Reserve Bank of Fiji

Insurance Supervision Policy Statement No. 9

Policy Guideline on Complaints Management

NOTICE TO INSURANCE COMPANIES UNDER THE INSURANCE ACT 1998

APRIL 2010

1.0 Introduction

1.1 This guideline is issued under Section 3(2) (a) of the Insurance Act 1998 as part of the Reserve Bank of Fiji's standards governing the conduct of insurance business in Fiji. The purpose of this notice is to outline the Reserve Bank of Fiji's minimum requirements relating to complaints management by Insurers licensed to conduct insurance business in Fiji.

1.2 Safeguarding the interests of policyholders and beneficiaries of insurance policies is a fundamental requirement in the financial system. These interests if neglected could lead to differences between the insured or beneficiaries and the Insurers through customer complaints. Unresolved complaints may lead to losses for the customers, or the Insurers. The publication of complaints through the media may damage the reputation of Insurers in the public eye and could erode public confidence in the Insurance Industry if complaints are not handled with proper procedures.

1.3 One of the functions of the Reserve Bank of Fiji is to "promote sound financial structure". Therefore, the Reserve Bank deems it necessary to establish minimum guidelines for customer complaints management that must be implemented by the Insurers. This would assist the insured and policy beneficiaries to develop a positive attitude knowing that there are procedures that would adequately address their cause, should the need arise.

1.4 The minimum standards in this guideline have been aligned to international standards.

2.0 Objectives of this Guideline

2.1 The objective of this guideline is to provide the Insurers with a minimum framework for complaints management, to ensure that customer complaints are promptly investigated and resolved in a satisfactory manner.

2.2 This guideline applies to Insurers who may be recipient of complaints, whether verbal or written, lodged by the customer or authorised customer representative in relation to the products and/or services it provides, or fails to provide, including what could be unfair treatment of customers or unreasonable conduct by the Management and staff of the Insurer.

3.0 Minimum Requirements of this Guideline

3.1 The minimum requirements of this guideline are stipulated in two parts.

3.2 The first part outlines the responsibility of the Board of the Insurer (or its proxy) to approve the policy framework for complaints management. The second outlines the operational procedures for complaints management.

4.0 Complaints Management Policy Framework

4.1 The Insurer must establish and have an in-house complaints management policy framework governing complaints management procedures and practices which must include but not be limited to the following:

a. A clear mandate for complaints management and resolution within the insurance companies;
b. Roles and responsibilities;
c. Delegation of complaints authority;
d. Resources and training;
e. Confidentiality;
f. Conflict of interest;
g. Record keeping; and
h. Review of complaints management policy.

4.2 The Insurer must submit a copy of the Complaints Management Policy to the Reserve Bank within 30 calendar days of it being approved or reviewed.

4.2 **Roles and Responsibilities**

4.2.1 The Board of Directors or its proxy must approve the complaints management policy and the associated key procedures. A complete governance structure in relation to complaints management, compliance of policies and procedures must be put in place. Complaints management function must be subject to internal audit.

4.2.2 The role of Senior Management must include, but not be limited to the following:

a. implement the policy and procedures approved by the Board or proxy;
b. ensure that the Insurer's staff gives appropriate priority to helping complaints handling staff investigate and resolve complaints;
c. ensure that complaints that cannot be resolved by complaint handling staff are referred to appropriate authorities in line with an approved delegation of complaints authority; and
d. ensure that adequate training is given to complaints handling staff at all levels.

4.2.3 The Insurer is required to have a unit or function established specifically or combined with other duties in each branch with designated staff to handle and resolve complaints lodged by the customer or authorised customer representative.

4.2.4 The Insurer should ensure that complaints handling staff:

a. are independent, unbiased and skilled;
b. keep complaint registers updated;
c. acknowledge in writing by no later than seven working days from the date complaint is received, clearly stating the name of the designated officials or unit manager that could be contacted for redress as per the approved delegation of complaints authority, their telephone and fax number, and email address for proper and timely contact by the customer or authorised customer representative;
d. are familiar with the complaints management policy; and
e. have knowledge of the products and activities of the Insurer.

4.3 **Delegation of Complaints Authority**

4.3.1 Senior management must establish a clear delegation of complaints authority. The delegation of complaints should take into account relevance, complexity and sensitivity of the complaints.

4.3.2 Delegation should include the names of positions of staff and senior executives involved and the types of complaints they are to handle. This includes complaints that would be referred to legal practices, or other complaints investigatory entities. This would avoid complaints held at levels that do not have the authority to resolve such complaints.

4.4 Resources and Training

4.4.1 The complaints handling system must be properly staffed and resourced. The Insurer must meet quality and timeliness standards for complaints handling.

4.4.2 Complaints handling staff should be well versed with the Insurer's complaints handling policies and procedures.

4.5 Confidentiality

4.5.1 The Insurer should implement and maintain proper procedures to maintain confidentiality of all complaints it receives from customers or authorised customer representatives.

4.5.2 Information privacy should be observed when collecting, storing, using and disclosing personal information obtained in the complaint handling.

4.5.3 The Insurer should ensure that the identity and information relating to any complaints, or complaints against staff should be treated with confidentiality including whistleblowers' complaints.

4.6 Conflict of Interest

4.6.1 The Insurer should ensure that complaints are investigated by an employee who was neither directly nor indirectly involved in the matter which is the subject of the complaint.

4.6.2 The Insurer should implement other measures as it deems necessary to ensure that any potential conflict of interest for employees is effectively alleviated.

4.7 Record Keeping

4.7.1 The Insurer's branches must maintain Complaints Registers and records of complaints received. The registers should include, but not be limited to the following:

a. The name and address of the complainant;
b. the policy number to which it relates;
c. the date of the complaint;
d. the brief description and where possible amount of the complaint;
e. Progress on the complaints; and
f. Settlement date.

4.7.2 Head/main offices must maintain a Master Register of all complaints throughout Fiji for record keeping, reporting and transparency purposes.

4.7.3 In situations where complaints received require legal proceedings and other professional investigatory skills, the Insurer must have in place adequate procedures to cover these areas of complaint handling. Such complaints also need to be recorded and updated in the Master Register held at the head/main office.

4.7.4 The Insurer is required to record, retain the receipts, handling and resolution of complaints in line with the timeline required under the statute of limitation.

4.8 Review of Policy

4.8.1 The Insurer must ensure the availability of the complaints management policy to all of its branches and staff for internal use and reference.

4.8.2 Senior management must be responsible for reviewing the complaints management policy at least annually.

5.0 Operational Procedures for Complaints Management

5.1 Receiving of Complaints

5.1.1 The Insurer shall accept complaints lodged by customers or authorised customer representatives.

5.1.2 Complaints may be lodged in writing or verbally, by any reasonable means (for example, letter, telephone, facsimile, email, or in person). Complaints can also be lodged by filling an Insurer prescribed complaint form.

5.1.3 Special attention should be given to customers with intellectual disability, language problem, poor mental health and difficulty in understanding written information.

5.1.4 Complaints may be received at any Insurers' branch, and shall not only be restricted to the branch at which the customer bought the insurance policy.

5.1.5 Where possible, electronic complaints lodgement system could be programmed to send an automated response to reassure the customer that the complaint was received.

5.1.6 A description of the complaints handling system, or the Insurers prescribed complaint form should be accessible to customers, via the Insurer's website, if possible, or in correspondence with customers, through pamphlets and posters.

5.1.7 Complaints registered online should be also registered on the main complaints register kept at the head or main office.

5.2 Complaints Handling and Dispute Resolution

5.2.1 The Insurer must endeavour to resolve complaints received no later than twenty-one working days unless legal proceedings are required.

5.2.2 When complaints are resolved, the Insurer must convey the decision in writing to the customer or authorised customer representative as soon as practicable.

5.2.3 Where legal proceedings are required, relevant parties concerned, including the complainant must be informed accordingly. Outcome from the legal proceedings must be communicated soon after the proceedings.

5.2.4 For complaints lodged, the Insurer may require complainants to enclose photocopies of originals and full disclosure of supporting documents. The twenty-one working days timeline begins from the date when the Insurer receives full documentation from the complainant.

5.2.5 The Insurer must provide the status of complaints at any time, either voluntarily, or when the customer or the authorised customer representative makes a request.

5.2.6 Where complaints cannot be resolved, the Insurer must state clearly the reasons and is to be signed by the appropriate senior executive.

5.2.7 The Insurer must provide complainants with internal and/or external review options if he or she is dissatisfied with the outcome, or with the manner in which the complaint was handled. If a complainant wishes to refer his/her complaint to a senior officer, then this must be facilitated provided the senior officer is within the delegation of authority.

5.3 **Monitoring of Complaint Handling and Resolution**

5.3.1 The Insurer must establish internal reporting mechanism on complaint resolution process, effective procedures to monitor complaints, and produce regular reports to senior management for review. All complaints reports must be read by senior management.

5.3.2 Monitoring of complaints handling and resolution may include gathering data on:

a. complaints received;
b. complaints substantiated;
c. complaints acknowledged or resolved outside target time and those that remain outstanding;
d. complaints going to court;
e. suggestions from customers arising from complaints; and
f. complainants who remain dissatisfied with the resolution of the complaints.

6.0 Oversight by the Reserve Bank

6.1 The Reserve Bank will conduct ongoing monitoring of the Insurer's compliance with the requirements of this policy.

6.2 In addition to ongoing monitoring, the Reserve Bank will carry out on-site examination of the complaints management policy and implementation.

6.3 Where complaints have been referred to the Insurer by the Reserve Bank, such complaints must be fully investigated. The Insurer must respond appropriately by no later than seven working days of receipt of complaints from the Reserve Bank.

6.4 The Reserve Bank will establish an advisory group from a wide representation of the community that will meet once every six months. Members of such a group will, among others, include Non Government Organizations, Consumer Council of Fiji, the Fiji Chamber of Commerce and Church and other Religious Groups. At such meetings, the Reserve Bank will brief the advisory group of the complaints management of Insurers and receive feedback on issues of concern by the public on the Licensed Insurance Companies.

6.5 The Insurer must submit its Quarterly Complaints Reports to the Reserve Bank, including the return in Annex 1, "RBF Form Q-CMRI".

7.0 Implementation and Arrangements

7.1 This guideline applies to Insurance Companies licensed under the Insurance Act 1998. This guideline becomes effective from 03 May 2010.

7.2 This guideline will be reviewed as deemed necessary from time to time and changes maybe made to the policy or procedures as contained herein.

Reserve Bank of Fiji
April 2010

Annex 1:
RBF Form Q-CMRI

SCHEDULE

Interpretation –

(1) Any term or expression used in this Notice that is not defined in this Notice:

- (a) which is defined in the Act, shall, unless the context otherwise requires, have the meaning given to it by the Act;
- (b) which is not defined in the Act and which is defined in any of the Reserve Bank of Fiji Policy Statements shall, unless the context otherwise requires, have the meaning given to it by those policy statements; and
- (c) which is not defined in the Act or in any of the Reserve Bank of Fiji Policy Statements shall, unless the context otherwise requires, be interpreted in accordance with generally accepted accounting practice.

(2) In this Notice, unless the context otherwise requires:

'Act' means the Insurance Act 1998 unless otherwise specified.

'Authorised Customer Representative' means any individual, agency and legal entity with the consent of the insured to act on its behalf or in its name.

'Conflict of Interest' means where a responsible person influences the Insurer's decisions in ways that could result in their personal gain, benefit or advantage of any kind.

'Complaint' means the expression of customer dissatisfaction arising from potential financial loss or poor services to the customer including those caused by error or negligence on the part of the Insurer.

'Complainant' means either the authorised customer representative or customer.

'Customer' means any party using the services of the Licensed Insurance Companies.

'Insured' means an Insured with the meaning given to it by the Act.

'Insurer' means an Insurer with the meaning given to it by the Act.

'Reserve Bank' means the Reserve Bank of Fiji.

'Senior Management' include those persons whose conduct is most likely to have a significant impact on the Insurer sound and prudent management, including senior managers, senior executives and the General Manager or Chief Executive Officer.