MONITOR ADMINISTRATORS (PTY) LIMITED

COMPLAINTS MANAGEMENT FRAMEWORK

Version 1.1

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COMPLAINTS MANAGEMENT FRAMEWORK

1. BACKGROUND

The Company, as an authorised Financial Services Provider, has a responsibility to conduct itself honestly, with integrity, fairness, dignity and ethically wherever it operates. Furthermore due regard is given to the environment and the societies in which it operates, to ensure the fair treatment of policyholders and beneficiaries.

The Complaints Management Framework formalises the practices required by and procedures utilised by the Company to ensure the effective management of all policyholder and/or customer complaints received.

It also guides the Company to identify the root cause of the complaints thereby assisting with the improvement of internal policies and procedures

2. OBJECTIVES

The objective of this framework is to ensure that customers are provided with the best possible complaint resolutions service and to align the actions of all employees of the Company with the prescriptions of the law regarding complaints management within the financial services industry, as regulated by the Financial Sector Conduct Authority ("FSCA") within South Africa.

The following measures have been taken to ensure an effective complaints management system:

a) Ensuring we treat our clients fairly;
b) Appropriate assignment of complaints management, with defined time frames for responses and resolution;
c) Effective reporting and analysis of complaint data in order to identify trends relevant to such complaints;
d) Efficiently resolving complaints within predetermined timelines;
e) Managing our complaints more effectively;
f) Ensuring requirements are met for reporting to the Registrar.

3. DEFINITIONS

a) "**Advice**" means, subject to subsection (3)(a) of the FAIS Act, any recommendation, guidance or proposal of a financial nature furnished by any means or medium, to any client or group.

b) "**Business Day**" means any day except a Saturday, Sunday or public holiday.

c) "**Complainant**" means a person who has submitted a specific complaint and includes:

- A policyholder or a policyholder's successor in title;
- Beneficiary or the beneficiary's successor in title;
- A person who pays a premium in respect of a policy;
- A potential policyholder; and
- A policyholder's legal representative (e.g. broker).

d) **"Complaint**" is an expression of dissatisfaction by a person to a financial institution 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, regardless of whether such an expression of dissatisfaction is submitted together with or in relation to a policyholder query that-

- The insurer or its service provider has contrived 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;
- The insurer or its service provider's maladministration or wilful or negligent action or failure to act, has caused the person harm, financial loss, prejudice, distress or substantial inconvenience; or
- The insurer or its service provider has treated the person unfairly.

e) "**Complaints Management**" means the management of the entire lifecycle of the complaint.

f) "**Complaints Management Head**" means the departmental Senior Manager of the Company to which the complaint relates.

g) "**Complaints Reporting System**" means the set of electronic applications and related case management software of the insurer for the recording, classifying, routing, escalation and resolving of individual complaints received by the Company.

h) "**Complaints handling**" means the process of attending to and resolving complaints, including any ongoing transaction with Complainants.

i) "**Compensation payment**" is a payment, whether monetary or in the form of a benefit or service by or on behalf of the financial institution to a complainant, to compensate the complainant for a proven or estimated financial loss as a result of the financial institution's contravention, non-compliance, action, failure to act or unfair treatment resulting in the reason for the complaint. The financial institution accepts liability for having caused the loss concerned but excludes any:

- Goodwill payment;
- Payment contractually due to the complainant in terms of a policy; or
- Refund of any amount paid by or on behalf of the complainant to the financial institution where such payment was not contractually due. This includes any interest on late payments.

j) "**Evidence**" means the information the Company has obtained in order to review, adjudicate and resolve a complaint and shall include all information submitted by any entity and/or the Complainant and shall be stored and recorded on the complaints management system.

k) "**Goodwill payment**" refers to a payment, whether monetary or in the form of a benefit or service by or on behalf of the financial institution, as an expression of goodwill aimed

at resolving the complainant where the financial institution does not accept liability for any financial loss to the complainant as a result of the matter complained about.

l) **"OLTI**" means the Ombudsman for Long Term Insurance.

m) "**OSTI**" means the Ombudsman for Short Term Insurance.

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

o) "**Rejected**" in relation to a complaint 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 any 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 proposals to resolve the complaint.

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

- upheld immediately by the person who initially received the complaint;
- upheld within the financial institution's ordinary process of handling customer queries in relation to the type of agreement, product or service complained about only if that process does not take more than fifteen (15) business days to be completed from the date the complaint was received;
- brought to the attention of the financial institution where the financial institution does not have reasonable opportunity to record the details of the complaint as may be prescribed in relation to reportable complaints

q) "**Upheld**" means that a complaint has been finalised in full or partially in favour of the complainant and that:

- The complainant has accepted the matter and has been resolved in full;
- It is reasonable for the financial institution to assume that the complaint has been accepted; or
- All steps taken by the financial institution to resolve the complaint have been met, and/or the complainant has indicated their satisfaction with any arrangements to ensure such steps will be met by the financial institution within an acceptable time frame.

4. RECORD KEEPING

a) All complaints received, reportable and non-reportable, must be accurately, efficiently and securely stored and maintained for a minimum period of five (5) years.

b) All reportable complaints received are recorded in the complaints management system of the relevant insurer and are appropriately assigned to the relevant department.

c) Information relating to the complaint received is recorded in the complaints management system of the insurer which includes voice recordings, emails and all other supporting documentation relevant to the complaint.

5. CATEGORISATION OF COMPLAINTS

The Company's complaints are categorised as follows:

a) Administrative complaints, relating to debit orders, penalties, cancellations, admin processes, privacy or confidentiality breaches.
b) Complaints relating to the advice rendered to the complainant including, but not limited to, misrepresentations by the advisor, adviser knowledge or skills, wrong or unsuitable advice.
c) Claims complaints, pertaining to an error in processing claim for claims pay outs, claim repudiation, unclaimed benefits and beneficiary disputes.
d) Communication / information complaints, including incomplete or unsuitable communication, documentation not being received, insufficient updates given and unclear or confusing information provided.
e) Complaints Handling, addressing poor or slow service.
f) Product / Policy complaints encompassing benefit discrepancies, policy cover or excesses, suitability and premium queries.
g) Service / Accessibility addressing the failure to keep promises, poor turnaround times, incompetence and queries not being attended to.

6. COMPLAINT RESPONSE REQUIREMENTS

All complaint responses provided by the Company or the Ombudsman to the complainant must ensure that:

a) All communication to the complainant is clear and straight forward;
b) Objectivity, and not subjectivity, is applied to a conflict of interest;
c) Strict adherence is applied to the required established time frames for responses;
d) Treating the customer fairly is applied at all times;
e) Feedback is regularly provided to the complainant during the entire complaint resolution process.

7. COMPLAINT MANAGEMENT PROCESS

a) All complaints must be centralised to complaints@monitorsa.co.za
b) All complaints communication must be in plain language and easily understandable.
c) Refer to the Complains Resolution Process Flow contained herein.

8. PROCESS FOR COMPLAINTS RELATING TO A COMPANY ERROR, EMPLOYEE OR SERVICE

a) The centralised complaints channel will be monitored on a daily basis by all the relevant complaints handling staff and Senior Managers.
b) The nature of the complaint will assessed to determine whether the complaint is reportable or non-reportable.
c) If the complaint is an enquiry, the complaint will not be recorded on the Complaints Management Tool or any internal Compliments and Complaints Register.
d) Each departmental complaint received must be noted on the internal departmental Compliments and Complaints Register within 24 hours from receipt of the complaint and the insurer Complaints Management Solution Tool (if applicable).
e) Complaint categorisation will be determined.

f) Acknowledgement of receipt of each complaint will be forwarded to the complainant.

g) The acknowledgement of receipt can be done telephonically and/or via email and will include the following details as a basic minimum:
   - The departmental contact person who will be attending to the complaint;
   - Estimated timelines within which the complaint will be addressed;
   - Details of the internal complaints escalation and review process in the event that the complainant is not satisfied with the outcome of the complaint; and
   - Details for the escalation of any complaints to the office of the relevant Ombudsman where applicable.

h) A decision will be made on each complaint as soon as reasonably possible but within a period not exceeding 15 working days after gathering and investigating all relevant and appropriate information and documentation.

i) Each complainant will be kept adequately informed of the progress of the complaint and any causes which may delay the finalisation of the complaint within the anticipated timeframes.

j) A written response will be forwarded to the complaint via email or any preferred method as requested by the complainant at finalisation thereof.

k) Where a complaint is upheld, any commitment to make a compensation payment, goodwill payment or to take any other action, will be carried out without undue delay and as per the agreed timeframes with the complainant.

l) Where a complaint is rejected after thorough investigation thereof, the complainant will be provided with clear and adequate reasons for the decision and be informed of the escalation or review process.

9. PROCESS FOR COMPLAINTS RELARTING TO AN OURSOURCED PARTNER

a) The Company will ensure that each outsource partner, operating in terms of a service level and outsource agreement, is fully aware of the minimum requirements relating to the receipt of complaints and the handling process thereof.

b) The Company will ensure that each service provider or outsource partner (where applicable) has adequate complaints management processes in place to ensure the accurate reporting of all reportable complaints and the fair treatment of complainants.

c) The Company will ensure that each outsource / service level agreement includes an obligation on the relevant supplier to submit complains to the Company as prescribed and in the format required by the Company, which would allow the Company to analyse the complaints data.

d) Complaints received by the Company will be referred to the outsource business partner for resolution within 48 business hours after receipt thereof.

10. COMPLAINT ESCALATION AND REVIEW PROCESS

a) If the complainant is still dissatisfied with the outcome of the complaint, and the complainant believes there is merit for their complaint being reviewed, the matter will be referred to the relevant departmental Senior Manager for review of the complaint together with a Director and Compliance Manager.

a) Processes 8 (h) – (l) will remain the same.

b) Should the complainant still be dissatisfied with the outcome, after the escalation and review process has been completed, and the complainant believes there is merit for their

complaint to be further reviewed, the matter can be referred to the relevant insurer (whose details will be available on request).

c) As a final attempt at resolution, should the complainant prefer, the case can be lodged with the relevant Ombudsman. Refer to the definitions 3 (l) – (m).

11. COMPLAINT RESOLUTION TIME FRAMES

a) Registration of complaints

All complaints received by each internal department of the Company must be logged on the departmental complaints register and the relevant insurer's complaints management system and within the prescribed timelines per insurer.

b) Acknowledgement of complaints received

Registered complaints need to be acknowledged with the complainant within twenty four (24) hours of receipt of complaints.

c) Complaint investigation and resolution

All complaints need to be resolved within four (4) weeks from date of receipt of the complaints from the complainant. Should there be any delay in resolving the complaint, the Company will communicate with the complainant advising them of the delay and the reason for the unexpected delay experienced.

Social media complaints that have been resolved will be communicated by the departmental Senior Manager who will post the final response with regards to the complaint. Detailed discussions with clients regarding complaints will not be done over social media. Where possible, clients should be requested to follow more secure / private means of lodging complaints in order to protect the client's personal information.

12. DECISIONS RELATING TO COMPLAINTS

In the event of a complaint being upheld, any commitment provided by the Company to make compensation or goodwill payment, or any such action, the action will be carried out without delay and within the time frame agreed upon with the complainant.

13. CONTACT DETAILS FOR THE FAIS OMBUDSMAN

Postal Address	:	PO Box 74571 Lynnwood Ridge
Telephone	:	+27 12 470 9080
Fax	:	+27 12 348 3447
Email	:	info@faisombud.co.za
Website	:	www.faisombud.co.za

COMPLAINTS RESOLUTION PROCESS