COMPLAINTS MANAGEMENT POLICY

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COMPLAINTS MANAGEMENT POLICY

INTRODUCTION

The Financial Advisory & Intermediary Services Act No. 37 of 2002 (the "FAIS Act") deals with complaints in some length. The Financial Services Board (FSB) has adopted a Treating Customers Fairly (TCF) framework as the basis for its supervision of the conduct of business of regulated financial institutions. The TCF framework will also be a key component of the future market conduct regulatory authority's mandate to promote fair treatment of financial customers. Effective management of customer complaints by financial institutions is a vital component of financial consumer protection.

DEFINITIONS

FINANCIAL INSTITUTION

Financial Institution means Centriq Insurance Holdings Limited consisting of Centriq Insurance Company Limited, Centriq Life Insurance Company Limited and Nova Risk Partners Limited ("Centriq") as well as Centriq Partners consisting of Binder Holders and Independent Intermediaries. And Mutual & Federal Risk Financing Limited provides large commercial and industrial organisations with world-class captive management and risk financing services. Mutual & Federal Risk Financing Limited is a licensed Non-Life Insurer.

COMPLAINT

An expression of dissatisfaction by a complainant, relating to a product or service provided or offered by a financial institution, or to an agreement with the financial institution in respect of its products or services and indicating that:

a. the financial institution or its service provider has contravened or failed to comply with an agreement, a law, a rule, or a code of conduct which is binding on the financial institution or to which it subscribes;
b. the financial institution or its service provider's maladministration or wilful or negligent action or failure to act, has caused the complainant harm, prejudice, distress or substantial inconvenience; or
c. the financial institution or its service provider has treated the complainant unfairly and regardless of whether such an expression of dissatisfaction is submitted together with or in relation to a customer query.

REJECTED

In relation to a complaint means that the complaint has not been upheld and the financial institution rejected the complaint as finalised after advising the complainant that it does not intend to take any further action to resolve the complaint. This can arise either where the financial institution rejects a complaint without offering to take steps to resolve it because the financial institution regards the

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complaint as unjustified or invalid, or where the customer or prospective customer does not accept or respond to the financial institution's proposals to resolve the complaint and the financial institution then advises the complainant that it does not intend to take any further action to attempt to resolve the complaint.

COMPLAINT

Means a payment, other than a goodwill payment, by a financial institution to a complainant to compensate the complainant for a proven or estimated financial loss incurred as a result of the financial institution's contravention, non-compliance, action, failure to act, or unfair treatment forming the basis of the complaint, where the financial institution accepts liability for having caused the loss concerned.

"Compensation payment" excludes –

a. payment of amounts contractually due to the complainant in terms of the financial product or service concerned, or
b. refunds of amounts paid by or on behalf of the complainant to the financial institution where such payments were not contractually due but includes interest on late payment of amounts or refunds referred to in a) or b).

CUSTOMER

"Customer" of a financial institution means any user, former user or beneficiary of one or more of the financial institution's financial products or services, and their successors in title.

CUSTOMER QUERY

Means a request to the financial institution by or on behalf of a customer or prospective customer, for information regarding the financial institution's products, services or related processes, or to carry out a transaction or action in relation to any such product or service.

GOODWILL PAYMENT

Means a payment by a financial institution to a complainant as an expression of goodwill aimed at resolving a complaint, but where the financial institution does not accept liability for any financial loss to the customer as a result of the matter complained about.

PROSPECTIVE CUSTOMER

"Prospective customer" of a financial institution means a person who has applied to or otherwise approached the financial institution in relation to becoming a customer of the financial institution, or a person who has been solicited by the financial institution to become a customer or has received marketing or advertising material in relation to the financial institution's products or services.

REPORTABLE COMPLAINT

"Reportable complaint" means any complaint other than a complaint that has been:

a. upheld immediately by the person who initially received the complaint; upheld within the financial institution's ordinary processes for handling customer queries in relation to the type of agreement, product or service complained about, provided that such process does not take more than five business days to complete from the date the complaint is received; or
b. submitted to or brought to the attention of the financial institution in such a manner that the financial institution does not have a reasonable opportunity to record such details of the complaint as may be prescribed in relation to reportable complaints.

SERVICE PROVIDER

Means another person with whom the financial institution to whose products or services the complaint relates has an arrangement in relation to the marketing, distribution, administration or provision of such products or services, regardless of whether or not such other person is the agent of the financial institution.

UPHELD

"Upheld" in relation to a complaint means that the complaint has been finalised in such a manner that the complainant has explicitly accepted that the matter is fully resolved or that it is reasonable for the financial institution to assume that the complainant has so accepted. A complaint should only be regarded as upheld once any and all undertakings made by the financial institution to resolve the complaint have been met.

COMPLAINTS MANAGEMENT POLICY

- To ensure the adequate protection of policyholders and or customers.
- To ensure the sound and prudent management of complaints.
- To ensure that we have an effective internal control system in place to monitor the fair treatment of the complainant in rejections and complaints handling.
- To ensure the complainant is treated fairly in the assessment of rejections and complaints.
- To ensure that complaints are investigated fairly and that possible conflicts of interest are identified and mitigated.
- To ensure that all complaints are recorded in a Complaints Register or a similar register.
- To ensure that all rejections are recorded in a Rejections Register or a similar register.
- To ensure that the insurer provides information on complaints, rejections and complaint-handling, which data will at the very least cover:
    a. The number of complaints received / rejections authorised;
    b. The reasons for the complaint / rejection;
    c. Whether the complaint was resolved or escalated;
    d. The outcome of the complaint.
- To ensure that the complaints and rejection data is analysed in order to identify and address any recurring or systemic problems and potential and operational risks, by:
    a. Analysing the causes of individual complaints so as to identify root causes common to the different types of complaints;
    b. Considering whether such root causes may also affect other processes or products, including those not directly complained of; and
    c. Correcting, where reasonable to do so, such root causes.
- To resolve the complainant's complaint in a timely and fair manner.
- To resolve the complaint in a manner that is objectively reasonable towards the complainant, the business and its personnel.
- To avoid conflicts of interest between the complainant and the company, its employees and its representatives.
- To ensure that the complainant knows the complaints policy and procedure that is followed.
- To provide an outcome in writing.
- To be transparent at all times and to keep the complainant informed of resolution procedures.
- To ensure the complainant has access to the complaints procedure (on the insurer's website or on request in the form requested).
- To promptly investigate and respond to complaints.
- If the complaint is not resolved the complainant must be advised of further steps available (i.e. the OSTI, FAIS Ombud).

COMPLAINTS SUPPORT

- In order to achieve the abovementioned objectives, the insurer will at all times ensure that the following is in place:
    a. A Complaints Management Process (CMP), meeting prescribed standards.
    b. Ensure that we meet the standards for complaints record keeping.
    c. Ensure that we meet the standards for complaints monitoring and analysis.
    d. Ensure that we have levels of escalation in place.

- The insurer provides an Incident Register for recording of complaints.
  The register contains the following fields:
  a. **Received:**
     The date on which the letter was received. The receipt period starts its calculations here.
  b. **Date Captured:**
     The date of the day on which the complaint is captured.
  c. **Received From:**
     The name and designation of the person that submitted the complaint must be entered here. It may be a complainant or a complainant's representative.
  d. **Complaint Reference Number:**
     This field contains the complainant's reference number linked to an internal system.
  e. **Complainant Surname and Initials:**
     Enter the surname of the complainant making the complaint.
  f. **Complaint Description/Type:**
     Short summary of the complaint.
  g. **Captured by:**
     The name of the person who captured the complaint.
  h. **Responsible person internally:**
     Who will deal with the complaint and ensure that it is resolved.
  i. **Activity Update:**
     Log all developments and movements.
  j. **Outcome of Complaint:**
     Summary of what decisions were taken and outcome of complaint.
  k. **Date of Final Communication to complainant:**
     Date of letter to the complainant.
  l. **Claims Manager Final Sign Off:**
     Designated compliance officer to sign off a complaint as finalised.
  m. **Learnings:**
     This is a field where any possible lessons learned from the handling of this complaint can be entered.

- Complaints Registers maintained by the NMI or UMA, must be sent to the insurer on a monthly basis, highlighting the progress on the complaint:
  a. Was the complaint resolved or not?
  b. If not resolved, has it been escalated to the Claims Specialist at the insurer for intervention?

INTERNAL COMPLAINTS MANAGEMENT PROCESS

In line with achieving the Treating Customers Fairly Outcomes, the following underpins our complaints procedure:

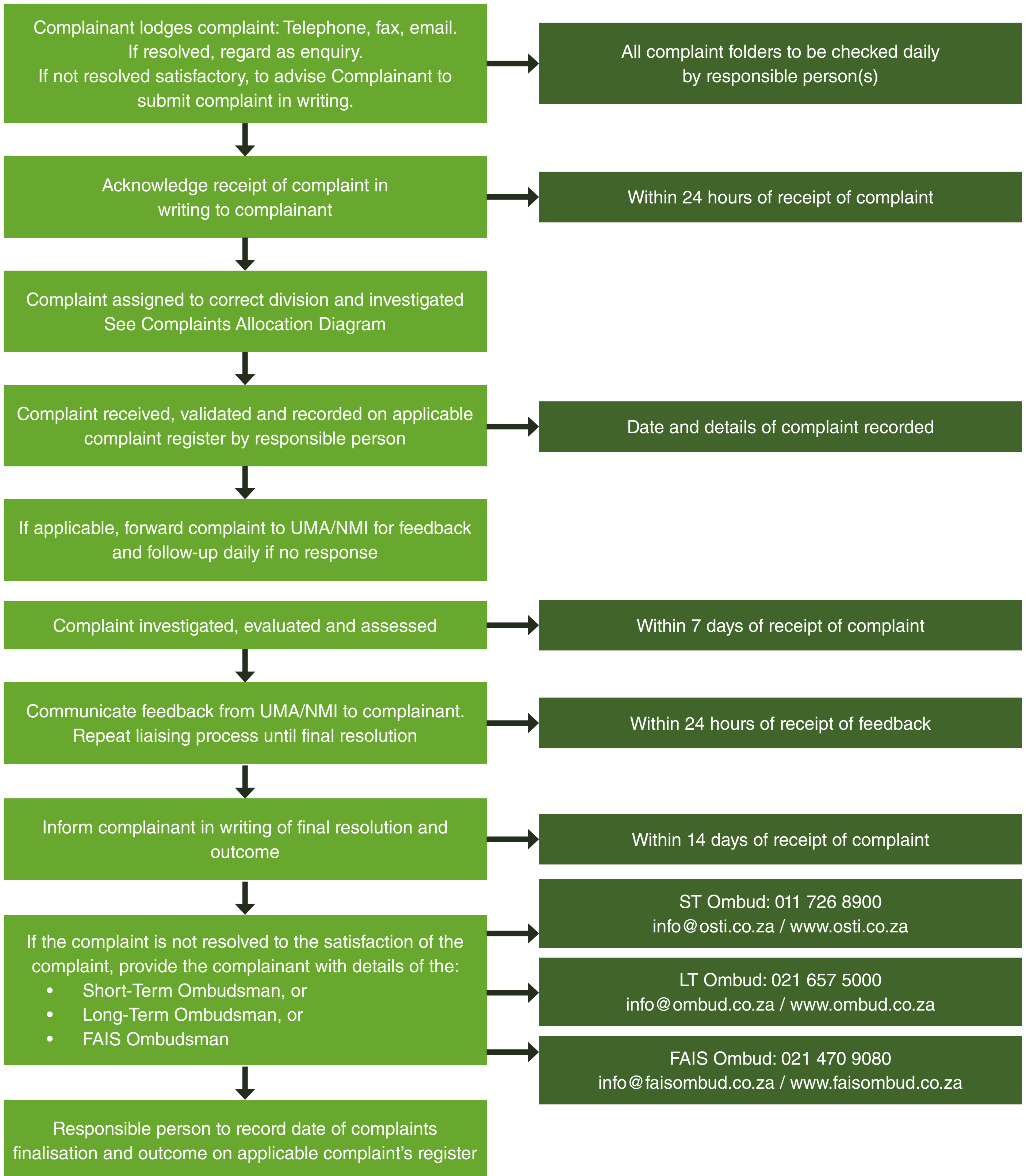
- On request or when acknowledging receipt of a complaint, written information regarding the complaints-handling process is provided.

- The following information will be provided to the complainant in a clear and up-to-date manner:
  a. Type of information to be provided by the complainant.
  b. Identity and contact details of the person or department to whom the complaint should be directed.
  c. The process that will be followed when handling a complaint.
  d. Estimated timelines.
  e. The availability of an ombudsman or alternative dispute resolution mechanism.
  f. Further handling of the complaint.

- When responding to a complaint, the following must be done:
    a. Gather and investigate all relevant evidence and information regarding the complaint.
    b. Communicate in plain language, which is clear and easily understood.
    c. Provide a response without any unnecessary delay or at least within the time limits.
    d. When an answer cannot be provided within the expected time limits, the complainant must be informed about the causes of the delay and indicate when the investigation is likely to be completed.
    e. When providing a final decision that does not fully satisfy the complainant's demand, a thorough explanation of our position on the complaint must be included.
    f. Provide details about further redress available to the complainant if he/she is not satisfied with the outcome e.g. the availability of an ombudsman or ADR mechanism.
    g. Such decision should be provided in writing.

- We deal with complaints as follows:
    a. Log the date and contents of the complaint in the Complaints Register.
    b. If a complaint is not in writing, ask the complainant to lodge the complaint in writing.
    c. Acknowledge receipt of the complaint in writing within 24 hours of receipt, and give the complainant the name(s) and contact details of the person / department responsible for the resolution of the complaint. Assign complaint accordingly.
    d. Investigate, evaluate and assess the complaint to ascertain whether the complaint can be resolved immediately by the insurer. A telephonic discussion must ensue with the partner concerned.
    e. If the complaint can be resolved immediately, take the necessary action and advise the complainant accordingly.
    f. If the complaint cannot be resolved immediately, the acknowledgement letter must set out the steps to be taken to resolve the matter and the expected date of and process for resolution.
    g. Forward the complaint to the non-mandated intermediary (NMI) or underwriting manager (UMA) for resolution, feedback and comment.
    h. The NMI or UMA has seven (7) days in which to respond to the insurer.
    i. The insurer to peruse feedback and if satisfied, send response to complainant.
    j. If the insurer is dissatisfied with the response from the UMA or NMI, the insurer to liaise with UMA or NMI until resolution is reached. The insurer is to communicate feedback from the NMI or UMA to the complainant within 24 hours of receipt of feedback. In the final letter, the provisions relating to the channels of escalation as well as the details of the relevant Ombudsman scheme must be provided. Notification must also be provided with regard to the process and timelines should the complainant elect to pursue the matter by way of litigation.
    k. If unable to resolve the complaint within fourteen (14) days, notify the complainant in writing. Notify the complainant giving full written reasons as to why the outcome was not favourable, and advise the complainant of their right to seek legal redress by referring the complaint to the Office of the Ombudsman.
    l. Advise the complainant that he/she has 6 months from receipt of such notification to refer the matter to the Ombudsman. The Ombudsman's name, address and other contact details must be provided.
    m. Update the register with all developments/activities.

COMPLAINTS HANDLING PROCESS FLOW



OMBUDSMAN COMPLAINTS

We deal with ombudsman complaints as follows:

Short Term Ombudsman (OSTI)

Established in August 1989, The Office of the Ombudsman for Short-Term Insurance provides consumers with a free, efficient and fair dispute resolution mechanism. It offers consumers a "no risk" mechanism to resolve disputes with insurers. The Office can assist consumers with the following personal lines short-term insurance:

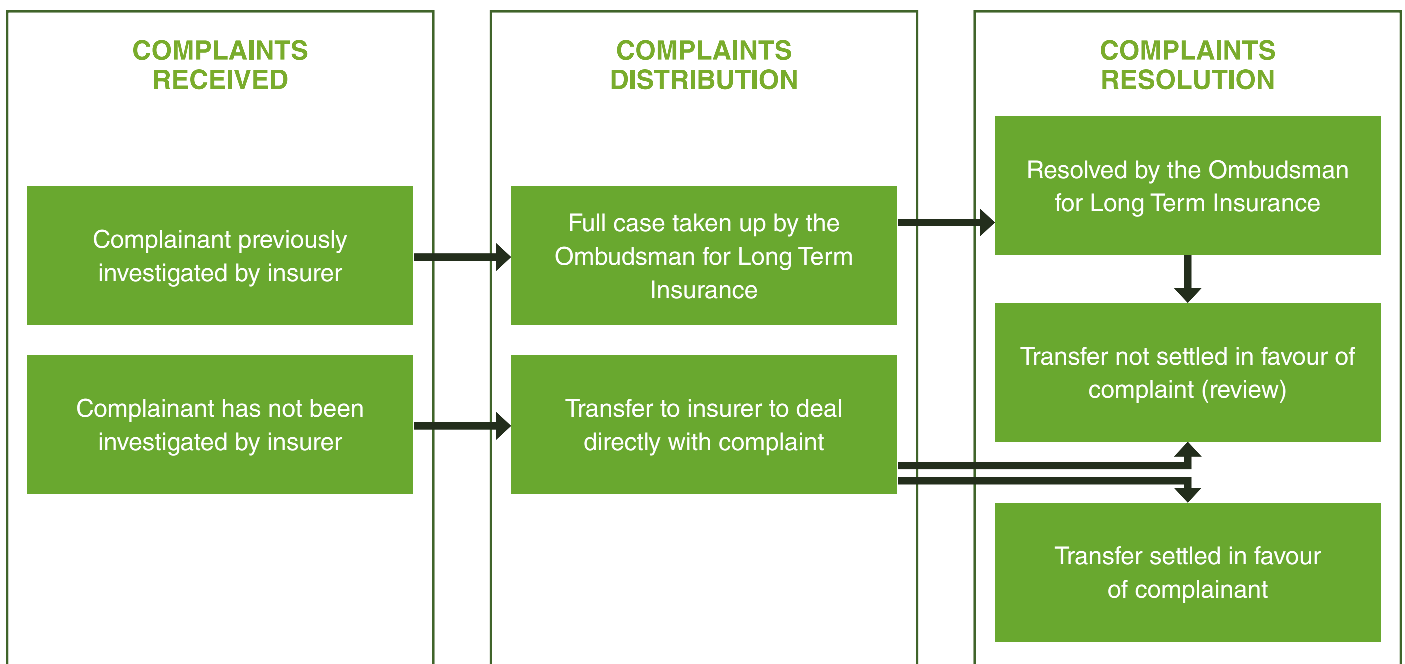
a. Motor
b. House owners (Buildings)
c. Householders (Contents)
d. Cell phone
e. Travel
f. Disability
g. Credit protection insurance
h. Commercial Insurance on a Limited basis, i.e. claimants such as small businesses, including a sole proprietor or trader, a juristic person, partnership or trust that has a turnover in the last financial year of less than R25 million. Claim disputes, which the Office can assist with, include fire and allied perils, glass, theft, motor, travel, sickness and accident and SASRIA claims (affiliated to the aforesaid covers).

Long Term Ombudsman

The function of the office is to mediate in disputes between subscribing members of the long-term insurance industry and policyholders regarding insurance contracts.

It is an independent office which is accountable to an independent Long-term Ombudsman Council for providing an efficient and independent service to policyholders and others in response to disputes arising from long-term insurance policies.

The international practice is that a complaint against an insurer will only be accepted after the insurer has had an opportunity to resolve it. In line with this, in early 2014, the new business model was adapted. The layout is confirmed in the flow diagram below.



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FAIS Ombudsman

The FAIS Ombud role is to resolve disputes between financial services providers and their clients in a procedurally fair, informal, economical and expeditious manner. The FAIS Ombud jurisdiction is limited to violations which occurred on or after 30 September 2004 and to claims not exceeding R800 000.00.
The complaint will be considered if it is alleged that the provider or representative:

a. has contravened or failed to comply with a provision of the FAIS Act and that as a result thereof the complainant has suffered or is likely to suffer financial prejudice or damage;
b. has wilfully or negligently rendered a financial service to the complainant and has caused prejudice or damage to the complainant or which is likely to result in such prejudice or damage; or
c. has treated the complainant unfairly

Our Internal Process – Ombudsman

a. Log the date and contents of the ombudsman complaint in the Ombudsman Complaints Register.
b. Acknowledge receipt of the complaint in writing within 24 hours of receipt.
c. Forward the complaint together with all supporting documentation to the non-mandated intermediary (NMI) or underwriting manager (UMA) for reply, feedback and comment to each and every allegation and statement.
d. Follow up with NMI or UMA on a daily basis and inform NMI or UMA of the 50% rebate on the ombudsman fees should the complaint be resolved within 14 days in favour of the complainant.
e. Formalise a reply and respond to the Ombudsman as per the requirements of the relevant Ombudsman Scheme.
f. Discuss the matter and our response with our Compliance Officer (FAIS Ombudsman matters only).
g. Our formal response is to be drafted in conjunction with our Compliance Officer (FAIS Ombudsman matters only).
h. Cooperate with the procedure implemented by the Ombudsman to investigate and resolve the complaint (mediation, conciliation, arbitration with or without legal representation).
i. Consider Ombudsman recommendation, if any, in an attempt to resolve the complaint.
j. All interested parties to consider ground, reasons, merits, and financial implications (business decision) in determining whether or not to accept the Ombudsman recommendation.
k. If the recommendation is not accepted by the Insurer or complainant, the Ombudsman will make a determination (dismiss the complaint or uphold the complaint).
l. The Insurer / NMI / UMA will comply with the Ombudsman determination which is regarded as a civil judgment.
m. Update the Ombudsman Complaints Register with the final outcome.

COMPLAINTS RELATING TO SERVICE PROVIDERS

These complaints relate to matters escalated by a customer where he expresses dissatisfaction with the service he has received from a service provider of the financial institution.

It is important that the financial institution has a service level agreement in place, which service level should regulate the relationship between the financial institution and the service provider.

The TCF outcome which provides an overview and which should link to these types of complaints is TCF outcome 5(b). Complaints falling into this category should be recorded and must follow the complaints handling process as set out in this document.

COMPLAINTS ANALYSIS

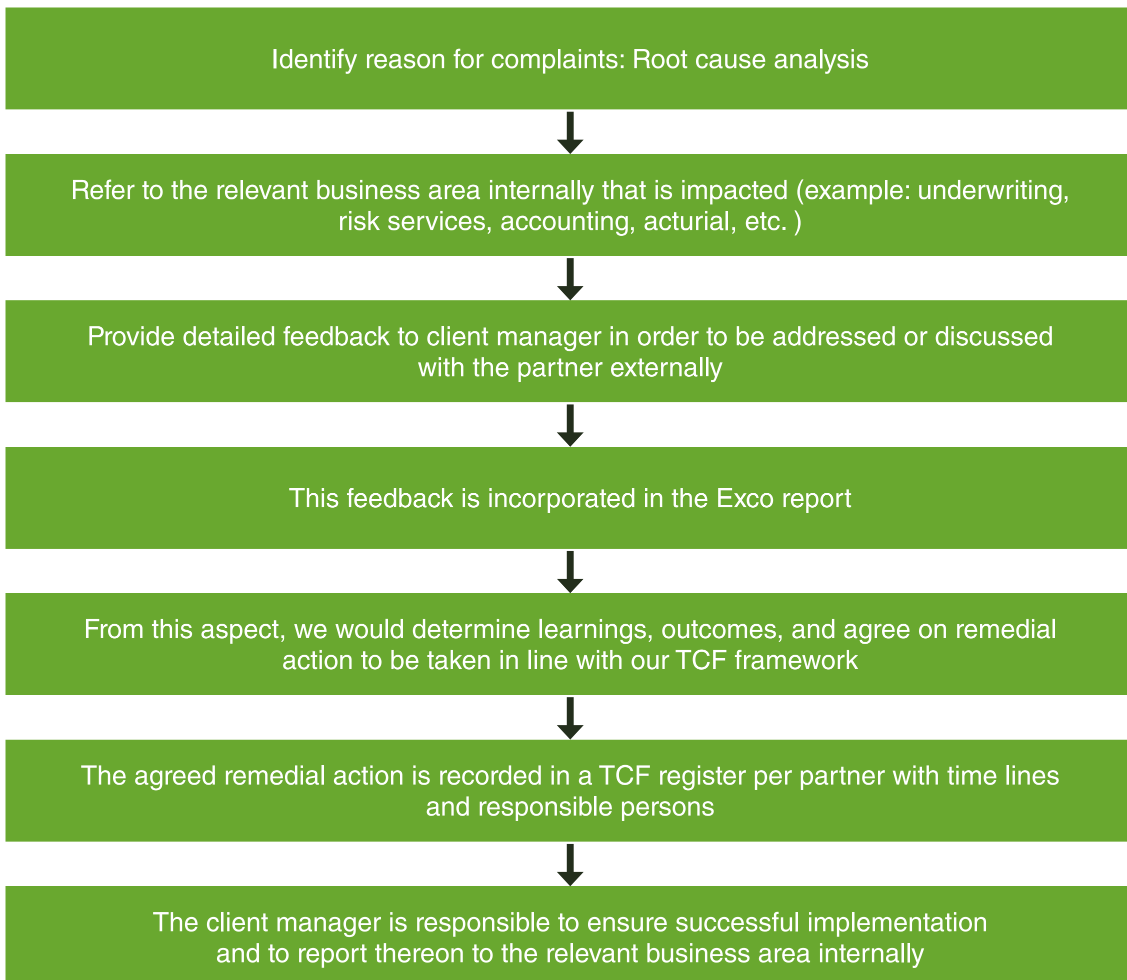
Effective monitoring and analysis of complaints is a key tool for the insurer to use to identify, manage and mitigate emerging TCF related and other market conduct risks within our operations, to identify opportunities for improving TCF outcomes for our customers, and to prevent recurrences of poor outcomes and errors.

In order for the insurer to use complaints information to manage conduct risks and effect improved outcomes and processes as proactively as possible, complaints information should be scrutinised and analysed on an ongoing basis. Depending on the volume and nature of complaints received, a combination of qualitative and quantitative analysis should be undertaken. Qualitative analysis can for example include reviewing particular complaints as case studies and using them for staff training purposes or as motivations for process or product improvements. Quantitative data can be used to identify positive or negative trends and take these into account to confirm the success of initiatives or mitigate emerging risks, as the case may be.

Complaints analysis should be used to:

a. Identify root causes common to categories of complaints and instances where such root causes are likely to affect other customers, products or processes.
b. Identify failings in control systems.
c. Detect poor staff or service provider performance, lack of skills or misconduct. Track the success of the firm's TCF delivery, or risks to TCF delivery.
d. Demonstrate the benefits of effective complaints management by using lessons from complaints analysis to effect meaningful improvements for customers and the business.

COMPLAINTS ANALYSIS WORKFLOW



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TCF ALIGNED COMPLAINTS CATEGORIES

The six TCF Outcomes constitute a set of principles against which the conduct of business of firms in relation to their customers, as well as the effectiveness and suitability of the regulatory and supervisory approach of the FSB (as market conduct regulator), will be tested.

Against this background, it makes sense for both firms and the regulator to be able to use complaints information to measure the industry's progress in delivering the TCF Outcomes, and to identify and mitigate risks to the delivery of those Outcomes. To achieve this, the FSB proposes that financial institutions be required to manage and categorise complaints in line with the TCF Outcomes.

- The six TCF Outcomes comprising the TCF framework are:
    a. Outcome 1: Customers can be confident they are dealing with firms where TCF is central to the corporate culture
    b. Outcome 2: Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly
    c. Outcome 3: Customers are provided with clear information and kept appropriately informed before, during and after point of sale
    d. Outcome 4: Where advice is given, it is suitable and takes account of customer circumstances
    e. Outcome 5: Products perform as firms have led customers to expect, and service is of an acceptable standard and as they have been led to expect
    f. Outcome 6: Customers do not face unreasonable post-sale barriers imposed by firms to change product, switch providers, submit a claim or make a complaint.

- The 9 TCF aligned complaints categorisation entails the following:
    a. Outcome 2: Complaints relating to the design of a product or service
    b. Outcome 3: Complaints relating to information provided
    c. Outcome 4: Complaints relating to advice
    d. Outcome 5(a): Complaints relating to product performance
    e. Outcome 5(b): Complaints relating to customer service
    f. Outcome 6(a): Complaints relating to product accessibility, changes or switches
    g. Outcome 6(b): Complaints relating to complaints handling
    h. Outcome 6(c): Complaints relating to insurance risk claims
    i. Other complaints

DUTIES OF MANAGEMENT

a. Management must all times control and supervise the resolution process.
b. Management to audit the complaints register on a monthly basis.
c. Update the complaints register on an ongoing basis. Ensure that processes are updated and that events leading to specific types of complaints are avoided in future.
d. If redress is made and an employee or representative was at fault, decide on the possible restitution of the loss to the company by such person.
e. Decide on possible disciplinary action against employees or representatives that committed acts of misconduct or negligence.

DOCUMENT REVISION HISTORY

VERSION NUMBER			
	1	**Updated:** July 2018	**Updated by:** Operations Department
	2	**Updated:** October 2019	**Updated by:** Operations Department
	3	**Updated:** January 2021	**Updated by:** Operations Department

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