INFINITE CREDIT UNDERWRITING MANAGERS COMPLAINTS PROCECEDURE AND MANAGEMENT FRAMEWORK.

The basic requirements are that:

1) Complaints Management Framework must be approved at Executive level, either Board or the Key Individual, and should be overseen by a senior person.
2) Complaints facilitation should be carried out by suitably experienced and qualified persons, defined either by name or title, who are impartial and have no conflict of interest.
3) The Management Framework is to be regularly reviewed. We suggest annually.
4) Record keeping must be comprehensive and accurate.
5) Staff should be adequately trained in the procedures.
6) Executive Management are to be regularly informed of the status regarding complaints

The various Documented Procedures defined as requirements in the regulations are referred to in the ***A.C. Complaints Management Assessment Tool***, which can be used as a Gap Analysis option to assist with the formulation/review of your Complaints Management Framework.

CATEGORISATION, RECORD KEEPING AND ANALYSIS OF COMPLAINTS

1) Prime requirement is that a formal complaint needs to be reduced to writing, this could be by way of e-mail, or any other electronic/digital media which can be reduced to writing. The initial procedure for the submission of a complaint should be noted in the standard Disclosure Document. A suggested wording is as follows: -
   "We have established a complaints management framework in order to ensure the effective and transparent resolution of complaints and the fair treatment of our clients and/or persons who are dissatisfied with our service, staff or the products we offer. Should you need to submit a written complaint please contact the following person:

Name:

E-mail:

Tel:

We have a complaints policy in place, which can be provided upon request by contacting the above-mentioned person. The policy is also available on our website"

2) A Complaints Register is required and the **Sensible Risk Solutions**, makes provision for all relevant details including the categorisation of complaints as required in terms of GCOC and PPR. There are 9 appropriate categories. The TCF outcomes, which might be affected, are also able to be defined for each complaint. Provision is made to define the results of Root Analysis and rectification of procedures where required.

3) A comprehensive and accurate record of all relevant detail, and documentary evidence relating to the complaint is to be retained for a minimum of 5 years after settlement.

4) It is essential that the communication lines between Complainant and Insurer/Provider are clear and transparent and the Complainant is constantly kept up to date with developments, timelines and detail of the person handling the complaint at every stage of the process until finalisation.

5) ALL complaints as defined (Reportable and Non-Reportable), are to be registered, and categorised, but as far as the statistical requirements are concerned, only Reportable Complaints are required to be included in the calculations. Non-Reportable Complaints, effectively those which can be upheld within 5 working days of the submission of the initial complaint, must also be registered as mentioned, and need not be included in the statistical analysis BUT they need to be analysed, along with Reportable Complaints, (Root Cause analysis) as part of Management Information, to identify whether any procedural improvements need to be made in your TCF policy and procedures, to avoid repetitious complaints.

Infinite Credit notes that this notwithstanding, any Complaint which is resolved within the 5 working day period, but which required escalation to a higher level for a resolution to be agreed, then such a complaint should be registered as a Reportable complaint.

The definition of the person responsible for the recording of the information, the form of recording, and the frequency of reporting is formalised in this document.

This register is to be updated on a monthly basis, even if it is a negative report with no complaints, or should be updated more frequently if necessary, depending on the frequency of complaints, and the report/register should be referred to senior management for review and identification of any need for amendments to policies or procedures.

The Compliance Officer should be copied in on the Complaints register, at least quarterly, and in the event of a complaint which could have serious consequences, then he/she should be advised as soon as possible in order to offer any assistance in the resolution process.

6) As previously mentioned, Insurers are obliged to submit statistics to the FSCA, and consequentially, they will demand from Infinite Credit specific reporting requirements. While we recognise as standard FSP there is no specific reporting requirement to the FSCA at this stage, we however will retain all appropriate data will ensure that it is recorded and retained for the standard 5 years, against the day when an FSCA inspection is to be carried out. We also note that there is also the probability that the annual Conduct of Business reports, once these have been formalised, will require details of complaints to be uploaded and submitted to the FSCA. Thus, the need to ensure that all appropriate information be recorded on the register, to be able to supply the relevant statistics.

7) Sensible Risk Solution also notes that It is a shared requirement that insurers/providers must ensure that not only their Representatives, but their service providers as well, have adequate procedures in place for the management of complaints, and the insurer/provider has an obligation to ensure that oversight arrangement, communication and reporting requirements

between them and their mandated service providers are adequate to enable the Insurer/Provider to ensure that clients are being fairly treated.

COMPLAINTS ESCALATION AND REVIEW PROCESS

The establishment of a Complaints Escalation and review process is a defined requirement. The process must allow for escalation internally by the initial complaints handler as well as allowing the Complainant to escalate the complaint if not satisfied with the decision of the primary handler. A senior, impartial functionary, if possible, should be identified as the appropriate person to manage and handle the escalated complaint. It is recognised that the large number of Providers are of a size that it is not possible to appoint any form of committee, and that the Key Individual will be the person responsible for the resolution and it is recommended that where appropriate the complaint may be referred to your Compliance Officer, as a part of the escalation process, for guidance and to assist in the decision making.

The escalation process must not be “overly complicated”, nor impose any unduly burdensome requirements on the Complainant, and must be fully disclosed to the Complainant, at the time of registration of a complaint and regularly throughout the process as needed and as the situation develops.

Timelines noting acceptable response periods, should be defined, disclosed, and should be observed, as also the progressive steps in the process towards resolution, and the personnel involved. Effectively the Complainant is to be kept fully informed at every stage of the resolution process.

Complaints Upheld – Whilst there may be various resolutions, if it requires that a payment is to be made, this must be made without undue delay as the regulations allow for interest to be levied on payments not paid timeously.

The regulations do not dictate specific time requirements, but there should be an agreement between insurer/provider and Complainant, as to the time within which payment must be made, and that should be achieved as soon as practicable. From which one can assume that unless extensions are agreed for whatever reason, then the Complainant would be justified in claiming interest if deadlines are not met.

Rejected Complaints – Notification of rejection must define the reasons for the rejection and confirm the Complainant's rights of recourse for escalation and review of the initial rejection, and if the escalation process confirms the rejection, then the Complainant should be given the details of the appropriate Ombud, to whom the Complainant can then refer his complaint.

The basic requirement is that the provider must endeavour in all cases to resolve a complaint through its internal escalation process, before a final determination or ruling by the Ombud, without delaying or impeding the complainant's access to the Ombud.

ENGAGEMENT WITH THE OMBUD AND REPORTING

Insurers and Providers are required to have appropriate procedures in place to engage with the Ombuds, maintaining open and honest communication and co-operation with the Ombuds.

It is noted that Insurers/UMAs but not intermediaries such as Sensible Risk Solutions, will be required to interact with the Insurance Ombud. Infinite Credit will cooperate with the process where required. Similarly, non-mandated Intermediaries with Binders could become involved with the Insurance Ombud as well as the FAIS Ombud, depending on whether the complaint is Advice related, and the Insurance Ombud regarding complaints relating to claims and policy conditions, etc. Providers with no outsourced Admin function will deal primarily with the FAIS Ombud.

Providers must communicate contact details of the Ombud's and the relevant services and their availability to the client, and this information must be disclosed at the start of the relationship and at any appropriate time during the relationship with the client. The Ombud's contact details are required to be noted in the Disclosure Document.

Infinite Credit noted that the FSCA expects all Insurers/Providers to monitor determinations, publications and Guidance Notes issued by any relevant Ombud in order to identify any exposures or risks relevant to the FSP.