THE OMBUDSMAN
For Short-Term Insurance

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THE OMBUDSMAN'S BRIEFCASE

Newsletter of The Ombudsman for Short-Term Insurance

WHAT'S INSIDE?

FROM THE EDITOR'S DESK

THE OMBUDSMAN FOR SHORT-TERM INSURANCE RELEASES THE ANNUAL REPORT FOR 2015

The 2015 Annual Report was launched in May to various stakeholders at the Johannesburg Country Club.

A highlight of the report is a continued improvement in the turnaround time of complaints, which is the average time taken to resolve disputes. The turnaround time reduced from 89 days in 2014 to 74 days in 2015. The Ombudsman attributes part of this improvement to a 4.5% decline in the number of complaints received in 2015 compared to those received in 2014.

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FROM THE EDITOR'S DESK: CONTD...

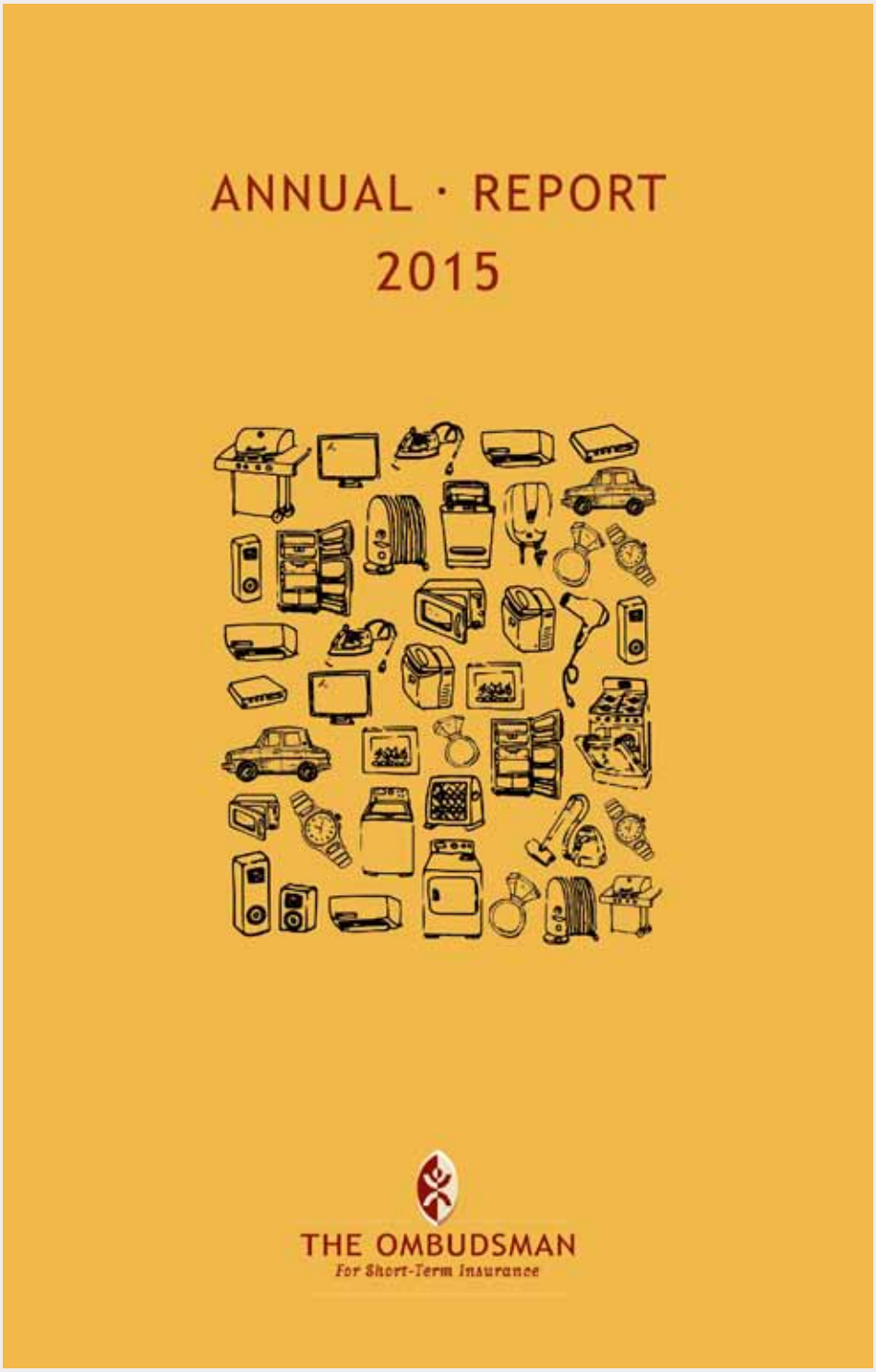
Another feature of the office's statistics is the reduction in the turnover rate (i.e.the percentage of complaints overturned in favour of the insured). This had a knock on effect causing a reduction in the Rand value recovered for complaints.Commenting on the the decline in the turnover rate, the Ombudsman reported:

"Many factors may have contributed to this decline. In times of economic stress, consumers tend to file complaints with the office out of hope rather than conviction that he/she has been treated unfairly.Another factor may be the effect that initiatives such as the Treating Customers Fairly campaign is having on the approach taken by insurers to claims resolution..."

The highest number of complaints received in 2015 related to motor insurance (48%), followed by houseowner's policies (18%) and household contents cover comprising of 8% of all complaints received. Commercial insurance made up 7% of all complaints received. Only 31 complaints remained unresolved after a six-month period.

Statistics relating to individual insurers and case studies reflecting our approach in certain matters are also included in the report.

Printed copies of the Annual Report are available from our office and an electronic version can be downloaded from the OSTI website at http://www.osti.co.za/annual-reports.html



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.

THEFT OF VEHICLE NOT REPORTED TO POLICE "AS SOON AS POSSIBLE"

KING PRICE

DETAILS OF COMPLAINT

Mr. B reported a claim to his insurer for the theft of his vehicle from an outside parking area. Mr. B arrived at this destination at around 09:00. When he returned to his vehicle that afternoon, he realized that his vehicle had been stolen. The insurer rejected the claim on the ground that Mr. B did not report the claim to the police as soon as it was reasonably possible to do so. Mr. B approached the Ombudsman on the basis that he had complied with a condition in the policy wording requiring the loss to be reported to the police within 24 hours.

INSURED'S VIEW

Immediately upon realising that his vehicle had been stolen, Mr. B contacted the insurer's emergency assist line to inform the insurer about the theft of the vehicle. The operator advised Mr. B that he would need to go to the nearest SAPS station to report the incident. As he did not have transport, he took a taxi to a shopping mall, where his wife was shopping at the time. Shortly after, they went to the police station in that area to report the incident. He was told that he could not report it there and needed to report it to the police station in the area where the incident occurred. As he needed to return home to attend to his children, he reported the theft the next morning at around 8:30.

INSURER'S VIEW

The insurer stated that Mr. B reported the loss to the SAPS around 16 hours after he discovered that his vehicle had been stolen. Had he reported it immediately or as soon as it was reasonably possible to do so, the chances of recovering the vehicle would have increased. The insurer argued that it was prejudiced by Mr. B's failure to report the incident within a reasonable time. The insurer also stated that Mr. B could have called 10111 to report the incident telephonically.

In rejecting the claim the insurer relied on its policy wording dealing with its claim's procedure. The policy wording was sent to Mr. B and he therefore had a duty to familiarize himself with the terms and conditions of cover. The relevant clause reads as follows:

"How to claim
What to do in the event of a claim
Tell the police

- If you've been involved in a car accident, you must report it to the police station within 24 hours, even if there's no damage to your car.
- If you've suffered a theft, hi-jacking, burglary or any crime-related event, you must tell the police of this, as soon as possible, but no later than 24 hours after becoming aware of the event."

The insurer stated that Mr. B had not provided it with a reasonable explanation as to why he did not report the incident as soon as possible. It therefore maintained its decision to reject the claim.

OMBUDMAN'S VIEW

The Ombudsman listened to the telephone conversation when Mr. B contacted the insurer's

emergency assist line. It was noted that the operator did not advise Mr. B that he could call 10111 to report the theft. Mr. B also stated that he was not aware that he could report the theft telephonically and, had the operator informed him of this, he would have done so immediately.

After considering the facts and the relevant policy wording, the view was taken that Mr. B had reported the incident as soon as it was reasonably possible for him to do so and that, in any event, the time period within which he reported the incident still fell within the 24 hours period stated in the policy wording. Mr. B had therefore complied with the policy condition. The insurer was requested to settle the claim, which it agreed to do.

MOTOR VEHICLE INSPECTION NOT DONE WHEN REQUIRED

Budget

DETAILS OF COMPLAINT

Mrs. V's claim for damages to her vehicle was repudiated by her insurer and she sought the assistance of this office to reverse this decision. The insurer repudiated the claim on the grounds that, in spite of a requirement under the policy that she do so, she did not have her vehicle inspected at policy inception and, contrary to information given by her to the insurer, her vehicle was not brand new.

INSURER'S RESPONSE

In justification of the first grounds for its repudiation, the insurer submitted that it required a vehicle to be taken for inspection at inception of cover first in order to prove that the vehicle to be insured is in fact in existence and secondly, to establish the condition of the vehicle. Under the policy, a failure on the part of the insured to comply with this requirement entitles the insurer to limit the scope of the policy to third party cover only. Accordingly the insurer asserted that it was justified, under the express terms of the contract, in its rejection on this ground.

As far as the second ground in concerned, during the claim investigation process, the insurer discovered that the vehicle had been purchased from a Salvage Management Disposal (SMD) by a third party after having been written off in an accident in 2012. The vehicle was therefore not brand new as had also been indicated at inception of the policy. The insurer also established that the manufacturer's warranty on the vehicle had been suspended when the vehicle was written off. The insurer accordingly rejected the claim on the basis that the insured did not provide it with true and complete information at the inception of the policy.

OMBUDSMAN'S VIEWS

An investigation by the Ombudsman of this complaint revealed that at sales stage, Mrs. V's husband was informed both of the insurer's inspection requirement and on the consequences of a failure to comply with this requirement. The claim documents submitted by Mrs. V to the office included her policy schedule which also contained the special condition that cover would be limited to third party claim cover until the vehicle had been inspected at an approved assessment centre.

The Ombudsman was of the view that the insurer was accordingly entitled to reject the claim on this ground.

With regard to the repudiation on the basis of true and complete information, the Ombudsman advised Mrs. V that the insurer had correctly repudiated the claim as the insurer had been informed that the vehicle was

brand new when, in fact, it had been previously written off and the warranty suspended .

As a result the Ombudsman upheld the insurer's rejection of the claim.

PERSONAL ACCIDENT CLAIM

Standard Insurance Co Ltd

DETAILS OF COMPLAINT

Mr. E, who had Personal Accident Insurance, was involved in a motor vehicle accident on 21 May 2015. Following three months in the intensive care unit, Mr. E was transferred to frailty care, where he passed away on 15 October 2015.

The insurer repudiated the death claim on the ground that Mr. E had died of natural causes. Death by natural causes is not an insured peril under Personal Accident Insurance. The policy covers death and permanent disability as a result of an accident.

INSURER'S VIEW

Based on the notice of death, the insurer determined that the cause of death was frailty as a result of old age, hypertension and heart failure. The insurer argued that Mr. E had survived the motor vehicle accident on 21 May 2015 and had passed away due to an unfortunate turn of events. The death certificate noted natural causes as the cause of death.

OMBUDSMAN'S FINDINGS

Mr. E's dependents submitted a complaint to our office. The Ombudsman considered Mr. E's medical records and found that he had suffered traumatic physical injuries and subsequent medical complications as a result of the accident. Mr. E, who was 78 years old at the time, experienced multiple rib fractures, severe head injury with multiple brain contusions and a subdural haemorrhage. He required ventilation.

He experienced a prolonged and complicated hospital stay and never regained his orientation. His clinical condition continued to deteriorate and he developed a number of further complications such as lung contusions and ventilator associated pneumonia.

Relevant definitions contained in the policy wording:

Accident - a sudden and unexpected event at a specific time and place. It must cause external visible bodily injury to the insured person that could lead to a claim for death or disability.

Bodily Injury – bodily injury or physical suffering within 12 months of the accident that caused it, as listed in the policy's benefits table... The injury cannot have any other cause such as a physical problem, weakness or illness that existed before the accident. Injury includes exposure to the elements (lack of shelter) because of an accident but it excludes any sickness or infection, unless it was directly because of an accidental bodily injury.

OMBUDSMAN'S VIEWS

The Ombudsman found that, whilst the final diagnosis was heart failure, the evidence indicated that this was due to medical complications resulting from the accident. It was important to note that Mr. E's medical history did not suggest he had suffered from heart disease or hypertension prior to the accident. The final diagnosis was not related to any prior admissions to hospital and did not arise out of previously received medical treatment.

The event insured against in a Personal Accident Insurance contract is an accident. There must be a proximate causal relationship between the accident, injury and subsequent death. In the view of the Ombudsman there was little doubt that the unfortunate consequences, which followed the accident of 21 May 2015, resulted in the policyholder's death. The definitions above support this conclusion.

ADVICE FROM THE OMBUDSMAN: CASE STUDIES

The Ombudsman agreed with Mr. E's dependents and found that the proximate cause of his death was as a result of the accident on 21 May 2015. The Ombudsman recommended that the insurer settle the claim in line with the benefits provided under the policy.

The insurer agreed and settled the claim in full.

NON-DISCLOSURE OF PREVIOUS LOSSES

MIWAY

DETAILS OF COMPLAINT

Mr. R was dissatisfied with the rejection of his claim for fire damage to his house.

The claim was rejected by the insurer on the basis that, at underwriting stage, Mr. R did not inform the insurer of losses previously suffered. Mr. R was of the view that the insurer should have carried out a background check on him when the policy incepted.

Mr. R further submitted that the insurer failed to provide him with the terms and conditions of the policy schedule alerting him to the fact that the incorrect claims' history had been noted on the schedule.

INSURER'S RESPONSE

The insurer advised that, at the time of telephonically underwriting the policy, Mr. R was asked by the consultant to disclose to the insurer all claims or incidents that he, or any member of his household, had experienced in the last three years. This was irrespective of whether a claim was submitted or whether he was insured or not at the time. After listening to the recorded conversation, it was noted that examples of claims or incidents were provided to Mr. R. The examples included accidental damage, house break-ins, weather related damage etc.

Mr. R submitted that, at one time, after load shedding, a fridge and deep freezer were damaged. No further claims or incidents were disclosed by him at the time.

After the inception of the policy, the policy terms and conditions, as well as the policy schedule were e-mailed to Mr R. The schedule contained the information furnished by him at the inception of the policy and it was clear that he had only disclosed one claim or incident.

The insurer advised that during the validation of the claim it was established that Mr. R had eight previous claims prior to the inception of this policy. He had however only disclosed one.

The insurer advised that, had the insured disclosed that he had had eight claims prior to the inception of this policy, the insurer would have not accepted Mr. R as a risk based on his claims' history.

THE OMBUDSMAN'S VIEW

The Ombudsman advised Mr. R that, during the underwriting of the policy, the insurer had requested that he disclose all his previous losses. It was clear that Mr. R had provided the insurer with incorrect information and did not disclosed all his losses, when he should have. The insurer created a duty of disclosure on Mr. R to provide the insurer with correct information. The insurer was as a result prejudiced by the incorrect information provided by Mr. R.

The Ombudsman was satisfied that the insurer had indeed provided Mr. R with his policy schedule and the terms and conditions of the policy via e-mail within 30 days of the inception of the policy. Therefore Mr. R had had the opportunity as well as

the obligation, to familiarize himself with the information contained in the policy documentation.

The Ombudsman further informed Mr R. that the insurer alerted him to the fact that the policy is issued in good faith and based on the information provided by him. The insurer was therefore under no obligation to carry out a background check on Mr. R as it relied on the information provided by him.

The insurer voided the policy from inception and refunded all the premiums paid by him since the inception of the policy.

The Ombudsman upheld the insurer's rejection of the claim as well as the voidance of the policy.

INSURER DELAYS

STANDARD INSURANCE

DETAILS OF COMPLAINT

Ms. A suffered a burglary at her premises, which were being let out to tenants at the time.

The insurer accepted liability for the claim and authorized repairs.

During the course of the repairs, a second burglary occurred, following which the tenant vacated the premises.

A further two burglaries occurred whilst the insurer's service provider was carrying out the repairs. One of the burglaries occurred whilst the security guard placed at the premises was sleeping.

The time between the first and the last claim took approximately 7 months to be resolved.

THE DISPUTE

A dispute arose between the insured and the insurer relating to the costs of hiring a security guard during the period of repairs as well as Ms. A's loss of rental income.

The insurer's contention was that the policy had a limit of R2500 per claim for security costs. It was the insurer's further contention that the tenant had vacated the premises for safety and security reasons and not as a result of the premises being uninhabitable as a result of the loss. It asserted that it could therefore not be held responsible for the loss of rental income.

The Ombudsman's view was that the policy did provide for a R2500 limit per claim in relation to security costs. In addition, the policy only provided cover where the insured premises were rendered uninhabitable.

Under these particular circumstances, and from a fairness and equity perspective, the Ombudsman held the view that the insurer could not sustain its argument. The insurer had taken an unreasonable amount of time to resolve the claims and to complete the repairs.

Furthermore, it would be unreasonable to expect Ms. A to let the premises in the condition it was in. The premises would have been unattractive to potential tenants and Ms. A would not have been placed back in the position which she was in before the loss.

In other words, even though the premises may have been habitable in the strict sense of the word, the circumstances would have rendered it incapable of being let. The Ombudsman asked the insurer to pay all the costs that were being claimed.

The insurer eventually agreed to settle the claim and was asked

ADVICE FROM THE OMBUDSMAN: CASE STUDIES

by the Ombudsman to pay mora interest on the claim as a result of it unreasonably delaying the resolution of the matter.

DAMAGE TO A HIRED TRAILER

SANTAM

DETAILS OF COMPLAINT

Mr. G claimed for damages to a trailer he had hired. The insurer received a liability claim from the insurer of the trailer to indemnify the owner for the damages sustained to the trailer.

INSURER'S RESPONSE

The insurer rejected the claim on the ground that the trailer was not insured under Mr. G's policy and therefore he did not enjoy cover for the loss.

The insurer based its rejection on a special exclusion in the policy, which stated that:

"We will not be liable for
12.2Damage to property
12.2.1 Belonging to or held in trust by or in the custody or control of you or your family."

Accordingly the insurer argued that Mr. G did not enjoy cover as the trailer did not belong to him but was in his custody or control at the time of the incident.

The trailer is the property of the third party and as a result is not covered under Mr. G's policy with his insurer.

THE OMBUDSMAN'S VIEW

In considering the representations made by both parties, the Ombudsman advised Mr. G that, as the trailer was not covered in terms of the policy and based on the exclusion relied on by the insurer, he did not enjoy cover for the trailer.

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

OSTI CARES

Human Rights Day

In commemoration of Human Rights Day, the OSTI team attended the Masibambane After Care facility in Eldorado Park on the 15th of April 2016.

Masibambane takes care of approximately 300 children aged between 5 and 18 years of age. The facility assiststhe children with their homework, provides school and sport supplies and a meal on a daily basis.
The OSTI team donated toiletries and school supplies during their visit.

The winter months are the perfect time for maintenance: tips for consumers

1) The dry winter months are the best time to carry out roof maintenance. Homeowners/buildings insurance policies do not cover maintenance related issues. Regular maintenance helps prevent resultant internal damage.

2) Buildings insurance policies do not cover damage arising from wear and tear, including wear and tear to your roof. Regularly inspect your waterproofing and sealant to avoid damage to your roof and internal damage.

3) Don't assume that all wall cracks are as a result of an insured peril. Buildings insurance policies do not generally cover damage arising from a gradually operating cause, such as the settlement of foundations. Get an expert opinion and take the necessary precautions to avoid a costly repair.

4) Inspect and maintain the tiling in all areas of your home. The tiles should not just become loose, even if water falls on the area. Poor tiling is generally excluded from buildings insurance policies.

5) Not all buildings insurance policies cover leaking taps or burst pipes. Check your policy wording to ensure that it provides the cover suitedto your particular needs and requirements.

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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For the latest and most up to date news, follow us on @Ombud4ShortTerm

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We welcome your feedback and/or comments.