IN THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS

PRETORIA

Case Number: FSOS 00308/11-12/ KZN 3

In the case between:

ANGELINE NOMBUSO KHOZA **Complainant**

and

BENSURE MANAGEMENT SERVICES **Respondent**

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

A. THE PARTIES

[1] The complainant is Angeline Nombuso Khoza, an adult female whose address is given as P O Box 60969 Phoenix 4080 ("the complainant").

[2] The Respondent is Bensure Management Services which represents the underwriters of the policy in question herein and who are Bensure Insurance Underwriters Ltd, FSP no 26/10/4353 of 399 Main Avenue Ferndale Randburg 2194 ("the respondent").

B. WORKERS LIFE

[3] Workers Life Insurance Ltd (Workers Life) is a registered financial services provider with registration number being FSP4353 and which was authorised on the 25th May 2005. In May 2009 Workers Life acquired the entire share capital of Bensure Insurance Underwriters. Accordingly Workers Life acknowledged, in writing, that post such acquisition it became responsible for Bensure's obligations towards its policy holders including any outstanding claims. The insured event, relevant to this complaint, occurred on the 9th January 2010, after Workers Life acquired Bensure.

[4] The claim as well as the repudiation thereof took place after Workers Life acquired Bensure. All correspondence since the claim was made was directed to Bensure after the latter was acquired by Workers Life. Complainant was not aware that Bensure had been acquired by Workers Life. This Office, initially, directed correspondence and notices to Bensure and was also not aware of the acquisition. A response was however received in respect of all correspondence and notices from administrative services employed by Workers Life.

C. JURISDICTION

[5] Complainant initially filed a complaint with the Ombud for Short Term Insurance, (OSTI). OSTI was unable to make progress, mainly because they were unable to get a response from the respondent. They then referred the matter to this Office in terms of the Financial Services Ombud Schemes Act no 37 of 2004. Respondent (in particular, Workers Life) initially questioned this offices jurisdiction to deal with

the matter. After referring respondent to the FSOS Act, no objections regarding jurisdiction were made. There is no dispute over the jurisdiction of this Office to deal with the matter.

D. FACTUAL BACKGROUND

[6] Complainant entered into a written contract of insurance with respondent on or about the 25th March 2009. The policy number is JT00010689 and the insurance policy is known as "Journey Traveller ER" (the policy). The policy was duly issued and complainant began paying her monthly premium. In broad terms, as stated by complainant, the policy provided cover if complainant was involved in an accident and admitted to hospital through the casualty or trauma ward and remained in hospital for more than 24 hours. Complainant points out that she commutes to work, using taxis, and believed she needed such cover.

[7] On the 9th January 2010 complainant was involved in an accident. She was traveling in a taxi when it rolled over. The accident was a very serious one. Two fellow passengers died on the scene and complainant was trapped in the wreckage for almost an hour. She was in pain and had to wait for the fire department to arrive. The police and paramedics were unable to remove her from the taxi, the fire fighters succeeded in cutting her out of the wreck with specialised equipment. Exactly what caused the accident is not relevant to this determination. However, a comprehensive police report was made available to the respondent. Certainly there is no allegation that complainant's negligence was the cause of the accident.

[8] From the scene of the accident complainant was taken to Kingsway Hospital in Amanzimtoti. She was duly admitted and spent 4 days in hospital, complainant was discharged on the 13th January 2010.

[9] On the 23rd February 2010 complainant filled out a claim form and submitted it to respondent. On the 13th April 2010 respondent, in writing, rejected complainant's claim. The letter states:

"We regret to inform you that your claim has been repudiated.

According to hospital reports you were admitted for observation and cannot be deemed as life-threatening."

Despite further representations by complainant, respondent refused to pay the claim and stood by its repudiation.

E. THE ISSUE

[10] There is no dispute that:

a) On the 9th January 2010 there was a valid contract of insurance between respondent and complainant;

b) On the 9th January 2010, complainant had complied with her obligations in terms of the contract;

c) On the 9th January 2010, an insured event took place and complainant made a claim against the policy; and

d) On the 13th April 2010, respondent rejected the claim.

[11] The issue is whether or not, bearing in mind the terms of the contract of insurance and the surrounding circumstances of the claim, respondent was justified in rejecting the claim.

[12] According to complainant, she was involved in an accident where she almost lost her life. This is precisely the event against which she took out insurance cover and the respondent had treated her "unfairly" in repudiating the claim. She requires payment of her claim in full, in the amount of R30 000 – 00.

F. SETTLEMENT

[13] In keeping with the procedures of this Office and in terms of the Act, this Office requested the parties to make an attempt at settling the dispute. On the 21st September 2015 Workers Life made an offer to pay complainant R15 000 – 00 without any admission of liability. This offer was rejected by complainant. On the 9th October 2015 Workers Life increased their offer to R20 000 – 00. This too was rejected and the matter was then referred for determination.

G. THE CONTRACT

[14] Prior to entering into the policy, respondent made certain representations to the complainant regarding the proposed cover to be provided. The representations were made in writing and which representations were accepted by complainant as true. The representations described the benefits of this policy, *inter alia,* as follows: "*Journey is a portfolio of offerings designed to support the individual from their earliest requirements to their most complex of their needs as their lives change*

and evolve throughout their future. A journey starts with a small step that is, in this case, Traveller.

The benefits provided are described as:-

Traveller-ER

Health insurance providing catastrophe cover for serious illness and accidents."

In a further document, the following representation is made:

*"Traveller-ER provides you with **R5 000** immediately in the event of a critical health incident. A critical incident entails admission to any hospital via the emergency/trauma unit for a period of 24 hours or more. This policy covers illness and trauma."*

The policy promised a benefit of up to R30 000.

Complainant chose the policy and contracted for the full benefit of R30 000.

[15] Complainant accepted the above representations and entered into the policy which was duly issued under policy number JT00010689. A certificate of membership was issued to complainant which confirmed that she had selected the "Journey Traveller ER" option which provides cover in the amount of R30 000. The premium was R112 per month.

[16] Upon taking the policy, complainant received a document setting out the terms and conditions applicable. This document is titled "*Traveller-ER Rules"* and the following terms are relevant to this determination:

*"**2.1 Underwriter:** The underwriter is Bensure Insurance Underwriters Ltd (BIU).*

2.2 Accident: *Accident means an unexpected event which leads to the insured requiring an emergency admission into a hospital for the purpose of a medical or surgical procedure.*

2.3 Insured Event: *An insured event is an unexpected illness, disease or accident suffered by the Insured, which results in the insured being admitted to a hospital via an emergency unit and having to spend a minimum of 24 consecutive hours in hospital as a result of that emergency event.*

3.2 *The underwriter undertakes to pay a fixed amount, as specified on the application form accepted by the insurer, to the insured, on the occurrence of an insured event.*

5.3 Amendment of Policy: *Notwithstanding anything to the contrary herein, BIU reserves the right, by giving the insured at least four months written notice, to amend this policy at any time in whole or in part.*

BIU and the insured may agree to amend this policy at any other time or times than already provided herein."

H. AMENDMENT TO POLICY

[17] Of significance to this determination is respondent's claim that the terms of the policy were amended and in terms of the amended policy, respondent was entitled to reject the claim. Respondent delivered a copy of the policy "as amended" to this Office. The relevant changes are the ones made to the definition of "***Accident****" and "**Insured Event**".* According to this document the following definitions appear:

*"**2.2 Accident:** Accident means an unexpected acute life-threatening event, which leads to the Insured requiring an emergency admission into a hospital for the purpose of a medical or surgical procedure (this does not include observation/s).*

*"**2.6 Insured Event:** An insured event is an unexpected acute, life-threatening event, illness, disease or accident suffered by the Insured, which results in the Insured being admitted to a hospital via an emergency/trauma unit and being required to spend a minimum of three consecutive days in a high care or ICU ward, or in a general ward in conjunction with emergency theatre time, as a result of such event.*"

These definitions represent a substantial amendment to material terms of the policy document handed to complainant. The amended document is not merely an "updated" version as respondent described it. It is also these amended definitions that laid the basis for respondent's rejection of complainant's claim.

[18] According to respondent the complainant did not meet the criteria set out in the policy for her to make a claim. The respondent states that the complainant did not suffer a "life-threatening" event as she suffered soft tissue damage and was admitted to the ward for purposes of observation.

In a letter to this Office, Zenith Administration Services, on behalf of respondent, stated as follows:

"*The complainant did not meet the criteria of the terms and conditions of the policy as she sustained soft tissue damage and was admitted to hospital for observation. This cannot be classified as life threatening and <u>all updates of policy terms and conditions were communicated to the complainant".</u>* (Emphasis added)

[19] On their own version, respondent relies on the terms and conditions of an "updated" or amended contact of insurance. The claim itself is based on the policy documents as received by complainant when she entered into the contract of insurance. According to complainant this is the only document she received and no notice of amendment and/or amended policy was delivered to her. There can be no doubt that the amendments relied on by respondent are material amendments and cannot be effected unless "*at least four months written notice"* was given to the insured. This is a term of the contract.

[20] This Office inquired about the effectiveness of the amendment and respondent was called upon to state when and how notice of the amendment was conveyed to the complainant. To this request the respondent provided an extremely vague and unhelpful response. In a letter dated 14th April 2014, respondent states as follows:

"The updated terms and conditions are communicated via the South African postal service, and were sent to the complainant prior to 2010. Please take notice that it is up to complainant to inform us of any change of personal information, such as address."

[21] This Office has a number of difficulties with the respondent's response to this crucial inquiry; they are:

a) The duty is on the insurer to give at least four months written notice of any material amendment;

b) According to the Act and the General code of conduct for FSPs, the insurer is obliged to keep the insured informed of material changes to the policy so that the insured may make an informed decision as to whether or not to accept the amendments and continue with the policy; and

c) A record of material correspondence with the insured must be kept and maintained.

d) The respondent does not provide this Office of any proof of postage, one would reasonably expect such an important notice to be delivered by registered post;

e) Respondent does not even provide the address to where the notice was allegedly posted;

f) There is a time bar that operates, namely that at least four months' notice be given. Respondent cannot even give a date when it allegedly posted the notice of intention to amend;

g) According to respondent the notice was sent "prior to 2010"; bearing in mind that the insured incident happened on the 9th January 2010, it becomes crucial to inform this Office of the exact date of the notice.

h) Respondent is unable to furnish this Office with a copy of the notice to amend; nor is there any proof that complainant responded approving the amendment.

[22] In the premises, this Office finds that, on a balance of probabilities, respondent failed to prove that it complied with paragraph 5.3 of the rules of the policy. It therefore follows that this Office cannot place any weight on the amended policy relied on by the respondent. This Office finds that the policy as delivered to the complainant was, at all material times, valid and binding on the parties.

I. THE INSURED EVENT

[23] The following facts are undisputed:

a) On the 9th January 2010, when the policy was valid and binding on the parties, complainant was involved in a serious motor vehicle accident;
b) As a result of the accident she suffered injuries and was admitted to hospital via the emergency/trauma ward;
c) Complainant was admitted to a ward for more than 24 hours, she was admitted for 4 days;
d) Complainant suffered extensive soft tissue injuries, including to her arms, knees and back;
e) Complainant was receiving physiotherapy a year after the accident.

[24] According to the policy, respondent was obliged to pay to complainant an amount of R30 000 "on the occurrence of an insured event". Bearing in mind the undisputed facts and the definition in the policy of "accident" and "insured event"; complainant met the criteria of the terms and conditions of the policy and was entitled to claim.

[25] It is significant that respondent does not rely on any grounds for rejection emanating from the policy. Their grounds come from an allegedly amended policy only. This Office has found that there was no effective amendment and respondent is bound by the policy as issued to complainant.

J. CONCLUSION

[26] Respondent was in breach of the policy in failing to make payment of complainant's claim. On respondent's own version, it had not founded any rejection based on the policy and is therefore obliged to pay R30 000. Respondent's reliance on an amended policy is bad in law.

K. THE ORDER

[27] In the premises I make the following order:

1. The complaint is upheld;
2. Respondent, is ordered to pay the complainant an amount of R30 000;
3. Respondent is ordered to pay complainant interest on this amount at the rate of 10,25% per annum from the 9th February 2010 (being one month after the insured event) to date of payment.

DATED AT PRETORIA ON THIS THE 23rd DAY OF MARCH 2016.

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NOLUNTU N BAM
OMBUD FOR FINANCIAL SERVICES PROVIDERS