NATIONAL RISK DISTRIBUTION

Complaints Resolution Policy

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DOCUMENT MANAGEMENT

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1. INTRODUCTION

1.1 PURPOSE AND OBJECTIVES

The purpose of this policy is to outline the approach of the Company in dealing with Complaints received from members and prospective members.

1.2 SCOPE/FIELD/APPLICATION

This policy applies to all employees of the Company, with specific reference to those employees in the Complaints, Customer Care, Claims and Pre-Authorisation departments. To ensure widespread understanding, staff shall be thoroughly aware of the principles set out in this document.

1.3 AVAILABILITY

The document is readily available to all employees and managers and all these stakeholders shall be appropriately and adequately informed of its provisions. Access to internal procedures, documentation and policies is available to external stakeholders on request.

1.4 RESPONSIBILITY AND AUTHORITY

The Compliance Department will be the custodian of the policy. Required changes and amendments must be channelled through the Head of Compliance for review and will be submitted to the Board of Directors for approval.

2. POLICY

2.1 COMPLAINT CATEGORISATIONS

Complaints are differentiated to ensure that the appropriate attention is given to complaints depending on their nature. Complaints are categorised in accordance with the following minimum categories: -

a) Complaints relating to the design of the policy or related service, including the premiums or other fees or charges related to that policy or service;

b) Complaints relating to information provided to policyholders;

c) Complaints relating to advice;

d) Complaints relating to policy performance;

e) Complaints relating to service of policyholders, including complaints relating to premium collection or lapsing of policies;

f) Complaints relating to policy accessibility, changes or switches;

g) Complaints relating to complaints handling;

h) Complaints relating to insurance risk claims, including non-payment of claims; and

i) Other complaints.

2.1.1 WHAT CONSTITUTES A COMPLAINT

The Financial Advisory and Intermediary Services Act 37 of 2002 defines a Complaint as a Complaint relating to a financial service rendered by an FSP or its representatives to a member or prospective member on or after the date of commencement of the FAIS Act, and in which it is alleged that the provider or its representative has:-

(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;

(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.

2.2 WHAT CONSTITUTES OTHER COMPLAINTS

As an authorised financial services provider, the FSP is committed to rendering services honestly, fairly, with due skill and it is for this reason that other complaints by members are recorded and tracked for quality control purposes.

The following are examples of other complaints:

(a) Unjustified or invalid complaints;

(b) Non-member complaints;

(c) Service provider complaints.

2.3 LODGING A COMPLAINT

Any member that has experienced any of the categories of complaints mentioned above in 2.1 by the FSP or Insurer's service provider may lodge a complaint in writing or verbally.

2.3.1 COMPLAINTS ESCALATION AND REVIEW PROCESS

The complaints escalation and review process should:-

(a) Follow a balanced approach, bearing in mind the legitimate interests of all parties involved including the fair treatment of the complainants;

(b) Provide for escalation of complex or unusual complaints at the instance of the initial complaint handler;

(c) Provide for complainants to escalate complaints not resolved to their satisfaction;

(d) Be allocated to an impartial, senior functionary within the insurer or appointed by the insurer for managing the escalation and review process.

2.3.2 WHERE TO SUBMIT A COMPLAINT

Complaints may be submitted as follows:-

By email;

By fax;

Via the website;

Via social media (Facebook, Google reviews, Hello Peter);

Or telephonically.

Any complaints received by employees should be forwarded to the Complaints Department. This can either be done electronically or telephonically.

Any complaints received from legal entities representing dissatisfied members or the Ombudsman Council should be relayed to the Complaints Department without delay.

A central email address (complaints@affinityhealth.co.za) is used to communicate with all members that have lodged a complaint.

2.3.3 BASIC PRINCIPLES OF THE COMPLAINTS RESOLUTION SYSTEM

National Risk Managers is committed to maintain an internal complaint resolution system and procedures based on the following:-

(a) Maintenance of a comprehensive complaints policy that outlines the company's commitment to, and system and procedures for, internal resolution of complaints;

(b) Transparency and visibility: ensuring that members have full knowledge of the procedures for resolution of their complaints;

(c) Accessibility of facilities: ensuring the existence of easy access to such procedures at any office or branch of the provider is open to members, or through ancillary postal, fax, telephone or electronic helpdesk support; and

(d) Fairness: ensuring that a resolution of a complaint can during and by means of the resolution process be affected which is fair to both members and the company and its employees.

2.4 STANDARDS FOR COMPLAINTS RECORD KEEPING

To ensure effective complaints monitoring and analysis, complaints need to be accurately, efficiently, and securely recorded. Complaints recorded include:-

(a) All relevant details of a complainant and the subject matter of the complaint;

(b) Copies of all relevant evidence, correspondence and decisions;

(c) The complaint categorisation as set out in 2.1;

(d) Progress and status of complaints, including whether such progress is within or outside the prescribed timeline.

The following data in relation to complaints needs to be recorded on an ongoing basis:-

(a) Number of complaints received, upheld, rejected and the reason for rejection;

(b) Number of complaints escalated by complainants using the internal complaints escalation process;

(c) Number of complaints referred to the Regulators (CMS or Ombud) and their outcome;

(d) Compensation and goodwill payments;

(e) Total number of complaints outstanding.

Record of complaints shall be appropriately maintained for a period of five years and regular reporting to senior management will be carried out.

2.5 APPEALS

A complainant that is aggrieved at the outcome of a complaint is entitled to appeal the decision of the company. Complainants will be advised of this right when the outcome of a complaint is communicated.

Internal appeals against a decision may be lodged, in writing and will be assessed by the Complaints Manager who will provide an outcome to the complainant, within two weeks of receipt of the appeal.

The complainant will also be advised of further steps, such as the right to refer the dispute to the insurer or the Regulator, for further review.

2.6 UPHELD AND REJECTED COMPLAINTS

Where a complaint is upheld, any commitment to make a compensation, goodwill payment or to take any other action must be carried out without undue delay and within any agreed timeframes.

Where a complaint is rejected, the complainant must be provided with clear and adequate reasons for the decision and must be informed of any applicable escalation or review processes, including how to use them and any relevant time limits. The member may within six months pursue the Regulator with the complaint, whose details are as follows:

Particulars of the Council for Medical Schemes

Private Bag x 34, Hatfield 0028

Tel: 0861 123 267

Fax: 086 673 2466

Email: complaints@medicalschemes.com

Website: www.medicalschemes.com

Particulars of the FAIS Ombudsman

Po Box 74571, Lynnwood Ridge 0040

Tel: 012 470 9080 to 012 470 9097

Fax: 012 348 3447

Email: info@faisombud.co.za

Website: www.faisombud.co.za

Particulars of Long-Term Insurance Ombudsman

Private Bag X45, Claremont 7735

Tel: 086 066 2837

Fax: 021 674 0951

Email: info@ombud.co.za

2.7 EMPLOYEE TRAINING

The Company undertakes to:-

(a) Ensure that adequate training is provided to all relevant employees, ensuring full knowledge of the FAIS Act and TCF Outcomes regarding resolution of complaints;

(b) Have an appropriate combination of experience, knowledge and skills in complaints handling, fair treatment of members, the subject matter of the complaints concerned and relevant legal and regulatory matters;

(c) Not be subject to conflict of interest;

(d) Be adequately empowered to make impartial decisions or recommendations;

(e) Ensure that employees are aware of provisions for the escalation of reportable complaints; and

(f) Ensure that employees are made aware of the contents of this policy as well as its effect and purpose.

2.8 COMMUNICATION TO INSURER AND REGULATOR RELATING TO COMPLAINTS

When the Company has received a complaint from a Complainant via the insurer the following is to be conducted:-

(a) Acknowledge receipt of complaint from Insurer;

(b) Complaints Manager to allocate complaint to a relevant Complaints Officer;

(c) Complaints Officer to communicate with the Complainant and resolve complaint;

(d) Feedback of the outcome to be provided to the insurer.

The Company will ensure the following when communicating with the Regulator:-

(a) Maintain open and honest communication and co-operation between itself and the Regulator; and

(b) Endeavour to resolve a complaint before a final determination or ruling is made by the Regulator, or through its internal escalation process, without impeding or unduly delaying a Complainant's access to the Regulator.

3. DEFINITIONS, ACRONYMS, ABBREVIATIONS AND TERMS

The terms in this document should be interpreted as meaning:

(i) **Complainant** means a person who submits a complaint and includes a:-

a) Policyholder or policyholder's successor in title;

b) Beneficiary or the beneficiary's successor in title;

c) Person whose life is insured under a policy;

d) Person that pays a premium in respect of a policy;

e) Member, or

f) Potential policyholder or potential member whose dissatisfaction relates to the relevant application, approach, solicitation or advertising or marketing material, or

g) Who has a direct interest in the agreement, policy or service to which the complaint relates, or a person acting on behalf of a person referred to in (a).

(ii) **Complaint** means an expression of dissatisfaction by a person to an insurer or, to the knowledge of the Insurer, to the insurer's service provider (UMA) relating to a policy or service provided or offered by that insurer which indicates or alleges, regardless of whether such expression of dissatisfaction is submitted together with or in relation to a policyholder query, that:-

a) the insurer 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 insurer or to which it subscribes;

b) the insurer or its service provider's maladministration or wilful or negligent action or failure to act, has caused the person harm, prejudice, distress or substantial inconvenience; or

c) the Insurer or its service provider has treated the person unfairly.

(iii) **Compensation payment** means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of an insurer to a complainant to

compensate the complainant for a proven or estimated financial loss incurred as a result of the insurer's contravention, non-compliance, action , failure to act, or unfair treatment forming the basis of the complaint, where the insurer accepts liability for having caused the loss concerned, but excludes any:-

a) goodwill payment;
b) payment contractually due to the complainant in terms of a policy; or
c) refund of an amount paid by or on behalf of the complainant to the Insurer where such payments were not contractually due; and
d) includes any interest on late payment of any amount referred to in paragraphs (b) or (c).

(iv) **Employee** means a person employed by the Company for purposes of remuneration in exchange for work done.

(v) **Goodwill payment** means a payment, whether in monetary form or in a form of a benefit or service, by or on behalf of an Insurer to a complainant as an expression of goodwill aimed at resolving a complaint, where the Insurer does not accept liability for any financial loss to the complainant as a result of the matter complained about.

(vi) **Ombudsman** means the Ombud Council, whose role is to resolve disputes between financial services providers and their members in a procedurally fair, informal, economical and expeditious manner.

(vii) **Policyholder query** means a request to the insurer or the insurer's service provider by or on behalf of a policyholder, for information regarding the insurer's policies, services or related processes, or to carry out a transaction or action in relation to any such policy or service.

(viii) **Rejected** means that a complaint has not been upheld and the insurer regards the complaint as finalised after advising the complainant that it does not intend to take further action to resolve the complaint and includes complaints regarded by the insurer as unjustified or invalid,

or where the complainant does not accept or respond to the insurer's proposal to resolve the complaint.

(ix) **Reportable complaint** means any complaint other than a complaint that has been:-

a) upheld immediately by the person who initially received the complaint;

b) upheld within the insurer's ordinary processes for handling policyholder queries in relation to the type of policy or service complained about, provided that such process does not take more than five business days from the date that the complaint is received.

(x) **Upheld** means that a complaint has been finalised wholly or partially in favour of the complainant and that:-

a) the complainant has explicitly accepted that the matter is fully resolved; or

b) it is reasonable for the insurer to assume that the complainant has accepted; and

c) all undertakings made by the insurer to resolve the complaint have been met or the complainant has explicitly indicated its satisfaction with any arrangements to ensure such undertakings will be met by the insurer within a time acceptable to the complainant.

(xi) **Writing or Written** includes communication by telefax or any appropriate electronic medium that is accurately and readily reducible to written or printed form.

4. REFERENCES

This Policy should be read in conjunction with the following:

- ✓ Long term Policyholder protection Rules.
- ✓ FSB Discussion Document on Treating Customers Fairly Complaint Management.
- ✓ National Risk Managers (PTY)LTD Complaints Resolutions Procedure (NRM(COMP_PRO_009).

5. COMPLIANCE AND DEVIATIONS

It is the responsibility of all Company employees and representatives to comply with all statutory and regulatory requirements, as well as corporate policies. Any deviation from this or a related procedure should be communicated, in writing, to the Head of Compliance for inclusion into exception reports. The communication should detail the reason for the deviation and should contain clear instructions of the alternate process to follow.

6. REVIEW OF POLICY

This Policy will be reviewed every two years, as well as in line with any applicable changes to legislation or foundational documentation.

7. APPENDICES

Appendix A: Complaints Register Template.

APPENDIX A

The Company is required to have a complaint register and to record complaints within it.

The below is mandatory in a complaint register to be kept by the Company.

Name and Surname of the complainant as well as their details	
Nature of the complaint and the date the complaint was received	Advice, admin and service issues, fraud, claim related complaints etc.
Categorisation of the complaint	Reportable or Non-reportable.
What TCF Outcome the Complaint falls into	9 TCF Outcome Choices: 2; 3; 4; 5(a); 5(b); 6(a); 6(b); 6(c) and other.
Who will respond to the complaint	Complaints Department I.e. Complaints Manager or the Complaints Officer
Actions to be taken to respond to the member and how the response has been made and by whom	Complaints will be responded to electronically or telephonically by the Complaints Department.
The outcome of the process and how the complaint was dealt with/resolved and whether it was within the allocated time	Whether favourable or not, investigations carried out within the allocated 3 weeks
The associated inherent risk of the complaint. What controls have been evaluated and have been implemented to prevent such complaints from reoccurring	Whether financial or non-financial. E.g Evaluating Employee performance, policy wording, claims procedures etc. to determine where the lack is and how to improve those in order to eliminate or lessen future complaints.
Reported to the manager of the employee where the complaint arose	If the complaint arose out of the misconduct of an employee in a certain department, that employee's manager will be notified of such.