Insurancewise Complaints Resolution Systems and Services (Pty)Ltd

FSP 32023

Insurancewise FAIS complaints policy

Instructions to all Insurancewise employees and mandated F&Is:

1. Read this policy document carefully so that you fully understand it.
2. If a client makes a complaint, then you must provide them with a copy of this policy document.
3. You must immediately (within 24 hours) advise the Insurancewise complaints handler of the complaint by sending a detailed email to Quinten Knox at quinten@insurancewise.co.za You may not correspond or communicate with the complainant in any way whatsoever about the complaint. Inform the client to communicate with the abovementioned complaint handler.

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'Consider, for instance, the familiar scenario when someone appears to be having a moan, and they are told to stop complaining. 'I'm not complaining', comes the reply, 'I'm just saying'. Often the person really is complaining and doesn't want to admit it, but the very concept of complaint opens up the wriggle room for plausible denial. This is, I think, because the features of directness and non-acceptance which are central to complaint admit of many degrees. It can therefore be hard to know how much our expressions that things are not right contained either or both".

"Even if you prefer a slightly different definition, it should be plain that what we complain about can be trivial or profoundly important."

"The act of complaining is hence not what is fundamental to complaint: it is a symptom, not the disease itself. Just as the severity of a medical complaint should not be measured by how loudly it draws attention to itself but by the extent to which the body really is damaged, so we should not mistake the loudness of a complaint for its seriousness."

- *'Complaint, From Minor Moans to Principled Protests'*
  Julian Baggini, Profile Books Ltd, 2010, ISBN 9781846680632

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INTRODUCTION

Policies are high-level guidelines that direct how a business is expected to act, decide and govern itself in recurring situations. In a regulated financial services environment, a policy does not merely state a preference or a general aspiration. It establishes a formal internal standard against which conduct, oversight, accountability and decision-making can be measured. A policy therefore gives structure to management intent. It tells staff and stakeholders what the organisation stands for, what principles it applies, what outcomes it seeks to produce and what limits it imposes on itself in the pursuit of those outcomes. For this reason, a policy is different from a process. A process explains the operational sequence by which a task is completed, such as receiving a complaint, recording it, investigating it, communicating with the complainant and closing it. A policy, by contrast, sets the governing rules and principles that must shape every one of those procedural steps. In practical terms, a policy answers the questions of "why", "what standard", "within what boundaries" and "toward what purpose", whereas a process answers the questions of "who", "when", "how" and "in what order". Both are necessary, but they perform different functions. Without a policy, processes may become inconsistent, mechanical or detached from the regulatory and ethical standards that must inform them. Without processes, a policy may remain abstract and may fail to influence daily operations. In a sound governance framework, policy and process must therefore work together. The policy provides the normative framework, and the process provides the operational pathway. This document is accordingly intended to serve as the governing complaints policy framework for Insurancewise, setting the standards, principles, responsibilities and controls that must apply whenever a complaint is received, assessed, escalated, resolved, recorded, reported and analysed.

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Every policy must support a clear, lawful and practical purpose. A policy should never exist merely to populate a compliance file or to create the appearance of governance. In a financial services business, a policy must function as a live control instrument. It should reduce uncertainty, guide consistent conduct, allocate responsibility, support decision-making, promote fair treatment of clients and reduce the risk of error, misconduct, unfair outcomes and regulatory breach. In the complaints environment, the purpose of

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policy is especially important because complaints often reveal not only whether a client is dissatisfied, but whether there has been a failure in disclosure, advice, administration, communication, claims handling, product performance, complaint handling itself, or the broader culture of the provider. A complaint is therefore not only an event to be resolved; it is a source of governance intelligence. A properly designed complaints policy must enable the business to recognise complaints early, classify them correctly, respond fairly, remedy errors promptly, identify patterns, prevent recurrence and improve customer outcomes over time. The policy must also ensure that complainants are not discouraged, ignored, overburdened or treated defensively. Its purpose is not to protect the organisation from criticism at the expense of complainants. Its proper purpose is to ensure balanced, lawful, fair and efficient complaint resolution within a system that is accessible, transparent and accountable. In this sense, a complaints policy also supports broader conduct governance. It helps embed fair treatment, plain-language communication, proper record keeping, escalation discipline, management oversight and regulatory responsiveness across the business. A complaints policy that is fit for purpose must therefore be usable in practice, understandable to its intended audience, and capable of guiding both routine complaints and complex disputes to an appropriately reasoned conclusion.

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Within the FAIS regulatory framework, the existence of a complaints policy is not a matter of choice or business preference. It is part of a mandatory complaints management framework that must be established, maintained and operated by a provider, excluding a representative, in a manner that is proportionate to the nature, scale and complexity of the provider's business and risks; appropriate to its business model, policies, services and clients; investigative in orientation; fair to complainants; and free of unreasonable barriers. The framework must also contain defined objectives, principles, responsibilities, performance standards, procedures, escalation mechanisms, record keeping measures, monitoring arrangements, communication standards, ombud engagement processes and reporting arrangements. The governing body and key individuals carry responsibility for effective complaints management and for approval and oversight of implementation. Reportable complaints must be categorised, recorded and analysed. Decisions must distinguish clearly between upheld and rejected complaints. Complainants must receive clear acknowledgements, process information, progress updates and reasons for outcomes. The

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provider must maintain records, analyse trends, utilise complaints data to manage conduct risk, engage appropriately with ombuds and comply with prescribed reporting obligations. This policy is therefore drafted not merely to reflect good practice, but to meet the specific requirements of the General Code of Conduct for Authorised Financial Services Providers and Representatives, including Part XI on complaints and the related principles of fair, honest, skilled and diligent financial services, plain-language communication, proper systems, adequate records and governance accountability. It must be read and applied as a binding internal governance framework for Insurancewise's complaints management arrangements.

THE GOAL AND PURPOSE OF THIS POLICY

The goal of this policy is to make explicit Insurancewise's commitment to treating customers, staff and stakeholders equally and fairly, with particular emphasis on ensuring that clients do not face unreasonable post-sale barriers when making an insurance-related complaint. This aligns with the requirement that a provider's complaints management framework must not impose unreasonable barriers to complainants and must ensure the fair treatment of complainants.

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The purpose of this policy document is to codify Insurancewise's complaint resolution framework so that staff, clients, potential clients and stakeholders may access, understand and apply the standards, rights, duties and procedures that govern complaint handling. This is consistent with the Code's requirements for transparent, visible and accessible complaint processes, plain-language communications and clear disclosure of how and to whom complaints must be submitted.

The imperative for this policy is also to ensure compliance with the laws, rules and regulatory requirements applicable to financial services providers under the Financial Advisory and Intermediary Services Act, 2002 and Board Notice 80 of 2003, as amended, particularly the complaints provisions contained in Part XI of the General Code of Conduct.

COMPLAINTS MANAGEMENT

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Insurancewise FAIS complaints policy

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1. Definitions

For purposes of this policy, the following definitions apply. The wording below is based on the definitions set out in the policy text and the General Code of Conduct. Interpretive guidance is added to ensure consistent application in practice.

1.1 Client query

"Client query" means a request to the provider or the provider's service supplier by or on behalf of a client, for information regarding the provider's financial products, financial services or related processes, or to carry out a transaction or action in relation to any such product or service.

A client query is not automatically a complaint. It usually seeks information, clarification, an update, a document, a correction, an administrative action or execution of an instruction. For example, a client may ask for a policy schedule, request a premium statement, ask how to change banking details or enquire about claim status. Such a query becomes relevant to complaint classification because the definition of "complaint" expressly states that an expression of dissatisfaction may be submitted together with or in relation to a client query. In other words, a communication can begin as a query and become a complaint if it also indicates or alleges non-compliance, maladministration, harm or unfair treatment. Staff must therefore avoid dismissing a matter as "just a query" where dissatisfaction is clearly being expressed.

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1.2 Complainant

"Complainant" means a person who submits a complaint and includes a client; a nominated beneficiary or successor in title; the life insured under an insurance policy; a premium payer or investor; a member of certain statutory or contractual schemes; a person with a direct interest whose dissatisfaction relates to approach, solicitation, marketing, advertising material or an advertisement; or a person acting on behalf of any such person.

This definition is deliberately wide. It means Insurancewise must not restrict access to complaint mechanisms only to the contracting policyholder. A complainant may include a beneficiary, life insured,

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premium payer, authorised representative, executor, curator, guardian or any person acting for a qualifying person. It also reaches beyond post-contract administration to include pre-sale conduct such as solicitation, marketing and advertising where the dissatisfied person has a direct interest in the agreement, product or service concerned. The practical effect is that complaint intake must focus on whether the person falls within the definition, not on whether that person appears in a narrow client database as the primary account holder.

1.3 Complaint

"Complaint" means an expression of dissatisfaction by a person to a provider or, to the knowledge of the provider, to the provider's service supplier relating to a financial product or financial service provided or offered by that provider which indicates or alleges, regardless of whether such an expression of dissatisfaction is submitted together with or in relation to a client query, that—

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(a) the provider or its service supplier has contravened or failed to comply with an agreement, a law, a rule, or a code of conduct which is binding on the provider or to which it subscribes;

(b) the provider or its service supplier's maladministration or willful or negligent action or failure to act, has caused the person harm, prejudice, distress or substantial inconvenience; or

(c) the provider or its service supplier has treated the person unfairly.

This is the central definition in the policy and must be interpreted broadly, carefully and purposively. Each element matters.

(a) "Expression of dissatisfaction"

An expression of dissatisfaction is any communication, conduct or statement that objectively conveys that the person is unhappy, aggrieved, dissatisfied, dissatisfied in part, or regards a situation as wrong, unacceptable, deficient, unfair or harmful. It does not need to use the word "complaint". It may be oral, written or electronic. It may be calm, emotional, brief, formal, informal, direct or indirect. It may be

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framed as a query, demand, criticism, objection or request for rectification. What matters is substance, not label. An expression of dissatisfaction can therefore include statements such as “this was handled badly”, “I was never told this exclusion existed”, “your consultant misled me”, “you have treated me unfairly”, “my claim was ignored”, or “my premium was taken after cancellation”.

What it does **not** mean is every neutral enquiry, mere request for information, or ordinary transactional instruction. A simple request for a policy document or an update, without any allegation of wrongdoing, poor service, unfairness, harm or dissatisfaction, remains a client query. Likewise, a purely abusive statement with no discernible complaint content may require conduct management, but if it also contains dissatisfaction about a regulated product or service it should still be treated as a complaint. The test is objective substance, not tone.

Five examples of an expression of dissatisfaction in an insurance context are:

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- “I was told the policy covered accidental damage, but now the claim is being declined.”
- “Your office debited my account twice this month and no one fixed it after I reported it.”
- “I have asked three times for cancellation and premiums are still being deducted.”
- “The adviser rushed me into signing and never explained the waiting period.”
- “Your claims department has kept me waiting for weeks without any proper feedback.”

Five examples of communications that are **not**, without more, expressions of dissatisfaction are:

- “Please send me a copy of my policy schedule.”
- “What date is my next premium due?”
- “Please update my address on your system.”
- “How do I nominate a beneficiary?”
- “Can you explain how to submit supporting claim documents?”

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(b) "By a person"

This means the communication may come from any natural or juristic person who falls within the definition of complainant or acts on behalf of such a person. It does not require technical legal drafting or representation. Staff should not reject a complaint because it is made by a family member, executor, guardian or authorised intermediary if authority can reasonably be established.

(c) "To a provider or, to the knowledge of the provider, to the provider's service supplier"

A complaint need not be sent directly to Insurancewise's designated complaints mailbox to qualify as a complaint. If it is made to Insurancewise, the complaint is clearly received. If it is made to a service supplier and Insurancewise knows of it, the matter still falls within the definition. This prevents outsourcing from becoming a shield against responsibility. The provider remains accountable for complaints relating to services provided in connection with its financial products, financial services or related services, and must have referral and monitoring processes for representatives and service suppliers.

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What this cannot mean is that Insurancewise may ignore complaints simply because the first recipient was a binder holder, administrator, call centre, claims handler or other outsourced functionary. Once the provider knows, or reasonably ought to know through its systems, the complaint must be managed within the framework.

(d) "Relating to a financial product or financial service provided or offered by that provider"

There must be a sufficient nexus between the dissatisfaction, and a financial product, financial service or related service provided or offered by Insurancewise. The complaint may concern advice, disclosure, solicitation, claims handling, premium collection, policy wording, amendments, accessibility, lapsing, switches, administration, advertising or complaint handling itself. The words "provided or offered" mean the matter can concern an actual concluded product or service, or a pre-sale offering or marketing interaction.

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What this does not mean is any unrelated grievance about matters wholly outside the provider's regulated business. A dispute about a building's parking arrangement, for example, would not ordinarily qualify unless it forms part of unfair access to the complaints process or another regulated conduct issue.

(e) "Which indicates or alleges"

The complainant need not prove the complaint at intake stage. It is enough that the communication indicates or alleges the relevant problem. "Indicates" covers implication, inference or indirect communication. "Alleges" covers a direct assertion or claim. This wording lowers the threshold for recognition of complaints and ensures that complaints are investigated rather than screened out prematurely because the client did not articulate the issue with legal precision.

(f) "Regardless of whether such an expression of dissatisfaction is submitted together with or in relation to a client query"

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This phrase makes clear that a complaint and query may coexist. A client might ask, "Please tell me why my claim was declined, because I believe your assessor ignored the photos and treated me unfairly." That is both a query and a complaint. Staff must classify according to substance and route the matter through the complaints framework where the complaint definition is met.

(g) Paragraph (a): contravened or failed to comply with an agreement, a law, a rule, or a code of conduct

This limb addresses non-compliance. "Agreement" includes the policy contract, mandate, fee agreement, service terms or any undertaking made to the client. "Law" includes FAIS, insurance legislation, consumer protection provisions where applicable, privacy laws and any other binding legal rule. "Rule" includes subordinate instruments or internal rules made binding through regulation or contract. "Code of conduct" includes the General Code of Conduct and any subscribed code binding the provider.

Examples in an insurance context include:

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- Failure to honour a policy term after the insured event occurred.
- Failure to provide required disclosures in plain language before policy inception.
- Failure to acknowledge or process a complaint in line with the complaints framework.
- Failure to apply a cancellation request according to the agreed process.
- Failure to disclose commission, fees or exclusions where disclosure was required.

What this limb does not require is that the complainant cite the exact section number or legal instrument. The substance of the allegation is enough.

(h) Paragraph (b): maladministration or wilful or negligent action or failure to act

"Maladministration" generally refers to poor, improper, disorganised, unjustifiable or defective administration. It can include lost documents, failure to diarise, incorrect data capture, unexplained delay, failure to follow process, sending correspondence to the wrong address, failure to escalate, or poor record management. "Wilful" points to deliberate conduct. "Negligent" points to failure to exercise reasonable care. "Failure to act" covers omissions where action was required.

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Five examples of maladministration in insurance are:

- Claim documents were received but never uploaded or allocated for assessment.
- A cancellation request was received but not processed, causing further debits.
- A consultant captured the wrong cover amount or banking details.
- A beneficiary nomination form was received and misfiled, causing delay at claim stage.
- A complaint was acknowledged but then left dormant without investigation.

Five examples of conduct that would usually not amount to maladministration, without more, are:

- A lawful claim decline supported by policy wording and proper reasons.

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- Delay caused solely by the client's failure to submit required documents after reminders.
- Standard verification steps required by law or fraud controls.
- A change in premium that was clearly disclosed and contractually authorised.
- Inability to complete a request because the person lacked authority and no proof was provided.

(i) "Harm, prejudice, distress or substantial inconvenience"

"Harm" may include financial harm, practical harm, reputational harm or emotional harm linked to the complained-of conduct. "Prejudice" is broader and can include disadvantage, impairment of rights, loss of opportunity or procedural detriment. "Distress" captures anxiety, upset, humiliation or emotional strain. "Substantial inconvenience" means inconvenience that is material, significant or more than trivial. A minor delay of a few minutes is not usually substantial. Repeated failed contacts, urgent medical cover disruption, prolonged uncertainty during a claim, or repeated documentation requests after prior submission may be substantial.

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(j) Paragraph (c): treated the person unfairly

"Unfairly" is a broad conduct standard and should be interpreted consistently with the duty to render financial services honestly, fairly, with due skill, care and diligence, in the interests of clients and the integrity of the financial services industry. Fairness generally implies impartiality, reasonableness, consistency, good faith, proportionality, transparency and respect for legitimate expectations created by the product, service or communication. Unfairness may arise even where there is no deliberate misconduct.

Five examples of potentially unfair treatment in an insurance context are:

- A client is given a claim rejection with no intelligible reasons or reference to policy wording.
- Similar claims are treated differently without a valid basis.

- A vulnerable client is pressured into a replacement policy without clear explanation of disadvantages.
- A complaint is ignored because the client is viewed as difficult or persistent.
- Cancellation is made easy at point of sale but excessively difficult after sale through avoidable barriers.

Five examples of conduct that is not unfair, if handled properly, are:

- Declining a claim for a clearly excluded event, with prompt reasons in plain language.
- Requesting proof of authority from a third party before disclosing confidential information.
- Asking for outstanding supporting documents that are genuinely necessary to assess a claim.
- Applying waiting periods that were properly disclosed and contractually incorporated.
- Referring a matter for internal escalation because the complaint is complex or unusual.

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Fairness and unfairness differ not only in outcome but in method. A fair process is transparent, reasoned, consistent and proportionate. An unfair process is arbitrary, opaque, dismissive, biased, inconsistent or unduly burdensome. A fair outcome may still disappoint a complainant; an unfair outcome often involves both disappointment and procedural or substantive injustice.

1.4 Compensation payment

"Compensation payment" means a payment, in money or in the form of a benefit or service, by or on behalf of the provider to compensate a complainant for proven or estimated financial loss caused by the provider's contravention, non-compliance, action, failure to act or unfair treatment forming the basis of the complaint, where the provider accepts liability, excluding a goodwill payment, a payment already contractually due, or a refund of an amount not contractually due, but including interest on late payment of such amounts.

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The key features are causation, financial loss and acceptance of liability. Compensation is remedial and linked to responsibility. It is not the same as paying what the policy already required, and it is not merely a gesture. Where Insurancewise accepts that its conduct caused loss, the matter should be assessed as potential compensation.

1.5 Goodwill payment

"Goodwill payment" means a payment, in money or in the form of a benefit or service, made as an expression of goodwill to resolve a complaint where the provider does not accept liability for financial loss.

This definition matters because goodwill should not be confused with compensation. A goodwill payment may be appropriate where service was poor, inconvenience was caused or a pragmatic resolution is desirable, but the provider does not admit legal liability for compensable loss. The basis for any goodwill payment must nevertheless be properly documented, approved and communicated.

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1.6 Member

"Member" in relation to a complainant means a member of a pension fund, friendly society, medical scheme or group scheme contemplated in the relevant legislation and rules.

Although some elements may arise less often in Insurancewise's ordinary insurance context, the definition is retained because it forms part of the framework and can become relevant where products or services intersect with grouped or scheme-based arrangements.

1.7 Rejected

"Rejected" means a complaint has not been upheld and the provider regards it as finalised after advising the complainant that no further action will be taken, and includes complaints regarded as unjustified or

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invalid, or where the complainant does not accept or respond to the provider's proposals to resolve the complaint.

Rejection is not merely an internal conclusion. It requires communication to the complainant and reasons sufficient to explain why the complaint is not upheld. It also triggers a duty to inform the complainant of escalation or review options and relevant time limits.

1.8 Reportable complaint

"Reportable complaint" means any complaint other than one upheld immediately by the first recipient, one upheld within ordinary client-query processes within five business days of receipt, or one brought to the provider's attention in a manner that did not afford a reasonable opportunity to record prescribed details.

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This definition is important for record keeping, categorisation, data analysis and reporting. Not every complaint is reportable, but every complaint must still be assessed carefully. Staff must distinguish between immediately resolved matters and complaints that require formal recording and reporting as reportable complaints.

1.9 Upheld

"Upheld" means a complaint has been finalised wholly or partially in favour of the complainant and the complainant has accepted that it is resolved, or it is reasonable for the provider to assume such acceptance, and all undertakings made by the provider have been met or satisfactory arrangements exist to meet them within a time acceptable to the complainant.

A complaint is not truly upheld merely because the provider intends to act. The undertakings must either be completed, or there must be explicit satisfaction with arrangements for completion. Closure coding must therefore follow evidence, not assumption.

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2. Complaints management framework

2.1 Establishment and maintenance

Insurancewise must establish, maintain and operate an adequate and effective complaints management framework to ensure effective resolution of complaints and fair treatment of complainants. The framework must be proportionate to the nature, scale and complexity of the business and risks; appropriate to the business model, policies, services and clients; investigative in character; free of unreasonable barriers; and inclusive of all matters required by the Code. The framework must be reviewed regularly and all changes documented.

2.2 Core requirements

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The framework must provide for objectives, key principles and allocation of responsibilities; performance standards and remuneration strategies that support objectivity; documented procedures for complaint management and categorisation; timeframes and extensions; escalation, decision-making, monitoring, oversight and review processes; record keeping and analysis; communication arrangements; ombud engagement; reporting obligations; management of complaints involving representatives and service suppliers; and regular monitoring of the framework itself.

2.3 Allocation of Responsibilities

The board of directors, or if there is no board the governing body, together with key individuals, is responsible for effective complaints management and must approve and oversee the implementation of this framework. Any person who makes decisions or recommendations on complaints must be properly trained, suitably experienced and knowledgeable, free from conflicts of interest, and adequately empowered to act impartially.

3. Step-by-step complaint process

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The following step-by-step process applies to every complaint, adapted where necessary to the category and complexity of the matter. This section converts the framework requirements into an operational sequence that must be followed in practice.

Step 1: Receipt of complaint

1. The complaint may be received verbally, in writing, electronically, through a representative, through a service supplier, or together with a client query.
2. The receiving staff member must immediately assess whether the communication contains an expression of dissatisfaction falling within the complaint definition.
3. The staff member must not reject the matter merely because the complainant does not use the word "complaint", is emotional, combines the matter with a query, or sent it to the wrong department.
4. If the matter concerns a representative or service supplier, it must be referred in accordance with the applicable referral process while remaining within Insurancewise's oversight framework.

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Step 2: Initial triage and classification

1. Determine whether the matter is a client query only, a complaint, or both.
2. Determine whether it can be upheld immediately or within ordinary query processes within five business days, or whether it is likely to become a reportable complaint.
3. Determine whether urgent risk, vulnerability, claim payment hardship, ongoing premium prejudice, data error or other immediate harm requires accelerated handling.
4. Identify whether the complaint relates to product design, information, advice, performance, service, accessibility/change/switch, complaints handling, insurance risk claim, or another category.

Step 3: Logging and record creation

1. Create a complaint record as soon as reasonably possible.

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2. Record the complainant's details, policy or account reference, date received, channel received, handler, summary of issues, category, initial status, and whether the matter is potentially reportable.
3. Secure all available evidence, including emails, recordings, notes, policy documents, claim records, mandates, disclosure records and system activity.
4. If the complaint was received by a representative or service supplier, record referral details and oversight actions.

Step 4: Acknowledgement to complainant

1. Acknowledge receipt within a reasonable time.
2. Inform the complainant of the contact person or department handling the complaint, indicative timelines, the internal escalation and review process, the option of approaching the relevant ombud where applicable, and the rights and duties applicable under the ombud rules.
3. Use plain language and avoid technical, defensive or ambiguous wording.
4. If information is missing, specify clearly what is needed, why it is needed and by when it should be provided.

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Step 5: Investigation

1. Gather all relevant and appropriate information and circumstances.
2. Investigate the complaint objectively and impartially, with due regard to fair treatment.
3. Consider contractual documents, policy wording, disclosure records, advice records, communications, system notes, call recordings, claim documents, service-level timelines, legal requirements and internal procedures.

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4. Distinguish facts, disputed facts, assumptions, procedural failures, legal issues and remedial possibilities.
5. Where the matter concerns a service supplier or representative, obtain their response and supporting records but do not abdicate provider responsibility.

Step 6: Category-specific assessment

Each complaint must additionally be assessed according to its category:

- **Product design / fees / premiums / charges:** assess product structure, suitability of design issue, disclosure of fees or premiums, and whether the complaint reveals systemic design or pricing concerns.
- **Information provided to clients:** assess whether information was factually correct, plain, adequate, timely and not misleading.
- **Advice:** assess needs analysis, suitability, disclosures, replacement implications and record of advice.
- **Performance:** assess whether dissatisfaction arises from actual poor product/service performance, misunderstanding, disclosed risk, or failure in expectation management.
- **Service / premium collection / lapsing:** assess administration quality, debit practices, notices, instructions received, and consequences of lapsing.
- **Accessibility / changes / switches / redemptions:** assess barriers, delays, authority checks, change processing and communication.
- **Complaints handling:** assess whether the complaint process itself created delay, opacity, burden or unfairness.
- **Insurance risk claims / non-payment:** assess claim notification, evidence, wording, exclusions, timelines, reasons, fairness and communication quality.

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- **Other:** assess whether an additional internal sub-category should be used for trend analysis and conduct-risk management.

Step 7: Decision making

1. The complaint handler must formulate a reasoned outcome based on facts, law, contract, fairness and available evidence.
2. Where necessary, escalate complex or unusual complaints internally.
3. Decision makers must be impartial, properly trained and free from conflicts of interest.
4. Determine whether the complaint is upheld, partially upheld, rejected, resolved through corrective action, resolved by goodwill payment or resolved by compensation payment.

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Step 8: Internal escalation and review

1. If the complaint is complex, unusual, high value, legally sensitive, repetitive, systemic or disputed on material facts, it should be escalated by the initial handler.
2. If the complainant is dissatisfied with the outcome, the complainant must be able to escalate internally without excessive paperwork or administrative burden.
3. The escalation function must be impartial and senior.
4. The review must balance the legitimate interests of all parties while keeping fair treatment of the complainant central.

Step 9: Outcome communication

1. **Preparation and ownership of the outcome communication**

Before any outcome is sent to the complainant, the complaint handler must prepare a written outcome recommendation supported by the relevant facts, documents, chronology, contractual provisions, legal or code requirements, fairness considerations and proposed remedy or rejection rationale.

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The initial complaint handler is responsible for preparing the factual summary, assembling the evidence bundle, identifying the complaint category, recording the investigation steps taken, and drafting the proposed outcome. A complaints manager, key individual, senior operations manager or other impartial senior functionary designated by Insurancewise must review and approve the outcome where the complaint is complex, high-value, legally sensitive, reputationally significant, concerns advice suitability, alleges unfair treatment, may result in compensation, or has already been escalated internally. This ensures that decisions are impartial, properly authorised and aligned with the framework requirement that complaint decision-makers be adequately trained, skilled, empowered and free from conflicts of interest.

As an internal service standard, routine complaints should receive a substantive outcome communication within 15 business days of receipt, unless the matter is resolved earlier or the complexity of the complaint reasonably requires a longer period. Where more time is required, the complainant must be informed before the initial target date expires, the reasons for the delay must be explained, outstanding investigative steps must be identified, and a revised target date must be given. In no case should delay be unexplained, open-ended or caused by avoidable internal inefficiency.

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2. **Content of the outcome where the complaint is upheld or partially upheld**

Where the complaint is upheld, whether wholly or partially, the outcome letter must state clearly that Insurancewise has upheld the complaint in whole or in part, identify the issues that were accepted, distinguish them from any issues not accepted, and explain the factual and contractual or fairness basis for the decision in plain language.

The communication must specify precisely what remedial action will be taken. This may include correction of records, reversal of an incorrect debit, reinstatement of a policy, reconsideration of a claim, issue of revised disclosure, apology, expedited processing, payment of an amount contractually due, compensation payment where liability for loss is accepted, or goodwill payment where the complaint is resolved pragmatically without admission of liability. The communication must also identify the person, role or department responsible for each action, such as finance for payment, policy administration for

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reinstatement, claims for reassessment, compliance for oversight, or the complaints office for closure monitoring.

As an internal standard, where the complaint is upheld and no external dependency exists, Insurancewise should confirm the remedy and implementation date in the same communication, and the agreed action should ordinarily be completed within 5 business days for simple administrative corrections, 10 business days for standard payments or reversals, and 15 business days for more complex corrective steps requiring coordination across departments. Where these periods cannot reasonably be met, the complainant must be told why, what remains to be done, who is attending to it and when completion is expected.

3. **Content of the outcome where compensation or goodwill is proposed**

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Where Insurancewise proposes a compensation payment, the decision record and outcome communication must make clear that the payment is compensatory in nature, that it arises from accepted liability for loss caused by the provider's contravention, non-compliance, act, omission or unfair treatment, and that the amount has been calculated on a proven or reasonably estimated loss basis. The communication should explain, in sufficient but plain terms, how the amount was determined, what documents or assumptions were used, whether interest is included, and whether acceptance by the complainant is required before payment is made. Compensation should be approved by a suitably senior authorised manager, and where the amount exceeds a set internal threshold, by an additional senior authority such as the key individual, executive manager, or designated governance committee.

Where Insurancewise proposes a goodwill payment, the communication must state that the payment or service is offered as a goodwill measure to resolve the complaint and does not amount to an admission of legal liability for financial loss. Goodwill may be appropriate where service fell below standard, inconvenience was substantial, communication was poor, delay occurred, or the matter is best resolved commercially, and fairly even though legal liability is not accepted. Examples include a modest ex gratia payment for avoidable inconvenience, waiver of a fee, priority handling of a pending administrative process, or a non-monetary service recovery intervention. Goodwill should never be used to disguise

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compensable loss, to suppress a valid complaint, or to create ambiguity about whether the complaint was upheld.

As an internal standard, all compensation and goodwill offers should remain open for acceptance for at least 10 business days unless urgency, product mechanics or ombud timelines justify a shorter period and the shorter period is fair in the circumstances. If the complainant accepts, implementation must move immediately to Step 10. If the complainant rejects the proposal or fails to respond within a reasonable period after reminder, the matter may be treated in accordance with the definition of "rejected" only if the complainant has first been clearly advised of the consequences and given a fair opportunity to respond.

4. **Content of the outcome where the complaint is rejected**

Where the complaint is rejected, in whole or in part, the communication must do more than state a conclusion. It must identify the complaint, summarise the material facts considered, state the relevant contractual, factual, legal, procedural or fairness grounds for the rejection, and explain why Insurancewise does not intend to take further action on the rejected aspects of the complaint. A rejection should not be formulaic, defensive or vague. It should be reasoned enough to allow the complainant to understand the basis of the outcome and to decide whether escalation is warranted.

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Grounds for rejection may include, for example, that the policy wording clearly excludes the event complained of; the alleged advice or disclosure failure is not supported by the record; the complaint is contradicted by contemporaneous documentation; the provider did not cause the alleged loss; the complainant has not established authority to act and refuses to provide proof; the matter relates to a lawful contractual outcome properly communicated; or the complainant failed to engage with a fair proposed resolution. However, a complaint should not be rejected merely because the complainant is insistent, emotional, legally unsophisticated, or unable to frame the issue in technical terms.

The rejection communication must also set out the complainant's further rights. At a minimum, it must state the internal escalation or review route, the person, office or department to whom an escalation may be addressed, the period within which internal escalation should be lodged, the relevant ombud option

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where applicable, and any applicable time limits. As an internal standard, Insurancewise should allow at least 15 business days from the date of the rejection communication for internal escalation, while making clear that this does not limit any shorter external statutory or ombud time period that may apply. The complainant must also be informed that they may approach the relevant ombud after internal escalation or where the framework or applicable ombud rules permit direct referral.

Step 10: Implementation of remedy

1. **Allocation of implementation responsibility and execution timelines**

Once a complaint is upheld or a resolution proposal is accepted, the complaint must move immediately from decision phase to implementation phase. Implementation responsibility must be allocated expressly and not left implicit. The complaints handler remains responsible for overall coordination and diary control; the complaints manager or designated supervisor remains responsible for oversight and escalation of delays; and the business unit that must perform the remedy remains responsible for substantive execution. Thus, finance is responsible for compensation and goodwill payments; policy administration is responsible for corrections, reinstatements, cancellations, endorsements and system amendments; claims is responsible for reassessment, settlement action or claim communication; adviser management is responsible for conduct interventions relating to representatives; and compliance is responsible for oversight where systemic or regulatory issues arise.

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Every remedy must be accompanied by a documented implementation plan recording the action to be taken, the responsible person or department, the approval obtained, the due date, dependencies, and the proof required to confirm completion. As an internal standard, straightforward non-monetary corrections should ordinarily be completed within 5 business days of the outcome or acceptance; ordinary monetary payments or premium reversals within 10 business days; and complex multi-step remedies within 15 business days, unless a different period is agreed with the complainant or is objectively required by an external dependency. These internal standards give practical effect to the Code requirement that upheld complaints, compensation payments, goodwill payments and other action be carried out without undue delay and within agreed timeframes.

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2. **Monitoring, proof of completion and communication during implementation**

Implementation must be actively monitored. It is not enough to issue an instruction and assume performance. The complaints handler must track progress against the implementation plan, obtain documentary proof of each completed step, and maintain a record of completion on the complaint file. Depending on the nature of the remedy, proof may include payment confirmations, updated policy schedules, corrected debit orders, reinstatement letters, revised claim determinations, screenshots of corrected system records, signed settlement acceptance, or correspondence confirming completion.

If implementation is delayed for any reason, the complainant must be informed promptly of the cause of the delay, the revised completion date and the interim steps being taken. Internally, any missed implementation target should automatically escalate to the complaints manager or other designated senior functionary for intervention. Repeated delays, unexplained delays or delays caused by service suppliers must be treated as complaint-handling risk issues and recorded for conduct-risk analysis and management reporting.

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Where a remedy requires the complainant to provide banking details, supporting documents, acceptance of settlement wording or any other co-operation, this must be requested clearly and promptly. The provider should still move as far as possible with all steps within its own control, rather than suspending the whole matter unnecessarily.

3. **Closure, upholding, rejection after proposal failure, and post-remedy controls**

A complaint may only be closed as upheld when the requirements of the definition of “upheld” are met, namely that the complaint has been finalised wholly or partially in favour of the complainant, the complainant has accepted the resolution or it is reasonable to assume acceptance, and all undertakings have been met or satisfactory arrangements acceptable to the complainant are in place. For this reason, no complaint should be marked as finally upheld merely because a decision to remedy has been made. Completion, or accepted arrangements for completion, is essential.

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Insurancewise FAIS complaints policy

Where Insurancewise has made a fair proposal to resolve a complaint by compensation, goodwill or other remedial action and the complainant does not accept or does not respond within a reasonable period after proper follow-up, the complaint may fall within the definition of "rejected". Before classifying it in that way, the file must show that the offer was clearly communicated, the complainant was given a fair response period, at least one follow-up communication was sent where feasible, and the consequences of non-response or non-acceptance were explained. This is important because the definition of "rejected" includes situations where the complainant does not accept or respond to the provider's proposals to resolve the complaint.

After closure, the complaints function must verify that the closure coding is accurate, the amounts paid are correctly recorded as compensation or goodwill, reasons for rejection are captured where applicable, and any root-cause, staff-conduct, training, product, disclosure, system or service-supplier issue has been referred for remedial governance action. Post-remedy review is essential because the framework requires ongoing scrutiny and analysis of complaint information to manage conduct risks, improve outcomes and prevent recurrence of poor outcomes and errors.

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Step 11: Finalisation and closure coding

1. Confirm whether the complaint is upheld, partially upheld, rejected, withdrawn or otherwise resolved in a manner compatible with the framework definitions.
2. Record whether the matter was reportable, escalated, referred to ombud, compensated or resolved by goodwill payment.
3. Record closure date, outcome reasons and final communication.
4. Ensure closure coding matches the definition of "upheld" or "rejected" and is supported by evidence.

Step 12: Post-closure analysis and reporting

1. Include the complaint in ongoing complaint data sets and trend analysis.
2. Identify root causes, conduct risks, recurring errors, training needs or policy gaps.

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3. Report relevant information to executive management, the governing body or board and any relevant committee.
4. Use the findings to improve products, services, processes, disclosures, controls and customer outcomes, and to prevent recurrence.

4. Category-specific notes

Although the general steps above apply to every complaint, the following additional requirements must be observed by category.

4.1 Advice complaints

Advice complaints require review of the client's stated needs and objectives, financial situation, risk profile, product knowledge, suitability analysis, replacement analysis where relevant, and the record of advice. A key question is whether the client was placed in a position to make an informed decision and whether any limitations in the advice process were properly disclosed.

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4.2 Information and disclosure complaints

These complaints require assessment of whether representations were factually correct, plain, adequate, appropriate, timely, readable and not misleading. Staff must compare what was communicated with what ought to have been communicated under the Code and contract.

4.3 Service and administration complaints

These complaints focus on turnaround times, administrative accuracy, premium handling, correspondence, cancellation processing, records, policy maintenance and service responsiveness. Repeated delays, unexplained inaction and inaccurate data capture are strong indicators of maladministration.

4.4 insurance risk claim complaints

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Claims complaints require careful review of notice, evidence, policy wording, exclusions, waiting periods, loss causation, assessor reports, communication quality and timeliness. Even where a claim is correctly declined, the complaint may still be upheld in part if communication, delay or process fairness was defective.

4.5 Complaints about complaints handling

These are especially important because they test the integrity of the framework itself. Staff must assess whether the complainant faced unreasonable barriers, delays, opaque communication, repeated referrals, excessive paperwork, poor updates or inadequate reasons.

5. Record keeping, monitoring and analysis

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Insurancewise must ensure accurate, efficient and secure recording of complaints and complaints-related information. In respect of each reportable complaint, the record must include relevant complainant details, subject matter, evidence, correspondence, decisions, categorisation, and progress and status including whether timelines were met.

Insurancewise must maintain ongoing data on the number of complaints received, upheld, rejected and the reasons for rejection, the number escalated internally, the number referred to an ombud and their outcomes, the number and amounts of compensation payments, the number and amounts of goodwill payments, and the total number of outstanding complaints. This information must be scrutinised and analysed on an ongoing basis to manage conduct risk, improve outcomes and prevent recurrence of poor outcomes and errors.

6. Communication with complainant

Insurancewise's complaint processes and procedures must be transparent, visible and accessible through channels appropriate to its clients. No charge may be imposed for use of the complaints process, and all communications must be in plain language. Wherever feasible, a single point of contact must be available for submitting complaints.

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Clients must be told what information is required from a complainant, where and how complaints must be submitted, expected turnaround times, and any other relevant complainant responsibilities. Complainants must also be kept adequately informed of progress, delays, revised timelines and the final decision.

7. Engagement with ombud and reporting

Insurancewise must have appropriate processes for engagement with any relevant ombud, clearly communicate the availability and contact details of relevant ombud services at all relevant stages of the client relationship, and display or make available ombud information at its premises and on its website where applicable. It must maintain records and analysis of complaints referred by an ombud and monitor ombud determinations, publications and guidance to identify failings or risks in its own policies, services or practices.

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Insurancewise must maintain open and honest communication and co-operation with any ombud and should endeavour to resolve complaints before a final determination or ruling is made, without impeding or unduly delaying the complainant's access to the ombud. It must also have appropriate processes to comply with any prescribed requirements for reporting complaints information to the relevant authority or to the public where required.

8. Governance, training and review.

This policy must be approved by the appropriate governing structure of Insurancewise and overseen by the board of directors or, where no board exists, the governing body together with key individuals responsible for effective complaints management. Complaint handlers and decision makers must receive training on complaint identification, classification, fairness, plain-language communication, records, escalation, ombud engagement and remedial decision-making.

The policy and the complaints management framework must be reviewed regularly, and any changes must be documented. Reviews should take account of complaint trends, audit findings, ombud outcomes,

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regulatory developments, operational incidents, service supplier performance and recurring client harm indicators.



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