THE OMBUDSMAN
For Short-Term Insurance

Issue No.3 of 2016
October 2016

THE OMBUDSMAN'S BRIEFCASE

Newsletter of The Ombudsman for Short-Term Insurance

WHAT'S INSIDE?

ADVICE FROM THE OMBUDSMAN: CASE STUDIES

Please note that each matter is dealt with on its own merits and no precedent is created by the findings in these matters. The case studies are intended to provide guidance and insight into the manner in which OSTI deals with complaints.

NAMED RIDER MOTORCYCLE POLICY

CENTRIQ

Mr. H's insurer rejected his claim for accidental damage to his motorcycle on the ground that the person riding the motorcycle at the time that the damage occurred was not a named rider on the policy.

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In his complaint to this office,

Mr. H argued that he had clearly communicated to his independent broker that he had bought the bike for his son to use to travel to school. He felt that the claim had been unfairly rejected on the basis that he had made this disclosure to his broker. He also pointed out that the policy schedule contained a list of additional excesses that were applied to riders under the age of 25.

Mr. H argued that this additional excess ought not to have been included on the policy schedule in circumstances where the named rider was over twenty five years if the insurer did not intend to cover persons other than the named rider. Mr. H argued that the claim should be settled with an additional excess being charged for his son who was under the age of 25.

The insurer maintained that it had not received any communication from the broker stating that Mr. H's son was a named rider of the bike. As cover was excluded for any person not noted as a named rider on the policy schedule, the insurer persisted in the rejection of the claim. The insurer requested that the complaint be directed to the FAIS Ombudsman for investigation into the conduct and possible negligence of the broker.

The Ombudsman requested that the insurer provide a copy of the proposal form and or a recording of the underwriting conversation in order to show that the insurer had created a duty on Mr. H to disclose the details of the named riders. The insurer was also required to demonstrate that Mr. H was informed that if he failed to provide the correct details of the named riders on the policy there would be no cover for additional riders of the motorcycle.

The proposal form that the insurer provided did not create a duty on Mr. H to disclose the details of the named riders on the policy. Furthermore, there was no recording of an underwriting conversation as the risk was accepted on the proposal form alone.

OMBUDSMAN'S VIEWS AND FINDINGS:

A recommendation was made for the claim to be paid as the insurer had failed to demonstrate compliance with the Policyholder Protection Rules, in particular, Rule 4.3 (i) which requires an insurer to provide an insured, prior to the entering into of a policy, with the "concise details of any special terms and conditions, exclusions, waiting periods, loadings, penalties, excesses, restrictions or circumstances in which benefits will not be provided."

The insurer agreed to settle the claim and deducted the additional excess for the rider being under the age of 25 years. Mr. H accepted this settlement.

TRAVEL INSURANCE

SANTAM

Mrs. C selected cover under a Travel Insurance Policy that was effective from the date of departure for her holiday on 20 November 2015, up until the date of her return on 28 November 2015.

During her holiday Mrs. C fell ill. As a result she was unable to attend a number of planned activities for which she had paid in advance. Due to a lack of available

flights Mrs. C was unable to return home any earlier than planned. She therefore stayed on for the duration of her holiday, returning home on her scheduled flight on 28 November 2015.

On her return she submitted a claim for reimbursement for the costs associated with the missed holiday activities under the section of the policy dealing with international journey curtailment. However, her insurer declined to accept the claim.

Cover under this clause is provided only if the international journey is curtailed as a result of unexpected death, sudden illness or injury to the insured, the insured's travel companion, a member of the insured's immediate family or business associate as deemed necessary by a medical practitioner. If the claim falls within the scope of cover, the insurer will pay for, or reimburse the insured, the non-refundable portion of travel or accommodation arrangements paid for by the insured.

The insurer stated that it was unable to compensate Mrs. C for this claim as the policy only makes provision for additional or non-refundable portions of travel and accommodation arrangements paid for by an insured. The policy does not make provision for unattended holiday activities.

The insurer further indicated that it would not be able to compensate Mrs. C for the cost of her accommodation as this was utilised for the full period of the booking.

OMBUDSMAN'S VIEWS AND FINDINGS:

The Ombudsman was requested to interpret the word "curtailment" in terms of the policy. The Ombudsman advised the parties that the first step in interpreting a contract is to determine the ordinary grammatical meaning of the words used in the contract. Very few words bare a single meaning and the "ordinary" meaning of words in a contract will necessarily depend upon the context in which they are used, their interrelation and the nature of the transaction as it appears from the entire contract.

This office considered the context in which the insurer used the word "curtailment', its interrelation with the rest of the contract and the nature of the transaction. The Ombudsman was of the view that the ordinary grammatical meaning of the word "curtail" was intended to mean, "To cut short".

The Ombudsman advised Mrs. C that the insurer had correctly interpreted its policy terms and conditions.

The Ombudsman upheld the insurer's rejection of the claim.

LATE NOTIFICATION OF THE THIRD PARTY CLAIM

SAXUM INSURANCE

The insured, Ms. A, was involved in a motor vehicle accident with a third party on 26 September 2010. The third party instituted legal action against Ms. A in 2012. A Summons was issued and following Ms. A's failure to defend the matter, default judgment was granted against her. A warrant of execution was issued and a notice of attachment was served on Ms. A on 27 October 2014.

According to Ms. A she never received the summons instituting action against her and only became aware of the fact that the third party was seeking

redress in October 2014 when the notice of attachment was served. Immediately on receipt of the notice of attachment she informed the insurer about the matter.

The insurer rejected liability for the third party's claim on the basis of late notification of the claim by Ms. A. The insurer submitted that its rights had been severely prejudiced by the late notification of the claim as default judgement had already been granted and Ms. A's property had been attached.

The insurer referred to the policy wording, which states that, "if you become aware of any possible prosecution or legal proceeding or claim against you, you must immediately inform the insurer in writing".

OMBUDSMAN'S VIEWS AND FINDINGS:

The Ombudsman advised the insurer that there was nothing to suggest that Ms. A was being untruthful when she argued that she had never received the summons. Her version was reasonably conceivable.

Moreover, after reading the relevant section of the policy wording and the information provided, it was the Ombudsman's view that there had been no real prejudice suffered by the insurer. This was because Ms. A had submitted a valid claim in terms of which she was entitled to protection against a third party action. She had informed the insurer immediately upon becoming aware of the legal proceedings instituted against her.

The Ombudsman recommended that the insurer settle the claim by paying the principal debt.

The insurer agreed and made an offer to Ms. A on this basis, which offer she accepted.

RECEIPT OF THE POLICY WORDING

ALEXANDER FORBES

Mrs. Z submitted a claim to her insurer for damage caused as a result of rising damp. Relying on an exclusion in the policy for damage caused as a result of gradual deterioration or operating causes or as a result of defective workmanship, the insurer rejected the claim on the grounds that no insured peril had occurred in terms of the policy.

Following the rejection of her claim, Mrs. Z lodged a complaint with this office. Mrs. Z did not contest the actual basis on which the insurer declined liability nor did she argue that the damage was the result of a cause other than that stated by the insurer. Instead she disputed the rejection of the claim on the ground that the insurer had not supplied her with the policy documents containing the above exclusions. She argued that, in the absence of receipt of such documents, and owing to her lack of knowledge of the policy exclusions, the insurer could not rely on the provisions of the policy wording.

It was also Mrs. Z's contention that she had previously held a policy with another insurer, where she would have enjoyed the said cover. She stated that she would have kept her previous policy if she had been properly informed of the policy exclusions by the current insurer.

The relevant policy documentation in this matter included the policy wording, the policy schedule, the proposal form and its supporting documents. The insurer contended that the documents were sent to Mrs. Z as a complete set, including the policy wording.

Mrs. Z had confirmed receipt of the schedule and other documents but not the policy wording. However the insurer stated that, as was the usual practice, the

documents were all sent as one package.

The proposal form that was signed by Mrs. Z on 26 September 2016 contained the following clause: **"NB: There are qualifications and restrictions in the coverage, and a copy of the wording showing the full extent of cover,** together with the Conditions, Limitations, Exclusions, and First Amounts Payable which can be requested from Alexander Forbes, if desired, prior to the signing of this proposal." (Our own emphases in bold and underlined)

Mrs. Z's argument that she "did not have any reason to believe that there could be another list of exclusions" was therefore disproved by the available evidence. All the evidence suggested that a policy wording was provided to her or that she could have even requested the policy wording prior to accepting the policy.

According to the insurer, it was also clear from the evidence that even if it were accepted that the policy had not been received, Mrs. Z still had a duty to request the policy wording from the insurer. It appeared that there had not been any effort on the part of Mrs. Z to request the policy wording during a period of approximately two years.

Furthermore, the insurer argued that Mrs. Z had submitted a previous claim in which the policy wording had been discussed. It should therefore have become clear to Mrs. Z that the policy schedule was not the only document containing all the provisions of the policy.

OMBUDSMAN'S VIEWS AND FINDINGS:

The Ombudsman had regard to the submissions and arguments made by both parties. After examining Mrs. Z's previous policy it pointed out that the previous policy did not in fact provide cover for gradual deterioration, operating clauses or defective workmanship. Instead it expressly excluded cover for loss or damage caused by rising damp and defective design and workmanship.

The Ombudsman also considered that fact that the insurer's grounds for rejecting the claim are fairly standard and that most policies in the market have similar limitations and exclusions.

The Ombudsman went on to specify that the policy documentation includes the policy schedule, the policy wording, the proposal form (where applicable), the sales conversation (where the policy is sold telephonically), and any other relevant documents issued from time to time by the insurer. The policy wording is a standard document which usually takes the form of a booklet. The policy schedule will contain any details particular or specific to the named insured person(s). The proposal form and/or the sales conversation will contain information detailing the basis on which the policy is underwritten and issued. Other documentation might also be relevant for specific purposes.

The Ombudsman pointed out that even if it were accepted that the insurer had failed to provide the policy wording, this would not necessarily mean that the claim must be honoured by the insurer.

It was further pointed out that in terms of South African law, and more specifically what is known as the Expedition Theory (or Die Versendingsteorie), if the insurer can prove that it sent documentation to the insured's

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correct address then the documents will be presumed to have been received by the insured within a reasonable period, unless the insured can prove the contrary.

It was the Ombudsman's finding that Mrs. Z had not proven her allegation that the schedule, which she had received, should be considered as the governing contract between the parties and not the policy wording as well. She had also not proven that she had not received the policy wording or that the insurer had acted in a deceitful manner.

There was no further evidence that there was any other basis on which to hold the insurer liable for the claim.

The Ombudsman upheld the rejection of the claim by the insurer.

OSTI CARES

In recognition of Mandela Day 2016, staff of the office of the Ombudsman for Short-Term Insurance attended at the Othandweni Children's Home to donate and deliver maintenance supplies.

Othandweni Children's home takes care of approximately 100 children between the ages of 0 to 18. These children are permanently housed at the home and are taken care of with the help of the Johannesburg Child Welfare.

NEW STAFF MEMBERS AT OSTI

We have pleasure in welcoming two new members of the professional staff at OSTI.

Nadia Gamieldien - Assistant Ombudsman

Prior to joining OSTI in September 2016, Nadia worked as an associate at a law firm in its insurance litigation department where she gained experience in litigation, dispute resolution, insurance law and personal injury law. Nadia has also gained vast experience in the handling of disputes brought before the magistrates courts and high courts, as well as disputes which are subject to arbitration proceedings.

Her passions are food and the law.

Kgomotso Molepo - Junior Assistant Ombudsman

Kgomotso joined OSTI in September 2016 and hails from the insurance industry where he worked as a consumer dispute representative. He has a passion for dispute resolution and has gained vast experience in customer service.

In his spare time, he enjoys socializing with his friends and outdoor adventure activities.

CONSUMER TIPS

Don't be a victim of smash & grab. Lock your valuables in your boot & keep your cell phone out of sight.

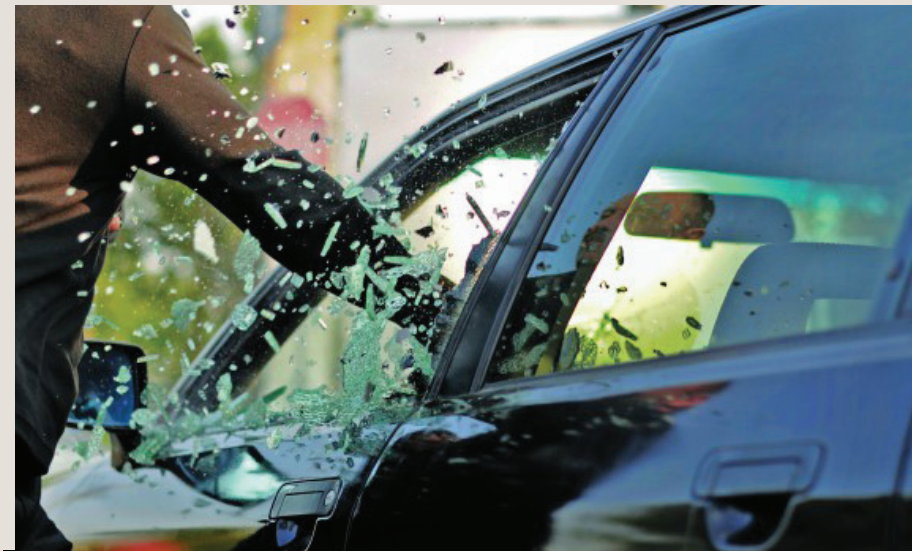
Insure the things you love. Everything in your home costs money to replace. Don't let disaster leave you empty handed.

Don't text while driving. It reduces your reaction time dramatically and takes your eyes off the road.

Changing bank accounts? Don't let your policy lapse due to non-payment of premium. Inform your insurer of any changes.

Getting bikini & speedo fit at the gym? Don't become a victim. Keep your things safe by locking them away in your locker.

Trying to get a little more out? Inflated claims will be rejected. Honesty is the best policy.



WHAT DOES THE OMBUDSMAN DO?

How we can assist you if you have a complaint with your short-term insurer

The Ombudsman for Short-Term Insurance (OSTI) resolves disputes between insurers and consumers. We are an independent organisation appointed to serve the interests of the insuring public and the short-term insurance industry. Our mission is to resolve short-term insurance complaints fairly, efficiently and impartially. We offer a free service to consumers whose claims have been rejected or partially accepted by their insurer. We apply the law and principles of fairness and equity.

WHAT TO DO

IF YOU HAVE A COMPLAINT?

Before contacting our Office, we would advise you to complain to your insurance company first. It is best to complain in writing. Make sure that you keep copies of all correspondence between you and your insurer.

If you are not happy with your insurer's decision you can complete our complaint form and send it back to us either by post, fax or email.

If you would like to lodge a complaint or require assistance, please contact our Office by calling

011 726 8900 or 0860 726 890

or download our complaint form via our website at

www.osti.co.za, click on lodge a complaint and then click on steps to follow.

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We welcome your feedback and/or comments.