FINANCIAL SERVICES AUTHORITY

SAINT VINCENT & THE GRENADINES

GUIDANCE NOTE: NO. 7

On

Complaints Handling for Insurance Entities

Issued: September 14, 2017

INTRODUCTION

The conduct of insurance business in St. Vincent & the Grenadines ("the State") is regulated under the Insurance Act, Chapter 306 of the Laws of Saint Vincent and the Grenadines, Revised Edition 2009 ("the Act"). Regulation and supervision of insurance business is exercised by the Financial Services Authority ("FSA"), acting under the authority of the FSA Act, Act No. 33 of 2011.

The majority of complaints in the insurance industry relates to claims and benefit payments. While most insurers handle and pay claims in a timely and fair manner, some insurers can succumb to the temptation to look for ways to avoid paying claims. The FSA requires insurers and intermediaries to deal with claims and complaints effectively and fairly through a simple, easily accessible and equitable process. As such, the FSA has developed these guidelines in order to enhance efficiency, transparency, disclosure of information to policyholders in order to increase customer satisfaction.

The FSA envisages that an efficient complaints handling procedure/process will result in improved service delivery to the public.

The following Guidelines are issued pursuant to section 10 of the Financial Services Authority Act, No. 33 of 2011 to Insurance Companies and Insurance Brokers ("Insurance Entities") in the development of a an appropriate framework for the handling of complainants by policy holders or the public in general. Insurance Entities are required to ensure that a complaints handling policy is put in place within six months of the publication of these guidelines.

PURPOSE

These Guidelines are designed to set out minimum criteria for complaints handling by Insurance Entities.

SCOPE OF APPLICATION

These Guidelines apply to all Insurance Entities operating in the State. The Guidelines are not intended to be prescriptive but represent the minimum requirements and does not prevent an Insurance Entity from instituting enhanced policies and procedures.

DEFINITIONS

"***Complaint***" means an expression of dissatisfaction, oral or written, by a complainant for which redress is being sought in relation to, a service or product that is provided by an insurance company or intermediary.

"Complainant" means a person who files a complaint against an insurance company or intermediary.

COMPLAINTS POLICY

An Insurance Entity is required to establish an internal **Complaints Handling Policy and Procedures**, to address customer complaints. The policy must be documented and clearly outline the process from receipt of a complaint to the resolution of the complaint.

All Insurance Entities are required to have procedures in place that address the number of complaints, nature and disposition of each complaint and the time required to process each complaint. The Insurance Entity should undertake an appropriate analysis of patterns of complaints to investigate whether complaints are isolated or a widespread issue.

Insurance Entities should ensure that the internal complaints process is transparent and visible so that complainants have full knowledge of the procedures to be followed for the resolution of their complaints. As such, Insurance Entities should publish, whether by way of its official website, brochures, pamphlets, a notice displayed in a prominent or conspicuous position on their premises, or by way of terms included in the policy document, clear and accurate information on the complaints handling procedure within the Insurance Entity.

COMPLAINTS DOCUMENTATION

Insurance Entities should make the following information available to customers:

- how to make a complaint;
- to whom a complaint should be addressed;
- documents and information which should accompany the complaint;
- timeline for the handling of a complaint ; and
- any other information which may be of relevance to the Insurance Entity and complainant.

The above information should be written in clear, plain language that can be easily accessed by consumers in general.

Customers should be advised that notification of a complaint may be done using any of the following means of communication:

- Direct verbal reporting
- Telephone call
- Text message
- E-mail
- Fax
- Letter
- Any other form of technology of wide usage.

Provided that where the mode of communication used lacks written evidence, the Insurance Entity shall inform the complainant of the need to follow up such communication with a letter and/or completion of an appropriate form.

COMPLAINTS HANDLING SYSTEM/PROCEDURE

Complaints handling is an important role in an organisation and should be recognized as such by management. An effective complaints handling system should be a '*fit for purpose*' system. That is a system that is varied to fit the insurer's circumstances and is proportionate to the number and type of complaints it receives.

Whilst Insurance Entities should ensure that all of its employees are familiar with its internal complaints procedure, it may be useful to have a designated officer responsible for the handling of complaints.

The assigned person should be responsible for:

- receiving and reviewing complaints made to the Insurance Entity;
- seeking resolution through a thorough investigation of the matters outlined in the complaint;
- responding within a reasonable time to all complaints;
- dealing with complaints in an efficient and professional manner; and
- maintaining records of all complaints received, whether satisfactorily resolved or otherwise.

The complainant should receive an acknowledgement of the complaint filed within five (5) working days.

A complaint shall be investigated and if valid, settled within a reasonable timeframe from the date of the filing of the complaint.

A complainant shall be informed in writing of the Insurance Entity's final response in a timely manner.

Where possible, the final response letter shall indicate the reasons or circumstances which have been considered for the settlement or non-settlement, as the case may be, of the complaint.

The final response letter shall propose, as appropriate, any offer or other means of settlement made to the complainant.

COMPLAINTS REPORTING

The Insurance Entity shall maintain a log of all complaints to track each complaint and resolution thereof. The complaints log should include *inter alia*:

- Date of complaint
- Subject of complaint
- Action taken

- Outcome

The log should be made available for inspection by the FSA during its onsite examination process.

In addition to the complaints log, the FSA may request additional information relating to complaints handling by the Insurance Entity, such as any reports that may have been presented to the Insurance Entity's Board of Directors.

<u>REFERRAL TO THE FSA</u>

A complaint may be referred to the FSA by the complainant where no settlement has been reached within a reasonable timeframe.

The FSA will entertain complaints only to the extent that all attempts to settle the complaint have failed and the customer is not satisfied with the outcome.

The FSA may require an Insurance Entity to address a complaint and propose means of redress to the extent that the complaint deals with regulatory breaches, malpractice or unfair treatment.

In discharging its functions under these Guidelines, the FSA may request an Insurance Entity to provide copies of the complaint letter and the final response letter.

<u>RECORD KEEPING</u>

Insurance Entities shall keep records of complaints for a minimum of three (3) years from the date of filing of the complaint, but where an insurance contract extends to more than 3 years; such record shall be kept for the duration of the contract.

APPENDIX 1: SPECIMEN COMPLAINTS LOG

Subject of Complaint	Date Received	Action Taken	Outcome

COMMENCEMENT

This Guidance Note shall come into effect this 14th day of September, 2017.

Issued by:

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