BROLINK

COMPLAINTS POLICY

Your rights as a consumer of Financial Services

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BROLINK

The Complaints Resolution System

Background to the complaints policy

The FAIS Act General Code of Conduct requires of all authorised financial service providers to institute a Complaints Policy that meets certain requirements. The Complaints Policy is a form of alternate dispute resolution, to be utilised as a last resort before referring a matter to the FAIS Ombud. The basic principle of a complaints resolution mechanism is that an aggrieved consumer of financial services can take comfort that the financial services provider will tend to such complaint with a view to attempt to resolve the issue before such complaint is formally adjudicated by an independent body, such as the FAIS Ombud.

The General Code provides the framework for complaints resolution, but this is strengthened by the Policyholder Protection Rules (Long-term and Short-term Insurance Acts) and the FSCA's Treating Customers Fairly outcomes. These frameworks provide further guidance as to fair outcomes in complaints resolution and are consumer focused. This policy is therefore designed with all the prescripts in the mentioned frameworks in mind.

Unresolved complaints regarding the delivery of a financial service, as defined in this policy, may be referred to the FAIS Ombud. Issues that relate to a product provider's conduct or decisions, and not directly to the delivery of any advisory or intermediary service delivered by the provider, may be referred to the relevant Ombud with jurisdiction (Banking Adjudicator, Ombud for Long-term Insurance, Ombud for Short-term Insurance, Pension Funds Adjudicator, Council for Medical Schemes, etc.).

The Requirements of a robust complaints policy

Any authorised financial service provider (FSP) or binder holder must establish and maintain a complaints management framework to ensure the fair treatment of complainants that:

1. is proportionate to the nature, scale, and complexity of the insurer's business and risks;
2. is appropriate for the business model, policies, services, policyholders, and beneficiaries of the insurer;
3. enables complaints to be considered after taking reasonable steps to gather and investigate all relevant info and circumstances, with due regard to the fair treatment of complainants; and
4. does not impose unreasonable barriers to complainants.

The complaints management framework must provide for:

1. objectives, key principles, and the proper allocation of responsibilities for dealing with complaints;
2. performance standards, remuneration and reward strategies (internally and where any functions are outsourced) for complaints management to ensure objectivity and impartiality;
3. documented procedures for management & categorisation of complaints, incl. expected turn-around times and the circumstances under which it may be extended;
4. employing complaints resolution personnel that are skilful at as well as aware of their responsibilities and have knowledge of the TCF and PPR frameworks;
5. continuous training of all personnel involved in the complaints process by ensuring that such staff are not only proficient in their approach to handling complaints but also have adequate knowledge of the subject matter that led to any complaint in order for them to expertly resolve complaints;
6. training of all personnel on their duties and responsibilities and creating complaints and customer services awareness amongst other personnel to minimise the risk of complaints occurring;
7. regular review of its complaints management framework and document any changes thereto; and
8. documented procedures which clearly define the escalation, decision-making, monitoring, oversight, and review processes.

It is the intention and commitment of the provider to comply with these principles in all dealings with complainants and as required in the General Code (amended 2020) and the PPR issued in terms of the LTIA and STIA.

Definitions

Client query	Any request by a client or made by a person authorised by the client regarding information on the products or service offering of the provider.
Complaints Officer	The person appointed by the provider as custodian of this Policy. This person also takes responsibility for maintaining the Complaints Register and Complaints Reporting.
Complaint	An expression of dissatisfaction to an insurer / their service provider (to the knowledge of the insurer) relating to a policy or service which indicates / alleges, that - • The insurer or their service provider failed to comply with an agreement, a law, a rule, or a code of conduct; • the insurer or their service provider's maladministration or wilful / negligent action or omission, caused the person harm, prejudice, distress or substantial inconvenience; • the insurer or its service provider has treated the person unfairly; regardless whether submitted together with or in relation to a policyholder query.
Compensation payment	Any payment (monetary value, service or benefit) made to a complainant to make good on a proven or estimated financial loss suffered by the complainant, which can be ascribed to a fault of the provider (failure to perform a duty, non-compliance, unlawful act, etc.) and where the provider accepts responsibility for the loss. Compensation payments include interest but exclude: - Any goodwill payment (as defined); - Payment that was in any event contractually due to the complainant; and - Refund of monies the complainant paid to the provider and that wasn't due.
Complaint	Where it is alleged that the provider and/or its representatives and/or personnel: • contravened a section or rule contained in the General Code; or • failed to adhere to any section contained in the Act; and through the aforesaid failure: • caused a client to suffer damage or prejudice the client; or • the client is likely to suffer damage or be prejudiced. Where it is alleged that the provider and/or its personnel and/or its representatives: • were negligent in the rendering of financial services; or • delivered financial services wrongful and with intent; and • the client has suffered damages as a result of the wrongful services delivered; or • the client has been prejudiced by the wrongful services delivered; or • the client is likely to suffer damage or be prejudiced by the wrongful services delivered. Where it is alleged that the client was treated unfairly by the provider and/or its personnel and/or its representatives.
Complainant	A person/ someone acting on their behalf, who has a direct interest in the agreement, policy, or service, and includes a – 1. policyholder or their successor in title; 2. beneficiary or their successor in title; 3. person whose life is insured under a policy; 4. person that pays a premium; 5. member of a group scheme or potential policyholder or potential member of a group scheme, which member may be a member of a medical aid, pension fund or a group scheme policy issued under the STIA or LTIA; and whose dissatisfaction relates to the relevant application, approach, solicitation, advertising, or marketing material.
Escalation	The process whereby a complaint that potentially has a particularly severe impact on the business of the provider, relates to a particularly sensitive issue, relates to a senior functionary or is particularly complex, is escalated by the Complaints Officer to a senior person suitably qualified and experienced to deal with the matter.
Goodwill payment	Any payment (monetary value, service, or benefit) made to a complainant as an expression of goodwill to resolve a complaint but the provider doesn't accept liability for the complaint cause.
Rejected	Means that a complaint was not upheld – Insurer regards the complaint as finalised after advising the complainant that it does not intend to take any further action to resolve the complaint – Incl. complaints regarded as unjustified or invalid / where the complainant does not accept or respond to proposals to resolve the complaint.
Reportable complaint	Any complaint unless– 1. upheld immediately by the person who initially received the complaint;

	2. upheld within the insurer's ordinary processes for handling policyholder queries, provided that such process does not take more than five business days from the date the complaint is received; or 3. submitted to or brought to the attention of the insurer in such a manner that the insurer does not have a reasonable opportunity to record such details of the complaint.
Upheld	Means that a complaint has been finalised wholly or partially in favour of the complainant and – 1. the complainant has explicitly accepted that the matter is fully resolved; or 2. it is reasonable for the insurer to assume that the complainant has so accepted; and 3. all undertakings made by the insurer to resolve the complaint have been met or the complainant has explicitly indicated its satisfaction with any arrangements.

Basis of Complaints resolution

A financial services provider must adhere to the following principles in complaints handling and resolution:

- to consider the facts and circumstances surrounding all complaints in a fair manner, review the complaint and derive value therefrom;
- to investigate or cause to investigate all complaints in a transparent manner and report thereon in full;
- all complaints will be deemed important and receive adequate consideration; and
- to manage the process of investigation and reporting of all complaints in a professional manner.

Allocation of responsibilities

The ultimate responsibility for establishing of this Complaints Management Policy and Framework lies with the Board. The responsibility to execute the requisite actions to ensure the effective functioning and maintaining of this Policy lies with the key individuals. The Board must annually oversee and review the efficacy of the Policy and framework.

Complaints Officer

The person assigned with the responsibility of complaints management, allocation of investigations, complaints resolution and reporting to clients is Linda Botes and Pieter Oberholzer.

Complaints records

All complaints received must be recorded in the register. It may not necessarily relate to advice provided or a financial service rendered by the provider and may be solely aimed at a product supplier, for instance where a claim is repudiated. Any complaint received telephonically or verbally must also be recorded in the register.

Records must be retained of the complaint register as well as all documentation obtained during the resolution process and that relates to the complaint. These records must be retained for a period of 5 years after the complaint was finalised (resolved internally or date of Ombud decision).

The complaints register must contain the following information on reportable complaints:

- Details of complainant
- Brief description of complaint (including classification category)
- Progress and outcome details

Complaints classification

All complaints must be classified in the complaints register according to the type of complaint and considering the basis of the complaint as set out in the TCF Outcomes. The classification of complaints can therefore be set out as follows:

Category	Outcome	Description
Product or service design	**2**	Features of the product or service are unfair, inadequate, confusing, too complex or unsuitable for the target market. The pricing or costs are excessive or confusing.

Marketing & information	**3**	Complaints relating to documentation supplied that is
		confusing, inadequate, inaccurate, misleading, or confusing. Covers marketing and advertising material and any other information specific to a product or service. May relate to failure to provide information on a product.
Advice	**4**	Any allegation that advice was inaccurate, misleading, did not take client circumstances into account, advice withheld when it should have been given, etc. Allegations of conflict of interests or integrity lapses. Allegations that the adviser was unskilled or inexperienced.
Product performance	**5**	Limitations on products, failure to keep the client informed of product changes, insurers' rights to unilaterally terminate a product, etc. Does not include repudiation of claims. May include poor investment returns.
Services provided	**5**	Complaints regarding processing of transactions such as applications and requests such as amendments. Includes complaints regarding employee behaviour such as rudeness or incompetence. May relate to systems and technology that is inadequate. Complaints regarding third parties are included.
Switches, changes or accessibility to products	**6**	Barriers or limitations to access to funds or transfer to another supplier and barriers to changes to the product. Complaints regarding penalties, termination charges or administrative hurdles.
Complaints handling	**6**	Delays in outcomes, failure to communicate progress, poor communication, inaccessibility to complaints procedure. Complaints regarding adverse outcomes are not regarded as new complaints and are not reclassified.
Claims repudiation and claims handling	**6**	Includes delays, poor administration, inaccessible processes and poor workmanship of third parties. Non-payment of claims may relate to documentation or evidence not submitted or issues regarding claims criteria (client failed to keep to policy requirements, specific event not covered under the policy, etc.). Disbursements of savings, investments or retirement funds are not included here but relate to product performance or accessibility to products.

If it appears from the complaints received that these do not fall within the categories set out in the matrix or it appears that some complaints are particular to the services the provider renders, additional complaints categories may be developed and added to the matrix. Such complaints may also be particular or specifically relate to the client base of the provider.

Undertakings in relation to complaint procedures

The provider will at all times maintain a robust internal complaints resolution system and will, in each instance of a complaint levelled at the provider, actively seek to resolve the complaint. The following principles shall apply:

- All complaints will be dealt with as prescribed in this policy.
- No complaint shall be neglected or regarded as more important as another.
- The resolution of all complaints shall be approached in a manner that is fair to the complainant.
- All complaints will be documented.
- The procedure will be transparent so that clients can be assured that there is a commitment to the resolution of their complaints.
- The procedure is easy to use and clients can lodge complaints using convenient communication systems.
- Clients may not be charged any fees for complaints submission, complaints handling or complaints resolution.

Complaints Procedure

The Complaints Officer will deal with complaints from complainants in good time and in a fair manner and respond promptly. The following procedures will apply to the resolution of all complaints:

Initial stage (decision-making stage)

- Any client complaint must be reduced to writing and delivered to the provider by hand, e-mail, post or fax.
- The prescribed complaints form (available from the Complaints Officer or on the company website) must preferable be used to formulate and lodge a complaint.
- All complaints received must be submitted to the Complaints Officer for recording in the complaints register. A complaint will only be elevated for resolution once all the prerequisites have been satisfied and all information required has been received.
- All relevant information and documentation must be attached to the complaint.
- If the information is insufficient to establish the basis of the complaint or the documentation provided is incomplete, the client must be requested to clarify issues and/or furnish additional information or documentation.
- The provider's personnel must offer to assist complainants to reduce their complaints to writing in the event of any telephonic or verbal complaint. This will be offered to any client that has a verbal complaint but has not reduced it to writing. In the event that a complaint is reduced to writing by any staff member of the provider, the complainant must be provided a copy of the recorded complaint and he or she must sign it prior to submitting it to the Complaints Officer
- If a complaint is not reduced to writing it will not be investigated and the complainant must in all such cases be informed that it can only be resolved if reduced to writing.
- The provider will record all complaints in the Complaints Register and acknowledge receipt of the complaint within 24 – 48 hours. This is irrespective of whether it relates to any advice provided or a specific intermediary service delivered. A complaint received verbally but that is not reduced to writing must be recorded but it may be closed as if being resolved, even though a note must be made to record the fact that it is unresolved. The reason for recording all complaints in the register is for TCF purposes and establishing a database of TCF risk.
- The Complaints Officer will evaluate any complaint and make a decision on the classification of any complaint received. Such a decision must be made within 48 hours of receipt of a complaint and the complainant must be informed in writing of the outcome of the initial evaluation. The initial decision can be that:
    - The complaint is not valid and cannot be investigated. The client must be informed of the fact and be advised that the matter can be referred to the Ombud. The reasons for not investigating the complaint must be provided in full. Where applicable, documentary proof or supporting documentation must accompany the letter, setting out the reasons for the decision in full. All relevant information and supporting documentation must be obtained prior to making a decision, including copies of documentation held by third parties, such as product providers and administrators.
    - The complaint may be valid but additional information is required. The complainant must be informed in full of what documentation, description, proof is required as well as the date by which the additional information is sought. The complainant must further be informed that the investigation into the complaint cannot commence before the additional information is furnished.
    - The complaint is valid and will be investigated to find a resolution with 10 – 15 working days.
- The Complaints Officer shall either investigate the complaint personally or, within 24 hours of deciding that any complaint is valid, appoint a person internally to investigate it.
- If the complaint falls outside of the ordinary complaints parameters due to it being more complex than usual and therefore cannot be disposed of by personnel usually responsible for complaints handling, the Complaints Officer shall escalate the complaint. Such complaint must be referred to the key individual responsible for the area the complaint originates from. The compliance officer must be notified that such a complaint was received. The Complaints Officer must monitor the complaint resolution process for client communication and reporting purposes.
- The Complaints Officer will, within a 24-hour period after deciding that a complaint is valid and that it will be investigated, send a confirmation letter to the complainant. The process that will apply to the investigative process must be explained to the client in the confirmation letter. The name and contact details of the investigator must also be included. A copy of this letter must be sent to the compliance officer for monitoring of the process.

- For purposes of compliance with section 18 (b) and (d) of the Act details of the investigation officer must be properly recorded internally.

The resolution stage (investigation stage)

- If the complaint can be resolved immediately the complainant must be informed without delay and be fully informed of the steps that would be taken to resolve the matter. The expected date of final resolution must be supplied. If the complaint can't be resolved immediately, but will be resolved within 10 – 15 working days, and should the complaint be escalated, the complainant must be furnished with a summary of steps to be taken to resolve the matter as well as the expected date of resolution.
- If the complaint affects a product provider, administrator or any third party, the relevant party must be informed thereof and be given an opportunity to comment on the issues brought up in the complaint.
- If the complaint is actually against a party that is not the provider, for example a product provider that repudiated a claim on grounds outside of the control of the provider, the complainant must be informed of the fact and given an opportunity to withdraw the complaint and direct it at the correct party. If the complainant however chooses to keep the complaint active, the provider and the product supplier should jointly investigate and attempt to resolve the complaint.
- The Complaints Officer or internal investigator must ensure that the complaint and all allegations levelled or demands made, is fully investigated and considered during the process.
- The investigation must be conducted as if independently and the process must be left completely unfettered by management of the provider. The investigator must be objective and impartial at all times during the process, even if the result of the investigation may be damaging to the provider.
- If there is any delay during the process of investigation and resolving the complaint, the complainant must be informed thereof and be provided a date of expected resolution.
- The investigator must issue a full report to management of the provider (or, if the Complaints Officer is not the investigator, to the Complaints Officer) upon conclusion of the investigation, setting out all findings emanating from the investigation as well as recommendations on resolving the issues. The compliance officer must be provided a copy of any final or interim report relating to any internal investigation.
- The report must be considered for:
  - The manner of resolving the complaint (including restitution, apology, PI claim, etc.).
  - Disciplinary action in the event of wrongdoing.
  - Corrective action to be taken in processes affected by the complaint.
  - Any steps necessary to be taken avoid a recurrence of the event.
  - If the complaint cannot be resolved within the 4-week period after receipt thereof, the complainant must be informed thereof as well as his or her right to refer the matter to the FAIS Ombud or approach a court of law for legal aid.
- The complainant must be advised that the complaint may within 90 days and a further 6 months be pursued with the Short Term Ombud whose name, address and other contact particulars will be recorded in the rejection letter to the complainant.
- If the complaint is one that is subject to the jurisdiction of any Ombud other than the FAIS Ombud, the complainant must be made aware of this fact and he must be provided the details of such Ombud as well as any time restrictions for submission that applies to such complaint.
- In any rejection letter the prescripts of the TCF Policy must be carried out and the complainant must be fully apprised of the reasons for rejection of the complaint and he must be provided documentary proof of the reasons why his complaint cannot succeed in overturning the original decision of the product provider (in the event of repudiation of a claim). Specific reference must be made to the clause(s) in his policy that he for instance did not comply with and the relevant clauses or sections must be quoted. Where relevant, legal precedent or Ombud decisions may be referred to or quoted.
- In any case where a complaint is upheld (resolved in favour of a complainant), the provider will ensure that a complete and appropriate level of redress is offered to the complainant. Such remedial action or redress must be instituted without any delay. Redress may include any compensation payment or goodwill payment. In the event of a settlement the complainant must be provided a document to sign as receipt of the monies, service or benefit and must acknowledge that the complaint is resolved. The details of the amounts paid and reasons for the payment must be recorded in the register and any complaints report.

The final stage (Follow-up procedures)

- Follow-up procedures to avoid repeated/recurring complaints will be instituted after each complaint is resolved or otherwise dealt with and this will enable the provider to improve its service.
- If it appears that the mistake may have an influence on any other client's portfolio, immediate steps will be taken to remedy such affected portfolio or portfolios.
- If disciplinary steps are required, such steps must be instituted without delay.
- The complete information and result of all complaints must be taken up in the management information of the provider, to be utilised for review of processes as required in terms of the TCF policy.

Rules of the office of the FAIS Ombud

In all instances where a client is informed of his or her right to refer a complaint to the Ombud, the letter to the complainant must contain the following wording, informing the complainant properly of the rules of the office of the Ombud: Rule 6(b): If the respondent (service provider) can't resolve a complaint to the satisfaction of the complainant within 10 – 15 working days of receipt of the complaint, the complainant has to be informed that:

- the matter may be referred to the Office of the FAIS Ombud if the complainant is desirous of taking the matter further; and
- the referral has to be made within 6 weeks of receipt of the abovementioned notification.

Complaints reporting

The provider may under certain circumstances be required to report complaints to insurers (as part of the TCF risk management or in terms of the PPR as part of the complaints framework of the insurer). When reporting on complaints, the matrix as set out above must be used, except where the insurer prefers or prescribes a different classification. When complaints are classified or grouped for reporting purposes, a complaint or complaint group must be classified with the category in the matrix or the insurer's matrix that is most applicable to the type of complaint. All reportable complaints (as defined) must be reported on within the timeframes and in the format required by the insurer. Reporting requirements usually are recorded in a binder-, intermediary- or administration agreement.

Complaints risk management

The provider has an ongoing duty to remain compliant with the TCF & PPR principles. This entails the collation of management information in order to review the complaints handling history. Information that is relevant to complaints management risk is:

- The number of reportable complaints and outcomes of each;
- Details of complaints upheld, outstanding & rejected (and reasons for the rejection);
- Complex complaints escalated to a key individual;
- Non-reportable complaints and how these were resolved; and
- Complaints referred to an Ombud.

There is an ongoing obligation on the provider to review and analyse the complaints domain to determine where the provider's TCF and PPR risk areas are. Risk areas must be assessed to determine which lapses or trends in complaints frequency, types of complaints, etc. require remedial action. The following issues must be considered in deciding whether remedial action is required as well as how imminent such action must be taken:

- Whether turn-around times were adhered to;
- Whether the outcomes of complaints were fair under all circumstances;
- Whether complaints that were not reportable indicate noteworthy trends in relation to the types, volumes or incidences of such informal complaints;
- Whether reportable complaints indicate any risk areas in relation to aspects such as advice, service delivery or lack of internal control; and
- Whether complaints reports to be scrutinised and analysed on an ongoing basis and to be utilised to manage conduct risks, to improve outcomes for policyholders.

General

The following additional issues regarding complaints resolution should be noted:

- The internal complaint resolution system and procedures of the provider will be reviewed and updated regularly.
- The policy will be accessible to clients at all times and copies will be furnished if so requested. Access will be facilitated through electronic mail, fax or postal services, according to the preference of the client. An abridged version of this policy will be posted on the provider's website or may be distributed to new clients together with their compliance documentation. Access to the complaints procedure and facilities will be made available at all offices of the provider.
- Documents will include a reference to the duties of the provider and the rights of a client.
- Care will always be taken to ensure that clients are aware of the procedures to be followed relating to complaints investigation and resolution.

Escalation

Brolink has an escalations process if you as complainant is dissatisfied with the service received from Brolink at any time during the complaints process. You may also lodge an escalation request if you are dissatisfied with the outcome of a complaint and would like it internally reviewed. An escalation request can be directed to our Manager for complaints: linda.botes@brolink.co.za

In the event that the complainant is dissatisfied with the outcome of their complaint, the matter may be referred to our Insurer. The insurer details have been noted in the policy terms & conditions and will be provided at the complaint handling stage.

1. If we are unable to resolve your complaint to your satisfaction within 6 (six) weeks after receipt thereof you may refer the matter to the Office of the FAIS Ombud. The FAIS Ombud generally deals with complaints regarding poor or wrong advice by a broker but may adjudicate a matter relating to claims rejection or any other form of prejudice you may suffer as a result of an adverse decision. Access to the Office of the FAIS Ombud is free.

2. A complaint must be submitted to the FAIS Ombud in writing, accompanied by the available documentation in your possession. The contact details of the FAIS Ombud are:

   PO Box 74571,
   Lynnwood Ridge,
   0081

   Tel: (012) 470 9080
   Fax: (012) 348 3447

3. On submitting a claim to the Ombud you must satisfy the Ombud that you attempted to resolve the dispute with us and you must produce the final response (if any) as well as your reasons for disagreeing with our final response.

4. You may also refer an adverse decision by an insurer or the insurer's agent to the Ombud for Short-term Insurance [OSTI]. Such a complaint must be referred within 6 (six) months of receipt of the notification that your matter cannot be resolved (or a claim is finally repudiated).

   The address for the OSTI is:
   P O Box 32334
   Braamfontein
   2017

   Tel: (011) 7268900 or 0860 726890
   Email: info@osti.co.za

Failure to refer the matter to the OSTI may lead to the matter prescribing (meaning that if the matter isn't resolved with nine (9) months of repudiation) your claim against the insurer may prescribe. Referring a dispute to Brolink, the OSTI or the relevant insurer's internal Ombud will stay prescription. You should however take legal advice on your options in this regard and ensure that where you dispute a claim repudiation, your attorney has limited time within to issue summons in event of failure to resolve the dispute or complaint.