CEDAR HEALTHCARE (PTY) LTD

COMPLAINTS POLICY

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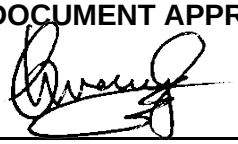
DOCUMENT INFORMATION

Document Version	2
Publishing Date	1 November 2021
Last Review Date	10 January 2023
Frequency of Review	Annually as and when required
Next Review Date	January 2024

DOCUMENT APPROVAL



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10 January 2023
Date

1. INTRODUCTION

Section 27(1) of The Financial Advisory and Intermediary Services Act 2002 (FAIS) deals with the receipt, prescription, jurisdiction and investigation of Complaints. Cedar Healthcare have the required systems and procedures in place for the purpose of timeous and efficient resolution of Complaints received within specified timeframes.

2. PURPOSE

This Policy defines what a Complaint is and sets out the procedures to be followed by Cedar Healthcare within prescribed timelines to ensure the effective resolution of a Complaint.

In terms of section 17(1)(a) of the General Code of Conduct for Authorised Financial Services Providers and Representatives ("the General Code of Conduct") a provider must establish, maintain and operate an adequate and effective complaints management framework, in order to ensure the effective resolution of complaints and the fair treatment of complainants.

Cedar Healthcare's complaints management framework is based on the following outcomes:

- Is proportionate to the nature, scale and complexity of the provider's business and risks;
- Is appropriate for the business model, policies, services, and clients of the provider;
- Enables complaints to be considered after taking reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of complainants;
- Does not impose unreasonable barriers to complainants; and
- Must address and provide for the matters as contained in Part XI of the General Code of Conduct.

In order to achieve the abovementioned outcomes, Cedar Healthcare has adopted a complaints policy which outlines the organisation's commitment towards the fair, transparent and effective resolution of complaints. The organisation will also ensure that the Complaints Management Framework is regularly reviewed in order to ensure the effectiveness of same.

3. DEFINITION OF A 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 –

(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 wilful 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.

4. DEFINITION OF A COMPLAINANT

Complainant means a person who submits a complaint and includes a –

(a) client;

(b) person nominated as the person in respect of whom a product supplier should meet financial product benefits or that persons' successor in title;

(c) person whose life is insured under a financial product that is an insurance policy;

(d) person that pays a premium or an investment amount in respect of a financial product;

(e) member;

(f) person whose dissatisfaction relates to the approach, solicitation marketing or advertising material or an advertisement in respect of a financial product, financial service or related service of the provider,

(g) person who has a direct interest in the agreement, financial product or financial service to which the complaint relates, or a person acting on behalf of a person referred to in (a) to (f);

5. DEFINITION OF A 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.

6. COMPENSATION PAYMENT

Compensation payment means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of a provider to a complainant to compensate the complainant for a proven or estimated financial loss incurred as a result of the provider's contravention, non-compliance, action, failure to act, or unfair treatment forming the basis of the complaint, where the provider accepts liability for having caused the loss concerned, but excludes any –

(a) goodwill payment;

(b) payment contractually due to the complainant in terms of the financial product or financial service concerned; or

(c) refund of an amount paid by or on behalf of the complainant to the provider where such payment was not contractually due;

(d) and includes any interest on late payment of any amount referred to in (b) or (c);

7. GOODWILL PAYMENT

Goodwill payment means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of a provider to a complainant as an expression of goodwill aimed at resolving a complaint, where the provider does not accept liability for any financial loss to the complainant as a result of the matter complained about**.**

8. MEMBER

Member in relation to a complainant means a member of a –

(a) pension fund as defined in section 1 (1) of the Pension Funds Act, 1956 (Act 52 of 1956);

(b) friendly society as defined in section 1 (1) of the Friendly Societies Act, 1956 (Act 25 of 1956);

(c) medical scheme as defined in section 1(1) of the Medical Schemes Act, 1998(Act131 of 1998); or

(d) group scheme as contemplated in the Policyholder Protection Rules made under section 62 of the Long- term Insurance Act, 1998, and section 55 of the Short-term Insurance Act, 1998

9. REJECTED

Rejected in relation to a complaint means that a complaint has not been upheld and the provider regards the complaint as finalised after advising the complainant that it does not intend to take any further action to resolve the complaint and includes complaints regarded by the provider as unjustified or invalid, or where the complainant does not accept or respond to the provider's proposals to resolve the complaint.

10. REPORTABLE COMPLAINT

Reportable complaint means any complaint other than a complaint that has been –

(a) upheld immediately by the person who initially received the complaint;

(b) upheld within the provider's ordinary processes for handling client queries in relation to the type of financial product or financial service complained about, provided that such process does not take more than five business days from the date the complaint is received; or

(c) submitted to or brought to the attention of the provider in such a manner that the provider does not have a reasonable opportunity to record such details of the complaint as may be prescribed in relation to reportable complaints.

11. UPHELD COMPLAINT

Upheld means that a complaint has been finalised wholly or partially in favour of the complainant and that:

(a) the complainant has explicitly accepted that the matter is fully resolved; or

(b) it is reasonable for the provider to assume that the complainant has so accepted; and

(c) all undertakings made by the provider to resolve the complaint have been met or the complainant has explicitly indicated its satisfaction with any arrangements to ensure such undertakings will be met by the provider within a time acceptable to the complainant

12. INTERNAL COMPLAINTS REVIEW AND ESCALATION PROCESS

Internal Complaints Review and Escalation Process means the system and procedures established and maintained by Cedar Healthcare in accordance with the General Code of Conduct for the resolution of reportable complaints lodged against Cedar Healthcare by complainants.

13. ESTABLISHING A COMPLAINTS MANAGEMENT FRAMEWORK

The organisation is committed towards rendering financial services with the proper due skill, care and diligence and in the best interests of its clients.

Despite the organisation's high service standards there may be instances where a client nevertheless prefers to submit a formal complaint against the organisation. In such instances the organisation will follow the complaints management framework.

14. COMPLAINTS HANDLING PROCESS

The following processes will be followed by Cedar Healthcare when dealing with Complaints:

- Log the date and contents of the complaint in the Complaints Register.
- If a complaint is not in writing, ask the client to lodge the complaint in writing as per example in Annexure A (Complaints registration form).
- Acknowledge receipt of the complaint in writing within 5 days of receipt and give the client the name(s) and contact details of the staff responsible for the resolution of the Complaint.
- Investigate the complaint to ascertain whether the Complaint can be resolved immediately.
- If the Complaint can be resolved immediately, take the necessary action and advise the client accordingly in writing.
- If the Complaint cannot be resolved immediately, send the client a written summary of the steps to be taken to resolve the matter and the expected date of resolution.
- If unable to resolve the Complaint within 3 weeks of logging the Complaint with the Complaints Register, notify the client by means of a written acknowledgement. This will outline the current status of the Complaint and the expected date of final resolution.
- If unable to resolve the complaint within a further 3 weeks of the written acknowledgement (6 weeks since complaint logged), notify the client giving full written reasons as to why the outcome was not favourable, and advise the client of their right to seek legal redress by referring the Complaint to the Office of the Ombudsman.
- Notify the client that he/she has 6 months of receipt of such notification to refer the matter to the FAIS Ombud. The Ombud's name, address and other contact details must be provided.
- Update the Complaints register with all developments/activities.

15. ALLOCATION OF RESPONSIBILITIES

- The board of directors of Cedar Healthcare is responsible for effective complaints management;

- The board of directors will therefore oversee and approve the effectiveness and implementation of Cedar Healthcare's complaints management framework.

16. RESPONSIBLE AND ADEQUATE DECISION MAKING

Any person in the organisation that is responsible for making decisions or recommendations in respect of complaints generally or a specific complaint must –

- Be adequately trained;

- Have an appropriate mix of experience, knowledge and skills in complaints handling, fair treatment of customers, the subject matter of the complaints concerned and relevant legal and regulatory matters

- Not be subject to a conflict of interest; and

- Be adequately empowered to make impartial decisions or recommendations.

17. CATEGORISATION OF COMPLAINTS

Cedar Healthcare categorises reportable complaints in accordance with the following nine categories:

- Complaints relating to the design of a financial product, financial service or related service, including the fees, premiums or other charges related to that financial product or financial service;

- Complaints relating to information provided to clients;

- Complaints relating to advice;

- Complaints relating to financial product or financial service performance;

- Complaints relating to service to clients, including complaints relating to premium or investment contribution collecting or lapsing of a financial product;

- Complaints relating to financial product accessibility, changes or switches, including complaints relating to redemptions of investments;

- Complaints relating to complaints handling;

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

- Other Complaints.

Where Cedar Healthcare considers it necessary to add additional categories relevant to its financial products and / or services, it will do so in order to support the effectiveness of the organisation's complaints management framework, and by doing so enhancing improved outcomes and processes for its clients.

18. INTERNAL COMPLAINT ESCALATION AND REVIEW PROCESS

Through the adoption of this policy, Cedar Healthcare establishes an appropriate internal complaints escalation and review process and the organisation is committed to ensuring that the procedures within the complaints escalation and review process is not overly complicated and does not impose unduly burdensome paperwork or other administrative requirements on complainants.

The internal complaint escalation and review process:

- follows a balanced approach, which bears in mind the legitimate interests of all parties involved, including the fair treatment of complainants;

- provides for the internal escalation of complex or unusual complaints at the request of the initial complaint handler;

- provides for complainants to escalate complaints not resolved to their satisfaction.

19. DECISION RELATING TO COMPLAINTS

Where a complaint is upheld, any commitment by the organisation to make a compensation payment, goodwill payment or to take any other action must at all times be carried out without undue delay and within the agreed timeframes.

Where a complaint is rejected, the organisation will provide the complainant with clear and adequate reasons for the decision and will also inform the complainant of the organisation's escalation or review process.

20. ENGAGEMENT WITH THE OMBUD AND REPORTING

- Cedar Healthcare is committed to transparent engagement with any relevant Ombud in relation to its complaints;

- In light of the above, Cedar Healthcare will monitor determinations, publications and guidance issued by any relevant Ombud with a view to identifying failings or risks in the organisation's policies, services or practices;

- Cedar Healthcare will maintain open and honest communication and co-operation between itself and any Ombud with which it deals;

- Cedar Healthcare is also committed to resolving a complaint before a final determination or ruling is made by an Ombud, or through the organisation's internal escalation process, without impeding or unduly delaying a complainant's access to an Ombud;

- Cedar Healthcare will ensure that it has the appropriate processes in place to ensure compliance with any prescribed requirements for reporting complaints related information to any designated authority, or to the public as may be required by the Regulator.

21. COMPLAINTS REGISTER

Cedar Healthcare's complaints register will contain the following fields:

Received	This field will reflect the date on which the letter was received
The receipt period starts its calculation here	
Date captured	The date of the day on which the complaint is captured
Received from	The name and designation of the person that submitted the complaint must be entered here
It may be a client or a client's representative	
Complaint reference number	This field contains the clients' reference number linked to an internal system
Client surname and initials	Enter the surname of the client making the complaint
Complaint description / type	Short summary of the complaint
Captured by	The name of the person who captured the complaint
Responsible person internally	Who will deal with the complaint and ensure that it is resolved
Activity update	Log all developments and movements
Outcome of complaint	Summary of what decisions was taken

Date of final communication to client	Date of letter to the client
Compliance officer final sign off	Designated compliance officer to sign off a complaint as finalised
Learnings	This is a field where any possible lessons learned from the handling from this complaint can be entered

22. NON-COMPLIANCE

Any form of Non-compliance with this policy will be seen as a serious form of misconduct, which may lead to disciplinary action and possible dismissal.

ANEXURE A

Complaints Registration Form

Client details:

Surname:		Title:	
First Name(s):			
Occupation:			
Identity Number:			
Address/Email to which wemay communicate with you:			
Telephone (daytime)		Cell:	

Details of the person/s against whom you are complaining:

Name of Person:	
Position/Role e.g. Advisor/Admin	

Details about the product of service relevant to your complaint:

Financial product Insurance/Retirement/Investment/Deposit etc.	
Reference/Account no	
Brief description of the complaint	
When did you first realise the problem	
Did you complain before? Give date and name of person	
Provide full details about the complaint or attach a letter providing the following: List in date order the phone calls meetings, or letters youhave received or exchanged with the person against whom you are complaining.	
Reference of documents attached e.g. Annexures A, B etc. with description	

Client name and signature	
Date signed	