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COMPLAINTS RESOLUTION POLICY

1. Purpose of this policy:

We are a licensed Financial Services Provider with the authority to provide financial advice and intermediary services in terms of the Financial Advisory and Intermediary Services Act. As such we have certain specific duties to you, our clients.

One of these duties is to offer you a formal complaints resolution system, which will enable you to exercise your rights as provided for in the Financial Advisory and Intermediary Services Act. Effective management of customer complaints is a vital component of Treating Customers Fairly. The purpose of this document is to provide all staff and customers with a comprehensive understanding of how to deal with and lodge complaints in the most effective manner possible.

It is important to record all complaints to ensure that we learn from the outcomes when we analyse those complaints. This document recommends practical procedures and processes for reviewing and resolving customer complaints in a courteous, timely, effective and fair manner; standards of which are aligned to the Complaints Management Discussion Document which forms part of the TCF ('Treating Customers Fairly') Regulatory Framework. This document will be reviewed on an annual basis.

Effective management of customer complaints is key to supporting our aim in which dissatisfied customers can be transformed into advocates or loyal supporters of our business which ultimately builds trust and lasting relationship sustainability.

In line with the TCF principle aims, we strive to raise standards in the way we operate, by introducing changes that will benefit our customers and increase their confidence in our brand.

Complaints Management is a key component of TCF Outcome 6 which states that:

"Customers do not face unreasonable post-sale barriers imposed by firms to change product, switch providers, submit a claim or make a complaint."

This document serves as a guideline to achieve the following throughout the complaint management process:

- To understand what constitutes a complaint (regulatory definition) so that there is a consistent understanding across the FSP. This is especially important when capturing complaints onto the system
- To set consistent standards and requirements for us to implement internal complaints management processes, including record keeping, monitoring and analysis
- To thoroughly investigate the complaint
- To identify possible service breakdowns
- To ensure fair treatment of customers in line with the TCF principles
- To make informed decisions
- To ensure timely resolution
- To conduct root cause analysis
- To put forward and manage possible solutions through corrective action improvements
- To ensure that our complaints process is fair, transparent, accessible and visible to our customer

2. Policy Statement:

Viva Life is committed to providing its clients with quality service and undertakes to manage the affairs of its clients in such a way that it would not be necessary to have a complaint about our service, integrity and commitment. However, should it happen that a client does have a complaint, we undertake to:

2.1 Resolve client complaints in such a way that is fair to our clients, our FSP and our staff;
2.2 We undertake to inform all our clients of the procedures established for the internal resolution of their complaints, details of which will be given to them in writing;
2.3 We undertake to ensure easy access to our complaint resolution process at our offices. Complaints can be submitted by e-mail, telephone, HelloPeter portal and via the complaint's inbox portal.
2.4 The departments responsible for resolving complaints are the Policy Holder Services department (PHS) and Compliance department.
2.5 Empower and properly train our people to deal with complaints, as well as with the escalation of complaints;
2.6 If necessary, appoint an independent mediator to resolve the complaint to the benefit of both the client and our FSP;
2.7 Deal with complaints in a timely and fair manner, with every complaint receiving proper consideration in a process that is managed appropriately and effectively by the responsible staff member;
2.8 Offer appropriate remedy in all cases where a complaint is resolved in favour of a client;
2.9 Inform clients of their right to refer their complaints to the FAIS Ombud, should a complaint not be resolved to their satisfaction within six weeks from the date on which the complaint is received
2.10 Maintain records of all complaints received for a period of 5 years, which will specify the outcome of all the complaints lodged
2.11 If so required, implement follow-up procedures to:

2.11.1. Implement remedial actions to prevent similar complaints from occurring
2.11.2. Improve services and procedures where necessary by resolving the complaints within a reasonable time before the six-week period.

3. Definition of a complaint:

3.1. **"Complainant"**: is a person / someone acting on their behalf, who has a direct interest in the agreement, policy or service, and includes a –

- policyholder or their successor in title;
- beneficiary or their successor in title;
- person whose life is insured under a policy;
- person that pays a premium;
- member of a group scheme or; and
- potential policyholder or potential member of a group scheme - whose dissatisfaction relates to the relevant application, approach, solicitation, advertising or marketing material.

3.2. **"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.

3.3. **"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.

3.4. **"Compensation payment"**: to compensate a complainant for a proven or estimated financial loss incurred as a result of the insurer's wrongdoing - insurer accepts liability for having caused the loss concerned – excluding:

- goodwill payment;
- payment contractually due in terms of a policy; or
- refund of an amount which was not contractually due.

3.5. **"Goodwill payment"**: a payment (monetary or in the form of a benefit or service as an expression of goodwill aimed at resolving a complaint, where the insurer does not accept liability for any financial loss to the complainant.

3.6. **"Reportable complaint":** any complaint (as per the definition above) unless–

- upheld immediately by the person who initially received the complaint;
- 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
- 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.

3.7. **"Upheld"**: that a complaint has been finalised wholly or partially in favour of the complainant and –

- the complainant has explicitly accepted that the matter is fully resolved; or
- it is reasonable for the insurer to assume that the complainant has so accepted; and
- all undertakings made by the insurer to resolve the complaint have been met or the complainant has explicitly indicated its satisfaction with any arrangements.

4. Submitting your complaint:

PLEASE	THEN	OR
Give us a chance to resolve the matter. To ensure our focused attention, please use the following contact details: **Viva Life Head Office** Culross on Main, Building 3, 34 Culross Road, Bryanston, 2191 Call: 086 154 3326 Email: support@vivalife.co.za Fax: 086 559 9541	If complaints about our service are not resolved, we are accountable to the FAIS Ombud. Their contact details are as follows: **Office of the FAIS Ombud** P.O. Box 74571 Lynnwood Ridge 0040 Call: 0860 324 766 Email: info@faisombud.co.za Fax: +27 12 348 3447	If complaints about our products don't get resolved, we are also accountable to the Long-Term Insurance Ombud. Their contact details are: **Ombudsman for Long-Term Insurance** Private Bag x45 Claremont 7735 Call: 0860 103 236 Email: info@ombud.co.za Fax: +27 21 674 0951

Should you wish to lay a complaint with us please follow the procedure as outlined below:

If any of our representatives:

4.1 did not comply with the Financial Advisory and Intermediary Services Act and that you suffered financial prejudice as a result;
4.2 intentionally or negligently gave financial advice or rendered an intermediary service to you which caused prejudice or damage or is likely to cause damage;
4.3 treated you unfairly,

The Complaint must be submitted in writing and forwarded to our complaints department. Please include the following details with your complaint:

(a) Your name, surname and contact details;
(b) A complete description of your complaint;
(c) The name of the person who provided you with financial advice or an intermediary service;
(d) The date on which the matter complained about occurred;
(e) All documentation relating to your complaint;
(f) How you would prefer to receive communication from us regarding your complaint i.e. by e-mail, telephone, fax and post. Please provide us with the e-mail address, fax number or address where you would prefer to receive such communication.

5. Complaints System

The complaints system has been adapted to accommodate the requirements listed below from the FSCA. It is therefore crucial that this information forms part of the minimum requirements for capturing complaints from any source. The following information must be captured:

5.1. All relevant details of the complainant and the subject matter of the complaint, including copies of all relevant evidence, correspondence and decisions.

5.2. Appropriate TCF-aligned categorisation of complaints (to include the 9-minimum required categories)
Financial institutions should categorise, record and report on complaints by identifying the TCF Outcome category to which a complaint most closely relates and group complaints accordingly. Paragraphs 6.1 to 6.9 provide more detail on the minimum complaints categories required and set out examples of types of complaints which would typically fall under each category. For some of the TCF Outcomes (Outcomes 5 and 6), additional subcategories are proposed. There is, therefore, a total of nine minimum categories which should be used, wherever applicable.

5.3. Progress and status of the complaint, including whether such progress is within or outside any relevant prescribed timelines or internal service levels.

5.4. Details of numbers of complaints received, complaints upheld, rejected complaints, complaints escalated by complainants to the internal review function (where applicable), complaints referred to an Ombud, compensation payments and goodwill payments.

6. Complaints Categories

Below is a list of the main complaint reasons per value chain category to ensure accurate and aligned capturing. These complaint categories can then be condensed into the 9 complaint types, as prescribed by the FSCA:

6.1. Complaints relating to the design of a policy or related service, including the premiums or other fees or charges related to that policy or service e.g. Premiums too high, insufficient cover;

6.2. Complaints relating to information provided to policyholders e.g. incorrect inception date, no or poor response;

6.3. Complaints relating to advice;

6.4. Complaints relating to policy performance;

6.5. Complaints relating to service to policyholders, including complaints relating to premium collection or lapsing of policies;

6.6. Complaints relating to policy accessibility, changes or switches;

6.7. Complaints relating to complaints handling;

6.8. Complaints relating to insurance risk claims, including non-payment of claims; and

6.9. Other complaints.

7. TCF-aligned Complaint Categories

The categories for TCF outcomes are listed below with possible examples of the type of complaints that will form part of each category. These reasons are not fixed to a specific outcome and the outcome selected may differ according to the circumstances of the complaint e.g. ‘Inadequate cover type’ - this could be due to the design of the product or it could be a sales error where the incorrect cover level was sold or offered. The complaint system accommodates the manual capture of the outcome breached based on the complaint received. Often, more than one outcome is breached and therefore provision has been made to capture more than one outcome per complaint.

Examples of complaint reasons into the various TCF outcomes

Effective monitoring and analysis of complaints is a key tool to identify, manage and mitigate TCF-related and market conduct risks. Proper monitoring and analysis will maximise business value through the learnings created from analysis of complaint outcomes. The recording, monitoring and analysis process must provide for an adequate level of regular reporting to senior management levels.

Firms need to embed a qualitative and quantitative analysis which can be used to identify positive and negative trends for complaints received.

A standardized Monitoring and Analysis template has been developed so that there is consistency in complaints analysis. The template will be used to identify:

- Root cause analysis common to the categories of complaints
- Failings in control systems
- Detection of poor staff or service provider performance, lack of skills or misconduct
- Tracking of TCF delivery
- Identifying possible solutions

Risk management, internal audit and compliance functions will provide management reporting on the effectiveness and compliance with the requirements from the FSCA.

8. Reporting /Root Cause Analysis/Continuous Improvement

The FSCA are in the process of developing a more detailed proposal regarding regulatory complaints reporting which will be in a prescribed format. Proposed reporting templates are currently being considered by the FSCA.

The FSCA believes that the reputational impact of meaningful public disclosure can act as a deterrent to unfair customer treatment, and an incentive for companies to compete over the quality of the customer experiences they deliver. This could mean that Viva Cover will be required to report on our complaints in a public forum in a format prescribed by the FSCA.

The report will consist of the requirements given by the FSCA for all FSPs to abide by. In the interim, and to enable a more streamlined process for reporting, the central complaint system has been adjusted to ensure that the relevant fields are available for capture and reporting.

- For every complaint received, it is required that we do a root cause analysis to understand the reason for the complaint and put measures in place to mitigate these risks posed and generating the complaints.
- When recording complaints, Viva Cover may pick up trends for the same type of complaints or numerous complaints relating to a certain area of the business. Once the root cause analysis is done, any concerns raised, or risks identified will need to be corrected within the business. This is known as continuous improvement.
- There may be situations where we proactively identify gaps in our processes, systems, training or product without a customer lodging a complaint. This can follow the same process to highlight the risks and take action to remedy the situation.

9. Training

The requirements for complaint handling are guided by the FSCA Treating Customer Fairly Complaints Management Discussion Document. Employees attend regular TCF training sessions in order to maintain their awareness of the TCF outcomes and to ensure that the TCF principles are consistently applied in the day-to-day activities of the business.

10. Our Complaints Procedure

To ensure a quick and appropriate response to complaints, the following process has been implemented:

10.1. A complaint must be lodged in writing, stating clearly the reason for the complaint and any loss/damage suffered. Include any relevant supporting documentation (if any). The complaint can be submitted to us via e-mail, telephone, Live chat, PHS and HelloPeter portal and via the complaints inbox portal

10.2. On receipt of the complaint, the complaints department will acknowledge receipt to the complainant in writing within 3 (three) working days.

10.3. The complaint will then be forwarded to the relevant department to investigate the complaint to ascertain whetherthe complaint has merit and if deemed, a specific staff member will be assigned responsibility for the resolution of the complaint.

10.4 If further information is required, the staff member will request clarity or supporting (additional) documentation from the complainant.The request for information/clarity will also include the expected number of days to resolve the complaint following the receipt of the information/documentation and the name and contact details of the staff

10.5 Where additional information/documents have been requested from the complainant and the information is not forthcoming, a reminder has been sent in writing 5 (five) working days following the initial request.

10.6 Response to a complaint will be done within 21 (twenty-one) days, provided that all information required has been received and investigation has been completed. The maximum turn-around time for any complaint is 30 (thirty) days from receipt of the initial complaint, if all the necessary documentation and or information has been received. The complainant will be kept informed of the progress of the complaint on a regular basis.

10.7 Once the investigation is concluded the decision will be communicated by means of telephone and email stating all the facts and conclusion of the complaint to the complainant

10.8. In the case where the complainant is not fully satisfied with the conclusion of the complaint, an objection should be made either telephonically or in writing and additional information or documents, if any, should be provided. The objection will then be referred to the Head: Risk and Compliance for further investigation.

10.9 The Head will reinvestigate the complaint considering new documentation or information provided. The complaint will then be referred to the Risk and Compliance Committee who will perform a reassessment of the complaint and either endorse or denounce the conclusion. Detailed written correspondence on the conclusion of the investigation will be communicated to the complainant within 5 (five) working days of receipt of the objection with full details of the evidence at hand and the basis of the conclusion.

10.10 The Risk and Compliance Committee reserves the right to consult or refer the matter to the appropriate experts for further investigation. The complainant will be kept informed of all possible delays and the expected date of resolution.

10.11 If unable to resolve the complaint within 6 (six) weeks of logging the complaint in the Complaints Register or where Viva Life has been unable to resolve the complaint to the full satisfaction of the complainant, then the Head: Risk and Compliance will notify the complainant accordingly and advise the complainant of their right to:

10.11.1. Refer the complaint to the Ombudsman Office if the complaint wishes to pursue the matter; and
10.11.2. That the complainant should do so within 6 (six) months of receipt of such notification.