COMPLAINTS RESOLUTION POLICY

1. OVERVIEW

The Complaint Resolution Policy serves to provide guidance around the recording and handling of complaints with a view to continuously improve our service excellence.

This Policy will be used by all our employees, who will undergo extensive training on complaints handling, to ensure that every complaint will be dealt with the necessary professionalism that X'S Sure (PTY) Ltd (herein after referred to as "X'S SURE") expects from them.

The purpose of this policy is to:

- Ensure that the effective, fair and speedy resolution of all complaints are properly administered and controlled within X'S SURE.
- Ensure that X'S SURE complies with the Short-term Insurance Act, SAIA Code of Conduct, Financial Advisory and Intermediary Services Act (FAIS Act) and/or the Policy Holder Protection Rules (PPR), and any other applicable legislation.
- The importance of a complaints resolution policy as part of service excellence:
- Not only does X'S SURE aim to comply with legislation, it also values the delivery of service excellence in the way in which complaints are handled.

2. DEFINITIONS

In this policy, the definitions below are as follows:

- Complainant means any policyholder who makes a compliant in respect of any insurance- services provided by the insurer.
- Implications mean something that is suggested.
- Insurer means the company providing insurance.
- Legal privilege means the right to refuse to divulge information obtained in a confidential relationship.
- Policyholder means a person who holds an insurance policy, usually the client in whose name an insurance policy is written.
- Quantum means an amount of money legally payable (towards the settlement) in damages.
- Resolution means a course of action or solution determined or decided on.
- Transparent means candid, frank, open.

3. COMPLAINTS POLICY

X'S SURE has an internal complaints resolution process based on the following:

- We are transparent by ensuring that our policyholders have full knowledge of the procedures to resolve complaints whilst staying updated on progress.
- We promise fairness at all times when dealing with a complaint.
- We provide the necessary training to the relevant departments on how to handle complaints, including knowledge of the provisions of the legislation in respect of the resolution of complaints.

4. RESPONSIBILITIES RELATING TO THE COMPLAINTS PROCEDURE

Both policyholders and X'S SURE have responsibilities as set out below:

4.1 Policyholder responsibilities:

- Inform us of your complaint as soon as is reasonably possible.
- You may contact us telephonically since all conversations are recorded or in writing.
- Provide us with all information relating to your complaint to enable us to assist you timeously.
- Please note that if your complaint is FAIS related, the complaint MUST be in writing. Please refer to page 5 for an overview of the requirements in respect of complaints as per the Financial Advisory & Intermediary Services Act.

4.2 X'S SURE responsibilities:

- The person dealing with your complaint will acknowledge receipt within 24 hours and may request further information, if required.
- Keep records relating to such complaints for a minimum of five years from when the complaint arose.
- Unless we require further information, assessment or investigation, we will agree with you on a reasonable timeframe. However, we will attempt to resolve the complaint within 15 working days, failing which we will provide feedback at least every 10 working days.

5. INTERNAL DISPUTE RESOLUTION PROCESS

5.1 Complaints relating to a rejected claim:

If your complaint relates to a rejected claim we will:

- Provide reasons for the decision in writing.
- Inform you of the external complaints procedures available.
- The time limit for taking legal action and the implication, thereof.
- On request, provide the policyholder with copies of all available documents and information that influenced the decision and that are not subject to legal privilege.

- Should you still object to the decision you will need to inform us, in writing, as soon as is reasonably possible.
- Should we thereafter still stand by our initial decision, we will follow the procedure in (a) to (e) above in writing again.
- If the policyholder and the person handling the complaint cannot reach agreement, the matter will be escalated further. Guidelines for the dispute resolution are set out in paragraph below:

5.2 Non-rejection complaints and reviewing of complaints

- If your complaint relates to any other matter (except for rejected claims) or should you wish to have a decision regarding your complaint reviewed, we will treat it as a dispute and: a) You will be advised of your right to request an internal dispute resolution process.
- The person dealing with your complaint will acknowledge receipt as soon as is reasonably possible and provide you with their contact details. They may ask additional questions if necessary.
- Our internal dispute resolution process will be the same as the complaints resolution procedure.
- When we have made a decision relating to the complaint, we will respond to you in writing to confirm:

  a) Reasons for the decision.

  b) Facts on which the decision was based.

  c) Disputes will be escalated to Guardrisk to be reviewed and resolved.

Tel:	0860 333 361
Email:	complaints@guardrisk.co.za
Address:	102 Rivonia Road, Sandown, Sandton, 2146
Postal Address:	PO Box 786015, Sandton, 2146 Guardrisk Insurance Company Limited

  d) Should you not be satisfied with the resolution, we will inform you that you have the right to refer your dispute externally to the OSTI (Ombudsman for Short-term Insurance) or the FAIS Ombudsman as well as the timeframes for lodging the dispute.

6. CONCLUSION

- The complaints policy is intended to provide guidance in respect of the handling of complaints. We are committed to abide by this document and provide SERVICE EXCELLENCE.

7. SUMMERY OF LEGISLATIVE REGULATIONS

- The applicable legislation, regulations or codes are set out in the section below. Should you require further information do not hesitate to contact our Compliance department via email (compliance@xssure.co.za).

The Financial Advisory & Intermediary Services Act 37 of 2002 (FAIS)

What does FAIS say about complaints?

In terms of the FAIS Act, a complaint is defined as follows:

- "Complaint" means, subject to section 26(1)(a)(iii), a specific complaint relating to a financial service rendered by a financial services provider or representative to the complainant on or after the date of commencement of this Act, and in which complaint it is alleged that the provider or representative -

  (a) has contravened or failed to comply with a provision of this Act and that as a result thereof the complainant has suffered or is likely to suffer financial prejudice or damage;

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

  (c) has treated the complainant unfairly

  d) Chapter V - Duties of Authorised Financial Service Providers.

Maintenance of records

Section 18 (b):

- An authorised financial services provider must, except to the extent exempted by the registrar, maintain records for a minimum period of five years regarding complaints received together with an indication whether or not any such complaint has been resolved.
- Part XI, section 16-19 of the General Code of Conduct for authorised FSPs and representatives expand the requirements of the complaints procedure and is incorporated in the procedures in this document.
- SAIA Code of Conduct The SAIA Code of Conduct sets out the following guidelines about complaints:

8. COMPLAINTS HANDLING

- The following standards apply to the complaints handling procedures of members:
- The Insurer is committed to having processes in place to deal with complaints in an impartial and timely manner.
- Information about the Insurer's complaints handling procedure will be readily available and will be made available to policy holders.

- The Insurer will only ask for and use relevant information when dealing with a complaint.
- The Insurer will inform policyholders of the information used in the decision-making process. The policyholder shall have the opportunity to rectify any incorrect information.
- The Insurer must implement remedial action without delay.
- The Insurer shall deal with complaints received from policyholders relating to service providers in terms of the Insurer's complaints handling procedures.

9. INTERNAL DISPUTE RESOLUTION:

A) The following standards apply to member companies' internal dispute resolution:

- Insurers will respond to complaints within 21 days, provided they have all information required and/or an investigation has been completed.
- In cases where further information, assessment or investigation is required, the member will agree with the complainant on a reasonable timeframe not exceeding 30 days. Should it be impossible to reach agreement, the complaint will be dealt with as a dispute and will be referred to a different employee who has the appropriate knowledge, expertise, experience and authority to deal with it.
- The complainant will be kept informed of the progress of the complaint on a regular basis, and at least every 14 days.
- When the complainant is notified of the outcome of the complaint, the complainant will also be informed about how such a decision could be reviewed by another employee who has the appropriate knowledge, expertise, experience and authority to deal with disputes.

B) If a complainant wishes to have a decision regarding a complaint reviewed, the following standards are applicable:

- The insurer will treat it as a dispute.
- The insurer will notify the complainant of the name and contact details of the person assigned to liaise with the complainant in relation to the dispute.
- The dispute resolution process will follow the standards set out above.
- When a decision has been made, the insurer will respond to the complainant in writing giving:
  - i) Reasons for the decision.
  - ii) Information about how to access external dispute resolution or policy holder recourse mechanisms.
  - iii) Notify the complainant of the timeframe in which an external dispute should be lodged.

10. EXTERNAL DISPUTE RESOLUTION:

- All members are obligated to participate in the relevant Ombudsman schemes, including the OSTI, the Financial Advisory and Intermediary Services ("FAIS") Ombudsman, and other relevant schemes, and agree to abide by the Ombudsman schemes' rules and decisions.
- Insurers will refer policy holders to OSTI and other relevant Ombudsman schemes in order to deal with complaints that fall within their mandates.
- Members will include the details of the OSTI and other relevant Ombudsman schemes in disclosure documents, and documents regarding rejections of claims.
- When internal complaints procedures have been unable to resolve complaints and/or disputes, policyholders must be referred to the OSTI when the complaint and/or dispute relates to a rejected claim within the jurisdiction of the OSTI, or to the SAIA Code of Conduct if a breach of the Code has occurred.
- Members must respond to the OSTI or the SAIA Code of Conduct Complaints Committee in a timeous and comprehensive manner.

11. POLICY HOLDER PROTECTION RULES:

Decisions relating to claims and time-limitation provisions for the institution of legal claims.

- An insurer must accept, reject or dispute the quantum of any claim under a policy within a reasonable period after receipt of a claim.
- An insurer must within 10 days of taking any decision referred to in paragraph (a) in writing notify the policyholder of its decision. c) If the insurer rejects or disputes the quantum of a claim, the notice referred to in paragraph d) (b) must inform the policyholder –

  i. of the reasons for the decision;

  ii. that the policyholder may within a period of not less than 90 days after the date of receipt of the notice make representations to the relevant insurer in respect of the decision;

  iii. of the right to lodge a complaint under the Financial Services Ombudsman Schemes Act, 2004 (Act No 37of 2004) and the relevant provisions of the Act relating to the lodging of such a complaint, in plain understandable language:

  iv. in the event that the relevant policy contains a time limitation provision for the institution of legal action, of that provision and the implications of that provision for the policyholder in an easily understood manner; and

  v. in the event that the relevant policy does not contain a time limitation provision for the institution of legal action, of the prescription period that will apply in terms of the Prescription Act, 1969 (Act no. 68 of 1969) and the implications of that provision for the policyholder in an easily understood manner. (d) If a claim is

rejected or disputed or a quantum is disputed as contemplated in paragraph (a) on behalf of the insurer by a person other than the insurer, such other person must provide the notice contemplated in paragraph

- and include in that notice, the addition of the information referred to in paragraph
- the name of the contact details of the insurer and a statement that any recourse or enquiries must be directed directly to that insurer.
- If the policyholder makes representations to the relevant insurer in accordance with paragraph
- the insurer must within 45 days of receipt of the representation, in writing, notify the policyholder of its decision to accept, reject or dispute the claim or the quantum of a claim for a benefit under a policy.
- If the insurer, despite the representations of the policyholder, confirms the decision to reject or dispute the claim or the quantum of a claim, the notice referred to in paragraph (e) must inform the policyholder –

  i. of the reasons for the decision; and

  ii. include the facts that informed the decision; and

  iii. include the information referred to in paragraph (c)(ii) to (v).

12. TIMEFRAMES TO TAKE NOTE OF:

- The below timeframes should be taken into consideration when lodging a complaint to an insurer:
- Insurer is to be made aware of your complaint as soon as is reasonably possible, but within a reasonable time frame, from when you become aware.
- Insurer to respond to your complaint within 21 days provided they have all the necessary information.
- In the case of further information, assessment or investigation being required, the insurer and complainant must agree on a reasonable timeframe not exceeding 30 days.
- Complainant to be kept informed of the progress of the complaint at least every 14 days.
- If a decision on a claim has been made, the insurer must within 14 days of taking any decision notify the policyholder, in writing.
- If the policyholder needs to make representations to the insurer, this is to be done within a period of not less than 90 days after the date of receipt of the notice to make representation.