IN THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS

PRETORIA **CASE NO: FAIS 06695/13-14/ WC 1**

In the matter between:

DE HOOP STEENWERWE (PTY) LTD **Complainant**

and

FINMAR MAKELAARS (PTY) LTD **First Respondent**

HERMAN JACOBUS MARAIS **Second Respondent**

GUILLUAME FRANCOIS MARAIS **Third Respondent**

DETERMINATION IN TERMS OF SECTION 28(1) OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICES ACT 37 OF 2002 ('FAIS Act')

A. INTRODUCTION

[1] This complaint centres on a failure by the financial services provider to update the sum insured under the business interruption section of Complainant's short term insurance policy.

[2] Following an insured event, Complainant was deemed by its insurer, Santam, to be underinsured.

[3] Santam then applied an average condition to the claim. This resulted in the policy paying out less than it would have had Complainant been insured for the correct amount.

[4] To explain it simply, average reduces the claim pay-out by the percentage by which the insured is underinsured.

[5] Complainant is claiming the difference between what was paid and what should have been paid, had it not been for Respondents' negligence.

B. THE PARTIES

[6] Complainant is De Hoop Steenwerwe (PTY) LTD, a private company registered in accordance with the laws of South Africa with its registered business address being De Hoop Steen Pad, Daljosafat, 7646. Complainant is represented by its director, Mr Enslin Kotze.

[7] First respondent is Finmar Makelaars (Pty) Ltd, a private company duly registered in accordance with the laws of South Africa with its registered business address being 519 Main Street, Paarl, 7646. First respondent was at all relevant times a licensed Financial Services Provider (FSP nr:221).

[8] Second respondent is Herman Jacobus Marais, a key individual and director of the First respondent who resides at 701 Boschenmeer Estate, Paarl, Western Cape.

[9] Third respondent is Guilluame Francois Marais a key individual and director of the First respondent who resides at 903 Boschenmeer Estate, Paarl, Western

Cape.

[10] Respondent or Respondents must be read to mean the same person in this determination.

C. THE COMPLAINT

[11] The complaint is as follows:

11.1. Following a machinery breakdown which occurred on the 30th September 2013, Complainant submitted a claim in terms of its 'Machinery Breakdown' policy.

11.2. The claim which was in respect of business interruption had been reduced from R427 370.75 to R98 600.19. This is as a result of average being applied by the insurer

11.3. The insurer is Santam Limited, the policy itself being managed by Mirabilis Engineering Underwriting Managers (Pty) Ltd, in terms of an underwriting manager's agreement with Santam Limited.

11.4. The reduction of the claimed amount as a result of average was due to Respondent having failed to update the sum insured.

11.5. Complainant's 'Annual Gross Profit' and therefore, the 'SUM INSURED' was set at R4 112 500 whilst the insurer determined this amount to be R17 825 139.24.

11.6. The insurer thus applied the following calculation:

$$\frac{\text{Sum Insured } R4\,112\,500.00}{} \times \frac{\text{Claim } R427\,370.75}{}$$

= R98 600.19

Insurable Gross Profit R17 825 139.24 1

11.7. Prior to this, and on the 13th February 2013, Complainant had submitted to Respondent, its calculation of loss of income, with the request that Respondent confirm with the insurers that the method of calculation was correct. In support of this calculation Complainant included an extract from its financial statements.

11.8. Complainant's calculations indicated an insured amount of R17 500 000.

11.9. Wishing to finalise the matter, Complainant followed up on the 21st February 2013 when it enquired from Respondent as to whether any conclusion had been reached on the calculation.

11.10. On the 25th May 2013 and not having had any reply as to the gross profit calculation, Complainant again communicated with Respondent. Loosely translated, this reads as follows:

> *'Hello Hesmarie*
>
> *I cannot remember if I instructed you to adjust the insured value for the loss of income. It must be adjusted to the amounts as set out in the attached document.*
>
> *The banking details of the De Hoop steenwerwe and farm as well as the loss of income policies must be changed. The new bank information is attached hereto ….'*

11.11. The bank account details were duly amended; but not the gross profit sum insured, which remained at R4 112 500.

11.12. This contrasted with another of Complainant's policies, an Etana Business Policy with Etana Insurance Company Limited a policy schedule whereof dated the 6th September 2013 reflects the gross profit as R17 500 000.

11.13. This amount is reaffirmed in the Etana policy summary letter, which Respondent sent to Complainant on the 17th September 2013.

11.14. I point out that whilst the Etana policy also contained a business interruption section, the insured events under which it would have paid out differed from that of the Santam policy.

11.15. With the Etana policy having been amended to reflect the gross profit amount of R17 500 000 as first conveyed in Complainant's email of the 13th February 2013, whilst the Santam policy remained at the old amount, it is Complainant's contention that Respondents failure to update both policies indicates negligence on its part.

11.16. It is this negligence that led to Complainant being underinsured, in consequence whereof average was applied by the insurer.

11.17. Accordingly, Complainant claims the difference between the two amounts and bases its claim on Respondent's failure to confirm its method of calculation with the insurers.

11.18. In other words, had Respondent done as requested and verified the insured amount with the insurer, there would have been no basis for the

insurer to apply average, so argues Complainant,

11.19. Complainant therefore claims the difference between the amount that would have paid out but for it being underinsured, and the amount it actually received.

D. RESPONDENTS' REPLY

[12] The complaint having been submitted to Respondent, could not be resolved, hence a formal notice in terms of section 27(4) of the FAIS Act was forwarded to Respondent. The notice invited Respondent's statement in response to the complaint along with all documents and any other material that may support Respondent's case.

[13] Respondents attention was also drawn therein, to inter alia the following requirements of the FAIS Act:

13.1. The requirement of section 8 (1), namely the necessity to take reasonable steps to seek from the client appropriate and available information regarding the client's financial situation, financial product experience and objectives to enable the provider to provide the client with appropriate advice.

13.2. With respect to section 8 (1), It was pointed out that Complainant alleges that Respondent had failed to ensure that Complainant was adequately covered under the business interruption section of the policy.

13.3. Section 7(1) (c) (vii) of the Code. This requires that the provider make full and frank disclosure of any information that would reasonably be

expected to enable the client to make an informed decision.

13.4. Section 3(1) (d) of the Code requires that the client's instructions be dealt with as soon as reasonably possible.

[14] In response thereto Respondent stated as follows:

14.1. Complainant became its client on 13th August 2012. At this point there were two policies; these being with Santam and Mirabilis respectively;

14.2. Respondent conducted a thorough investigation into these policies. The cover being discussed with Complainant in great detail;

14.3. *'At this point we changed the policy of Santam to Etana (normal Business Policy) but kept the Mirabilis policy (Machinery Breakdown) in place. The policies were discussed in detail and Hesmarie Fourie discussed the principle of average with client. He was not interested to increase the Machinery Breakdown Consequential Loss simply because of the cost involved. At that stage the amount insured under Business Interruption under the Mirabilis policy was R4.2m and the additional cost would have been R4 138.98 which would have increased the insurance premiums by 425%. As De Hoop was very sensitive about premiums this was not done.'*

14.4. In support thereof Respondent points to an email dated the 15th August wherein it advises Complainant that the only way to prevent average being applied to the machinery breakdown policy, was to insure each machine for its new replacement cost. This required a replacement quotation for each machine. Respondent states that Complainant failed

to act on this advice;

14.5. I note that the email of the 15th August makes no mention of the insured amount under business interruption.

14.6. Respondent contends that whilst the business policy sum insured was increased steadily over the years, this was not the case with the machinery breakdown policy which had remained at R4.2m since 2005.

14.7. Respondent argues that this is not uncommon, given that the machinery breakdown policy focuses more on damage to machines which in many cases can be repaired quickly with minimum downtime. Respondent stresses that the danger of average was pointed out to Complainant;

14.8. As for Complainant's email of the 27th May 2013, Respondent contends that this followed a discussion about the Etana policy. Adverse business conditions had caused a fall in profits and this email was a follow up of a discussion between Hesmarie Fourie and Complainant. In this regard, Respondent also replied thereto on the 14th June 2013; attaching an Etana policy schedule and advising Complainant that the loss of income had been adjusted.

14.9. Complainant then replied to Respondents' email of the 14th June 2013, indicating that aside from a car that had to be removed at an earlier date they were happy.

14.10. Respondent again followed up on the 27th June 2013, when Respondent sent the Mirabilis machinery breakdown renewal schedule.

In so doing Respondent advised Complainant that Mirabilis required the turnover for the previous year as well as the projected turnover for the following year. Complainant was also advised to both check the insured values and advise Respondent of any changes in risk. The risks of average were also pointed out.

14.11. As no reply was received to the communication of the 27th June 2013, Respondent followed up on the 15th July 2013 with a reminder.

14.12. The policy was then renewed without any changes. In view of all of the above, Complainant knew exactly what they were covered for as well as the danger which underinsurance posed. Respondent further states that it was clear that the main purpose of the Mirabilis policy was to cover the machinery itself.

D. DETERMINATION

[15] In dealing with this matter I am continuously drawn back to the simple inescapable fact that the insured amount under the Santam/Mirabilis policy was wrong.

[16] That it may have been wrong when Respondent took over the role of financial adviser is no excuse for it was at that point that Respondent should '*take reasonable steps to seek from the client appropriate and available information regarding the client's financial situation, financial product experience and*

objectives to enable the provider to provide the client with appropriate advice'[1].

[17] Respondent was then required to analyse this information and identify the financial products appropriate to the client's needs[2].

[18] The advice provided in terms of section 8 must then be recorded as required by section 9 (1) of the Code.

[19] As part of this process, with business interruption forming a component of both polices, one would expect the manner and method of calculation of the sum insured, be verified and the discussion recorded as part of the record. These were after all business policies.

[20] The substantial difference in the insured amounts between the Mirabilis and the Etana policies should have been an immediate red flag. This difference has such material implications that I would expect to see some record relating thereto. There is none.

[21] It must be remembered that the duty rested on Respondent to take; '*reasonable steps to ensure that the client understand the advice and that the client is in a position to make an informed decision.'*[3]

[22] This would include '***concise details*** *(*my emphasis) *of any special terms or conditions, exclusions of liability, waiting periods, loadings, penalties, excesses, restrictions or circumstances in which benefits will not be provided.'*[4]

[23] In instances where Respondent was aware that an amount was incorrect it had

1 Section 8 (1) (a) of the Code
2 Section 8 (1) (b) and (c) of the Code
3 Section 8 (1) (2) of the Code.
4 Section 7 (1) (c) (vii) of the Code

a duty to specifically point out the implications thereof.

[24] Respondent contends that Complainant was not interested in increasing the machinery breakdown consequential loss because of the cost of the additional premiums. If so, why was this advice not recorded when section 8(4) (b) of the Code requires that where a client?

'elects to conclude a transaction that differs from that recommended by the provider, or otherwise elects not to follow the advice furnished .....the provider must alert the client as soon as reasonably possible of the clear existence of any risk to the client, and must advise the client to take particular care to consider whether any product selected is appropriate to the client's needs, objectives and circumstances.'

[25] It must also be remembered that as a requirement of section 7 (1) (d) (i) and (iii) of the Code Respondent had a duty to inform a client; '*that all material facts must be accurately and properly disclosed...*' and '*of the possible consequences of the mis-representation or non-disclosure of a material fact or the inclusion of incorrect information...*'

[26] Why then would Respondent knowingly be party to an incorrect disclosure without fully disclosing, discussing and recording the purpose and understanding thereof?

[27] Respondent stood to gain nothing from it, on the contrary it placed itself at risk. Yet nowhere is there any record of any aspect thereof being discussed. The complete lack of any reference to what is a substantial difference in the insured amount makes it highly probable that this never formed part of the

discussion between Complainant and Respondent.

[28] Even if this was missed a second opportunity presented itself with Complainant's email in February of 2013. Now assuming the veracity of Respondents version, namely that this arose out of a discussion pertaining to the Etana policy, it still begs the question as to why, once again Respondent failed to revisit the insured amount under the Mirabilis policy.

[29] It is rather prophetic that the aforementioned email contained the following statement:

> *'Would you please confirm with the insurers that my method of calculation is correct so that on the day that a claim arises we do not become angry with each other.'* (translated from Afrikaans)

[30] Now Respondents' argument that Complainant had ample opportunity to go through the policy schedule on the Mirabilis policy misses the point that the obligation is not on Complainant to act as a safety net where the very problem arises out of Respondents' failure to comply with the requirements of the Code.

[31] That Complainant failed to note that the amount had not been updated on the Mirabilis policy renewal schedule in no way alters the root cause of the problem. This being Respondent's initial failure to ensure that Complainant was correctly insured and then later the failure to verify with the insurers as requested, the correctness of Complainant's calculations and then update the policies.

[32] Complainant in turn argues that the instruction is unambiguous and, in no way

can it be restricted to the Etana policy. This argument is not without merit in that nothing within the communications between the parties appears to clarify that this instruction only pertained to the one policy. Had this indeed been the case I would have expected that this be clear from the communications. Section 3 (1) (a) (ii) of the Code requires that representations made and information provided to the client; '*be provided in plain language, avoid uncertainty and not be misleading.*'

[33] Now prior to concluding this part of the determination, and moving onto the issue of quantum I return to my opening statement, namely, the simple inescapable fact that the insured amount under the Mirabilis policy was wrong.

[34] Whilst Respondent has attempted to explain this discrepancy there are no records which would support Respondents' version. Aside from the previously mentioned section 9 of the Code which deals with the record of advice, we also have section 3 (2) (a) (i) of the Code which requires that; '*a provider must have appropriate procedures and systems in place to record such verbal and written communications relating to a financial service rendered to a client as are contemplated in the Act …*'

[35] '(ii) store and retrieve such records and any other material documentation relating to a client or financial service rendered to a client.'

[36] In the absence of said records, Respondents' defence is unsustainable.

[37] Hence, and for the reasons already elucidated I find in favour of Complainant. It remains for me to determine quantum.

F. QUANTUM

[59] Complainant claimed the amount of R427 370.75 in terms of the business interruption section of the Mirabilis policy.

[60] The claim was then reduced to R98 600.19 as a result of average having been applied.

[61] Complainant argues that Respondent as the financial adviser had a responsibility to ensure that the insured amount was correct. They point out that they had requested that the amount be confirmed with the insurer.

[62] Had this been the case there would have been no basis to apply average. The full insured amount would then have been paid out and not just the R98 600.19.

[63] One must of course factor in the additional premiums that would have been paid by Complainant on the increased cover, which savings must then be deducted from the claim.

[64] To apply said premium increases only from the date that the one policy was adjusted would be to ignore the fact that the root cause of this problem stems from the failure to ascertain and advise as to the correct amount right at the very inception of Respondents' dealings with Complainant. This being in August of 2012.

[65] It would therefore not be unreasonable to deem the 1st September 2012 as a reasonable start date for the correctly insured amount.

[66] The calculation then being as follows:

66.1 Rate .371% (as advised by the insurer)

66.2 1/09/2012 – 30/09/2013 = 395 days

66.3 Difference in the Insured Amount: R17 825 139.24[5] –

5 The insured amount which the insurer deemed to be correct.

R4 112 500[6]

66.4 = R13 712 639.24 @ .371%

66.5 (R50 873.89 / 365) x 395 days

66.6 = R55 055.31 (being total additional premiums had the Insured Amount been increased to R17 825 139.24 as at 1/09/2012).

[67] The claim amount therefore being the original claim of R427 370.75 less the R98 600.19 already paid out. This amounts to R328 770.56.

[68] From this we must then deduct additional premiums in the amount of R55 055.31.

[69] The adjusted claim amount becomes R273 715.25.

G. ORDER

[71] Accordingly the following order is made:

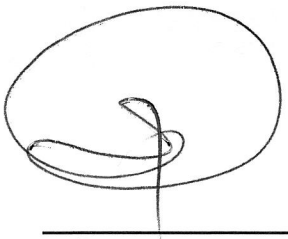
1. The complaint is upheld;

2. The Respondents are hereby ordered, jointly and severally, the one paying the other to be absolved, to pay to Complainant the amount of R273 715.25.

3. Interest at the rate of 9 %, per annum, seven (7) days from date of this order to date of final payment.

DATED AT PRETORIA ON THIS THE 18TH DAY OF DECEMBER 2015.

6 The amount for which the complainant was actually insured.



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