THE CIRCULAR - Issue 3 - July 2010

Introduction from Colin Neave

Welcome to the Financial Ombudsman Service Circular.

The Circular is designed to facilitate dispute resolution by providing practical information and explaining our approach on substantive issues.

The items in this Circular answer some of the frequently asked questions about:

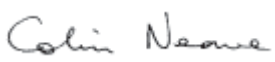
- FOS's approach to certain types of disputes including insurance claims about: *flood damage and driving under the influence*
- practical aspects of our new dispute resolution process including: how the *45 days allowed for internal dispute resolution* operates and the *role of case workers*
- what information parties need to provide to assist their cases when seeking to *establish that a document was sent* or *non disclosure in relation to insurance claims*
- FOS's approach to aspects of the Terms of Reference (TOR) including which *general insurance disputes will be considered by an ombudsman*

As we continue to see a high number of consumers in financial difficulty, this Circular addresses how we assess claims where an insurance policy excess may not have been paid because of financial difficulty.

We also include an update about the change to paragraph 6 of our TOR which sets a *reduced time frame for internal dispute resolution* for certain types of disputes.

We welcome your feedback about how we can improve the Circular so that the information we send you is relevant, timely and succinct.

Regards,



Colin Neave
Chief Ombudsman

Financial difficulty

Insurance policy excesses and financial difficulty

Consumers experiencing financial difficulty may be unable to pay a policy excess. This should not mean the claim cannot progress.

Set out below is FOS's approach to general insurance disputes where consumers, who are experiencing financial difficulty, are unable to pay their policy excess.

Dealing with urgent disputes

Where a dispute is lodged by an applicant who is experiencing financial difficulty, the TOR provide that FOS may vary the dispute resolution process to address the need for urgent resolution that these situations often require.

The TOR provide that where a matter is urgent or special circumstances exist, FOS may:

- reduce the IDR timeframe (paragraph 6.4), and
- proceed to a Determination without a Recommendation first being made (paragraph 8.6).

A dispute involving an applicant's inability to pay an excess is often a dispute brought by an applicant who is experiencing financial difficulty.

Relevant legal principle

When deciding a dispute, FOS is required to do what in its opinion is fair in all the circumstances having regard to:

- legal principles
- applicable industry codes or guidance as to practice
- good industry practice, and
- previous relevant decisions.

A recent Court of Appeal decision dealt with the issue where an insured was unable to pay their policy excess.

The insured in that case was covered under a broad form liability policy. A claim was lodged on this policy regarding a third party demand. The insured was unable to pay the policy excess and, as a result, the insurer denied liability for the claim.

The Court stated the insurer could not avoid its liability under the policy because of the insured's inability to pay the excess. The Court did not accept it was a requirement for an insured to pay the excess before the insurer becomes liable to indemnify the insured.

The Court also indicated these types of policy provisions would be regarded as an 'unusual term' within the meaning of section 37 of the *Insurance Contracts Act 1984*. As such, the notification requirements associated with this provision would apply.

The approach taken by the Court is relevant to how FOS will assess its approach to resolution of a dispute where an applicant is unable to pay the excess because of financial difficulty.

FOS takes the view that:

- an applicant's inability to pay the policy excess does not automatically allow an insurer to avoid liability for a claim which would otherwise fall within the policy terms, and
- an applicant's inability to pay the policy excess does not prevent FOS from considering a dispute.

Possible scenarios

The following scenarios provide practical examples of the application of this approach where an applicant can establish they are in financial difficulty.

These are not exhaustive examples but are designed to give both insurers and applicants a guide to the FOS approach to these matters in order to avoid unnecessary disputes.

Example 1

An applicant, who held comprehensive motor vehicle insurance, was involved in a single vehicle accident.

The applicant lodged a claim with the insurer for the damage to the vehicle.

The damage fell within the cover provided.

The applicant was unable to pay the policy excess because of financial difficulty.

The insurer denied the claim on the basis of the applicant's failure to pay the excess.

Result

FOS would consider the dispute and might conclude that:

- the insurer is liable to indemnify the applicant for the amount above the policy excess
- the applicant is obligated to pay the policy excess to the insurer, but an arrangement should be made to:
    - pay this excess over time, or
    - allow the insurer to pay a sum of cash in settlement of the claim from which the excess can be deducted.

Example 2

An applicant, who held comprehensive motor vehicle insurance, was involved in an accident with another vehicle.

The applicant was responsible for the accident and lodged a claim with the insurer for the damage to both vehicles.

The damage was covered by the policy.

The applicant was unable to pay the policy excess because of financial difficulty.

The insurer denied the claim on the basis of the applicant's failure to pay the excess.

Result

FOS would consider the dispute and might conclude that:

- the insurer is liable to indemnify the applicant for the amount above the policy excess
- the applicant is obligated to pay the policy excess to the insurer, but an arrangement should be made to:
    - meet the third party's claim
    - pay this excess over time, or
    - allow the insurer to pay a sum of cash in settlement of the claim for the damage to the applicant's vehicle from which the excess can be deducted.

Example 3

An applicant, who held a home building policy, lodged a claim under their policy when their home suffered storm damage.

The applicant was unable to pay the policy excess because of financial difficulty. The insurer required the applicant to pay the excess before it would authorise repairs to be carried out.

Result

FOS would consider the dispute and might conclude that:

- the insurer is liable to indemnify the applicant for the amount above the policy excess
- the applicant is obligated to pay the policy excess to the insurer, but an arrangement should be made to:
    - pay this excess over time, or
    - allow the insurer to pay a sum of cash in settlement of the claim from which the excess can be deducted.

Example 4

An applicant was involved in a collision with a third party's vehicle.

The applicant was responsible for the accident and is insured for third party property damage.

The third party issued a letter of demand against the applicant for the cost of repairs.

The applicant was unable to pay the policy excess because of financial difficulty.

The insurer denied liability for the claim.

The third party has commenced or is threatening legal proceedings.

Result

FOS would consider the dispute and might conclude that:

- the insurer is liable to indemnify the applicant for the amount above the policy excess, or
- the applicant will still need to deal with the third party's claim for the amount representing the policy excess.

TOR Update

Terms of Reference to change on 1July 2010

The Financial Ombudsman Service is approved to operate as an external dispute resolution (EDR) scheme under ASIC's Regulatory Guide 139 (RG 139). To retain our approval, we have to ensure that our Constitution and Terms of Reference (TOR) comply with RG 139 as revised from time to time. ASIC revised RG 139 on 7 May 2010. To comply with the revised version of RG 139, we have to amend paragraph 6 of the TOR by 1 July 2010.

In May, we prepared proposed amendments to paragraph 6 and invited stakeholders to comment on the proposals. We modified the proposed amendments after considering the comments made by stakeholders and our board approved the modified amendments on 3 June 2010.

Full details of the amendments are provided at the FOS website. The effect of the amendments, which will apply from 1 July 2010, is outlined below. Due to the amendments, we also have to revise section 6 of the Operational Guidelines to the TOR.

Paragraph 6.2 – Time limits (for lodgement of disputes)

The amendments insert a new time limit for lodgement of certain credit related disputes. The new time limit will apply where a dispute relates to a variation of a credit contract regulated by the National Credit Code (Credit Contract) as a result of financial hardship, an unjust transaction or unconscionable interest and other charges under the code. The new time limit will require a dispute to be lodged before the later of:

- 2 years after the date when the Credit Contract is rescinded, discharged or otherwise comes to an end, or
- where prior to lodging the dispute with FOS the applicant received an internal dispute resolution (IDR) response in relation to the dispute from the financial services provider – 2 years after the date of that IDR response.

The time limit currently stated in paragraph 6.2 continues to apply to disputes not subject to the new time limit. We will continue to be able to consider a dispute lodged after a time limit in exceptional circumstances or with the agreement of all parties to the dispute.

Paragraph 6.3 – Opportunity for IDR

The amendments reflect the periods allowed for the internal resolution of certain credit related disputes. The period usually allowed for IDR under paragraph 6.3 at present is 45 days. With the amendments, paragraph 6.3 will provide for the usual IDR periods to be as follows:

- in a dispute involving a request to vary a Credit Contract as a result of financial hardship or to postpone enforcement proceedings:
    - 21 days from the date of the request, or
    - if an agreement has been made as a result of the request, a further 30 days from the date of the agreement,
- in a dispute involving a default notice under the National Credit Code, 21 days from the date when the applicant first requested the FSP to remedy the matter, and
- in any other dispute, 45 days from the date when the applicant first requested the FSP to remedy the matter.

Paragraph 6.4 allows us to extend or reduce the IDR period for a dispute in certain circumstances. It will continue to do so after the amendments.

New paragraph 6.5 – Disputes lodged with other ASIC approved EDR schemes

The amendments insert a new paragraph 6.5 to provide for disputes referred to FOS by other EDR schemes approved by ASIC. For a referred dispute, the time limits specified in paragraph 6.2 will apply from the date when the dispute was lodged with the referring scheme and that date will be deemed to be the date of lodgement with FOS.

Investigating

Establishing that documents have been sent

Where a decision in relation to a dispute depends on FOS deciding whether or not a financial services provider (FSP) sent, and an applicant received, a specific document (eg a renewal, certificate of insurance, policy document, cancellation notice, letter of offer or default notice etc), there are steps both parties will need to take to satisfy FOS about the dispatch and receipt of the document.

The requirements listed below apply to many of the disputes we consider at FOS but there may be additional or alternate requirements created by applicable legislation or codes.

FSP wishing to satisfy FOS that a document was sent

Where an FSP seeks to rely on the delivery of a document to an applicant, the FSP usually needs to establish to FOS's satisfaction that, on the balance of probabilities, it sent the document to the applicant's last known address. In order to achieve this outcome, the FSP will need to provide FOS with the following:

- A copy of the document it says it sent to the applicant (Document).
- A copy of any record held by the FSP showing that the Document was actually sent and the date the Document was sent.
- A detailed explanation of its usual process for sending documents of the same sort.
- A copy of any record showing the process that was followed to send the Document, and, if the record was part of an internal report, an explanation of that record and/or report.
- Where the Document is said to have been sent in a group of documents sent out by the FSP or its agent on the same day, a signed statement by an appropriately qualified individual which sets out the following relevant information:
    - Identification and explanation of any computer or other records/reports the FSP relies on to show that the Document was one of a group of documents that was dispatched either directly by the FSP or through its agent.
    - Where the FSP has used an agent to send the Document, the agent's records show that the Document was included in the group of documents it received from the FSP for dispatch that day.
    - Information to show the Document was actually posted that day (eg postal company collection records match with the FSP or agent's record of the group of documents to be dispatched that day).
- Information to show that the address the Document was sent to was identified in the FSP's records as the last known address of the applicant.
- Confirmation that the Document was not returned to the FSP, including an explanation of the FSP's usual process for identifying that documents have been returned as undelivered.

Where the FSP is only able to provide a template rather than a copy of the Document sent

Sometimes, FSPs make a commercial decision not to keep copies of documents sent. Therefore the FSP may only be able to provide to FOS a template of the Document it says it sent (template Document).

If the template Document contains fields of information which are not completed and are relevant to the issues in dispute, FOS will require the FSP to provide information to show how the fields were completed. This would include the date and the address contained in the letter. If the FSP is unable to do so, it is unlikely FOS will be satisfied, on the balance of probabilities, that the Document containing the relevant information relied on was sent and/or that it contained the information the relevant information. FOS recommends that FSPs keep a record of relevant Documents sent to customers, either on a file or in electronic form, for at least a minimum period of seven years. This will ensure that if there is a dispute lodged with FOS, a copy of the Document can be produced as opposed to a template Document.

Applicant wishing to establish that a document was not sent and received

If an applicant says they did not receive the Document because the FSP sent it to an old or incorrect address, the applicant should provide the following information to FOS:

- A copy of any written correspondence the applicant sent to the FSP informing it of their correct address.
- If no written correspondence was sent, information as to how the applicant informed the FSP of their correct address. If this was conveyed by phone or face to face, this information should include:
    - the date of the conversation
    - the name of the person within the FSP's business whom the applicant spoke to
    - the content of the conversation (ie what was said), and
    - any record the applicant made of the conversation at the time.

FOS may make additional enquiries of both the FSP and the applicant in order to satisfy itself that a document was sent and/or received.

Investigating

Duty of disclosure regarding insurance contracts

Many of the disputes we see about insurance raise the issue of whether or not the applicant has fulfilled their duty to disclose certain information to the insurer. The following material sets out the information we require to properly assess these disputes.

When will an insurer ask questions about an application for insurance?

An insurer is obliged to ask an applicant (who is normally the insured) to answer a number of specific questions when first arranging a policy of insurance. These questions may be asked:

- orally (by telephone or in person)
- via the internet, or
- in a written proposal.

The applicant is required by law to provide answers for themselves and anyone else to whom the questions apply (eg another listed driver under a comprehensive motor vehicle policy) within their knowledge.

The obligation imposed on the applicant to answer these questions

If the applicant wants the insurance policy to cover the risks they are insuring against, then the applicant must fulfil their duty of disclosure. In assessing what an applicant must do to fulfil that duty, we have regard to the requirements of sections 21, 21A, 22, 26 and 28 of the *Insurance Contracts Act 1984* (ICA).

In brief, application of section 21 of the ICA requires the applicant to disclose every matter that they know, or could reasonably be expected to know, is relevant to an insurer's decision to enter into a contract of insurance with them.

It is important to note a person's duty of disclosure applies whenever they:

- first arrange
- renew
- extend
- vary, or
- reinstate

a policy of insurance.

In particular, whenever a person renews their insurance policy, they are entering into a new contract of insurance. As such, they are required to comply with their duty of disclosure each time they renew their insurance policy.

Of particular relevance to the disputes we consider is section 21A of the ICA which applies to an "eligible contract of insurance" unless it is entered into by renewal.

An eligible contract of insurance is a contract of insurance in the following classes of insurance:

- motor vehicle
- home buildings
- home contents
- sickness and accident
- consumer credit, and
- travel.

For eligible contracts of insurance, an insurer must ask the applicant specific questions relevant to the insurer's decision to enter into a contract of insurance. The applicant must then answer those questions by disclosing each matter known to the applicant and what a reasonable person in their circumstances could be expected to include in the answer. If the insurer fails to ask specific questions, then it is deemed to have waived the applicant's obligation to comply with their duty of disclosure.

This is a general summary of these sections. The sections can raise complex issues in some cases and how these sections apply to a particular case can vary.

The consequences of the applicant not fulfilling the duty of disclosure

If the applicant fails to fulfil this duty, the insurer may:

- refuse to pay a claim, and/or
- cancel the policy.

Given some claims can be of significant monetary value (e.g. substantial fire damage to a home), it is important for an applicant to comply with their duty of disclosure.

Our approach to a dispute about whether or not the applicant fulfilled the duty of disclosure

In response to a claim under a policy, an insurer may say an applicant failed to comply with their duty of disclosure. In these circumstances the insurer is responsible for establishing that, on the balance of probabilities, the applicant failed to comply with their duty of disclosure.

In considering these disputes, we ask:

- Has the insurer clearly informed the applicant of their duty of disclosure?
- Did the applicant's answer(s):
    - misrepresent, or
    - fail to disclose

information provided in response to certain questions asked by the insurer?

- Does the information provided by the insurer establish that the applicant knew a relevant fact that should have been disclosed?
- Can the insurer establish that, had it been aware of the information that was not disclosed, it would:
    - not have entered into a contract of insurance with the applicant, or
    - have entered into a contract of insurance on different terms?

Factors relevant to assessing whether or not the applicant fulfilled their duty of disclosure

Factors we consider in assessing whether or not the applicant fulfilled their duty of disclosure include:

- Was the applicant's untrue answer given because the applicant (or a reasonable person in the applicant's circumstances) believed the answer to be true? (Some examples where this may occur are:
    - when an individual was unaware that their vehicle was modified, or
    - if the applicant answered the questions without true knowledge of the facts regarding the driving history of family member who is a listed driver under the policy.
- Should the insurer have known about the factual matters relevant to the non-disclosure? For example, an insurer may be said to have knowledge of certain information if an applicant has disclosed a fact to it in relation to a previous policy or claim.
- Was the insurer's question to the applicant ambiguous?

What we ask the insurer to provide as part of our investigation?

In order to assess the merits of a dispute, we require the insurer to provide the following information and documentation to us:

Insurance contract

The following information is required to confirm the terms of the contract of insurance in dispute:

- a copy of the completed and signed proposal (if the relevant questions were answered in writing)
- a copy of the policy
- a copy of the certificate of insurance, and
- the date the policy and certificate of insurance were sent to the applicant.

If the policy was arranged by telephone or in person

When the policy was arranged orally and details of the conversation were recorded (eg in a recorded telephone conversation), the following information should be provided:

- a copy of the audio recording setting out:
    - when and how the duty of disclosure was explained
    - the questions asked by the insurer, and
    - answers given by the applicant
- a transcript of these parts of the audio recording.

If the policy was arranged orally and the conversation was not recorded

- a statement from the employee who arranged the policy setting out:
    - when and how the duty of disclosure was explained
    - the questions asked, and
    - the answers given by the applicant.
- When this employee is unable to recall the applicant's proposal specifically (which is often the case), the statement should include:
    - the process the employee has been trained to follow when arranging a policy
    - how this process was applied to the applicant's proposal, and
    - attachments containing the relevant computer screens to show whether the steps of the process were followed.
- If the employee is no longer employed at the time the dispute is referred to FOS, a statement from the employee's supervisor setting out:
    - the process the employee had been trained to follow when arranging a policy, and
    - attachments containing the relevant computer screens to show whether the steps of the process were followed.

If the policy was arranged over the internet

Where the policy was arranged over the internet, we require the following information:

- A copy of the proposal submitted by the applicant; and
- A statement from an appropriately qualified employee of the insurer containing explanations of:
    - the process an applicant would need to follow to arrange a policy via the internet
    - whether this process was implemented in the applicant's situation, and
    - attachments containing the relevant screen printouts to show how the steps of the process were followed.

Information to show the applicant did not comply with their duty of disclosure

In order to assess whether the insurer has established that an applicant has failed to comply with a duty of disclosure, we require the insurer to provide information to show the applicant has incorrectly answered the relevant questions.

For instance, if the alleged non-disclosure relates to a failure to disclose the driving history, the insurer should provide a copy of the applicant's driving history showing the discrepancy between the information provided in the driving history and the information provided by the applicant in answer to the insured's questions.

Information to show an insurer would not have accepted the applicant's risk on the same terms or at all

In order to assess whether, had it been aware of the information not disclosed, the insurer would have:

- not accepted the applicant's risk, or
- accepted the risk on different terms

we require the following information:

- A copy of the applicable underwriting guidelines that were in operation at the time the insurance contract was entered into.
- A statutory declaration from a person with the appropriate authority in the insurer's underwriting department identifying:
    - the underwriting guidelines that were in operation at the time the applicant breached their duty of disclosure, and
    - how the insurer would have applied the underwriting guidelines to the applicant's contract of insurance had the correct disclosure been made.
- Where there are no clear underwriting guidelines covering the situation, examples of similar declines of insurance which are:
    - reasonably contemporaneous to when the non-disclosure occurred, and

- similar in circumstances to the dispute. For example, if the non-disclosure is related to traffic history, the example should be that a policy was refused due to non-disclosure of traffic offences. An example of non-disclosure for modifications would not meet this requirement.

Where the underwriting guidelines require the exercise of an underwriter's discretional statutory declaration from the person who has (or would have had) the appropriate authority to exercise the relevant discretion explaining how that person would have exercised their discretion to the applicant's proposal together with any available examples to demonstrate the process by which the discretion is exercised.

Conclusion

In assessing these disputes, we take into account the law, good industry practice and fairness.

Flood claims

Home and contents insurance policies: storm and flood claims

Not all home and contents type insurance policies cover damage caused by the flooding that may be created as a result of a significant storm. This is primarily because some policies cover 'rain' water but not 'flood' water. Rain water damage and flood water damage are not the same.

Disputes about whether a home and contents insurance policy covers the insured for loss or damage caused by water entering a home after a storm raise some common issues which the Financial Ombudsman Service (FOS) must assess.

Policy wording

The first question we consider is: What words are used to create any exclusion for flood or storm damage in the policy?

We look at:

- the certificate of insurance, and
- the policy document/product disclosure statement.

If an exclusion for flood or storm water damage exists, it should be set out in these documents.

Storm damage

Although there is no standard definition of 'storm', we generally take the view that a home flooded by rain water would normally be regarded as storm damaged.

If the policy covers 'storm' damage and the dispute is clearly about damage caused to a home flooded by rain water, we will then consider the extent of the cover for storm damage.

Flood damage

There is no standard definition of 'flood' damage in home and contents insurance policies.

Sometimes flood damage caused by rain water is included in the policy definition but other forms of flood water are excluded. The source of the water which flooded the home and caused the damage may become a critical factor as to whether or not the damage is covered under the policy.

Did the insurer (FSP) 'clearly inform' the insured that the policy does not provide flood cover?

Where a policy does not provide cover for flood damage, we will assess whether the FSP clearly informed the applicant that the policy did not extend to flood cover. This is because a general insurer is under a legal obligation to 'clearly inform' their customers of an exclusion in the insurance policy relating to flood damage.

When an FSP fails to comply with this requirement, the insurance contract (ie policy) becomes a legislatively 'prescribed contract'. That means certain terms become a part of the policy cover even though they were not in the policy itself. Flood damage is covered under a 'prescribed contract', therefore an FSP may be come liable for flood damage suffered notwithstanding the policy was not intended to cover flood damage.

In most cases an FSP will fulfil its responsibility to clearly inform the insured of the exclusion if it:

- provided the policy outlining the exclusion to the insured prior to the insured suffering the loss as a result of flood damage, and
- the policy exclusion for flood damage is clear and unambiguous.

What caused the damage?

If 'flood' water damage is excluded under the policy, then FOS will assess information about the cause of the damage.

We will ask was the water that entered the home and caused all of the damage:

- 'rain' water and therefore the damage may be covered by storm damage provisions of the policy, or
- 'flood' water and therefore the damage may not be covered by the policy because of the flood damage exclusion,

or did a mixture of both 'rain' and 'flood' water cause the damage? In this situation, we would assess:

- was it 'rain' water that *first* entered the home and caused all of the damage in which case all of the damage may be covered by the policy, or,
- was it 'rain' water that *first* entered the home and caused part of the damage followed by 'flood' water which caused further damage, in which case part of the damage may be covered by the policy and part may not.

When the damage is effectively caused by two concurrent causes, and one cause is covered under the policy (eg rain water damage) and the other cause is excluded (eg flood water damage), the courts have held that the FSP is entitled to deny liability.

However, where rain water first floods a home, followed by flood water at some later stage, the damage caused by the initial rain water will be covered provided this damage can be separated from the subsequent flood water damage. It is a question of what is the dominant or proximate cause of the damage.

Example:
The storm damage to the home was caused by a mixture of flood water and rain water. The information available established that the flood water formed about 5% of the water in the house. This was partly because the flood water was too low to enter the home and could not have caused damage on its own.

Result:
We found that rain water was the proximate or dominant cause of the damage because the flood water had a minimal or insignificant contribution to the loss.

Who has to prove how the damage was caused?

The insured has the onus of establishing, on the balance of probabilities, that they suffered damage caused by an event which was within the policy. This could be that the damage was caused by a storm (rather than a flood).

If the insured establishes that, on the face of the facts, the damage was caused by an event which was within the policy, the onus shifts to the FSP to prove, on the balance of probabilities, the claim falls within a policy exclusion. This could be that the damage was caused by a flood (rather than a storm).

Hydrologist's report

In some cases, the cause of the damage is clear, such as when water from a fast flowing river breaks its banks and enters a home built on the bank. The subsequent damage is most likely flood damage, not storm or rain water damage.

However, where the cause is less clear because of a combination of events, an expert report, normally provided by a hydrologist, may assist to establish whether the origin of the water is flood water or rain water, and therefore whether or not the damage is covered by the policy.

FOS takes into account a hydrologist's report to assess issues such as:

- the amount of rainfall that fell prior to the time when a creek or river broke its banks,
- where the creek/river broke its banks, and
- the path the flood water took from the time it broke its banks until it reached the home.

In some cases FOS, with the agreement of the parties, will appoint an independent hydrologist to report on the damage.

Often it is necessary for FOS to attend the location with the parties and hydrologists to gain a complete picture of the events leading to the claim.

Other information

Other information FOS would consider in assessing the source of the water depends on the facts of a case but could include:

- photo or video footage establishing that rain water entered the home, or
- eye witness accounts.

It is up to both parties to provide information about the source of the flooding so an assessment can be made by FOS based on all of the available information.

FOS may make additional inquiries of both the FSP and the insured in order to satisfy itself as to whether the events fall within the policy or within one of the exclusions of the policy.

Only when FOS is satisfied it is in a position to make a determination will a written determination be made.

Working with our process

45 days for IDR

How the time period of 45 days for Internal Dispute Resolution (IDR) operates in practice

The time period of 45 days for a financial services provider (FSP) to respond to a complaint through its internal dispute resolution (IDR) process is an integral part of the new process under the new FOS Terms of Reference (TOR). We have published operational guidelines (OGs) about how the relevant provisions of the TOR operate.

Set out below is a full discussion of how the 45 day period for IDR operates including some of the applicable TOR and OGs. Where we are reproducing parts of the OGs, the text is colour coded.

Which disputes does the 45 day period for IDR apply to?

Any dispute lodged by an applicant with FOS after 1 January 2010 is governed by the current TOR irrespective of when the original complaint was made. Therefore, the 45 day time frame for IDR applies to all of the disputes lodged with us since 1 January 2010.

Date dispute lodged	Applicable TOR
Before 1/1/2010	Old TOR continue to apply
Between 1/1/2010 and 31/12/2011	New TOR apply
Schedule 1 states remedy cap	New TOR apply
On or after 1/1/2012	Schedule 2 states remedy cap

When is a dispute "lodged" with FOS?

As detailed in the OGs to paragraph 6.1 of the TOR, a dispute is treated as being "lodged" with FOS when it is first referred to FOS for resolution.
A dispute may be referred to FOS:

- By submitting an Online Dispute Form, available on the FOS website www.fos.org.au
- In writing, using the Dispute Form that an Applicant can download from the FOS website, or by email, fax or letter; or
- In a case where assistance from FOS is needed, by telephone.

When does FOS refer a dispute to IDR?

The first stage of the FOS dispute resolution process focuses on providing the FSP with an opportunity to resolve the dispute. We offer this opportunity in most cases when an applicant lodges a dispute with us and the applicant:

- has not raised it with the FSP, **or**
- has raised it with the FSP and less than 45 days have passed and the applicant has not received an IDR response.

In these two scenarios, we register the dispute and refer the dispute to the FSP for review and resolution if possible. If:

- 45 days have passed since the applicant first contacted the FSP or
- the applicant receives an IDR response that does not resolve the dispute,

the dispute goes straight to stage 2 of our dispute resolution process – Acceptance.

This means that in most circumstances:

- the FSP has up to 45 days to attempt to resolve the dispute, and
- the 45 day period starts from the date that the FSP is first advised of the dispute (in person, by telephone or in writing).

Specific categories of disputes have a reduced timeframe.

Where legal proceedings relating to debt recovery are on foot at the time the dispute is lodged an expedited dispute resolution process applies and the dispute progresses directly to Acceptance. This means the FSP is not provided with an initial opportunity to resolve the dispute.

Where the dispute involves:

- hardship applications,
- default notices, and/or
- enforcement proceedings (other than legal proceedings relating to debt recovery),

the FSP has up to 21 days to attempt to resolve the dispute. The 21 day period starts from the date that the FSP is first advised of the dispute (in person, by telephone or in writing).

In certain circumstances, we may consider extending or reducing this time frame.

ASIC's Regulatory Guide 165 (RG 165) reflects 45 day time limit for IDR

FOS's TOR reflect the requirements of RG 139 and 165. FSPs that hold AFSL licences and credit licences must have an IDR process that complies with RG 165.

RG 165 provides that:

- an FSP must provide a final response to a complainant within a maximum of 45 days (RG 165.80(b))
- the 45-day time frame to provide a final response to the complaint:
    - does not re-commence when new information is provided (RG 165.85(a))
    - is applicable to FSPs who operate multi-tiered IDR procedures (RG 165.104).

These provisions make it clear the FSP's IDR structure is irrelevant to the calculation of the 45 days by which a final response must be given to the customer.

While RG 165 refers to the National Credit Code, a "credit contract" under the FOS TOR means a contract regulated by the Uniform Consumer Credit Code or such other federal credit legislation as may replace it. Therefore the abridged timeframes will also apply to disputes involving credit facilities regulated by the Uniform Consumer Credit Code.

What is a complaint?

As the 45 day period for IDR starts running when a complaint is first made, it is therefore necessary to be clear about what amounts to a complaint.

The complaints that FOS will consider are complaints that are unresolved. In the TOR, the term "dispute" is used to describe unresolved complaints.

A "complaint", is defined in AS ISO 10002-2006 as:

"An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected"

For general insurers, the General Insurance Code of Practice mirrors this definition:

"An expression of dissatisfaction made to us related to our products or services or to our complaints handling process where a response or resolution is explicitly or implicitly expected."

When is a complaint made to an FSP for the purpose of calculating the 45 days for IDR?

As detailed in the OGs to paragraph 6.3 of the TOR, where the applicant requested the FSP to remedy the issues in dispute before lodging a dispute with FOS, the IDR period commences on the date of the expression of dissatisfaction to the FSP, whether in writing or by any other means.

FOS recognises that an applicant can complain to the FSP by letter, fax, telephone, in person or by email.

An FSP is defined in paragraph 14.1of the TOR to include:

employee, agent or contractor of the Financial Services Provider including any person who has actual, ostensible, apparent or usual authority to act on behalf of the Financial Services Provider or authority to act by necessity in relation to a financial service

This means that if an applicant complains to any employee, agent or contractor (such as an insurance assessor or collections agent) of the FSP, then that is a complaint made to the FSP.

When will FOS get involved?

If:

- 45 days have passed since the applicant first contacted the FSP or
- the applicant receives an IDR response that does not resolve the dispute,

the dispute goes straight to stage 2 of our dispute resolution process – Acceptance.

What is an IDR response?

There are requirements set out in industry codes and in RG 165 around the need for an FSP to provide a final response to a complaint. RG 165.82 provides that a final response means the FSP must write to the complainant informing them of:

- the outcome of their complaint
- their right to take their complaint to EDR, and
- the name and contact details of the relevant EDR scheme to which they can take their complaint.

Paragraph 14.1 of the TOR defines an "IDR Response" as:

… a communication in writing from the Financial Services Provider to an Applicant advising:

1. the Financial Services Provider's final position in relation to the Applicant's complaint after the conclusion of the Financial Services Provider's internal dispute resolution process; and
2. the Applicant's right to take the complaint to FOS and the timeframe for doing so and FOS's contact details."

Therefore, if:

- 45 days have not passed and
- the response provided by the FSP does not comply with this definition of an IDR response,

FOS will refer the dispute to the FSP for the balance of the 45 day IDR period.

However, an FSP should beware of the situation when its first-tier response does not clearly inform the applicant:

- it is a final decision, and
- what the dispute resolution process is following this initial response, including further IDR steps and/or EDR.

In these situations, it is possible FOS will accept this response as being the "IDR Response" and proceed with reviewing the dispute, even if the 45 day period has not lapsed to ensure an efficient and timely handling of the dispute.

Will a new issue raised after lodging a dispute with FOS mean the complaint returns to IDR?

The OGs also detail that if an applicant who lodges a dispute with FOS has previously been through IDR with the FSP, but later raises new issues in the dispute, FOS will normally refer these new issues back to the FSP to go through IDR before FOS considers the dispute.

In some circumstances, however, FOS may start to consider a dispute when new issues raised by the applicant have not been through IDR. This may happen when the new issues are:

- Closely related to issues that have been through IDR, or
- So minor that FOS considers they would be unlikely to impact on an IDR response provided by the FSP.

An example of a closely related new issue might be a dispute about the quantum of a claim which had been denied but was then accepted as part of the IDR review by the insurer.

An example of a minor issue that can arise which would be unlikely to impact on the FSP's IDR response might be where the applicant seeks to introduce material which is substantially the same as information already provided to support a matter already raised and responded to.

Can FOS extend the 45 day period for IDR?

Paragraph 6.4 provides FOS with the discretion to extend the 45 day period for IDR "if FOS considers special circumstances exist". The OG provides details as to how and when FOS may exercise this discretion.

The OGs provide the following examples of special circumstances:

- Where settlement negotiations are progressing, but taking longer than 45 days, and both parties agree to continue negotiations without FOS's involvement;
- Where an FSP is waiting for a report by an expert or external consultant before providing an IDR Response and FOS considers the resulting delay reasonable; or
- Where records an FSP needs to respond to a complaint are old and difficult to retrieve.

When deciding whether there are special circumstances, as well as considering the circumstances of the relevant dispute and general principles of fairness, FOS will consider:

- Whether the parties to the dispute agree to the extension of the IDR period;
- Whether the applicant had previously contacted the FSP about the dispute;
- Whether any settlement negotiations are progressing and, if so, how long they are taking;
- Whether the FSP is waiting for information to help it to provide an IDR response; and
- Whether the length of the extension requested is reasonable.

If FOS decides to extend the IDR period for a Dispute, it will advise both parties of the decision and the reasons for it and confirm the new IDR timeframe.

Can an FSP or applicant ask for an extension of the 45 day period for IDR?

Any party may ask for an extension to the IDR period.

If an FSP needs more time to provide an IDR response, the FSP can contact the applicant and seek the applicant's consent to an extension. This needs to be done as soon as the need is identified. If the applicant does not consent, the FSP can request FOS to extend the IDR period before the IDR period elapses.

The OGs set out that the request must:

- Be in writing;
- Be made as early as possible and before the 45 day IDR period expires;
- State the period of the extension sought;
- Explain the special circumstances considered to warrant the extension; and
- Provide copies of supporting documents.

FOS recommends that any FSP seeking an extension contact us by email, fax, letter or phone as soon as possible to let us know that an extension is being sought.

When might FOS reduce the 45 day period for IDR?

Under paragraph 6.4 of the TOR, FOS may start to deal with a dispute before the IDR period ends if FOS considers the matter urgent. This means FOS may commence investigating or otherwise considering the dispute. In these cases, the FSP would not be given 45 days or the balance of 45 days to provide an IDR response. The OGs provide details as to how and when FOS will exercise this discretion.

Examples of urgent situations include:

- Where the applicant is in ill health;
- Where an FSP is in administration, liquidation or has otherwise ceased trading;
- Where delaying investigation would significantly disadvantage a party; and
- Where any delay may cause or exacerbate financial hardship for the applicant.

In urgent situations, it is sometimes necessary to reduce the IDR period without first contacting the FSP. We will notify the FSP as soon as possible after the dispute has been moved into investigation.

If FOS decides to start dealing with a Dispute before the IDR period ends, it will advise both parties of the decision.

Conclusion

From a practical point of view, the things to note about the 45 day IDR period are that it:

- starts from the date a complaint is communicated to the FSP (noting this includes an FSP's agent, employee and/or contractor)
- applies regardless of whether an FSP operates a simple or multi-tier IDR process
- does not stop running if an applicant has failed to respond to a review or failed to initiate a further review in accordance with the FSP's IDR process
- may be extended in special circumstances, and
- may be reduced if FOS considers the matter urgent.

Role of a FOS case worker

Under the Terms of Reference which came into force on 1 January 2010, a new dispute resolution process was established which, broadly speaking has four stages: Registration, Acceptance, Case Management and Outcomes. As the year progresses more cases are moving into Case Management, so it seems timely to provide an update confirming the role of a case worker in the Case Management and Outcomes stages of the process.

The case worker's primary role is to work towards a fair resolution of a dispute. To achieve this, the case worker takes a questioning and investigative approach to disputes.

The dispute resolution process

The first two stages of the dispute resolution process at FOS are:

- Registration (when disputes are referred to the financial services provider's (FSP) internal dispute resolution process), and
- Acceptance (when we assess whether the dispute comes within our Terms of Reference).

In the third stage of dispute resolution, Case Management, a FOS case worker:

- refers the dispute to the FSP for a response
- may request additional information or action from the parties involved in the dispute, and
- decides on the most appropriate dispute resolution methods to use.

In the fourth stage of dispute resolution, Outcomes, a FOS case worker makes a decision about the dispute in the form of a Recommendation. In some circumstances a dispute may be expedited and bypass the Recommendation stage and move straight to a Determination.

Case worker identifies the appropriate dispute resolution methods

The case worker decides which of the following dispute resolution methods should be used:

- negotiation
- conciliation
- providing an assessment on the merits, or
- a decision.

In considering the most appropriate dispute resolution methods for a dispute, the case worker will take into account:

- the nature of the issues raised by the dispute
- the parties to the dispute, their circumstances, and the nature of their relationship

- any special circumstances or factors relevant to the dispute, and
- the principles outlining our commitment to dispute resolution as found in paragraph 1 of the Terms of Reference (timeliness, minimum formality, transparency, etc.).

Case worker requests for information and action

When the case worker investigates a dispute, they may need to ask the parties for additional information.

When we do this, we expect a party to comply within the timeframe specified unless one of the exceptions in paragraph 7.2 of the Terms of Reference applies. If a party believes that an exception applies, they need to explain their view and provide material to support their explanation within the timeframe specified in the request for information.

In addition to asking for information, paragraph 7.3 of the Terms of Reference allows the case worker to ask parties to take other actions that may assist our consideration of the dispute.

For example, the case worker may:

- ask a party to attend an interview, or
- ask an FSP to appoint an independent expert to report to us.

Keeping the parties informed

A case worker will:

- clarify the issues in dispute where required, and
- communicate relevant information to the appropriate party.

Resolution

A case worker may assist the parties to find a resolution through negotiation, mediation or conciliation. When a dispute is resolved, the case worker facilitates the finalisation and exchange of settlement documents.

Decisions

Where a matter is not resolved, once the case worker has collected and analysed all the relevant information, we are ready to make a decision about the dispute. To do this, the case worker will consider what is fair in the circumstances having regard to:

- legal principles
- applicable industry codes or guidance as to practice
- good industry practice, and
- our previous decisions.

A case worker's decision is a Recommendation. This is a comprehensive assessment that sets out:

- all the relevant facts of a dispute
- the information relied on
- the view we have reached about how the dispute should be resolved, and
- the reasons for that view.

We proceed to a Determination if, within 30 days of receiving a Recommendation, either:

- the FSP does not accept the Recommendation, or
- either party requests us to proceed to a Determination.

In this situation, the case worker prepares and then refers the dispute file to a Panel or Ombudsman.

Contacting case workers

FOS case workers generally have legal, industry and/or financial counselling training and experience. They also receive extensive training at FOS in the investigation of disputes, mediation, negotiation, conciliation and the requirements of our Terms of Reference. Please feel free to contact the FOS case worker assigned to your dispute to discuss any clarification you require and any options for resolution that you can identify.

Decisions about interest

Paragraph 9.5a) of the Terms of Reference (TOR) provides that if FOS decides a financial services provider (FSP) is required to pay compensation to an applicant, then FOS has the discretion to require the FSP to also pay interest on that compensation.

Example:
Applicant's claim is $280,000
FOS determines the FSP should pay compensation to the applicant of $280,000 plus interest for 2 years at 8% which is $44,800
FOS could determine the FSP should pay $324,800 to the applicant.

FOS will consider:

- the interest rate that should apply, and
- the period for which interest should be paid.

We have developed operational guidelines (OGs) about how FOS will make decisions to require payment of interest will operate.

We are receiving a number of queries about how interest payments are calculated by FOS. Further discussion is set out below about how FOS calculates the interest payable on a compensation amount. Where we are reference parts of the OGs, we have colour coded the text.

What factors will FOS take into account?

Factors FOS takes into account in decisions about interest include:

- The type of financial service that is the subject of the dispute;
- Whether any legislation could be used as guidance on interest rates and periods;
- Whether a contract provides for interest;
- What would be fair in all the circumstances; and
- If time has elapsed, how to maintain the real value of the compensation.

Insurance contracts

In general insurance cases, FOS may determine that interest should be paid on money the applicant has spent restoring the subject matter in dispute. Examples when this may occur in general insurance disputes include:

- payment made for repairs to a motor vehicle, or
- payment made for repairs to damaged property.

If the applicant has spent money on the subject matter in dispute, FOS may determine that interest is payable because the cost of restoration or repairs, which the FSP is liable for, may have increased due to the passage of time.

In life insurance claims, FOS may determine that interest should accrue on a benefit that was or should be paid under a life insurance policy, from the date by which FOS is satisfied the benefit should have been paid.

How does FOS identify the interest rate that should apply?

FOS will not impose a standard rate when making interest awards and will not have one rate for all cases. FOS will try to impose a rate that will maintain the real value over time of any award of compensation. FOS has discretion to apply a rate that best fits the circumstances and may apply a rate that replicates what a court might do or align with a statutory rate (where such a rate exists).

Insurance contracts

If, in a dispute relating to a contract of insurance as defined in section 10 of the Insurance Contracts Act 1984, FOS decides that the FSP should pay interest on compensation, FOS will use section 57 of that Act to determine the interest rate and the period for which interest should be paid.

Interest rates applicable to insurance disputes

Below is a table setting out applicable interest rates:

30-Jun-01	9.04%
31-Dec-01	9.01%
30-Jun-02	8.99%
31-Dec-02	8.16%
30-Jun-03	8.01%
31-Dec-03	8.60%
30-Jun-04	8.87%
31-Dec-04	8.33%
30-Jun-05	8.11%
31-Dec-05	8.20%
30-Jun-06	8.79%
31-Dec-06	8.89%
30-Jun-07	9.26%
31-Dec-07	9.33%
30-Jun-08	9.45%
31-Dec-08	6.99%
30-Jun-09	8.52%
31-Dec-09	8.47%

Note: If the interest period included two or more six monthly intervals, the applicable rate is the mean or average for the total period rounded down to the nearest lower quarter of 1%.

Other cases

FOS will also take into account the following:

- If another legislative provision applies to the issues in dispute and specifies a particular rate of interest, FOS may award interest at that rate.
- If the contract to which the dispute relates sets out a particular rate of interest, FOS may award interest at that rate.
- If there is no legislative or similar requirement that should be taken into account in the calculation, FOS will consider what interest rate would be fair in all the circumstances of the dispute and particularly what rate would maintain the real value of the compensation awarded to the applicant.

For example, in banking cases, the usual measure of damages adopted for loss of use of funds is the term deposit rate for the amount of money which the applicant has been denied access to for the period in relation to which they were denied access.

How does FOS calculate the period for which interest should be paid?

FOS will calculate the time period over which interest should be paid by taking into account factors such as:

- When the applicant lodged the dispute;
- Any delays caused by the parties;
- The extent to which the conduct of either party contributed to a delay in resolving the dispute; and
- The parties' conduct in the course of FOS dealing with the dispute to arrive at a position that would be fair in all the circumstances.

Insurance contracts

Interest is usually awarded from the date when the FSP 'first denies the claim'. However, if there is a significant delay between the date when the claim is made and the FSP's initial decision on the claim, a date pre-dating the first denial letter may be elected.

In some cases, interest may be awarded for a shorter period of time when an applicant has failed to reasonably progress their claim without good reason.

General insurance disputes may be referred to a Panel or to an Ombudsman for a Determination

It is of course, in the best interests of the parties to try and find a resolution of a dispute without the need to proceed to a Determination by FOS. However, in some instances, disputes will need to progress to a final Determination by FOS. In the Operational Guidelines (OGs) we have provided information about the categories of general insurance disputes (other than disputes lodged against general insurance brokers) that will usually be dealt with by a FOS Panel if a matter does progress to a Determination. Here we also set out some additional information about which disputes might go to an Ombudsman for a Determination.

Panel

In the OGs, we said that the following categories of dispute will usually be dealt with by a FOS Panel where, in the opinion of the Chief Ombudsman or their delegate, the interests of the parties and the scheme require the disputes to be dealt with by the Panel. This includes:

- all medical indemnity disputes
- strata title insurance and small business insurance disputes (other than disputes lodged against insurance brokers)
- disputes relating to claims arising from floods, storms, landslide, and other natural disaster events
- disputes raising complex factual questions about medical, engineering, alcohol related, occupancy or earth movement matters
- disputes where non disclosure in relation to a General Insurance Policy has been alleged and that might involve complex underwriting issues or insurance practice issues
- disputes raising complex and/or important issues involving relevant legislation
- disputes involving important issues with respect to the General Insurance Code of Practice and/or the need for guidance as to good insurance practice
- disputes raising complex and /or important issues involving the *Insurance Contracts Act 1984,* and
- disputes that involve similar circumstances to other disputes where a number of the disputes could be referred to a Panel to provide guidance for future Determinations.

Ombudsman

Disputes that do not fall into these categories will usually be considered by an Ombudsman. In the OGs, we specifically identified that general insurance disputes that involve an FSP alleging fraud by an applicant will be dealt with by an Ombudsman.

In addition, an Ombudsman will make the Determination for general insurance disputes where:

- within 30 days of receiving the Recommendation, the financial services provider (FSP) has not accepted the Recommendation (paragraph 8.5 of the TOR)
- within 30 days of receiving the Recommendation either party to the dispute requests FOS to proceed to a Determination (paragraph 8.5 of the TOR), or
- the dispute has been expedited to an Ombudsman (paragraph 8.6 of the TOR).

For more information about matters relevant to how a Determination is reached including the provision of information by the parties, interviews where a general insurance dispute involves a fraud allegation etc, see the commentary in the OGs on paragraphs 7 and 8 of the TOR.

Deciding insurance disputes involving assessment of a "driving under the influence" exclusion

Expedited process

Usually, FOS makes a Recommendation before making a Determination of a dispute. However, paragraph 8.6 of the Terms of Reference (TOR) provides that FOS may proceed to a Determination, without a Recommendation first being made, where FOS considers that this would be appropriate.

FOS considers that disputes which involve an assessment of whether an FSP has correctly denied liability for a claim because the applicant was "driving under the influence" should be expedited and proceed to a Determination by an Ombudsman or Panel without a Recommendation first being made.

Information to be provided by FSP

Where an FSP seeks to deny liability for a claim under an insurance policy on the ground that the claim is excluded because the insured was "driving under the influence", the FSP will need to provide FOS with the following:

- Statements from witnesses who observed the driver of the insured vehicle at relevant times, such as just prior to or after the accident
- If a witness:
    - says the driver appeared to be under the influence of alcohol or drugs and
    - has appropriate expertise in assessing the effect of alcohol or drugs on an individual,

  a description of the witness's level of expertise to make this assessment (eg for police, ambulance officers, etc).

- A statement from the driver of the insured vehicle setting out their travel and activities in the 12 hours leading up to and including the time of the accident. This statement should include:
    - the number, types and quantities of alcoholic drinks and/or drugs they consumed and when they consumed them
    - the places they went to (such as homes, restaurants, bars and night clubs) including at what time they went and for how long they stayed, and
    - their explanation of the events leading up to the accident.

- Statements or reports from expert scientific or medical witnesses who have assessed the information provided by:
    - witnesses who observed the driver of the insured vehicle at relevant times, such as just prior to or after the accident
    - the driver of the insured vehicle, and
    - the effect of any breath, saliva or blood analysis tests administered to the driver of the insured vehicle including a description of the nature of the tests and the time and date the tests were administered and assessed.

Information to be provided by applicant

The applicant needs to provide a statement from the driver of the insured vehicle setting out their travel and activities in the 12 hours leading up to and including the time of the accident. This statement should include:

- the number, types and quantities of alcoholic drinks and/or drugs they consumed and when they consumed them
- the places they went to (such as homes, restaurants, bars and night clubs) including at what time they went and for how long they stayed, and
- their explanation of the events leading up to the accident.

Relevant legislation

In assessing a dispute, FOS takes into consideration relevant legislation. Legislation that is relevant to FOS's assessment of whether an FSP was entitled to deny a claim because the insured was "driving under the influence" includes:

- ACT: *Road Transport (Alcohol and Drugs) Act 1977 s41A*
- NSW: *Road Transport (Safety and Traffic Management) Act 1999 s37*
- NT: *Traffic Act s48*
- SA: *Road Traffic Act 1961 s47C*
- TAS: *Road Safety (Alcohol and Drugs) Act 1970 s21*
- VIC: *Road Safety Act 1986 s58A*

This legislation may prohibit or limit the admissibility in a court of the outcome of breath and/or blood analysis tests as evidence which proves intoxication or drug use. FOS is not a court so we are assessing information to identify what most likely occurred. Therefore, while we take into account the limits imposed by this legislation, we may still reach a view that on balance, the information available to us supports the conclusion that the driver of the insured vehicle was driving under the influence.

In all cases of this sort we also take into consideration the effect section 54 of the *Insurance Contracts Act 1984* may have on the applicant's claim.