Issue No.3 of 2020

THE OMBUDSMAN'S BRIEFCASE

osti ombudsman for short-term insurance

FROM THE EDITOR'S DESK

In no time at all, we have reached the end of another quarter. Surviving 6 months of lockdown is no easy feat, so whether you have hit your stride or taking it one day at a time, we are glad that you are still here with us.

We saw a decline in the number of complaints lodged with our office during the initial months of lockdown. We anticipated an increase in complaints as the restrictions were lifted and as expected, we saw a 5% increase in complaints submitted to our office between March and August 2020 when compared to the same period last year.

554 of the complaints received between March and August 2020 relate to the COVID-19 pandemic and lockdown, with the majority of the complaints concerning business interruption and travel insurance claims.

At the end of August 2020, OSTI had closed 7336 complaints, a significant increase when compared to the 6143 files closed over the same period last year.

You may have seen from our annual reports over the years, that the largest number of complaints received by OSTI relate to motor vehicle insurance followed by buildings and household contents insurance.

In this edition we look at case studies that deal with other types of cover such as personal accident, travel insurance and insurance for mobile electronic devices.

Our office remains closed while we work toward ensuring compliance with the relevant COVID-19 regulations and providing a safe workplace for all our staff when we decide to re-open the office.

Please continue to be safe.

NEWS AND EVENTS

welcoming new team members to osti

In August 2020, we welcomed a new Assistant Ombudsman, Elizabeth Mzungu. Elizabeth joins us as an Assistant Ombudsman. She holds a BCom Law (cum laude) and LLB degree from the University of Pretoria as well as an Advanced Certificate in Financial Planning. Elizabeth served as an Adjudicator at the Ombudsman of Financial Services in Eswatini and brings with her 5 years' experience working in dispute resolution. She attributes her love for running and hiking to her being Kenyan by birth.

consumer workshop

On 2 September 2020, OSTI hosted its first online consumer workshop discussing what consumers do and do not do which contributes towards their claims and policies becoming invalidated.

Our Senior Assistant Ombudsmen highlighted common examples of consumer behaviour that influence the outcome of a claim, such as misrepresentation and non-disclosure of material information during the underwriting of the policy or during the existence of the policy and at claims stage, incorrectly assessing the value of property, and the non-payment of premiums.

If you would like to view the webinar and gain an in-depth insight into these topics, you can click through to our **Youtube channel:**
- https://youtu.be/W7-I_NxVlPQ?t=493

For more from our press office, visit:
https://osti.co.za/news-room/#press

OSTI CASE STUDY 1

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.

The case of Mr M

Mr M sustained injuries to his right leg and ankle, and left elbow after he fell off a truck whilst on duty. The incident occurred on 28 October 2010.

Mr M approached his insurer shortly after the accident, however he was not permanently and totally disabled at that stage. In May 2011, the insurer settled a claim for hospitalization, but he was still not permanently and totally disabled, and that portion of the claim was, once again, rejected.

In 2017, Mr M approached the insurer again. He was advised that because he was not permanently and totally disabled within a 24 month period, as stipulated in the policy, he did not enjoy cover and, further, that his claim had prescribed. It was after the rejection in 2017 that Mr M approached OSTI for assistance.

The insurer relied on the following policy wording to substantiate its rejection of the claim:

"Definitions

- *Permanent Total Disablement means total and absolute disablement which entirely prevents the Insured from engaging in or giving attention to his/her usual occupation or any occupation for which the Insured Person is qualified or has received specialised training in and which will in all probability be lasting and continuous for the lifetime of the Insured Person. The diagnosis and determination of the Permanent Total Disablement must be made by a physician and must be continuous and permanent for at least 24 consecutive months from the onset of the disablement. Documented evidence of the incident that caused the Permanent Total Disablement is required. The degree of Permanent Total Disablement will be determined immediately after it is established or as soon as it can reasonably be assumed that there will be no further improvement or worsening of the Insured Person's condition in consequence of the Accident, but not later than 24 months from the Date of Loss.*
- *Permanent and Total Loss means in reference to an arm or a leg or a hand or a foot or fingers or toes – the loss by physical severance or the total and permanent loss of use of said member.*
- *Sweeper Clause means in the event of a Permanent Disability not being listed under Partial Disability Insured Events in the Table of Benefits, [X] will indemnify the Insured Person up to a maximum of 50% of the Permanent Total Disablement Benefit."*

OSTI finds in favour of the insurer

The insurer's rejection of the claim was upheld by OSTI. However, Mr M requested that OSTI's decision be reconsidered on the grounds that he was able to demonstrate that he was permanently and totally disabled already in 2011. Mr M provided a report from his doctor which confirmed that Mr M was unable to follow his normal occupation and that he could only resume work on 4 April 2011. In addition, Mr M's doctor stated that Mr M will suffer pain for a long time and he might develop a deformity.

Mr M also referred to the Sweeper Clause in the policy.

The matter was reviewed by the Escalation Committee, which comprised the Ombudsman, the Deputy Ombudsman and four Senior Assistant Ombudsmen who were tasked with determining whether Mr M was permanently and totally disabled as required by the policy, whether he complied with the 24 month time limitation and, if so, whether his claim against the insurer had become prescribed.

The Committee stated that, having regard to the definition of permanent and total disablement contained in the policy wording, it was clear that the permanent and total disablement must be diagnosed within 24 months of the event giving rise to the disability.

OSTI CASE STUDY 1

A medical report from Mr M's doctor dated 28 February 2011 stated that Mr M ***"will have pain for a long time and might develop a deformity."*** The report also stated that Mr M first became unable to carry out his occupation on 28 October 2010 (being the date of the incident), however, Mr M was able to resume his occupation on 4 April 2011.

The Committee also considered a medical report of the incident prepared for the Department of Labour dated 28 January 2017. In this report, a different doctor confirmed that Mr M had been fit for normal work since 22 May 2012.

The Committee noted that the claim form submitted to the insurer in 2017 confirmed, firstly, that Mr M was still employed at the time and, secondly, that his occupation and work description before the loss was exactly the same as that during February 2017 with the exception of Mr M not lifting heavy objects.

Therefore, even if Mr M was able to overcome the 24 month time limitation, he had failed to bring his claim within the ambit of the policy wording by demonstrating that he was permanently and totally disabled.

Similarly, in order to enjoy cover under the Sweeper Clause, Mr M would have needed to demonstrate that he was permanently disabled which Mr M could not do.

The Committee also mentioned that, in view of the conclusions drawn above, the issue of prescription did not arise for consideration.

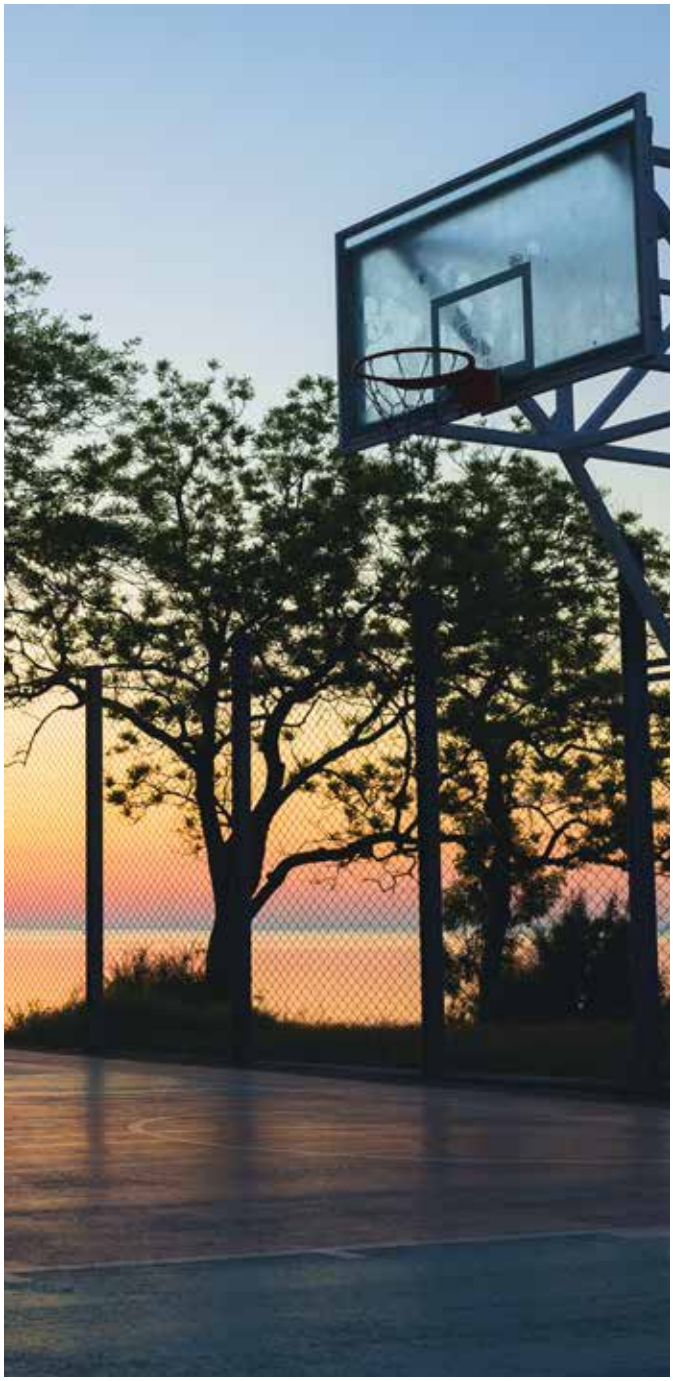
Mr M's complaint was dismissed.

OSTI CASE STUDY 2

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.

The case of Mrs N and the stolen cellphone

Mrs N claimed for a cell phone that was stolen from her bag. Mrs N stated that she had placed her phone in her bag and left her bag on the side of the netball court whilst she was playing netball.



The rejection

The insurer relied on the following provision in the policy to reject her claim:

"7.3 Prevention of loss

7.3.1 The Insured shall take all reasonable steps and precautions to safeguard the Equipment, including but not limited to, ensuring that the Equipment is:

7.3.1.2 not left exposed in a public place, place of recreation, mall or social occasion where it is vulnerable to easy removal or damage."

The insurer argued that the cell phone was not safeguarded and it had been left in a vulnerable situation where easy access could be gained to Mrs N's bag.

OSTI Recommends

OSTI stated that the ordinary grammatical meaning of the word ***"exposed"*** is not ***"covered or hidden; visible".*** Since the phone was in Mrs N's bag, it was not exposed. Mrs N was playing netball and it would be unreasonable for the insurer to expect her to safeguard her bag all the time.

OSTI recommended that the insurer settle the claim and the insurer agreed to do so.

OSTI CASE STUDY 3

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.

The case of Mrs G and her stolen luggage

In August 2018, Mrs G and her husband were catching a train from Paris to Disneyland in France. During the trip, Mrs G's luggage was sliced open and items within it were stolen. Her insurer rejected her claim saying she was not present with her luggage when the theft took place, as required by the policy.

Mrs G disagreed with the insurer and approached OSTI to mediate the dispute.

Mrs G's side of the story

The train from Paris to Disneyland was busy and, on boarding, Mrs G was separated from her husband. She also found herself surrounded by a group of young teenage girls. When the girls exited the train, Mrs G noticed that her luggage had been tampered with and certain items within the bag had been stolen.

The police report stated that Mrs G and her husband lost several high-end items, including a camera and its accessories, sunglasses, a tablet, headphones, jewellery, a speaker, a watch, a hair straightener and cash, among other belongings.

After reporting the incident to the police, along with a description of the girls, Mrs G and her husband were informed that the girls, more than likely, belonged to an organised crime ring.

OSTI CASE STUDY 3

The insurer's reason for rejecting the claim

The insurer rejected Mrs G's claim on the basis that Mrs G had failed to take the necessary measures to ensure the safety of her personal baggage. The wording in Mrs G's policy stated that, ***"[The] insured must take safety measures to make sure that personal baggage is safe and must not leave it unsecured or unattended or beyond reach** at any time in a public place."*

The insurer stated that, according to Mrs G's claim form, her baggage was not on her person at the time of the incident. The insurer based this assessment on the wording of Mrs G's statement on her insurance claim, as well as the wording the French police had used to describe the robbery. The insurer said that the police report notes the cause of loss as 'Vol a la tire' which translates to 'robbery' and not 'pickpocketing'.

A final point the insurer made was that the items could not possibly have been pick pocketed from Mrs G's bag without her noticing. The insurer said that Mrs G had further prejudiced her claim by disposing of her bag after the incident. This meant that her insurer could not verify Mrs G's account of how the thieves had gained access to the items inside the bag.

OSTI finds in favour of Mrs G

After studying the case, OSTI found in favour of Mrs G.

The insurer provided different examples demonstrating the context in which the phrase 'vol a la tire' was used. OSTI noted that the most common translation for 'vol a la tire', based on the information provided, was pickpocketing. The term was used most in the context of pickpocketing, street crimes, purse snatching and shoplifting. All the examples, said OSTI, referred to the theft of items from the victim's pocket or person without the victim noticing at the time.

OSTI explained that pickpocketing is a crime that typically takes place in the presence of crowds, making it difficult for the victim to notice the theft. As per Mrs G's statement to the police, she was indeed surrounded by a group of girls. She only noticed the loss once the girls had disembarked from the train. This indicated that Mrs G was on the train and had her bag with her at the time, said OSTI.

Based on Mrs G's account of the event, and the police statement, OSTI found that Mrs G had demonstrated on a balance of probabilities that the items were stolen from her bag, which she had on her person, while she was on a crowded train. The insurer had failed to demonstrate otherwise.

Satisfactory outcome for Mrs G

OSTI recommended that Mrs G be paid out in full for her loss to which the insurer agreed.

OSTI CASE STUDY 4

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.

The case of Mr B and the claim against his insurer

Mr B approached his insurer for assistance under his legal expenses policy. Mr B was dissatisfied with the services rendered by his insurer and submitted a complaint to OSTI. Mr B stated that the insurer was negligent in handling his claim for legal assistance and allowed it to prescribe.

Mr B had claimed for legal assistance with a dispute between himself and his employer. Mr B stated that his employer short paid him and referred the matter to his insurer to assist him in claiming the money that was short paid.

The insurer advised that Mr B's instruction to it was that he was short paid R1600 for work done. The insurer issued a letter of demand to Mr B's employer for R1600 in line with the instructions given by Mr B. The insurer provided OSTI with a letter addressed by Mr B to the insurer in which Mr B stated that other people, who he was working with, were paid R9800 while he was paid R8220.

The insurer also referred to the policy wording which contained restrictions and limitations to the cover. These restrictions and limitations included providing limited cover for the legal fees of Mr B's own attorney.

Mr B disputed the insurer's submissions stating that his instruction to the insurer was that he was short paid R10 151.62.

The insurer claimed that Mr B's version was untrue. The insurer denied receiving any instructions other than those contained in the letter mentioned previously, and asserted that it had acted on those instructions from Mr B.

OSTI noted that, in his application for assistance to our office, Mr B stated that he was claiming an amount of R3000. After considering Mr B's application for assistance, the contents of Mr B's letter to the insurer, the submissions made by the insurer and by Mr B, OSTI found that there was an irreconcilable dispute of fact about the alleged "mandate" given by Mr B to the insurer.

In light of the dispute of fact, it could not be determined whether Mr B had proven the breach of contract by the insurer on which he relied, nor did he prove the extent of the damage that he had allegedly suffered. On the face of it, the insurer had acted on the instructions given to it in the letter from Mr B.

Mr B's complaint was dismissed.

ARTICLE

Missed a premium payment? Here is what you should know

If, for any reason, policyholders find themselves unable to pay their insurance premiums, we recommend contacting their insurers to discuss any options that they may have available to assist their policyholders.

To prepare for the discussion with the insurer, the policyholder should first check the policy to familiarise him/herself with the policy requirements and provisions relating to the payment of the premium and missed premiums.

The policyholder should also familiarise him/herself with the provisions contained in the Policyholder Protection Rules.

Rules 11.6.6. and 11.6.7 of the Policyholder Protection Rules, which came into effect on 1 January 2019, require the insurer to give the policyholder written notice that it did not receive the premium within 15 days of the insurer becoming aware of the non-payment of the premium.

Rule 15.1 of the Policyholder Protection Rules states that policies must contain a provision for a period of grace within which to make payment of a premium after the due date. This period of grace must not be less than 15 days and only applies from the second month of the policy.

Here are few examples of the different provisions in policies relating to the payment of premium, the grace period and the lapsing of policies due to unpaid premiums:

1. *"If the premium for your policy is not received timeously, you will not have cover for the period for which you did not pay. From the second month's due payment you will be allowed a 15 day period of grace, for the payment of the premium. If we do not receive the premium for two months in a row, the Policy will be cancelled."*

   While this clause mentions the 15-day grace period, required by the Policyholder Protection Rules, it is silent on how payment of the premium should be made within the grace period. In this case the policyholder should check the policy wording for guidance. OSTI also recommends that the policyholder contact the insurer to establish what method of payment is accepted by the insurer.

2. *"I will have 15 days' grace from the collection date to make arrangements for funds to be collected from my chosen bank account, provided that the reason for the non-payment of premium was not as a result of a deliberate act by me. For monthly policies this grace period will only apply from the second month of cover onwards.*

   During the grace period I will still be covered, on condition that the unpaid premium is paid within the time period provided."

   This provision makes it clear that the policyholder must contact the insurer to arrange for payment to be made via debit order within the 15-day grace period.

   Other policies may place the duty on the insurer to debit the policyholder's account again on or immediately after the 15-day grace period.

3. *"Premiums are payable by means of a monthly debit order which will be presented on the date stated in the schedule and the policy will automatically be renewed for the same month. If the debit order is dishonoured by Your bank:*

   i) as a result of Your instruction to the bank to stop payment of the debit order, the policy will lapse from the last day of the month for which premium was received;

   ii) for any other reason, the following month a debit will be submitted to the bank for two months premium. If this debit is also returned unpaid, the policy will lapse from the last day of the month for which premium was received."

ARTICLE

Policyholders are often unaware that certain policies consider the cancellation or reversal of a debit order by a policyholder to be an indication that the policyholder no longer wishes to be bound by the policy. Therefore, in the event of a policyholder cancelling or reversing a debit order, the policy lapses with effect from the last day of the month for which premium was received by the insurer.

Certain policies will state that, if a debit order is not successful, for any reason other than a cancellation or reversal by the policyholder, the insurer will double debit the premium the following month. This means that the policyholder benefits from a longer grace period. However, the policyholder must ensure that there are sufficient funds in his/her bank account to satisfy the payment of two premiums when the next debit date arrives.

4. We have also seen policies which stipulate that payment of the premium is due in advance on the 1st day of every month. However, the policyholder is given the option to choose the date on which the premium is debited from his/her bank account.

   The policyholder may choose one of three dates on which the premium may be debited. For example, the 1st, 8th or 15th day of the month.

   The policy states, for example:

   1. *"The monthly premium will be collected on your chosen Debit Day listed below*
   2. *If your chosen Debit Day is the 1st or the 8th, and the Debit Order is returned unpaid by your bank, another collection will be attempted on the 15th.*
   3. *If this second debit is also returned, there will be NO COVER for that month.*
   4. *If your chosen Debit Day is listed as the 15th, and the Debit Order is returned unpaid by your bank, there will be no further collection attempt and there will be NO COVER for that month.*
   5. *Should this happen for two months in a row, your policy will be cancelled.*
   6. *Should your premium not be paid by the 15th of the month, and you choose to make a cash payment, please note that a Claim will ONLY be entertained if it occurs AFTER the payment date. Your Policy will also then remain in force.*

ARTICLE

7. ***Should you have elected Cash as your Payment Method, please note that above Conditions 5 and 6 apply.***
8. ***NB : Your chosen Debit Day is NOT the Premium Due Date (which is always the 1st of each month), but it is rather your chosen payment date, and falls within the 15 day grace period allowed for Premium payment."***

"The Premium Due Date is the 1st of each month, and the premium must always be paid on or before the 15th of each month, no matter what the Payment Method is."

The effect of the above provisions is that, although the premium remains due on the 1st day of the month, the policyholder may choose a later payment date which is inclusive of the grace period. If the payment is missed, there is no further opportunity to make up for it.

Remember, the insurer chooses the way premiums are paid and most insurers do not have the facility to accept payment by means of a cash deposit.

It is advisable to avoid allowing policies to lapse due to the non-payment of premium. If a policy lapses, it will have to be reissued and the underwriting process will need to be carried out afresh. This may have an effect on the premium. The policyholder may also be subject to waiting periods before cover actually commences.

When applying for cover with another insurer, the cancellation of a previous policy due to the non-payment of premiums will have to be disclosed to the prospective insurer.

What happens if there is a claim during the grace period?

A claim can be submitted during the grace period. However, most policies will contain a suspensive condition, such as the one in paragraph 2 on page 8. If the premium is not received within the grace period, the loss will not be covered.

When dealing with a claim that was rejected based on the non-payment of premium, depending on the circumstances of the case and the terms of the policy, consideration may be given to rule 17.12.1 of the Policyholder Protection Rules which reads:

"17.12 Claims received during periods of grace

17.12.1 If a claimant submits a valid claim in respect of an event that occurred during the period referred to in rule 15, the value of the claim may be reduced by the sum of the unpaid premium."

OSTI CARES

In trying to make the most of Mandela Day while under lockdown, OSTI reached out to a few local orphanages to see how it could support and uplift its community during this difficult time. The orphanage, Door of Hope, not only provides a place of safety for abandoned babies but also assists with finding a home for the children in its care. OSTI contributed nappies, baby formula, baby puree, sterilising liquid, disposable face masks, hand sanitisers and refuse bags to the Door of Hope.

We salute and give thanks to all organisations who take care of the most vulnerable members of our society, especially during crises such as the COVID-19 national state of disaster.

CONSUMER TIPS

what does OSTI do?

Our Mission

To resolve short-term insurance complaints fairly, efficiently and impartially.

We resolve disputes between consumers and short-term insurers:

- **as transparently as possible, taking into account our obligations of confidentiality and privacy;**
- **with minimum formality and technicality;**
- **in a cooperative, efficient and fair manner.**

We are wholly independent and do not answer to insurers, consumer bodies or the Regulator.

WE ARE ON TWITTER AND FACEBOOK

@OMBUD4SHORTTERM

OMBUD4SHORTTERM

We welcome your feedback and/or comments.

1 Sturdee Avenue, First Floor, Block A, Rosebank, Johannesburg

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 approach, you can complete our complaint form and send it back to us either by post, fax or email.

You can also lodge a complaint online, please visit our website and click on "Lodge a Complaint" and follow the easy prompts.

If you would like to lodge a complaint or require assistance, please contact our office by calling **011 726 8900** or our share-call number on **0860 726 890** or download our complaint form via our website at **www.osti.co.za,** click on **Lodge a Complaint** and then follow the prompts.

If you would like to be added to our mailing list, please contact us on:

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Share-call number: 0860 726 890
Fax number: 011 7265501
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