NATIONAL RISK DISTRIBUTION

COMPLAINTS RESOLUTIONS POLICY

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9. External stakeholder requests for access to internal Policies, Procedures, Frameworks, Charters, or other relevant documents must be addressed through the Internal Compliance Officer as the nominated Chief Information Officer of the Company.

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1. INTRODUCTION

1.1. PURPOSE AND OBJECTIVES

The purpose of this policy is to outline our approach and commitment in dealing with Complaints received from yourself, other members, and prospective members.

This policy ensures widespread understanding of the complaints process, which shows our dedication to ensuring that complaints are handled and resolved timeously and effectively, and the correct processes are adhered to when you lodge a complaint.

1.2. AVAILABILITY

The document is readily available to you, and you shall be appropriately informed of its provisions.

1.3. RESPONSIBILITY AND AUTHORITY

The responsibility of the implementation of this policy lies with the Complaints Manager, Complaints Department as well as the Management of the Company.

2. POLICY

2.1. WHAT CONSTITUTES A COMPLAINT?

We view any expression of dissatisfaction with our services, products, or conduct, as a complaint.

Under the Policyholder Protection Rules "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, relating to a policy or service provided or offered by that insurer which indicates or alleges, regardless of whether such an 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 of its service provider's maladministration or willful 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;

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:

a) 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) willfully or negligently rendered a financial service to the complainant which has caused prejudice or damage to the complainant or is likely to result in such prejudice or damage; or,

c) 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. TRACKING AND RECORDING OF COMPLAINTS

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

In addition to valid complaints, the following is also recorded and tracked:

a) unjustified or invalid complaints;

b) non-member complaints;

c) service provider complaints.

2.3. LODGING COMPLAINTS

Should you have experienced any of the categories of complaints mentioned above in 2.1, you may proceed to lodge a complaint in writing or verbally.

2.4. SUBMITTING A COMPLAINT

Complaints may be submitted as follows:

- by email;
- by fax;
- via the website;
- via social media (Facebook, Google reviews, Hello Peter, Instagram, and Twitter); or
- telephonically.

Any complaints received by staff on behalf of you should be forwarded to the Complaints Department without delay. This can either be done electronically or telephonically.

Any complaints received from legal entities representing you, the Regulator, or the Ombudsman should be relayed to the Complaints Department without delay.

A central email address (complaints@affinityhealth.co.za) is used to communicate with you and other prospective members that have lodged a complaint with us.

2.5. BASIC PRINCIPLES OF THE COMPLAINTS RESOLUTION SYSTEM

We are committed to maintain an internal complaint resolution system and procedures based on the following:

a) Maintenance of a comprehensive complaints policy that outlines our commitment to, and system and procedures for, internal resolution of complaints;

b) Transparency and visibility: ensuring that you have full knowledge of the procedures for resolution of your 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 you, 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 you, the company, and its employees.

2.6. STANDARDS FOR 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.

Records of complaints shall be appropriately maintained for a period of five years and regular reportingto senior management will be conducted.

2.7. 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 your fair treatment as the complainant.
b) Provide for escalation of complex or unusual complaints at the instance of the initial complaint handler.
c) Provide you with an opportunity to escalate complaints not resolved to your satisfaction.
d) Be allocated to an impartial, senior functionary within the insurer or appointed by the insurer for managing the escalation and review process.

2.8. APPEALS

If you are aggrieved at the outcome of your complaint, you are entitled to appeal against our decision. You will be advised of this right when the outcome of the complaint is communicated.

You will also be advised of further steps, such as the right to refer the dispute to the Regulator, Ombud or Tribunal, for further review.

2.9. UPHELD AND REJECTED COMPLAINTS

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

Where your complaint is rejected, you 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. You may, within the required timeframes outlined in the legislation, pursue the relevant Regulator with the complaint.

Details of relevant Regulatory bodies are as follows:

Details 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

2.10. COMMUNICATION TO THE INSURER AND REGULATOR

When we receive a complaint from you 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 you and resolve complaint;

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

e) Ensure the following when communicating with the Regulator:-

- Maintain open and honest communication and cooperation between ourselves and the Regulator; and
- 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:

No	Term/Acronym/Abbreviation	Definition
(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 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**	Defined in the context of 2.2
(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 toa complainant to compensate the complainant for a provenor 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 any applicable Ombud, whose role is to resolve disputes between 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 conduct 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. AMENDMENTS AND PROPOSED CHANGES

The Complaints Department is the owner of the policy and is therefore responsible for ensuring that the information in this directive is kept up to date.

Any required amendments, adjustments and proposed changes must be channeled through the Head of Compliance for review prior to approval.

The Governance Department is responsible for the administration of all Company Directive Frameworks and supporting documentation. Only the latest approved version of Company directives, available from the Governance Department, may be used by employees and stakeholders