)	Monitors Disputes with Consumers & Compliance with Code	0	0
7.2(a)	Failure to Promptly Remedy Non-compliance	0	0
	Total	**172**	**79**

Statistics

Table 12 Code of Practice Statistics

(July 2005 – June 2006)

	All Classes	Motor	Home & Contents	Home Building	Home Contents	Travel	Consumer Credit	Sickness & Accident	Valuables	Pleasurecraft	Caravans	Other Classes
Policies & Renewals	28,749,224	11,235,690	1,165,515	5,186,837	5,167,763	1,908,473	935,679	620,681	429,696	325,781	324,302	1,448,807
Claims	2,910,419	1,419,226	165,342	498,071	282,252	166,559	13,930	57,454	30,564	9,809	11,309	255,903
Rejected Claims	63,793	5,132	2,024	15,090	9,876	16,416	1,662	2,407	1,604	181	138	9,263
Disputes												
Agents	36	18	1	5	3	1	0	0	0	1	0	7
Employees	792	493	1	120	158	0	0	0	0	1	0	19
Policy Documentation	2,687	1,690	1	376	230	43	4	25	0	15	10	293
Claims	11,854	5,323	344	1,964	1,263	1,858	54	309	37	72	21	609
Other relating to Code	1,139	714	13	178	133	22	4	9	10	14	2	40
Total	**16,508**	**8,238**	**360**	**2,643**	**1,787**	**1,924**	**62**	**343**	**47**	**103**	**33**	**968**
Disputes Resolved in favour of Consumer	5,264	2,475	90	805	489	760	22	131	16	47	12	417
Disputes Resolved in favour of Insurer	11,110	5,754	263	1,846	1,286	1,064	39	215	29	59	21	534
Outstanding disputes	636	213	14	76	58	210	2	1	2	7	6	47

Table 13 Insurer IDR & Industry Statistics

(July 2005 – June 2006) **(for explanation, see page 44)**

	Total Policies	Total Claims	Number of Disputes	Number of referrals to IOS	In favour of Consumer
Insurance Australia Limited	4,213,951	386,841	5,033	255	62
Australian Associated Motor Insurers Limited	3,254,518	321,934	1,092	203	46
Allianz Australia Insurance Limited **	2,314,117	211,370	1,291	179	35
GIO General Limited	2,026,318	203,879	1,529	143	21
Insurance Manufacturers of Australia Pty Limited (RACV)	1,660,953	143,037	2,284	77	22
Suncorp Metway Insurance Limited	1,557,317	199,349	654	68	12
CGU Insurance Limited	1,481,014	263,996	594	131	34
Australian Alliance Insurance Company Limited	1,365,193	136,194	207	45	13
QBE Insurance (Australia) Limited	1,361,279	168,859	647	127	45
Vero Insurance Limited	1,330,283	101,290	558	146	42
RACQ Insurance Limited	921,005	102,132	177	44	8
RAA Insurance Limited	692,488	26,288	43	8	2
RAC Insurance Proprietary Limited	645,366	82,524	151	12	4
Commonwealth Insurance Limited	637,445	40,593	183	48	14
Westpac General Insurance Limited	592,352	27,442	118	32	15
Elders Insurance Limited	548,880	50,347	286	46	24
Wesfarmers Federation Insurance Limited	515,832	40,506	29	6	3
Swann Insurance (Aust) Pty Ltd	410,668	23,158	137	21	9
Combined Insurance Company of Australia	361,649	28,007	59	9	5
American Home Assurance Company	330,969	27,292	383	92	23
HBF Insurance Pty Ltd	227,269	29,850	59	16	5
ING General	220,604	1,151	2	2	0
RACT Insurance Pty Ltd	195,811	20,361	6	0	0
Lumley General Insurance Limited *	166,588	73,374	76	23	12
Zurich Australian Insurance Limited	158,994	13,965	33	6	3
Ace Insurance Limited	130,352	20,941	302	12	0
Hollard Insurance Company Pty Ltd *	121,539	33,778	78	19	5
Hallmark	117,564	1,590	16	2	1
Mutual Community General Insurance Pty Ltd	116,409	11,681	9	2	0
Cumis Insurance Society Inc	112,288	13,343	10	2	0
Auto and General Insurance Company Limited	103,294	8,573	63	0	0
Budget Insurance Company Limited	103,014	9,286	136	34	3
Lloyd's Australia Limited	96,178	12,284	76	20	7
EIG – Ansvar Limited	95,629	13,743	4	3	1
Australian Unity General Insurance Limited	94,962	8,428	40	13	15
Defence Services Homes Insurance Scheme	91,352	11,390	22	1	2
Farmers Mutual Insurance Limited	85,674	4,472	35	3	0
Territory Insurance Office	61,400	6,379	8	0	0
Virginia Surety Company, Inc.	44,525	4,516	43	3	1
Australian International Insurance Limited	31,428	4,777	11	2	1
Fortron Insurance Group Limited	29,345	4,780	7	2	2
Guild Insurance Limited	27,961	4,425	4	1	0
MTA Insurance Limited	26,238	424	2	0	1
Catholic Church Insurances Limited	25,868	4,428	3	0	0
St Andrew's Insurance (Australia) Pty Ltd	20,767	421	5	2	1
Chubb Insurance Company of Australia Limited *	15,492	6,380	0	0	0
Credicorp Insurance Pty Ltd	5,537	311	1	1	0
Mitsui Sumitomo Insurance Company Limited	435	35	0	0	0
TOKIO	380	48	0	0	0
Sompo Japan Insurance Inc.	290	22	0	0	0
Sunderland Marine Mutual Insurance Company Limited	226	46	0	0	0
NIPPONKOA Insurance Company Limited	131	14	0	0	0
AIOI Insurance Co. Ltd. *	83	29	0	0	0
American International Assurance Company (Australia) Limited ^	0	0	0	0	0
Australian Family Assurance Limited ^	0	6	2	3	0
CGU-VACC ^	0	130	3	0	0
Gerling ^	0	0	0	0	0
Medical Insurance Australia Pty. Ltd.				1	0
MIPS Insurance Pty. Ltd.				2	0
National Transport Insurance Limited ***				2	1
Professional Indemnity Insurance Company of Australia Pty Ltd				1	0
Total	28,749,224	2,910,419	16,511	1,870	500

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

** Figures include Club Marine and Mondial Assistance

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

^ These companies have ceased writing business but have the occasional claim on unexpired policies

Table 13 Insurer IDR & Industry Statistics

(July 2005 – June 2006) **(for explanation, see page 44)**

	% of claims on policies	% of IDR disputes to claims	% of IDR disputes referred to IOS	% IOS determinations resolved in Consumer favour
Insurance Australia Limited				
Australian Associated Motor Insurers Limited				
Allianz Australia Insurance Limited **				
GIO General Limited				
Insurance Manufacturers of Australia Pty Limited (RACV)				
Suncorp Metway Insurance Limited				
CGU Insurance Limited				
Australian Alliance Insurance Company Limited				
QBE Insurance (Australia) Limited				
Vero Insurance Limited				
RACQ Insurance Limited				
RAA Insurance Limited				
RAC Insurance Proprietary Limited				
Commonwealth Insurance Limited				
Westpac General Insurance Limited				
Elders Insurance Limited				
Wesfarmers Federation Insurance Limited				
Swann Insurance (Aust) Pty Ltd				
Combined Insurance Company of Australia				
American Home Assurance Company				
HBF Insurance Pty Ltd				
ING General				
RACT Insurance Pty Ltd				
Lumley General Insurance Limited *				
Zurich Australian Insurance Limited				
Ace Insurance Limited				
Hollard Insurance Company Pty Ltd *				
Hallmark				
Mutual Community General Insurance Pty Ltd				
Cumis Insurance Society Inc				
Auto and General Insurance Company Limited				
Budget Insurance Company Limited				
Lloyd's Australia Limited				
EIG – Ansvar Limited				
Australian Unity General Insurance Limited				
Defence Services Homes Insurance Scheme				
Farmers Mutual Insurance Limited				
Territory Insurance Office				
Virginia Surety Company, Inc.				
Australian International Insurance Limited				
Fortron Insurance Group Limited				
Guild Insurance Limited				
MTA Insurance Limited				
Catholic Church Insurances Limited				
St Andrew's Insurance (Australia) Pty Ltd				
Chubb Insurance Company of Australia Limited *				
Credicorp Insurance Pty Ltd				
Mitsui Sumitomo Insurance Company Limited				
TOKIO				
Sompo Japan Insurance Inc.				
Sunderland Marine Mutual Insurance Company Limited				
NIPPONKOA Insurance Company Limited				
AIOI Insurance Co. Ltd. *				
American International Assurance Company (Australia) Limited ^				
Australian Family Assurance Limited ^		→	→	
CGU-VACC ^				
Gerling ^				
Medical Insurance Australia Pty. Ltd.				
MIPS Insurance Pty. Ltd.				
National Transport Insurance Limited ***				
Professional Indemnity Insurance Company of Australia Pty Ltd				
Average				

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

** Figures include Club Marine and Mondial Assistance

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

^ These companies have ceased writing business but have the occasional claim on unexpired policies

Statistics

Table 13 Insurer IDR & Industry Statistics

(July 2005 – June 2006)

Explanatory Note for Summary of Insurers Annual Returns 2006 **(for table and graphs, see previous page)**

The column headed **Total Policies** is the total number of policies and renewals covering the classes of business issued to consumers during the year as defined in the General Insurance Code of Practice. The numbers are limited mainly to domestic contracts which include motor, home and contents, travel etc written by those insurers.

Total Claims are the claims reported during that period for contracts which fall within the Code.

Note: 1. Any data relating to Underwriting Agents or other Related Entities is included in the principal insurer's data.

2. The data is provided by the insurers and is not audited.

The **Percentage of Claims to Policies** is what is known as claims incidence and varies from 44% to 0.5% with an industry average around 10%. The reason some companies have a higher incidence is due to their product mix, generally one policy, with many members who are eligible to submit claims. They include motor fleets, where a single policy is issued to cover many vehicles and they have accidents, or it could be a policy to cover a sporting body e.g. netballers.

Note: Claims incidence can vary from year to year depending on weather events such as storms and cyclones as well as other major losses such as bush fires.

The **Number of Disputes** referred to the company's internal dispute resolution process in comparison to the number of claims handled is very low at an average of 0.6%, i.e. six requests for a review of a decision for every 1000 claims.

With the figure for the **Percentage of IDR Disputes Referred to IOS** when the IDR is completed, the consumer is told that if they are still not happy with the decision they may refer their dispute to IOS for a decision which is binding on the insurer. The percentage of disputes referred to IOS is 11.4%. The highest figure at 150% is for a company in run off which referred all disputes to IOS. The other high percentages are companies with very small dispute numbers.

The number of decisions made by IOS **In Favour of the Consumer** is expressed in the following column as a percentage of the number of determinations completed for the period. The discrepancy in some cases between the number referred and the number of decisions is due to timing. IOS has cases which are carried over from the previous year for determination as compared to the referrals received; i.e. 1,872 referrals received and 2,051 determinations made.

Participating Companies

A list of companies participating in the Service and Code signatories can be found on the website:

www.insuranceombudsman.com.au

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