RESOLVING COMPLAINTS

THE INSURANCE & SAVINGS OMBUDSMAN

IS AN INDEPENDENT SERVICE FOR RESOLVING INSURANCE AND SAVINGS DISPUTES, WHICH IS FREE TO CONSUMERS.

INSURANCE & SAVINGS OMBUDSMAN I·S·O

...WHEN YOU HAVE REACHED DEADLOCK.

"[The] Case Manager was really helpful and also realistic about expectations regarding case."

"My Case Manager kept me well informed over the period my case took to settle, and was helpful and sensitive to my situation."

"This office is well worth having for "Joe public" like me or we would get trodden over by Insurance Companies."

2007CONTENTS

COMMENTS FROM THE CHAI

THE YEAR COVERED BY THIS ANNUAL REPORT HAS BEEN A BUSY ONE FOR THE ISO AND FOR THE ISO COMMISSION.

Complaints resolved for the year showed a 21% increase over the previous year, from 173 to 209. Complaints accepted for investigation, consumer contacts and general enquiries were consistent with, or ahead of, the levels of the previous year. There have been a high number of presentations, contacts with consumer groups, industry groups and the media, and information disseminated through submissions, fact sheets, newsletters and information on the website.

Despite this workload, the ISO and her staff have continued to handle complaints and enquiries within agreed timeframes and with a high level of professionalism and expertise. The Commission is very appreciative of their work.

The terms of the Commission's 2 consumer representatives concluded during the year, and new representatives were appointed. Deborah Rundle was replaced in November 2006 by Claire Dale and Raewyn Fox was replaced in March 2007 by Sam Huggard. Claire Dale is a researcher at Auckland University and Sam Huggard is the Communications and Campaign Organiser for the Council of Trade Unions. Both have very useful experience in business, community and consumer organisations, and bring enthusiasm and commitment to their roles as Commission members. Both are rapidly becoming familiar with the ISO Scheme and the work of the Commission.

Dr Ian McPherson has continued as an industry representative and in his role as Chairman of the ISO Board. Rieny Marck has joined the Commission as the other industry representative. Their very able contribution, particularly their working knowledge and experience, greatly assists our understanding of the insurance industry.

The Commission is always keen to ensure that it carries out its governance role to a high standard and in accordance with best practice. To assess its performance against these benchmarks, the Commission conducted an evaluation exercise during the year.

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This gave us an overall clean bill of health, but also gave the opportunity to fine tune our processes. The evaluation will be done annually.

Following on from the evaluation, the Commission has produced Member Briefing Notes for the guidance of Commission members and alternates.

Two initiatives being worked upon during the 2007/08 year are also intended to address any area of possible shortfall in the operation of the Scheme or of the Commission. The first is the 5 yearly Review, due in 2008 and for which planning is well advanced. The second is a public awareness survey which will be conducted prior to the Review. It is intended that this survey will provide baseline data on consumer awareness of the Scheme and will be repeated biennially.

Of great interest to all those involved in the ISO Scheme are the findings and recommendations of the Reviews of Financial Intermediaries, Products and Providers. The Commission formally responded to the discussion paper on possible dispute resolution options and the ISO has been involved in contributing to and commenting upon the various papers and proposals for the regulatory environment.

The ISO Scheme continues to be held in high regard by the industry and by consumers making use of the service. It is now firmly established as an important feature of the insurance sector. It is an established part of ANZOA and of other New Zealand and international dispute resolution/Ombudsman forums, and this continues to provide an extremely useful source of advice and opportunity for information sharing and collegiality. We look forward to continuing with these positive relationships during the forthcoming year.

Alison Timms Chairperson, Insurance & Savings Ombudsman Commission

INSURANCE & SAVINGS OMBUDSMAN'S

I AM PLEASED WITH THIS YEAR, BECAUSE IT HAS BEEN BOTH CHALLENGING AND PRODUCTIVE, PARTICULARLY IN OUR PRIMARY AREA OF OPERATION – COMPLAINTS RESOLUTION.

For the year ended 30 June 2007, we received more complaints for investigation, than in the last 3 years. We received 201 complaints and completed investigations for 209 complaints. Over half of the complaints related to fire and general insurance, with the remainder split between health (19%) and life insurance and savings (26%). We also received 50 complaints which were resolved with our involvement before investigation. We had 1,600 telephone enquiries and over 3,500 calls to our 0800 number. We had a total of 533 complaint enquiries outside the ISO's jurisdiction to be dealt with, including 99 written complaint enquiries.

A lot of effort goes into promoting the ISO Scheme, to ensure consumers are aware of its existence. Equally, staff training for Participant companies is important, so information about internal complaints handling processes is communicated well and complaints are dealt with at the earliest possible opportunity. Accessibility and public awareness are always issues requiring our particular attention.

Fairness is required, not only of decision making, but also of process. The ISO Scheme puts a great deal of time and effort into managing how complaints are handled to ensure that consumers and Participant companies are dealt with fairly.

A balanced perspective is required of any ombudsman scheme and the ISO Scheme is no exception. Balancing competing interests is always challenging. The best results for all parties are often obtained where more time and effort have been used to facilitate better communication between the parties. This year, 32% of investigated complaints were upheld, partly upheld or settled by agreement between the parties. Recorded settlement amounts on about 50 complaints were just under $1.5 million.

REPORT

HIGHLIGHTS

We held our second CONFERENCE, in Auckland, in September 2006. The focus was on best practice. The day before the conference, we held a half day Complaints Handling Workshop facilitated by Trevor Slater, National Relations Manager for the Financial Industry Complaints Service Ltd Australia ("FICS"). Nina Harding from Australia, was the keynote speaker at the conference. She is an internationally respected mediator and trainer. Her keynote address established a business case for better complaints handling and described the benefits of cost saving, increased profits, customer retention, staff retention and risk minimisation. In other targeted sessions, Nina focussed on how apologies can be used very successfully, without attracting liability, to resolve complaints. As a follow-up to the conference, we held another Complaints Handling Workshop with Trevor Slater of FICS, in Wellington, in June 2007. This was on the basis that there are never enough opportunities for complaints handling training!

I gave 22 PRESENTATIONS and other members of staff were involved in 5 presentations, a total number of 27 presentations for the year. Some are to promote public awareness with consumers. Other training sessions, based on our experience with complaints, are to assist Participants and those working within the wider insurance and savings industry, to handle complaints better and develop good business practices. We dealt with 13 media enquiries for various publications.

We held 9 CONSUMER OUTREACH SESSIONS in conjunction with the Banking Ombudsman, Liz Brown, and the Electricity and Gas Complaints Commissioner, Judi Jones, in Dunedin, Cromwell, Lower Hutt, Upper Hutt, the greater Auckland area and Whangarei. This is part of an ongoing outreach programme in the community, to increase public awareness of the free service offered by the industry schemes. Working with social services, we are able to attract people from Community Law Centres, Citizens Advice Bureaux, Budget Advisers and other community groups.

Since 1 July 2006, we have recorded over 46,000 sessions on the WEBSITE. The website is updated on a monthly basis and has information about how to make a complaint to the ISO, together with information about the background and operation of the ISO Scheme. All of the papers from the 2006 conference are on the website, together with our 2 new *"Assessment"* newsletters and latest Annual Report. We now have all of the 2000 to 2006 Case Studies on the website and, from May 2007, a more comprehensive search engine was put in place to assist anyone wishing to search the Case Studies. In addition, from 1 December 2006, Consumer Information Sheets have been available on the following topics: 1. Breach of Conditions of Driver's Licence; 2. Modifications to Vehicles; 3. Proving Your Loss; 4. The Law – Duty of Disclosure; 5. Disclosure – Material Facts; 6. Sudden or Gradual Damage; 7. Basis of Settlement – Motor Vehicle Claims; 8. Policy Excesses; 9. Personal Superannuation Plans – Withdrawals and Transfers; 10. Health Disclosure; and 11. Pre-Existing Conditions – Health.

We were invited to assist the Ministry of Economic Development ("MED") on its advisory group considering insurance, as part of its REVIEW OF FINANCIAL PRODUCTS AND PROVIDERS ("RFPP"). This has been an ongoing commitment since 2006. Due to the size of the Review, it was decided that policy decisions and subsequent legislation would be done in 2 phases. The first phase will include registration of financial service providers, regulation of financial advisers and provision for comprehensive consumer dispute resolution and redress. We understand legislation will be introduced in 2007 and passed in 2008. Cabinet papers were released on 13 June 2007, which indicated that the government's preferred option for consumer dispute resolution is a model which provides for multiple industry-based dispute resolution schemes. The schemes will require approval from the Minister of Commerce and there will be mandatory membership for financial services providers who/which transact with consumers. The Minister may establish a reserve dispute resolution scheme if there are no approved schemes, or if there is not full coverage of the financial industry by those schemes which are approved.

The ISO Scheme's participation in the Australian and New Zealand Ombudsman Association ("ANZOA") is aimed at forming closer working relationships with other New Zealand and Australian Ombudsman Schemes. I was invited to take part in a conference for Financial Ombudsmen in Australia in August 2006 and rejoined ANZOA's Executive Committee in November 2006.

The FINANCIAL STATEMENTS showed that the ISO Scheme is in a sound financial position, with a budgeted net deficit of $60,000 and prudent reserves. While there was increased expenditure, we were able to hold the levies at $900,000 and operate with a reduced net deficit of $50,000.

CONCILIATION was introduced to the ISO's complaint handling process in 2007. It is a process by which the parties to a complaint, together with the assistance of the ISO as conciliator, try to resolve the complaint by teleconference. Conciliation is sometimes the first time the parties have actually talked to each other and delivers surprisingly good results. We hope to encourage more people to try conciliation at the outset of a complaint investigation. The process we have adopted was designed by FICS in Australia and we are very grateful to FICS for sharing the "how to" of their method of conciliation.

THANKS

I would like to thank the ISO Commission for its support and, in particular, the Chairperson, Alison Timms. Thanks also to Lionel Hinton and Iain Opray, who have provided significant direction as team leaders to my staff, whose tremendous skills and patience help so many consumers with their unresolved insurance complaints.

I would also like to remember Sid Narraway, our dear friend and colleague, who died shortly before this Annual Report went to print.

LOOKING FORWARD

In the coming year, we will have our new complaints management system ("ISOCS") installed by Lanworx, to enhance how we record complaints and access information.

We will also be preparing for the public Review of the ISO Scheme to be completed in 2008. It will be a targeted review, which may lead to recommendations for changes to the ISO Scheme's Rules and Terms of Reference, or to our process. We can benefit from reviewing past performance, learning how to build on good performance and improve on it in the future

Karen Stevens Insurance & Savings Ombudsman BA LLB MCIArb AAMINZ FNZIM ASB LTCL

WHAT COMPLAINTS CAN WE HELP WITH?

COMPLAINTS ABOUT...

- ✓ house, contents, vehicle, travel and health insurance
- ✓ income protection, mortgage protection, critical illness cover, life insurance and superannuation
- ✓ claims up to $150,000, or $1,000 per week unless the insurer agrees to a higher amount
- ✓ the cover provided by your policy
- ✓ claims made by, or on behalf of, the policy holder
- ✓ the amount payable under a claim
- ✓ small business claims

BUT NOT COMPLAINTS ABOUT...

- ✗ awards of compensation or damages
- ✗ commercial insurance, except small business claims
- ✗ third party or uninsured losses
- ✗ premiums, charges, excesses, returns, underwriting decisions
- ✗ financial advisors and brokers

HOW WE GOT OUR MESSAGE INTO THE COMMUNITY

IN 2006/2007:

SPEECHES AND PRESENTATIONS: We spoke at a total of 27 seminars and conferences.

CONSUMER OUTREACH: We co-hosted, with the Banking Ombudsman and Electricity and Gas Complaints Commissioner, 9 sessions for consumer advisers, including Citizens Advice Bureaux, Community Law Centres, Budget Advisers and other community groups.

0800 NUMBER: We received over 3,575 inward calls on our freephone number 0800 888 202, which provides information in a step down service and a message facility, with a direct operator link for those who want to speak to us.

WEBSITE SESSIONS: Over 46,700 people visited www.iombudsman.org.nz

COMPLAINT ENQUIRIES: We dealt with 1,601 telephone and 350 written complaint enquiries from consumers.

MEDIA ENQUIRIES: We handled 13 requests for information from newspapers and journals.

SUBMISSIONS: We made submissions in response to: the Human Rights Commission on the Guidelines on Insurance and Human Rights Act 1993; the Ministry of Economic Development on Financial Intermediaries; the Ministry of Economic Development on the Review of Financial Products and Providers (including Collective Investment Schemes, Consumer Dispute Resolution and Redress, Insurance, Platforms and Portfolio Management Services, Securities Offerings and Supervision of Issuers).

GOVERNMENT ADVISORY GROUPS: We were involved in the Insurance Advisory Group for the Ministry of Economic Development's Review of Financial Products and Providers.

"Thanks to [the Case Manager] we understood everything we didn't understand and more."

COMPLAINTS SUMMARY

There were 1,951 complaint enquiries (350 in writing), 201 complaints received for investigation and 209 complaints resolved in the 2006/2007 financial year, as set out in the tables below. There were 50 complaints resolved, as a result of involvement of the ISO Office before a formal investigation was undertaken.

STATUS	2006/07	2005/06
Complaints carried over from previous year and completed	39	21
Complaints received for investigation	201	191
Complaints under investigation	240	212
Complaints completed during the year	209	173
Complaints for investigation but incomplete at year end	31	39

RECEIVED BY SECTOR	2006/07		2005/06	
Fire and General	110	55%	109	57%
Health	39	19%	24	13%
Life and Savings	52	26%	58	30%
TOTAL	**201**		**191**	

OUTCOMES	2006/07		2005/06	
Complaints upheld	28	13%	25	15%
Complaints partly upheld	3	1%	5	3%
Complaints settled	37	18%	12	6%
Complaints not upheld	141	68%	131	76%
TOTAL	**209**		**173**	

"Your service was wonderful we only wish our insurance broker and insurance company had been as efficient."

A COMPLAINT ENQUIRY can be made by telephone or in writing and can relate to any aspect of an insurance or savings complaint, before it has been through the company's internal complaints procedure.

A COMPLAINT has gone through a company's internal complaints procedure and has been referred to the ISO Office, after *"deadlock"* has been reached and jurisdiction established.

A complaint is PARTLY UPHELD or UPHELD, when the ISO finds the company has not treated the consumer's complaint fairly, reasonably and in accordance with the policy terms. The resolution is partly or totally in favour of the consumer.

A complaint is SETTLED, when the parties agree to a favourable outcome for the consumer after a full investigation, without a formal decision being made by the ISO.

A complaint is NOT UPHELD, when the ISO finds that the company has treated the consumer's complaint fairly, reasonably and in accordance with the policy terms. However, sometimes the company has made/will make an ex-gratia payment, acceptable to the consumer.

IN THE YEAR ENDED 30 JUNE 2007, $1,460,808 WAS PAID BY THE COMPANIES TO CONSUMERS WHO HAD THEIR COMPLAINTS CONSIDERED BY THE ISO (NOT INCLUDING WEEKLY DISABILITY BENEFIT PAYMENTS UNDER INCOME PROTECTION, SUPERANNUATION OR LIFE POLICIES). IN ADDITION, THERE WERE 21 COMPLAINTS FOR WHICH A DECISION WAS MADE IN FAVOUR OF THE CONSUMER, BUT THE AMOUNT TO BE PAID HAD NOT BEEN FINALISED WHEN THE ISO FILE WAS CLOSED.

TIMELINESS

The average time to close the 209 complaints investigated in the year ended 30 June 2007, was 94 days from receiving the company's file.

CONTINUED...

JURISDICTION

In the 2006/2007 financial year, we received written enquiries about 99 disputes outside jurisdiction, which required consideration and a written response. We also received 434 telephone enquiries about disputes outside the ISO's jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO'S JURISDICTION

Not defined service	26%
Commercial/underwriting decision	25%
Brokers/company not Participant	21%
3rd party	14%
No remedy available	6%
Outside ISO's monetary limits	4%
Investment performance	2%
Outside time limits	1%
Subject other/previous proceedings	1%

TERMS OF REFERENCE ("TOR") AND RULES

Rule 10: The funding formula, which details how the annual Participant levies are calculated, changed from 1 July 2006. The ISO Board agreed to levy Participants on a share of 40% of the total levy, based on a number of complaints in the previous year; and a share of 60% of the total levy, based on a combination of a fee per Participant and the size of the Participant's business.

Definitions: The definition of *"Small Business"* in the TOR and Rules changed from 1 November 2006, by agreement with the Insurance Council of New Zealand Inc., to include the following types of insurance cover:

"Commercial Property Insurance, Business Interruption/Loss of Rents; Electronic Equipment Insurance; Machinery Breakdown; Motor; Business Travel; Personal Accident; Inland Transit in New Zealand that does not form part of an import and/or export; Marine Hull under 8-metres length overall."

The following types of insurance cover are excluded:

"Construction Risks, Fidelity Guarantee; Legal Liability (including Public Liability and Products Liability); Professional Indemnity; Directors & Officers; Marine Hull over 8-metres length overall; Import/Export Cargo."

HOW DO PEOPLE RATE US?

We send questionnaires to all consumers who have had their complaints investigated by the ISO for feedback. We use the information to monitor our process and evaluate our performance.

This year, we sent out about 200 questionnaires and 59 were returned to us. Of the 59 returned, half of those complaints were not upheld and, despite that, the responses were generally very positive.

THE ISO KEPT YOU WELL INFORMED ABOUT PROGRESS ON YOUR COMPLAINT

Don't know/Disagree	22%
Neutral	8.5%
Agree	69.5%

THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME

Don't know/Disagree	22%
Neutral	18.6%
Agree	59.4%

THE REASONS FOR THE DECISION MADE ABOUT YOUR COMPLAINT WERE EXPLAINED CLEARLY

Don't know/Disagree	6.7%
Neutral	15.3%
Agree	78%

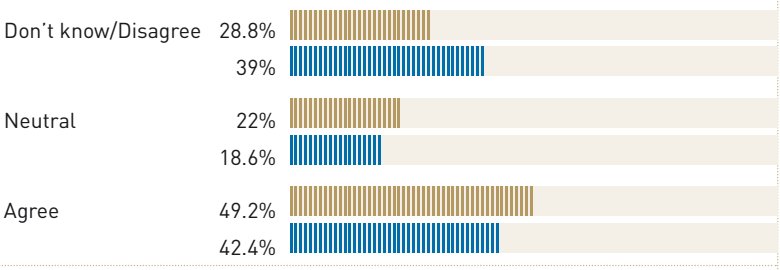
THE ISO'S INVESTIGATION OF YOUR COMPLAINT COVERED ALL OF THE ISSUES

Don't know/Disagree	17%
Neutral	15.2%
Agree	67.8%

CONTINUED...

THE ISO'S SERVICE IS EASY TO USE

INFORMATION PROVIDED BY PARTICIPANTS



Consumers received enough information from the Participant about the ISO Scheme.

Consumers received enough information from the Participant about its own internal complaints procedure.

"I was impressed by the prompt reply to my application and the excellent communication. It was a huge contrast to that of the Insurance Company involved! Excellent process, well-handled. I would certainly recommend the ISO to any others in a similar situation. My faith in fairness and justice was restored!"

CONSUMERS COMPLAINTS
CHECKLIST

1. Do you have a dispute with your insurer? → **Yes**
2. Have you read your policy to help you understand what your policy covers? → **Yes**
3. Have you been through your insurer's complaints process? → **Yes**
4. Have you had a letter from your insurer saying you have reached *deadlock*? → **Yes**

If consumers can answer **Yes** to all of these questions we can help.

CASE
STUDIES

IN THE CASE STUDIES, C = COMPLAINANT/CONSUMER AND P = PARTICIPANT/COMPANY.

1 INTERPRETATION – MEDICAL EVIDENCE

Background

In July 1990, C arranged income protection insurance with P. During 2005, C stopped work due to anxiety, depression, stress and fatigue. P accepted a claim and paid C a total disability benefit for 7 months.

C returned to work in a part-time capacity, in a less stressful position and P started paying a partial disability benefit. During this period C was diagnosed with sleep apnoea, he underwent nasal surgery and was given a CPAP machine to manage his sleep.

P arranged for C to be reviewed by Dr X, Psychiatrist. He provided a report to P stating that C's depressive episode was in complete remission and, from a psychiatric perspective, C was capable of returning to work full time in his usual occupation. He noted that C's ongoing fatigue was most likely related to his recently diagnosed sleep apnoea. P closed the claim.

Approximately a week after the claim was closed, P received a progress report from C's doctor, Dr Y, advising of a relapse in his condition. As a result of this, P arranged for a private investigator to follow C.

C was upset with P's position. He believed he was still entitled to a partial disability benefit, as his current position did not have the same levels of responsibility as his pre-disability occupation and, he did not believe he was able to work in the previous role. In addition C was particularly upset at P's use of a private investigator, because he had not made a claim for the relapse period and did not intend to do so.

"While my complaint was rightly upheld I am amazed how much detail and effort and investigation was undertaken by the Case Manager and how thorough the report on the decision was. There is clear evidence of a very capable reserve at the ISO regarding staff. I see 'win or lose' an in depth investigation precedes a decision."

Assessment

To close C's claim, P had relied on the psychiatric report that established C's depression was in full remission and he was, therefore, capable of returning to work full time in his usual occupation. However, P did not consider whether C's recently diagnosed sleep apnoea affected his work capacity.

The medical evidence available to P at the time of closing the claim indicated that C suffered from ongoing fatigue issues, which appeared to be related to his recently diagnosed sleep apnoea condition. On review, it was apparent that P had closed the claim without any investigation into whether C's sleep apnoea affected his work capacity. P's decision was based solely on C's resolved depressive episode.

There was insufficient evidence to determine whether C was partially disabled, so the ISO Office required occupational and vocational assessments in order to properly investigate C's complaint. However, before obtaining the reports, a conciliation conference by telephone was arranged with the ISO Office, C and P and, through this process, a satisfactory resolution was reached between the parties.

Result *Complaint settled*

"I feel you went over and above the call of duty on our case. Much appreciated."

2 DEATH CLAIM, REPLACEMENT POLICIES, SUICIDE

Background

In May 2004, C and his partner arranged for 2 policies held with P to be surrendered. The surrender was processed urgently, because C and his partner required the money as a deposit for a house. Less than a week after the surrender discharges were completed, C and his partner completed applications for a new cover with P and a policy was issued, covering C and his partner, with a commencement date of 1 July 2004 ("the new policy").

In October 2004, C's partner committed suicide. P advised C that, because of the policy exclusion for suicide within the first 13 months, there was no claim to process. C understood the new policy was replacing the previous policy on his partner's life and, as a result, the cover had been in place for more than 13 months.

P advised C the new policy was a new contract and was not connected to the policies which had been surrendered in May 2004. This was primarily because the personal statements completed for the new policy made no reference to the previous policies or their replacement.

In January 2005, C instructed P to cancel the policy. In December 2006, after some correspondence with C's barrister, P advised the matter had reached *"deadlock"*.

Assessment

In 2004, when C originally queried P's decision, P requested information from the adviser. The adviser said the subject of replacing the cover was discussed when the surrender discharges were signed but, at the time, the priority was to finalise the surrender of the previous policies as quickly as possible to enable the money to be available as a deposit for a house. He also referred to a needs analysis being completed when the surrender discharges were signed and indicated it was agreed he would come back later to arrange the new cover.

The Case Manager did not believe P had paid enough attention to the adviser's comments. In addition, the cover provided by the new policy was, with one exception, the same as what was recorded on the needs analysis which the adviser completed when the surrender discharges were signed and sent to the Case Manager during the investigation of the complaint.

The adviser told P he had not completed the usual replacement business forms, because it was not handled as a single transaction. However, it was apparent that what occurred clearly fell within the definition of replacement business, as set out in the adviser's agency agreement with P. Consequently,

the adviser was obliged to complete replacement business forms and provide copies to C, his partner and P. An additional obligation to provide this information arose under the provisions of the Manual of Practice Standards of Investment Savings & Insurance Association of NZ Inc.

Where business was replaced internally (the old policy and the new policy are with the same company), P's approach to the application of the standard exclusion for suicide was not clear. (This was a question which C's barrister had unsuccessfully pursued with P.) However, an internal email from October 2004, indicated that, at the time, P's approach was that the suicide clause would not apply to the extent of the cover replaced.

Under the ISO's Terms of Reference, the ISO is required to have regard to a number of factors, one of which is *"general principles of good insurance and savings practice"*. In recognition of this, the Case Manager approached 4 other companies to determine their practice, in relation to the standard suicide clause, where an existing policy is replaced internally. Each company was presented with a fact situation which effectively mirrored what occurred in practice.

Three of the 4 companies would have imposed a standard suicide clause on the new policy. However, in the event of suicide occurring within the period covered by the exclusion, the exclusion would only have applied to the extent of any increase in cover. The fourth company indicated it would have applied a special clause, stating that the suicide exclusion only applied to any increase in cover.

When asked what they would have paid in the event of suicide, each company had a slightly different approach. This was based on the sum insured under the policy which was terminated, with varying approaches to the inclusion or otherwise of reversionary bonuses and terminal bonuses and the deduction or otherwise of the surrender value paid on the policy, which had been terminated.

The Case Manager concluded the new policy replaced existing policies and that, as a result, replacement business forms should have been completed by the adviser. In addition, in recognition of the *"general principles of good insurance and savings practice"*, the suicide clause under the new policy should only have applied to any increase in cover. The Case Manager outlined the various approaches adopted by the other companies contacted and recommended a minimum payment of the sum insured on the policy on C's partner's life which had been surrendered. It was noted P would have to pay interest in accordance with section 41A of the Life Insurance Act 1908. The complaint was settled on this basis.

Result *Complaint partly upheld*

3 EXCLUSION – HEALTH, INTERPRETATION – SPECIFIC POLICY PROVISIONS

Background

C held health insurance with P. C underwent a total abdominal hysterectomy, because of a *"multifibroid uterus"*. This procedure was approved and paid for by P under the policy.

Six months later, C had a consultation with a Plastic & Cranio-Maxillo-Facial Surgeon. He suggested she undergo a *"formal anterior abdominal wall plication followed by the removal of the apron"* ("the procedure"), to deal with an *"overly lax anterior wall and excess skin"*. C contacted P, requesting prior approval for the procedure. P declined the request, advising that the procedure was not included in the list of procedures covered by the policy and the policy excluded cosmetic treatment.

Assessment

The policy set out that, for a procedure to be eligible for cover, it had to meet certain criteria. It had to be:

- listed in the policy;
- medically necessary; and
- not otherwise excluded by the policy.

1. Policy List

The procedure was not specifically listed in the policy. Therefore, the issue was whether the surgery could be considered to be included in the policy list by virtue of it being non-cosmetic plastic surgery.

P believed the surgery was cosmetic treatment and, therefore, excluded under the policy. The Case Manager believed it was more reasonable to consider C's circumstances and whether the particular surgery was being performed for cosmetic or non-cosmetic reasons. Non-cosmetic plastic surgery was not defined in the policy. However, the policy excluded cosmetic treatment. Therefore, non-cosmetic plastic surgery had to be surgery which did not come within the policy's definition of *"cosmetic treatment"*.

"I am satisfied with the way ISO staff approached me, discussed my concerns and outlined their position. I don't agree with the outcome – but am satisfied with how you came to that outcome."

Most surgeries, including those considered medically necessary (such as excision of a cancerous growth from the skin), will invariably alter a person's appearance. Nonetheless, these surgeries would not be considered *"cosmetic treatment"* in the context of the policy, because the primary reason they are performed is not cosmetic. Rather, they are performed for medical or functional reasons.

The Case Manager believed this view was supported by the wording of the *"cosmetic treatment"* definition, which encompassed surgery, procedures and treatment undertaken in order to improve, alter or enhance the insured's appearance, carried out for physical, psychological or emotional reasons. Medical/functional reasons were not included in the definition and, therefore, surgery, procedures and treatment which improved, altered or enhanced the insured's appearance, which were undertaken for medical or functional reasons, were not considered cosmetic treatment, in the context of the policy.

Although the surgery would have improved, altered, or enhanced C's appearance, it was not the primary reason for undertaking the procedure. Rather, it was to be performed for functional not cosmetic reasons. Accordingly, the Case Manager believed the procedure was non-cosmetic plastic surgery and listed in the policy.

2. Medically necessary

C's surgeon advised *"*[a]*lthough a medical condition ... caused the stretching of the anterior abdominal musculo-fascial apparatus, repair of this* [was] *not necessarily 'medically necessary'."* As such, the procedure could not be considered medically necessary under the policy.

3. Otherwise excluded

The cosmetic treatment exclusion was the only exclusion which could arguably have related to the claim but, as the surgery was non-cosmetic plastic surgery, this exclusion did not apply.

However, as the surgery did not meet all of the policy requirements, P was entitled to decline to cover the surgery.

Result *Complaint not upheld*

4 EXCLUSION – VEHICLE, FAIR AND REASONABLE, MECHANICAL FAILURE/BREAKDOWN

Background

On 30 December 1993, C insured his vehicle with P. On 7 November 2005, the policy was amended to include a 2005 Mercedes Benz ML320 diesel vehicle.

On 29 June 2006, C made a claim to P for the cost of repairing damage, which had resulted from petrol, instead of diesel, being placed in the vehicle's fuel tank on 12 December 2005. P's assessor provided P with a report and P wrote to C, declining the claim because the policy did not provide cover for any *"failure or breakage of the engine, transmission, mechanical, electrical or computer systems unless it occurred as a result of other damage to the vehicle for which a claim is payable"* ("the exclusion").

C made representations to P in support of the claim, on the basis that the vehicle's fuel system did not come within the meaning of the exclusion, but P maintained the decision to decline the claim.

Assessment

The Case Manager was surprised at the lack of information on P's file about the circumstances of the damage and why the claim had not been made until 7 months after the vehicle had been refuelled with petrol. Enquiries to C revealed that:

- within a few kilometres of the refuelling, the vehicle's engine started running rough and, as soon as C realised he had used the incorrect pump, he had the dealer uplift the vehicle;
- after removing the petrol and checking the vehicle, the dealer assured C it had not sustained any damage;
- however, the vehicle continued to be hard to start and ran rough despite further visits to the dealer; and
- finally, in June 2006, the dealer agreed to carry out further tests and discovered damage had been caused, at which point C made the claim to P.

In the course of considering claims for damage to vehicle engines, the ISO Office has checked with a number of insurers about their treatment of claims for mechanical failure or breakdown. The ISO Office believes insurers wish to avoid claims for mechanical failure or breakdown as a result of an internal failure, without the intervention of any external factor. However, much depends on the wording of each insurer's policy when applied to the circumstances of a particular claim and the interpretation the insurer wishes to place on the facts.

While the intention of each insurer in regard to claims for mechanical failure or breakdown is generally consistent, each uses a different wording. In the Assessment, the Case Manager provided 4 examples of wordings used by other insurers and noted that P's mechanical breakdown exclusion referred to a number of selected *"systems"*, but not all *"systems"* in a vehicle. The Case Manager concluded that the vehicle's fuel system did not come within the wording of the mechanical breakdown exclusion and P was not entitled to apply the exclusion to the claim.

Notwithstanding the above comments, the Case Manager also believed that even if the fuel system could be interpreted as being included as part of the *"mechanical systems"* in the exclusion, it would not be fair and reasonable to apply the exclusion to the claim. The damage was clearly not the result of an internal mechanical failure. It was the result of an accidental external event; namely, the insertion of the incorrect fuel and should be regarded as *"other damage"* to the vehicle.

Result *Complaint upheld*

"To [the Case Manager] and team I thank you from my heart for all the hard work you have done on my case. I hope cases now have a precedence to follow. Thank you."

5 FRAUD

Background

In July 2004, C arranged contents insurance with P.

In November 2006, C made a claim to P, because her deep freezer had become uplugged and *"everything"* in it had *"absolutely completely defrosted"*.

After investigation, P declined the claim, on the basis of a policy provision relating to *"FRAUD"*, because there were *"inconsistencies through out* (sic) *the claim in the information...* [C] *ha*[d] *provided."*

Assessment

Before P could decline the claim on the basis it was fraudulent, it had to prove the elements of a false/fraudulent claim to the civil standard (subject to the qualification that "clear and convincing" evidence is required).

The elements of a false/fraudulent claim, which P had to prove on the balance of probabilities, are as follows (*Blanshard v The National Mutual Life Association of Australasia Limited* (2004) 13 ANZ Insurance Cases, ¶61-621 (HC)):

1. There must be a representation which would give a misleading impression to a reasonable reader/listener;
2. The misrepresentation must have been deliberately made by the insured, in the sense that he/she:
   a) knew the misrepresentation was incorrect; or
   b) was deliberately reckless as to its truth or falsity;
3. It must not be possible to dismiss the misrepresentation as a matter *de minimis*; and
4. The insured must have intended the insurer to act on the statement.

P alleged C had made various statements (amounting to fraud) in support of the claim and the Case Manager considered each of these statements, as follows:

Statements about the previous claim

In a signed statement provided to P, C said she *"did not know the details"* of a previous claim. However, P's *"claim file notes"* indicated C had reported the previous loss to P and payment was made into her bank account.

The notes indicated P had *"negotiated"* the claim payment; however, they did not indicate P negotiated or discussed the settlement with C, or that she had provided the schedule of loss.

The Case Manager believed C's statement about the previous claim was erroneous, in the sense that it could have given the impression she had no involvement in the previous claim.

Even if C deliberately understated her involvement in the previous claim, P had to prove the statements could not be dismissed as a matter *de minimis*.

If a misrepresentation is *de minimis*, this means the statement is so insignificant or immaterial that it is not legally relevant and, therefore, it does not affect the validity of the particular claim.

Where an insurer alleges a claim is false/fraudulent, it must prove the misrepresentation was more than trivial: it must prove the misrepresentation was material. As held by Harrison J in *Blanshard*, the misrepresentation's *"impact and falsity must have been of real significance when considering the causes, nature, extent or investigation of the loss"* (Case Manager's emphasis).

It was significant that P had neither provided the ISO, nor C, with information regarding how the impact and falsity of her statement were of *"real significance"*.

Even though the statement was incorrect, P had the information relating to the previous claim and, therefore, the Case Manager did not believe the statement's impact and falsity was of *"real significance"*. Accordingly, the Case Manager dismissed the statement as *de minimis*.

C's statement that she was going to give the meat to the SPCA

When C reported the loss, she said *"I was gonna give most of the meat to the SPCA ... but there's far too much here, I'll give some of it to people but I thought I might give some of it to the SPCA ..."*

The investigator asked C to which S.P.C.A she had given the meat and, because she did not know (she had asked her partner to deliver the meat), she text messaged her friend and her partner to ask them.

The next day, the investigator telephoned the S.P.C.A and was told it had not

5 CONTINUED...

received any donations of meat on the specified day. The investigator telephoned C and advised her of this and C then told the investigator that she had discovered her partner *"had fogot*[ten] *about the meat in the boot of the car... and... when her partner realised the meat had gone off, he dumped it."*

The Case Manager did not believe C's statement that she *"thought* [she] *might give some of the* [the meat] *to the SPCA"* was a misstatement, because the evidence indicated she intended to donate some of the meat to the S.P.C.A.

There was no evidence that C said she actually gave the meat to the S.P.C.A. However, even if she had made this statement, there was no evidence the statement was made dishonestly. The evidence indicated C did not know until later that her partner had not delivered the meat. Therefore, these statements were not sufficient to allow P to decline the claim on the basis of fraud.

C's statement that all of the meat had defrosted

When C reported the loss to P, she said *"everything is completely defrosted, like, absolutely completely defrosted".*

However, C later said while most of the meat had defrosted, she gave away *"a half thawed bag of* [venison] *patties"* and she barbequed *"a half thawed bag of patties"* and *"a half thawed bag of steak"*.

The Case Manager believed C's initial statement was a misstatement. However, there was no evidence to indicate C made the statement knowing it was incorrect; rather, she contended that, at that time, she did not know all of the meat had not completely defrosted. In addition, there was no evidence that C was deliberately reckless about the statement's truth or falsity, i.e. that she made a deliberate decision not to enquire into the state of the meat so she would not have to reveal the true position.

Therefore, the Case Manager did not believe P had proven C made the statement deliberately. In this case, there was no "clear and convincing" evidence, on the balance of probabilities, that the claim was fraudulent. Therefore, P was not entitled to decline the claim.

Result *Complaint upheld*

FINANCIAL STATEMENTS

INSURANCE & SAVINGS OMBUDSMAN COMMISSION

FOR THE YEAR ENDED 30 JUNE 2007

DIRECTORY

FOR THE YEAR ENDED 30 JUNE 2007

NATURE OF BUSINESS

To appoint an Insurance & Savings Ombudsman with power (on behalf of the Insurance & Savings Ombudsman Commission):

(I) to consider, subject to the Terms of Reference, complaints in connection with the provision within New Zealand of any of the Services by any Participant; and

(II) to resolve such complaints whether by agreement, by making Assessments, Recommendations or Awards, or by such other means as shall seem expedient.

BUSINESS LOCATION

7th Floor, BDO House, 99-105 Customhouse Quay, Wellington

BANKERS	The National Bank of New Zealand Ltd Wellington
ACCOUNTANTS	BDO Spicers (Wellington) Limited Wellington
AUDITORS	Martin Jarvie PKF Wellington

STATEMENT OF FINANCIAL PERFORMANCE: For the year ended 30 June 2007

	Note	2007	2006
Income			
Levies		890,000	899,500
Casebook Sales		1,156	1,783
Brochure Sales		0	1,911
Conference		42,253	0
Workshop/Training Day		5,476	0
Interest Received		62,477	61,120
Depreciation Adjustment on Disposal of Fixed Assets		0	100
Total Income		**1,001,362**	964,414
Less: Expenditure			
Administration Costs		128,807	134,284
Audit Fees		4,183	4,225
Commissioners' Fees & Expenses		32,250	34,000
Conference		29,536	0
Depreciation - Office Equipment		18,227	27,398
Depreciation - Furniture & Fittings		722	1,351
Professionals & Consultancy		32,095	32,358
Occupancy		12,746	11,040
Promotion		5,725	15,156
Rent	3	83,174	75,180
Salaries		665,870	634,463
Scheme Review Fees & Expenses		0	2,625
Staff Costs		22,383	7,856
Workshop/Training Day		2,494	0
Total Operating Expenditure		**1,038,212**	979,936
Net Surplus (Deficit) Before Tax		**($36,850)**	($15,522)
Tax Expense	4	13,961	13,536
Net Surplus (Deficit) After Tax		**($50,811)**	($29,058)

This statement should be read in conjunction with the Notes To The Financial Statements.

STATEMENT OF MOVEMENTS IN EQUITY: For the year ended 30 June 2007

	Note	2007	2006
Balance at Beginning of Year		493,431	522,489
Net Surplus (Deficit) After Tax		(50,811)	(29,058)
Balance at End of Year	**7**	**$442,620**	$493,431

This statement should be read in conjunction with the Notes To The Financial Statements.

STATEMENT OF FINANCIAL POSITION: As at 30 June 2007

	Note	2007	2006
Equity			
Accumulated Funds Account	7	442,620	493,431
Total Equity		**$442,620**	$493,431
Represented By :			
Current Assets			
Accrued Income		3,027	0
Accounts Receivable		1,165	10,320
Prepayments		19,379	13,175
Cash & Bank		115,212	515,791
National Bank of N.Z. Term Deposits		350,000	0
G.S.T. Refund		16,982	3,206
Total Current Assets		**505,765**	542,493
Fixed Assets	2	**59,616**	34,291
Total Assets		**565,381**	576,783
Current Liabilities			
Income Received in Advance		0	13,111
Accounts Payable		120,392	69,330
Income Tax Payable		2,369	911
Total Current Liabilities		**122,761**	83,352
Total Liabilities		**122,761**	83,352
Net Assets		**$442,620**	$493,431

The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on 13 August 2007.

Chairperson:  Date: 13.08.07

Ombudsman:  Date: 13.08.07

This statement should be read in conjunction with the Notes To The Financial Statements.

NOTES TO THE FINANCIAL STATEMENTS: For the year ended 30 June 2007

NOTE 1 – STATEMENT OF ACCOUNTING POLICIES

ENTITY REPORTING & STATUTORY BASIS

The Financial Statements presented here are for the Insurance & Savings Ombudsman Commission.

The Financial Statements are prepared in accordance with Generally Accepted Accounting Practice ("GAAP") as defined in the Financial Reporting Act 1993.

DIFFERENTIAL REPORTING

The Insurance & Savings Ombudsman Commission is a qualifying entity within the Institute of Chartered Accountants of New Zealand differential reporting framework. The Insurance & Savings Ombudsman Commission is not publicly accountable and qualifies under the size criteria and has taken advantage of all differential reporting concessions available to it.

GENERAL ACCOUNTING POLICIES

The measurement base adopted is that of historical cost. Reliance is placed on the fact that the business is a going concern.

Accrual accounting is used to match expenses and revenues.

PARTICULAR ACCOUNTING POLICIES

Accounts Receivable: Accounts Receivable are valued at expected realisable value.

Fixed Assets: Property, Plant and Equipment are recorded at cost less accumulated depreciation. The cost of Fixed Assets is the value of the consideration given to acquire the assets and the value of other directly attributed costs which have been incurred in bringing the assets to the location and condition necessary for their intended service.

Depreciation

All fixed assets are depreciated using the straight line method of depreciation to write assets off over their expected useful lives. The rates are as follows:

Computer Equipment	25%
Office Equipment	10-48%
Furniture & Fittings	6-24%

Investment Income: Interest income is accounted for as it is earned.

Levy Income: Levies comprise amounts received and receivable from Participants in the Insurance & Savings Ombudsman Scheme, and are recognised on an accrual basis.

Goods & Services Tax: The statement of financial performance has been prepared so that all components are stated exclusive of GST. All items in the statement of financial position are stated net of GST, with the exception of receivables and payables, which include GST.

Employee Entitlements: Employee entitlements to salaries, wages and annual leave are recognised when they accrue to employees.

Taxation: The "taxes payable" method of accounting for taxation has been followed. Provision has been made for taxation after taking full advantage of all deductions and concessions permitted. No provision has been made for deferred tax due to there being no timing differences.

CHANGES IN ACCOUNTING POLICIES

All polices have been applied on bases consistent with those used in the previous year.

NOTE 2 – FIXED ASSETS

	Cost Price	Accum.Depn.	Net Value
Plant & Equipment - 2007			
Office Equipment	210,212	154,165	56,047
Furniture & Fittings	77,322	73,753	3,569
	$287,534	**227,918**	**$59,616**
Plant & Equipment - 2006			
Office Equipment	172,764	142,764	30,000
Furniture & Fittings	77,322	73,031	4,291
	$250,086	**215,795**	**34,291**

NOTE 3 – OPERATING LEASE COMMITMENTS

Analysis	2007	2006
Current	97,683	48,610
Non-Current	154,664	0
	$252,347	**$48,610**

Obligations payable after balance date on non-cancellable operating leases are as detailed above. Upon expiry the operating lease gives the Insurance & Savings Ombudsman Commission the right to renew the lease subject to a redetermination of the lease rental by the lessor.

NOTE 4 – TAXABLE INCOME RECONCILIATION

Income Adjustments	2007	2006
Book Profit/(Loss) Before Tax	(36,851)	(15,522)
Adjustment for Non-Taxable Income and Expenses	94,703	72,086
Taxable Profit/(Loss)	**$57,852**	**$56,564**
Tax Provision		
Tax @ Marginal Rates	13,961	13,536
Total Tax Provision	**$13,961**	**$13,536**

Tax is calculated on investment earnings less costs relating to that income. Only investment earnings are taxable. Income and expenditure within the circle of membership is non-taxable.

NOTE 5 – CONTINGENT LIABILITIES & COMMITMENTS

As at balance date, the Insurance & Savings Ombudsman Commission had capital commitments of $15,440 relating to the upgrade of the database (2006 Nil). As at balance date, the Insurance & Savings Ombudsman had no contingent liabilities (2006 Nil).

NOTE 6 – RELATED PARTY TRANSACTIONS

There were no transactions involving related parties during the year, other than those already disclosed elsewhere in these Financial Statements (2006 Nil).

NOTE 7 – ACCUMULATED FUNDS

Included in Accumulated Funds is $60,000 which is for the ISO Scheme Review which will be undertaken in 2008. (2006: $40,000).

AUDIT REPORT: To the Participants in the Insurance & Savings Ombudsman Scheme

We have audited the Financial Statements on pages 28 to 31. The Financial Statements provide information about the past performance of the Insurance & Savings Ombudsman Scheme (the "ISO Scheme") and its financial position as at 30 June 2007. This information is stated in accordance with the accounting policies set out on page 30.

INSURANCE & SAVINGS OMBUDSMAN COMMISSION'S RESPONSIBILITIES

The members of the Insurance & Savings Ombudsman Commission (the "ISO Commission") are responsible for the preparation of Financial Statements, which gives a true and fair view of the financial position of the ISO Scheme as at 30 June 2007 and of the results of operations for the year ended on that date.

AUDITOR'S RESPONSIBILITIES

It is our responsibility to express an independent opinion on the Financial Statements presented by the ISO Commission and report our opinion to you.

BASIS OF OPINION

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the Financial Statements. It also includes assessing:

- The significant estimates and judgements made by the ISO Commission in the preparation of the Financial Statements; and
- Whether the accounting policies are appropriate to the ISO Scheme's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with New Zealand Auditing Standards. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the Financial Statements are free from material misstatements, whether caused by fraud or error. In forming our opinion we also evaluated the overall adequacy of the presentation of the information in the Financial Statements.

Other than in our capacity as Auditors, we have no relationship with or interest in the ISO Scheme.

UNQUALIFIED OPINION

We have obtained all the information and explanations we have required.

In our opinion:

- Proper accounting records have been kept by the ISO Commission as far as appears from our examination of those records; and
- The Financial Statements on pages 28 to 31:
  - comply with generally accepted accounting practice; and
  - give a true and fair view of the financial position of the ISO Scheme as at 30 June 2007 and the results of its operations for the year ended on that date.

Our audit was completed on 13th August 2007 and our unqualified opinion is expressed as at that date.

Martin Jarvie PKF
Chartered Accountants, Wellington

SCHEME PARTICIPANTS: as at 30 June 2007

AA Insurance Limited
- SIS Insurance

ACE Insurance Limited
- Vodafone phoneInsure

Allianz New Zealand Limited
- Protecta

American Home Assurance Company (NZ Branch)

American International Assurance Co (Bermuda) Limited

AMI Insurance Limited

AMP Services (NZ) Limited

Ansvar Insurance Limited

ASB Group Investments Limited

Associated Marine Insurance Agents Pty Limited

Asteron Life Limited
- Asteron Retirement Investment Limited

Asteron Trust Services Limited

China Insurance (NZ) Company Limited

CIGNA Life Insurance New Zealand Limited

Combined Insurance Company of New Zealand

Dorchester Life Limited

Equitable Life Insurance Company Limited

Farmers' Mutual Insurance Association
- Farmers' Mutual Insurance Limited

Farmers' Mutual Life Limited

Fidelity Life Assurance Company Limited

Hallmark Life Insurance Company Limited
t/a GE Money Insurance Services

I.O.O.F of New Zealand - Friendly Society

IAG New Zealand Limited
- DriveRight
- Mike Henry Travel
- National Auto Club Underwriters Agency (NZ) Limited
- NZI
- NZI Marine
- State
- Swann Insurance (NZ) Limited

ING (NZ) Limited

ING Insurance Services (NZ) Limited

ING Life (NZ) Limited

Lumley General Insurance (NZ) Limited
- Australis Underwriting Agency
- Lumley Services (NZ) Limited

Manchester Unity Friendly Society

Medical Insurance Society New Zealand Limited

Medical Life Assurance Society Limited

MFL Mutual Fund

Mitsui Sumitomo Insurance Company Limited

National Mutual Life Association of Australasia Limited (The)
t/a as AXA NZ

Orange Insurance Limited

Pacific Life Limited

PSIS Life Limited

Public Trust

Sentinel Assurance Company Limited

SIL Mutual Fund

Southern Cross Medical Care Society
- Activa Health Limited

Southern Cross Benefits Limited (Travel)

Southsure Assurance Limited

Sovereign Assurance Company Limited
- Sovereign Superannuation Funds Limited
- Colonial Mutual Life Assurance Society

TOWER Health & Life Limited

TOWER Insurance Limited

TOWER Managed Funds Limited

Union Medical Benefits Society Limited
t/a UNIMED

Vero Insurance New Zealand Limited
- AMP General Insurance
- Autosure
- AXIOM
- Comprehensive Travel
- Mariner Underwriters Limited
- Vero Marine Insurance Limited

• Denotes subsidiary or associated company or business division

"The outcome was satisfactory and worked within a framework that maintained high standards. I had confidence in the process regardless of outcome."

"I was treated with courtesy, and given the information about my case. Thank you to all involved, even though my case was not upheld."

"Thank you for reviewing my case and although your finding was not in my favour I appreciate that time was taken to review it. I did realise that the law was not on my side but had hoped for some leniency by the Insurance Company, due to the unfortunate circumstances in the case that were beyond our control. I had nothing more to lose by requesting an independent review. I have certainly learnt a few valuable lessons as a result of this unfortunate event."

"I am sure that the ISO would have sorted it out quicker if it wasn't for the uncooperative attitude of [the Company]."

"Excellent service and our matter was handled very professionally given all the sensitivities involved. Your approach to this matter was very professional and much appreciated. The Insurer, with their final representative, resolved the situation with one meeting and to the extent that my mother's peace of mind has been restored and she has chosen to renew her insurances with the company involved. A win-win for all involved but which would not have arisen without your assistance. Again thank you and your team at the ISO."

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