key figures
as at 31 December 2018

9 779
FORMAL COMPLAINTS RECEIVED

9 474
FORMAL COMPLAINTS CLOSED

4 026
PRELIMINARY COMPLAINTS RECEIVED

104
DAYS AVERAGE TURNAROUND TIME

R87 250 982
AMOUNT RECOVERED

88 421
CALLS RECEIVED BY CALL CENTRE
mission

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

about us

We resolve disputes between consumers and short-term insurers:

• in a cooperative, efficient and fair manner;

• with minimum formality and technicality;

• as transparently as possible, taking into account our obligations for confidentiality and privacy.

This involves understanding all aspects of a dispute without taking sides, and making decisions based on the specific facts and circumstances of each dispute.
contents

06 Report by the Chairman
08 Report by the Ombudsman
12 Collaboration Breeds Success
16 Finance Matters
18 Office Statistics
20 A Statistical Analysis of Matters Closed by OSTI in 2018
24 Explanatory Notes and Insurer Statistics
28 Time Bar
30 Because I said so...
31 OSTI News
32 Intervening Insured Perils: an Application of Equity
33 No Cover - Material Change in Risk
34 Board of Directors
35 Staff of the Ombudsman
36 Terms of Reference
41 OSTI’s Interns on Consumer Literacy
42 Members of the Ombudsman Scheme
43 Useful Information about Other Offices
When I presented my first report last year, I made mention of the organisation’s achievements and its continued purpose in a changing insurance landscape.

OSTI’s role is not to resolve complaints in the quickest time period. Neither is its role, year-to-year, to improve the overturn rate. The role of OSTI, like any other independent Ombudsman operating within a framework of statutory regulation, is to implement justice and fairness in a process directed towards a resolution. The key responsibility of OSTI is to maintain a balance between the powers and duties of the insurer, on the one hand, and the consumer’s rights and obligations on the other. In an environment where the financial sector lives under persistent mistrust, those involved can only be held to account by an independent institution like OSTI.

OSTI’s ambition, supported by the board and the Ombudsman, Deanne Wood, and her team, was to present itself as an efficient and effective, industry relevant, reliable and independent dispute resolution process.

OSTI is now proudly an independent organisation, achieving a consistently measured and efficient resolution of complaints, with most importantly a high quality in those outcomes. As an organisation OSTI delivers fair and just outcomes, and this is a tribute to the administrative and professional skills, the admirable teamwork and the wisdom and dexterity of all those whose energy over the past few years has ensured a successful organisation. OSTI has shown that it is not only for powerful people or organisations. It is an organisation for everyone.

The Twin Peaks model of financial regulation in South Africa gave rise to a discussion on how the ombud system can be made better. The future is upon us. It hopes to see a single Insurance Ombudsman Scheme. This will give rise to one combined entry and exit point for all insurance complaints. The existing schemes, OSTI and OLTI, will remain in existence and, importantly, continue to operate separately within their defined objectives. There will be no cross-subsidisation or cross-population between OSTI and OLTI. The governance of the single Insurance Ombudsman

“Statistics are important, but they serve no more than a guide informing OSTI of its achievements.”
Scheme will be undertaken by a single board with representation from both OSTI and OLTI. The future is exciting...

2018 also saw change in the introduction of a new IT system and OSTI’s new logo. The new IT system has improved accessibility to OSTI, and the manner in which it can deliver efficient and quality outcomes.

Before I sign off, it is important that I take time to mention an internship programme introduced into OSTI by Deanne. This programme has been driven to great success by Deanne’s passion. In January 2019, OSTI welcomed four new interns, all of whom hold legal degrees. Through the internship programme, OSTI provides interns with experience, lessons and the tools for their future.

In short, a lot is happening. OSTI’s board and management remain engaged in bringing about a more successful organisation.

Haroon Y Laher
Chairman of the Board

21 April 2019
What an incredible year 2018 was for OSTI! In the ever increasingly short space of a single year OSTI transformed almost every aspect of its existing business. It took an in-principle decision to merge with the office of the Long-Term Insurance Ombudsman to create a single scheme for all insurance complaints, transitioned to a paperless complaints handling environment, initiated automation enhancements to its IT processes, redesigned its complaints handling procedures, changed the way in which it reports insurer statistics, rebranded its corporate image, took up occupation in fresh new premises in Rosebank, launched an intern program to advance the careers of young graduates, established a customer experience department measuring OSTI’s performance from the perspective of the consumer and effected improvements to its internal structures and staff management. That is a lot of change and newness to deal with in a single year.

Before detailing these new aspects of OSTI’s business I must pause to commend OSTI’s staff for the enthusiastic and professional way in which they embraced and adapted to these transformations. It was not always easy and there were many hurdles to overcome along the way. But, in the end, through teamwork, persistence, resilience and large servings of patience, extraordinary achievements were made across the entire spectrum of OSTI’s operations.

**Merger with Long-Term Insurance Ombudsman**

At the start of 2018, and in anticipation of the new regulatory and legislative framework within which all financial sector ombud schemes will soon be expected to operate, OSTI initiated an in-principle agreement with the Long-Term Insurance Ombudsman to amalgamate the two schemes into a single Insurance Ombudsman Scheme. This proposal has been endorsed by OSTI’s board and by its stakeholders and it is anticipated that the new single scheme will begin receiving complaints in the latter part of 2019.

**Paperless complaints handling and IT enhancements**

Lawyers are notorious users of paper and those who choose to ply their trade at the Ombudsman are no different. Prior to 2018 the first aspect any visitor to the engine room at OSTI would notice was the extraordinary amount of paper surrounding and, at times, engulfing, its workforce! During 2018 OSTI shifted into a new technological dimension with its paperless complaints handling system and automated administrative processes. Within a few months of its implementation the ubiquitous bulging files that were previously so characteristic of OSTI’s operations had
disappeared. Considering that OSTI has in excess of 3000 open files at any one time, this is a dramatic change to the landscape of its working environment. Darpana Harkison (Senior Assistant Ombudsman) and Marilize Blignaut (Project Coordinator) are commended for the enormous contribution that they made to making this transition possible.

**New complaints handling process**

In a continued effort to improve its service offering OSTI spent a considerable portion of its focus during 2018 designing a new complaints handling process. Many aspects of the new process were piloted during 2018 in order to ensure that its implementation with effect from 1 January 2019 was met with as little disruption to the organization as possible. Key aspects of this new process include a better complaints capturing system to ensure that OSTI is able to provide timeous assistance to all complaints falling within the ambit of its jurisdiction, a transfer process which allows insurers an opportunity to resolve complaints internally before intervention by OSTI if they have not yet had the opportunity to do so, an efficient and effective fast-track process to resolve complaints capable of swift determination, greater focus on conciliated and mediated outcomes and finally, a revised escalation process.¹

**Insurer statistics**

Last year I raised a concern about the way in which insurer statistics were reported and interpreted by the media, industry and consumers. It is perhaps worth mentioning, yet again, that statistical results are not necessarily indicative of performance. Thus, an insurer who scores a low overturn rate or has a low number of complaints submitted to this office is not necessarily “the best insurer”. Conversely, a high score in either of these areas is equally not necessarily an indication of poor performance by an insurer. In an effort to break the entrenched thinking around insurer statistics, and in the hope that it will encourage more conciliated outcomes OSTI has changed the way in which it reports its insurer statistics. In this year’s report the statistics reveal the number of matters where the insured received some benefit as a result of OSTI’s intervention (formally described as the overturn rate”) in two separate parts. The first part relates to matters where resolution was received consensually and through discussion or conciliation with the insurer. The second part reflects those matters where OSTI was required to make a formal recommendation or ruling in order to compel compliance from the insurer.

**New premises**

In July 2018 OSTI moved from Sunnyside Office Park in Parktown to its new premises at 1 Sturdee Avenue, Rosebank. OSTI is now more centrally located and has easier accessibility from the Gautrain and other major transport routes. The new premise also gave OSTI an opportunity to create a more modern working environment for its staff and to improve the communal facilities and general infrastructure. Special thanks to OSTI’s staff, in particular, Abri Venter (assistant ombudsman) and Marilize Blignaut, for the extraordinary amount of work that they put into making the move happen.

**Rebranded corporate image**

Capitalizing on the move to new offices OSTI rebranded and created a more modern logo. The new OSTI

¹ A flowchart detailing this process is available on OSTI’s website.
logo is a modern and simple corporate mark which communicates the core values and services provided by OSTI using a graphic eye to symbolize the watchful eye of OSTI. This, combined with geometric diamond shapes, symbolises fairness and equality through symmetry.

**Intern program**

At the start of 2018 OSTI launched a new intern program to provide law graduates aspiring to become advocates with an opportunity to acquire much needed legal experience in order to enhance their applications for admission to the Johannesburg Bar. Three such interns were admitted into OSTI’s program during 2018, Fatima Missi, Katleho Rudolph Leseba, Sibusiso Magxaki.

I am very grateful to the Johannesburg Bar for their willingness to assist OSTI in establishing this program. OSTI’s intern program was also extended to include prospective university graduates across a wide range of business related degrees who require work experience in order to complete their degree. During the latter part of 2018 OSTI employed two business interns, Lindokuhle Ntuli and Comfort Maluleke.

**Customer experience department**

In an effort to improve the overall customer experience, reduce the number of internal complaints and escalations and acquire a better understanding of OSTI’s strengths and weaknesses, a dedicated customer experience department was established in 2018. Naturally it will take some time before the learnings from this department filter down through the organization and the required changes to operations are implemented. However, in the short time since its establishment, this department has already provided OSTI’s management with much needed insight into many of the day-to-day concerns arising from customers who make use of OSTI’s services.
Senior Assistant Ombudsman Ayanda Mazwi is to be commended for the excellent work that she has done in establishing this department.

**In closing**

I am, as ever, extremely grateful to the chairman of OSTI’s board, Haroon Laher for the assistance and guidance that he provided to OSTI during 2018 and for his unfailing support. Thanks also go to the other members of the board for their insight, rigorous debate and commitment to the betterment of OSTI. I am also extremely grateful to the members of the audit committee for the advice and service that they provide to OSTI.

Finally, my sincere appreciation and thanks go to my management team and senior assistant ombudsmen who have worked tirelessly to make the transitions possible. OSTI achievements in 2018 would not have been possible were it not for their careful and measured advice and assistance in every decision-making process. As always, special mention must be made of my Deputy Ombudsman, Edite Teixiera-Mckinon for her unwavering support, wise counsel and ongoing willingness to embrace change.

This year’s annual review reflects many aspects of which OSTI can be proud. In reflecting on these I am grateful to our people for all their resilience, hard work and commitment to OSTI. We will continue to improve our business and to strive to provide the service that is expected of us.

**Deanne Wood**

Ombudsman for Short Term Insurance

April 2019
In last year’s Annual Report, the Ombudsman, Deanne Wood, touched on the anticipated evolution of financial ombud schemes under the then newly enacted Financial Sector Regulations Act 2017 (“FSRA”).

Deanne made mentioned of the consultative process that had taken place between the four voluntary financial ombud schemes (OSTI, the Long-Term Insurance Ombud, the Banking Ombud and the Credit Ombud) and National Treasury on proposals for the future construct of financial ombud schemes.

The dramatic overhaul of legislation governing the financial environment in South Africa will naturally have a consequential impact on the financial ombud schemes. Resistance to this change is futile and it is important to approach these changes with the right mindset because, after all, “the bamboo that bends is stronger that the oak that resists.”

A key driver for change and an area where OSTI must do some bending is in relation to chapter 14 of the FSRA.

Chapter 14 of the Act, headed “OMBUDS”, is still to come into effect, a government notice having been sent out on 18 March 2019 deferring its implementation date to 1 September 2019.

Under this chapter, an Ombud Council will be established with the objective to “assist in ensuring that financial customers have access to, and are able to use, affordable, effective, independent and fair alternative dispute resolution processes for complaints about financial institutions in relation to financial products, financial services, and services provided by market infrastructures” (Section 176). By the inclusion of the word “services” we envisage that we will be required to expand our jurisdiction to deal with purely service related complaints. Currently OSTI does not deal with service issues unless the service has a direct financial impact on the complainant. This change will have the effect of enlarging our jurisdictional coverage.

The Board of the Ombud Council will have a duty to keep the Minister of Finance informed of “trends in the nature of complaints and issues raised in complaints that ombud schemes are dealing with, and how those types of issues and complaints are being dealt with” and “the conduct of financial institutions that is giving rise to complaints to ombud schemes” (Sections 184(d) (ii) and (iii)). We will therefore be required to report to the Ombud Council not only on the trends emerging from lodged complaints but also on how these complaints were resolved. This may require further IT enhancements to our current systems to enable us to harvest more data.

1 Japanese proverb
In terms of Section 188(4)(a) “the Chief Ombud must convene meetings of the ombuds on a regular basis, but at least four times a year, to discuss the effective operation of the ombuds system.” Currently under the Financial Services Ombud Schemes Act, 2004, (“the FSOS Act”) we have only been required to present our annual reports to the Council established under this Act.

The Ombud Council may impose administrative penalties on an ombud scheme, a member of the governing body of an ombud scheme or on an ombud, may request information from an ombud or ombud scheme and may conduct supervisory on-site inspections and investigations of an ombud scheme or ombud. The Ombud Council may make rules, amongst others, in relation to the governance of ombud schemes, the qualifications and experience of ombuds, the types of complaints to be dealt with by a specific ombud scheme and dispute resolution processes.

Although there will be more operational oversight by the Ombud Council of ombud schemes than previously under the FSOS Act, Section 201(4) of the FSRA preserves the independence of ombud schemes and ombuds when it comes to decision making on complaints. This section reads “an Ombud Council rule must not interfere with the independence of an ombud or the investigation or determination of a specific complaint.”

If there is no recognized industry or statutory ombud scheme to deal with a particular kind of financial product or service, then the Ombud Council may, after consulting the relevant ombud schemes, designate one or more ombud schemes to deal with and resolve complaints arising from such product or service (Section 211). Again our jurisdiction may be expanded by the Ombud Council.

Collaboration between ombuds and ombud schemes is encouraged in Section 213 which includes “developing processes and procedures to jointly hear and determine complaints, on their own initiative or as may be required by Ombud Council rules.”

This encouraged collaboration from the legislature brings me to the next aspect of bamboo bending that OSTI must face. Against the backdrop of changes in the policy environment and the call by National Treasury for self-determined rationalization of ports of entry for consumers into these schemes, OSTI initiated an in-principle agreement with the Office of the Long-Term Insurance Ombudsman (“OLTI”) to amalgamate the two schemes into a single insurance ombud scheme.

The process of amalgamating with OLTI is still in an exploratory stage with key decisions to be taken during the course of 2019. The build-up to these decisions being taken presents the ideal opportunity to explore the rationale behind this decision and to ask the important questions about the necessity for this change – after all, if it ain’t broke, why fix it?

Insurance products and the accompanying services that they provide no longer fall neatly into expressly categorized divisions between long and short term insurance. This bundling together has also been recognized by the legislature through the enactment
of a single piece of legislation (the Insurance Act 18 of 2017) governing all aspects of insurance regulation under a single statute.

Increasing levels of awareness, although still low, have resulted in increasing customer demand and expectations when it comes to dispute resolution by ombud schemes. There are greater expectations of speed, simplicity and online assistance. These expectations enhance the need to ensure that the handling of insurance complaints is equally integrated. In OSTI’s and OLTI’s environments this would mean concurrently handling any short-term insurance (now referred to as “non-life” insurance in the Insurance Act) aspects of a complaint together with any long-term or life insurance aspects of the same complaint. An integrated office will mean that the time taken to resolve the entire complaint will be reduced and the consumer need not suffer any confusion about which of the two offices to approach.

An amalgamation will focuses on creating a single port of entry into and exit from an ombud scheme whilst ensuring a seamless experience for complainants of both life and non-life insurance. In considering this “single shop front”, we have had to re-evaluate our processes and procedures and compare them with those of OLTI in order to decide which process will work best. As a result of this re-evaluation, OSTI has already remodelled its complaints handling processes by:

1) enabling complainants to lodge complaints on-line and telephonically,
2) enabling the faster resolution of complaints that are capable of early initial assessment,
3) enabling and incentivising insurers to resolve complaints at complaint inception, and
4) enabling more complaints to be resolved through a facilitative process, being negotiation, conciliation and mediation.
George Bernard Shaw wrote: “Don’t wait for the right opportunity, create it.” The exploration of an amalgamation with another ombud scheme has given OSTI the opportunity to relook at the way in which it operates and to create the opportunity to improve its service offering.

Ombud schemes in other jurisdictions around the world have undergone major reconstruction and amalgamated to form one scheme, such as the Financial Ombudsman Service of the United Kingdom and the Australian Financial Complaints Authority. Although our ombud scheme for all financial complaints, it is almost inevitable that this is the direction that we are moving in.

**Conclusion**

Charles Darwin said “it is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change.”

Change isn’t inherently good or bad; it is something that is inevitable and something without which progress is impossible. The only way to participate in a constantly changing world is to find ways to connect. The less we change, the more siloed we become. In the last year, more than ever, OSTI has had an opportunity to see different perspectives, get different points of view and come up with new ideas and approaches that will help it to become even more effective in a world that continues to change.

**Edite Teixeira-Mckinon**

Deputy Ombudsman
2018 Annual Financial Statements

PricewaterhouseCoopers Inc. audited the annual financial statements for the year ended 31 December 2018. The financial statements were prepared in accordance with International Financial Reporting Standards and the requirements of the Companies Act of South Africa.

During 2018 financial year, OSTI changed its accounting policy for the recognition of revenue. The revised revenue recognition resulted in an adjustment of the retained income and deferred income figures.

The annual financial statements present fairly, in all material respects, the financial position of OSTI. We are proud of the fact that we have consistently achieved clean audit reports over the years. These clean audit reports provide a solid financial reporting base.

The approved and detailed audited financial statements are available on our website:

www.osti.co.za

A copy of our 2018 Annual Financial Statements will be emailed to all our members.
**Financial Position**
OSTI remains financially sound with all member insurers settling their outstanding debts in full for the financial year ended 31 December 2018.

The revenue of OSTI depends solely on fees levied to member insurers against new complaints received. We are pleased to note that despite difficult financial conditions, members continue to support the office.

OSTI recorded an increase of 9% in the number of complaints received for the 2018 financial year.

OSTI’s revenue for the year was R38.1 million, an increase of 12% compared to 2017 (R33.9 million). This increase is primarily attributable to the annual fee increase which, in 2018, went from R3 700 per complaint to R4 000.

OSTI continues to manage its cash balances closely to ensure that there is sufficient cash to meet financial obligations when they fall due.

**Liquidation of saXum Insurance company**
SaXum Insurance remains in liquidation. OSTI awaits the outcome of the claim it has submitted to the liquidator.

**Board, Audit and Risk Committee**
The Board and Audit Committee approves the financial reports and reviews strategic, operational and compliance risks quarterly. Their role is to ensure that risk management frameworks, methodologies and mitigations are implemented effectively. OSTI’s finance department thanks these members for their invaluable support and guidance.

**New Membership**
No applications for membership were received during 2018. The list of member companies is enclosed in this report.

**Miriam Matabane**
General Manager
office statistics

Finalisation per period

<table>
<thead>
<tr>
<th></th>
<th>65%</th>
<th>20%</th>
<th>15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalised within 4 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalised between 4 and 6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalised in over 6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases closed: 100%

Formal complaints closed

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>9 944</td>
<td>8 631</td>
<td>9 962</td>
<td>9 474</td>
</tr>
</tbody>
</table>

Rand value of complaints resolved in favour of insured - Claim type

<table>
<thead>
<tr>
<th>Year</th>
<th>Commercial</th>
<th>Home Owner</th>
<th>Household</th>
<th>Motor</th>
<th>Other</th>
<th>Non-Claim Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>R100 712 182</td>
<td>R15 498 553</td>
<td>R7 339 724</td>
<td>R6 463 292</td>
<td>R10 597 65</td>
<td>R16 029 454</td>
</tr>
<tr>
<td>2016</td>
<td>R99 139 593</td>
<td>R8 297 530</td>
<td>R2 897 530</td>
<td>R5 928 605</td>
<td>R11 829 77</td>
<td>R16 029 454</td>
</tr>
<tr>
<td>2017</td>
<td>R87 101 353</td>
<td>R5 928 605</td>
<td>R2 897 530</td>
<td>R5 928 605</td>
<td>R11 829 77</td>
<td>R16 029 454</td>
</tr>
<tr>
<td>2018</td>
<td>R87 250 982</td>
<td>R5 928 605</td>
<td>R2 897 530</td>
<td>R5 928 605</td>
<td>R11 829 77</td>
<td>R16 029 454</td>
</tr>
</tbody>
</table>
Claim types resolved ratio - 2018

Miscellaneous
- Total Closed: 1,490
- Resolved: 436
- Ratio: 29.26%

Home Owner
- Total Closed: 2,037
- Resolved: 254
- Ratio: 12.47%

Commercial
- Total Closed: 909
- Resolved: 147
- Ratio: 16.17%

Motor
- Total Closed: 4,510
- Resolved: 824
- Ratio: 18.27%

Household Contents
- Total Closed: 528
- Resolved: 77
- Ratio: 14.58%

Types of complaints by cases (on matters received for 2018)

- Motor: 4,716
- Household Contents: 529
- Commercial: 895
- Home Owners: 2,037
- Other: 1,473
- Non-claim Related Policy: 129

Total Complaints Received

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Received</th>
<th>Preliminary Matter</th>
<th>Formal Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>14,136</td>
<td>4,352</td>
<td>9,784</td>
</tr>
<tr>
<td>2016</td>
<td>14,916</td>
<td>4,741</td>
<td>10,175</td>
</tr>
<tr>
<td>2017</td>
<td>14,176</td>
<td>5,079</td>
<td>9,097</td>
</tr>
<tr>
<td>2018</td>
<td>13,805</td>
<td>4,026</td>
<td>9,779</td>
</tr>
</tbody>
</table>
During 2018, OSTI finalized a total of **9,474 formal complaints**. This was 97% of the total number of complaints registered in the same period.

OSTI classifies complaints according to the type of insurance policy the consumer complains about, the issues involved and the outcome of the dispute.

The remaining 17% of complaints related to other insurance products including personal accident, water loss, travel, all risk, mobile device, legal expenses, hospital cover and gap medical cover.

In more than two thirds of finalized complaints, consumers complained about the insurer’s decision on a claim. Overall, the majority of these complaints, at 36%, related to the rejection of a claim on the basis of an exclusion or warranty in the policy terms and conditions. This figure remained virtually unchanged when compared to 2017. It is clear to OSTI that many consumers do not know or understand what is in their policy documents. Because it is not possible to go through all of the terms and conditions of cover at sales stage, insurers are required to provide the insured with policy documents drafted in simple language. The insured must read these documents and consult the insurer or broker should there be a need for clarity. If a dispute relates to what the insured was told when the policy was being sold, OSTI considers all sales communications, written and verbal.

The remainder of finalized complaints related to complaints about non-claim related policy disputes, such as policy changes, cancellations or lapsing, premium increases and service related complaints.
“So what, in relation to these categories, did people complain about the most?”

Motor vehicle insurance disputes
The majority of complaints considered by OSTI, at 74%, were for accidental damage. This was also the case in 2017. Warranty and mechanical breakdown claims comprised 9%. Theft and hijack claims comprised 8%, a slight decrease from 9% in 2017.

The primary cause for complaints was the amount offered for the settlement of claims. The disputes varied from the calculation of vehicle and/or salvage values, uninsured credit short-falls and accessories, excesses and the use of alternate or second hand part prices in calculating the repair amount, to name a few.

The secondary cause for complaints was rejections based on the insured's alleged non-disclosure or misrepresentation of underwriting details at sales stage. However, OSTI saw a 22% decrease of such complaints in 2018 compared to 2017. OSTI has always emphasized the importance of the insured's contractual obligation to provide true and complete information when taking up a policy or updating it. Insurers are also required to conduct the sales process in accordance with the agreed industry code.

OSTI also recorded a 15% decrease in the number of considered complaints relating to rejections on the grounds that the insured was driving under the influence of alcohol (dui). We believe this decline can be attributed to several factors, including increased consumer awareness and responsibility on the dangers and consequences of dui, measures taken by the insurance industry (such as the ‘take me home’ service) and, the strong approach taken by OSTI on the insurer's evidentiary burden when defending this rejection. DUI still remains a very real problem for the insurance industry and we must caution consumers that a rejection may be justified on circumstantial evidence, despite the driver not having been tested for alcohol consumption by way of a breathalyzer or blood test or having been convicted of a criminal offence in relation to the incident.

The number of complaints related to rejections based on the policyholder's obligation to exercise due care and prevent loss increased substantially in 2018, by 48%, when compared to 2017.

18% of motor vehicle insurance disputes were resolved in favor of the insured, with a recovery of R53 641 058,00 where the dispute related to a claim.

Homeowners insurance disputes
Last year, 61% of complaints considered by OSTI under
homeowner’s insurance related to claims for damage caused by acts of nature. These claims relate primarily to storm related loss. In 2018, this figure dropped to 58%. Theft and burglary claims on the other hand increased from 4% in 2017 to 6% in 2018.

The primary cause for complaint, at 48%, was the rejection of claims on the basis of the condition of the property, this being wear and tear, lack of maintenance, defective design, construction, workmanship and building material. This was also the case in 2017. This rejection reason causes consumers a lot of unhappiness, however it is the insured’s contractual responsibility to ensure that the building structure is properly maintained and is in compliance with applicable building regulations. If the damage claimed for is attributed to the condition of the property, the policy may not respond even if an insured event did occur.

The secondary cause for complaint related to settlement calculations. Underinsurance is a real concern. This is when the sum insured is less than the property replacement value. In this case, the insurer will only settle proportionately and the insured will be responsible for the difference. For example - If the sum insured is R400 000 and the replacement value is R500 000, only 80% of the loss will be paid out. This can be devastating to the insured, particularly during these soft economic times. The main misconception is the insured’s belief that the municipal value, purchase price or bond amount is the correct value, without taking into account inflating building costs, renovations and reinstatement such as professional fees, demolition and debris removal which can add up to 20% of building costs. It may be necessary for the insured to seek professional advice on the replacement value - after all, for many of us our homes are our biggest assets.

12% of homeowner’s insurance disputes were resolved in favor of the insured, with a recovery of R12 369 548.00 where the dispute related to a claim.

Household content insurance disputes
Theft and burglary claims comprised 71% of complaints considered by OSTI under this category. 8% related to acts of nature, 6% to accidental damage and only 3% to damage caused by power surge.

As in 2017, settlement calculations were the primary cause for complaints. Although rejections based on the insured’s alleged fraudulent act, dishonesty or
misrepresentation on a claim was the second highest cause for complaints, our records indicated a noticeable 31% decrease in these complaints compared to 2017.

15% of household content insurance disputes were resolved in favor of the insured, with a recovery of R3 288 605.00 where the dispute related to a claim.

Commercial insurance disputes
The majority of complaints considered by OSTI related to motor vehicle (29%) and building claims (30%). Overall, the primary cause for the complaints was settlement calculations and rejections on the ground that conditions of cover were not met. The latter includes issues such as motor vehicle roadworthiness, commercial driver’s licenses, building security measures and fire safety. Insurers may conduct a professional risk survey during the underwriting process and, based on the findings, either endorse limitations or strict conditions of cover, with which the insured is contractually obliged to comply.

16% of commercial insurance disputes were resolved in favor of the insured, with a recovery of R13 987 137.00 where the dispute related to a claim.

OSTI evaluates its service and quality across a broad range of issues we see as critical to our success.

Based on OSTI’s overall performance, from its Contact Center to complaints submission and handling, 60% of complainants who completed our customer experience surveys indicated that they were satisfied with our service, process and communications. OSTI must work hard to improve this rating. This improvement also comes from enhancing consumers understanding of OSTI’s processes and the expectations that they have of our service.

Every service complaint helps us understand where we need to improve. Resolving disputes in the shortest time possible was a common issue raised by consumers. The average time to resolve disputes in 2018 was 104 days. In 2017, it was 131 days. The office target is 100 days. However, speed is only part of the picture. It is essential that consumers feel they have been treated fairly, whatever the conclusion reached on the dispute.

Strengthening internal controls and improving efficiency was a key objective of our new complaints handling process introduced on 3 January 2019.

Ayanda Mazwi
Senior Assistant Ombudsman
Explanatory notes

1. The data must be understood in the correct context and it is therefore necessary to record some words of explanation in relation to these statistics.

Ombudsman’s limited jurisdiction

2. The office of the Ombudsman has limited jurisdiction over commercial lines policies and, in any event, has jurisdiction for personal lines business only up to R3.5 million, save for home owners claims where the jurisdictional limit is R6.5 million. The statistics therefore focus only on personal lines claims (statistics provided by the Financial Sector Conduct Authority) and personal lines complaints received by this office. Commercial lines complaints which are not reflected in the statistics, represent only about 9.0% of the total complaints to the office of the Ombudsman.

3. No adverse conclusions should be drawn against any insurer based purely on the number of complaints against them received by this office.

Larger insurers issue proportionately more policies which cannot form the basis of a complaint to this office due to our jurisdictional limits. Thus, for example, when considering the percentage of complaints received by this office against a large insurer, the large insurer, upon a superficial analysis, therefore appears to attract a relatively low number of complaints. What is the more important statistic is the proportion of personal lines complaints relative to an insurer’s share of the total personal lines claims reported to the FSCA. The clearest indicator of this is column 5, being the number of complaints to this office per thousand claims received by an insurer. Where an insurer receives a high number of complaints to this office per thousand claims, this may be an indicator that claims are dealt with unfairly by the insurer. However, this statistic should be considered in conjunction with columns 8 and 9, being the share of matters resolved through conciliation/enforcement by parties/OSTI. The overturn rate is
an indication that the decision of the insurer was changed in some respect by this office with some additional benefit to the insured. Further comments on the overturn rate appear below.

4. Please note that a claim can be received by an insurer in year one and a complaint in respect of that claim may be received by OSTI only in year two – hence the number in column 1 may be greater than the number in column 3. The statistics record the numbers received by insurers and the OSTI respectively during 2018.

5. Also note that under column 1, certain insurers are shown by the FSCA statistics as having received no claims during 2018. This may be explained on the basis of either the company issuing only commercial lines policies or that the company is dormant. We repeat that only personal lines statistics are included in the table as this is what has been received from the FSCA (columns 1 and 2).

**Overturn rate**

6. The overturn rate per insurer as shown in the table is for personal lines claims only. It excludes commercial lines claims. If a high overturn rate is registered, this may, but does not necessarily, indicate that the insurer is not treating its customers as fairly as it should. However the overturn rate should be treated with considerable caution as a high overturn rate can also be indicative of a high degree of co-operation being received by the Ombudsman’s office from a particular insurer in resolving a complaint to the satisfaction of the customer. The Ombudsman takes into account the following two circumstances in determining the Overturn Rate:

a) The decision of the insurer is overturned by the Ombudsman by way of a recommendation which is accepted or by way of a Final Ruling.

b) A resolution of the dispute has been mediated by the Ombudsman with the insured receiving a benefit which he/she would not have received without the involvement of the Ombudsman.

**General**

7. Any media queries in relation to insurer statistics should be directed to the particular insurer.
## Insurer Statistics

<table>
<thead>
<tr>
<th>Name of Insurer*</th>
<th>Claims received by Insurers (FSCA statistics)</th>
<th>Share of claims received by the particular insurer (FSCA statistics)</th>
<th>Complaints received by OSTI</th>
<th>Share of the total number of complaints received by OSTI</th>
<th>Number of Complaints received by OSTI per thousand Claims received by Insurer</th>
<th>Complaints finalised by OSTI</th>
<th>Complaints finalised with some benefit to the insured</th>
<th>Share of matters resolved through conciliation by parties</th>
<th>Share of matters resolved through enforcement by OSTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abacus</td>
<td>3,530</td>
<td>0,10%</td>
<td>4</td>
<td>0,05%</td>
<td>1,133/1000</td>
<td>2</td>
<td>1</td>
<td>50,00%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Absa</td>
<td>134,943</td>
<td>3,84%</td>
<td>799</td>
<td>9,02%</td>
<td>5,921/1000</td>
<td>803</td>
<td>146</td>
<td>14,57%</td>
<td>3,61%</td>
</tr>
<tr>
<td>AIIG Insurance</td>
<td>15,413</td>
<td>0,44%</td>
<td>47</td>
<td>0,53%</td>
<td>3,049/1000</td>
<td>54</td>
<td>19</td>
<td>29,63%</td>
<td>5,56%</td>
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<tr>
<td>Alexander Forbes</td>
<td>52,817</td>
<td>1,50%</td>
<td>131</td>
<td>1,48%</td>
<td>2,480/1000</td>
<td>116</td>
<td>17</td>
<td>9,48%</td>
<td>5,17%</td>
</tr>
<tr>
<td>Allianz</td>
<td>453</td>
<td>0,01%</td>
<td>2</td>
<td>0,02%</td>
<td>4,415/1000</td>
<td>2</td>
<td>2</td>
<td>100,00%</td>
<td>0,00%</td>
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<tr>
<td>Auto &amp; General</td>
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<td>5,57%</td>
<td>343</td>
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<td>1,752/1000</td>
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<td>41</td>
<td>9,27%</td>
<td>3,83%</td>
</tr>
<tr>
<td>Bidvest</td>
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<td>0,55%</td>
<td>56</td>
<td>0,63%</td>
<td>2,878/1000</td>
<td>45</td>
<td>8</td>
<td>13,33%</td>
<td>4,44%</td>
</tr>
<tr>
<td>Bryte</td>
<td>131,090</td>
<td>3,73%</td>
<td>140</td>
<td>1,58%</td>
<td>1,068/1000</td>
<td>140</td>
<td>32</td>
<td>20,00%</td>
<td>2,86%</td>
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<tr>
<td>Budget</td>
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<td>323</td>
<td>3,65%</td>
<td>4,043/1000</td>
<td>281</td>
<td>31</td>
<td>7,47%</td>
<td>3,56%</td>
</tr>
<tr>
<td>Centriq</td>
<td>35,082</td>
<td>1,00%</td>
<td>146</td>
<td>1,65%</td>
<td>4,162/1000</td>
<td>138</td>
<td>40</td>
<td>24,64%</td>
<td>4,35%</td>
</tr>
<tr>
<td>Chubb</td>
<td>1,486</td>
<td>0,04%</td>
<td>7</td>
<td>0,08%</td>
<td>4,711/1000</td>
<td>7</td>
<td>1</td>
<td>14,29%</td>
<td>0,00%</td>
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<tr>
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<td>1,24%</td>
<td>57</td>
<td>0,64%</td>
<td>1,313/1000</td>
<td>43</td>
<td>6</td>
<td>9,30%</td>
<td>4,65%</td>
</tr>
<tr>
<td>Constantia</td>
<td>129,670</td>
<td>3,69%</td>
<td>147</td>
<td>1,66%</td>
<td>1,134/1000</td>
<td>167</td>
<td>49</td>
<td>18,56%</td>
<td>10,78%</td>
</tr>
<tr>
<td>Dial Direct</td>
<td>35,394</td>
<td>1,01%</td>
<td>117</td>
<td>1,32%</td>
<td>3,306/1000</td>
<td>106</td>
<td>10</td>
<td>6,60%</td>
<td>2,83%</td>
</tr>
<tr>
<td>Discovery</td>
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<td>5,26%</td>
<td>328</td>
<td>3,70%</td>
<td>1,773/1000</td>
<td>321</td>
<td>46</td>
<td>12,15%</td>
<td>2,18%</td>
</tr>
<tr>
<td>First for Women</td>
<td>45,135</td>
<td>1,28%</td>
<td>128</td>
<td>1,45%</td>
<td>2,836/1000</td>
<td>121</td>
<td>18</td>
<td>9,92%</td>
<td>4,96%</td>
</tr>
<tr>
<td>Genric</td>
<td>57,284</td>
<td>1,63%</td>
<td>60</td>
<td>0,68%</td>
<td>1,047/1000</td>
<td>63</td>
<td>17</td>
<td>19,05%</td>
<td>7,94%</td>
</tr>
<tr>
<td>Guardrisk</td>
<td>244,862</td>
<td>6,97%</td>
<td>526</td>
<td>5,94%</td>
<td>2,148/1000</td>
<td>494</td>
<td>158</td>
<td>27,53%</td>
<td>4,45%</td>
</tr>
<tr>
<td>Hollard</td>
<td>285,819</td>
<td>8,13%</td>
<td>535</td>
<td>6,04%</td>
<td>1,872/1000</td>
<td>529</td>
<td>128</td>
<td>20,42%</td>
<td>3,78%</td>
</tr>
<tr>
<td>Indequity</td>
<td>2,531</td>
<td>0,07%</td>
<td>4</td>
<td>0,05%</td>
<td>1,580/1000</td>
<td>3</td>
<td>1</td>
<td>33,33%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Infiniti</td>
<td>28,876</td>
<td>0,82%</td>
<td>62</td>
<td>0,70%</td>
<td>2,147/1000</td>
<td>67</td>
<td>9</td>
<td>10,45%</td>
<td>2,99%</td>
</tr>
<tr>
<td>King Price</td>
<td>81,146</td>
<td>2,31%</td>
<td>428</td>
<td>4,83%</td>
<td>5,274/1000</td>
<td>372</td>
<td>64</td>
<td>15,32%</td>
<td>1,88%</td>
</tr>
<tr>
<td>LEZA</td>
<td>28,271</td>
<td>0,80%</td>
<td>88</td>
<td>0,99%</td>
<td>3,113/1000</td>
<td>74</td>
<td>11</td>
<td>12,16%</td>
<td>2,70%</td>
</tr>
<tr>
<td>Lion of Africa</td>
<td>746</td>
<td>0,02%</td>
<td>81</td>
<td>0,91%</td>
<td>108,579/1000</td>
<td>37</td>
<td>25</td>
<td>62,16%</td>
<td>5,41%</td>
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<tr>
<td>Lloyd’s</td>
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<td>0,00%</td>
<td>3</td>
<td>0,03%</td>
<td>17,143/1000</td>
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<td>0</td>
<td>0,00%</td>
<td>0,00%</td>
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<tr>
<td>Lombard</td>
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<td>0,43%</td>
<td>26</td>
<td>0,29%</td>
<td>1,725/1000</td>
<td>16</td>
<td>5</td>
<td>18,75%</td>
<td>12,50%</td>
</tr>
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<td>MiWay</td>
<td>100,081</td>
<td>2,85%</td>
<td>484</td>
<td>5,46%</td>
<td>4,836/1000</td>
<td>476</td>
<td>52</td>
<td>8,19%</td>
<td>2,73%</td>
</tr>
<tr>
<td>Momentum ST</td>
<td>37,757</td>
<td>1,07%</td>
<td>100</td>
<td>1,13%</td>
<td>2,649/1000</td>
<td>113</td>
<td>5</td>
<td>4,42%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Monarch</td>
<td>20,036</td>
<td>0,57%</td>
<td>4</td>
<td>0,05%</td>
<td>0,200/1000</td>
<td>5</td>
<td>3</td>
<td>60,00%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Name of Insurer*</td>
<td>Claims received by Insurers (FSCA statistics)</td>
<td>Share of claims received by the particular insurer (FSCA statistics)</td>
<td>Complaints received by OSTI</td>
<td>Share of the total number of complaints received by OSTI</td>
<td>Number of Complaints received by OSTI per thousand Claims received by Insurer</td>
<td>Complaints finalised by OSTI</td>
<td>Complainants finalised with some benefit to the insured</td>
<td>Share of matters resolved through conciliation by parties</td>
<td>Share of matters resolved through enforcement by OSTI</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Nedgroup</td>
<td>67 045</td>
<td>1,91%</td>
<td>300</td>
<td>3,39%</td>
<td>4,475 /1000</td>
<td>281</td>
<td>65</td>
<td>21,35%</td>
<td>1,78%</td>
</tr>
<tr>
<td>New National</td>
<td>21 529</td>
<td>0,61%</td>
<td>250</td>
<td>2,82%</td>
<td>11,612 /1000</td>
<td>298</td>
<td>80</td>
<td>23,49%</td>
<td>3,36%</td>
</tr>
<tr>
<td>NMS</td>
<td>93 772</td>
<td>2,67%</td>
<td>7</td>
<td>0,08%</td>
<td>0,075 /1000</td>
<td>6</td>
<td>6</td>
<td>100,00%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Oakhurst</td>
<td>51 372</td>
<td>1,46%</td>
<td>293</td>
<td>3,31%</td>
<td>5,703 /1000</td>
<td>266</td>
<td>39</td>
<td>11,28%</td>
<td>3,38%</td>
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<tr>
<td>Old Mutual</td>
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<td>4,97%</td>
<td>636</td>
<td>7,18%</td>
<td>3,642 /1000</td>
<td>606</td>
<td>113</td>
<td>16,17%</td>
<td>2,48%</td>
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<tr>
<td>OUTsurance</td>
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<td>7,64%</td>
<td>345</td>
<td>3,90%</td>
<td>1,285 /1000</td>
<td>373</td>
<td>21</td>
<td>4,56%</td>
<td>1,07%</td>
</tr>
<tr>
<td>PPS</td>
<td>6 006</td>
<td>0,17%</td>
<td>5</td>
<td>0,06%</td>
<td>0,833 /1000</td>
<td>5</td>
<td>2</td>
<td>40,00%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Regentth (now Hollard Specialist Ins.)</td>
<td>46 969</td>
<td>1,34%</td>
<td>110</td>
<td>1,24%</td>
<td>2,342 /1000</td>
<td>105</td>
<td>26</td>
<td>22,86%</td>
<td>1,90%</td>
</tr>
<tr>
<td>Renasa</td>
<td>78 110</td>
<td>2,22%</td>
<td>111</td>
<td>1,25%</td>
<td>1,421 /1000</td>
<td>88</td>
<td>24</td>
<td>23,86%</td>
<td>3,41%</td>
</tr>
<tr>
<td>SAFIRE</td>
<td>7 428</td>
<td>0,21%</td>
<td>10</td>
<td>0,11%</td>
<td>1,346 /1000</td>
<td>9</td>
<td>0</td>
<td>0,00%</td>
<td>0,00%</td>
</tr>
<tr>
<td>SAHL</td>
<td>25 715</td>
<td>0,73%</td>
<td>95</td>
<td>1,07%</td>
<td>3,694 /1000</td>
<td>94</td>
<td>9</td>
<td>9,57%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Santam Ltd</td>
<td>369 098</td>
<td>10,50%</td>
<td>548</td>
<td>6,19%</td>
<td>1,485 /1000</td>
<td>541</td>
<td>92</td>
<td>14,97%</td>
<td>2,03%</td>
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<tr>
<td>Santam Structured</td>
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<td>1,18%</td>
<td>233</td>
<td>2,63%</td>
<td>5,601 /1000</td>
<td>228</td>
<td>24</td>
<td>7,89%</td>
<td>2,63%</td>
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<tr>
<td>SASRIA</td>
<td>1 298</td>
<td>0,04%</td>
<td>5</td>
<td>0,06%</td>
<td>3,852 /1000</td>
<td>4</td>
<td>2</td>
<td>50,00%</td>
<td>0,00%</td>
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<tr>
<td>Shoprite</td>
<td>2 892</td>
<td>0,08%</td>
<td>10</td>
<td>0,11%</td>
<td>3,458 /1000</td>
<td>12</td>
<td>6</td>
<td>41,67%</td>
<td>8,33%</td>
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<tr>
<td>Standard</td>
<td>115 536</td>
<td>3,29%</td>
<td>549</td>
<td>6,20%</td>
<td>4,752 /1000</td>
<td>546</td>
<td>77</td>
<td>11,54%</td>
<td>2,56%</td>
</tr>
<tr>
<td>Unitrans</td>
<td>3 618</td>
<td>0,10%</td>
<td>3</td>
<td>0,03%</td>
<td>0,829 /1000</td>
<td>4</td>
<td>0</td>
<td>0,00%</td>
<td>0,00%</td>
</tr>
<tr>
<td>Vodacom</td>
<td>96 000</td>
<td>2,73%</td>
<td>45</td>
<td>0,51%</td>
<td>0,469 /1000</td>
<td>36</td>
<td>21</td>
<td>52,78%</td>
<td>5,56%</td>
</tr>
<tr>
<td>Western National</td>
<td>23 796</td>
<td>0,68%</td>
<td>108</td>
<td>1,22%</td>
<td>4,539 /1000</td>
<td>138</td>
<td>33</td>
<td>13,77%</td>
<td>10,14%</td>
</tr>
<tr>
<td>Workerslife</td>
<td>7 900</td>
<td>0,22%</td>
<td>18</td>
<td>0,20%</td>
<td>2,278 /1000</td>
<td>10</td>
<td>4</td>
<td>30,00%</td>
<td>10,00%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3 513 905</td>
<td>100,000%</td>
<td>8 857</td>
<td>100%</td>
<td>2,52 /1000</td>
<td>8 558</td>
<td>1 589</td>
<td>15,31%</td>
<td>3,27%</td>
</tr>
</tbody>
</table>

Please Note:
The Statistics for ABSA Insurance Co Ltd include statistics for ABSA Idirect and ABSA Insurance Risk Management Services Limited.
The Statistics for Old Mutual Insure include statistics for Iwyze and Mutual & Federal Risk Financing.
*For the full name of the insurer please see the list of members at page 42.

The above expressions simply mean that it is better to act sooner rather than later. Delayed action may result in unsatisfactory results.

In the context of insurance claims, it often happens that insureds delay claiming or contesting the outcome of claims with which they do not agree.

Most policies require that a claim should be made within a specified period after the happening of an insured event. Failure to do so may result in claim benefits being forfeited. An expeditious claim or contestation is mainly to ensure that the claim validation process can be conducted while facts are fairly easily ascertainable and memories are still fresh; witnesses are likely still in the vicinity of the scene of the incident; video footage might still be available; and most of the evidence still intact.

Unfortunately, when insured persons delay without good reasons for doing so they compromise their prospect of claiming successfully. Sometimes they also delay in challenging decisions taken by their insurers regarding their claims. This is very ill-advised as most policies contain a clause limiting the time period for insureds to take action against their insurer. Sometimes this happens even where the insured might have been able to succeed on the merits of the dispute.

The Policyholder Protection Rules promulgated in terms of the Insurance Act as revised provide that the insurer must allow 90 days within which the insured may follow the insurer’s internal dispute process to have a dispute resolved. In addition, there is a further 180 days for other (further) action to be taken, including approaching the Ombudsman for assistance in having the dispute resolved.

Insurers who are members of the Ombudsman scheme have agreed that where a dispute is referred to the Ombudsman, the application of any time-barring and prescription periods will be suspended until the Ombudsman has resolved the matter.

In the light of the provisions mentioned above, insurers do sometimes rely on the time bar provisions and prescription to avoid the Ombudsman considering disputes referred to this office. Where the insured cannot show good cause why there was a delay in pursuing a matter through the Ombudsman’s office, the Ombudsman may find that the matter has become time barred. This means that even if the Ombudsman has a dim view of how the insurer handled a particular matter, the Ombudsman may not be in a position to assist that insured due to a lack of jurisdiction.

In a recent matter the Ombudsman had to grapple with the question whether or not a complaint had become time-barred.

In this matter, the insurer argued and detailed reasons why the matter was time-barred, submitting that the Ombudsman should not consider the dispute for this reason.

The insurer further argued that no good cause had been shown to justify the insured’s failure to lodge a complaint timeously with the Ombudsman’s office and accordingly there was no basis for condonation to be granted. The insurer argued that the Ombudsman could not deal with the dispute as it fell outside the Ombudsman’s jurisdiction.

The essential facts were that the insured had suffered a loss on 31 July 2015 and registered a claim with the insurer. The insurer declined this claim in writing
on 27 November 2015. Following the insured’s representations, the insurer maintained its rejection of the claim. The insured’s legal representative requested additional information from the insurer and then subsequently made additional representations. The insurer again declined the claim on 13 September 2016.

When the insured later (in July 2017) submitted a complaint to OSTI, the insurer raised time-barring as a defence. According to the insurer, the matter had become time barred and the Ombudsman did not therefore have the jurisdiction to deal with the matter.

The insurer submitted that the original decision was made on 27 November 2015. Having only approached the Ombudsman in July 2017, whereas the policy provided for a twelve months’ time bar period, the insured had approached the Ombudsman too late.

It was the insurer’s contention that although the insured’s queries and requests for re-evaluation were entertained, and a last communication in this regard was sent to the insured on 13 September 2016, this was not in any way a waiver by the insurer of its right to rely on time-barring as from the date that the first rejection was sent to the insured (i.e. 27 November 2015).

The insured’s argument was that the relevant date for considering whether or not the matter had become time-barred by the time the insured approached the Ombudsman’s office, was 13 September 2016.

According to the insured, this was the actual date on which the final decision to reject the claim was eventually taken by the insurer.

It was the Ombudsman’s view that the insurer’s submission that 27 November 2015 was the date on which the claim was (finally) rejected, presented a few problems which would make that proposition untenable.

The first was that the insurer’s rejection letter (of 27 November 2015) provided that the insurer may make further representations to the insurer and also that the insurer may approach the Ombudsman within a specified period.

The Ombudsman’s view was that it was envisaged that such a provision would entail that a real opportunity was granted to the insured to make such representations, and that the insurer would be diligent in considering the matter afresh. To have a different understanding would render the internal review process redundant. It would be unreasonable to provide that there should be a process available for the insured to follow, when such a process meant that the original decision remained in place and no prospect of a new decision existed.

From the circumstances and facts specific to this matter, this position would be even more untenable as the insured’s legal representatives had requested further details from the insurer prior to making representations. This therefore meant that the insurer must have dealt with new information, arguments or submissions when re-considering the matter. This also implied that, although the outcome of the matter was not different from the insurer’s initial stance, a new decision was made by the insurer, having considered the representations and any new information or arguments made by the insured or on its behalf.

The insured had merely exhausted the internal dispute resolution mechanisms like it was invited to do, and as it was entitled to do. The option to do this could not possibly have been envisaged to entail self-prejudice to the insured when making use of same. It was the Ombudsman’s view that it would be illogical to insist that the decision of 27 November 2015 was not overtaken by events, including the internal dispute resolution process.

It was therefore the Ombudsman’s view that 13 September 2016 would be the relevant date from which time-barring would commence running, being the date on which the insurer’s final decision was taken.

In terms of the policy and the rejection letter, the insured had twelve months within which to take further steps after the rejection.

From the time when the claim was rejected to when the insurer approached the Ombudsman, only ten months had elapsed. The matter was therefore not time-barred.

The second argument by the insurer that the insured had not shown reasonable cause for the delays in lodging a complaint or shown good cause why condonation should apply became redundant by virtue of the above conclusion.

Insurers will not hesitate to use time bar provisions in their policies to avoid disputes being pursued further by insured parties, where same may apply. It is therefore advisable that an insured person take steps to register a claim or to contest any decision as soon as possible after the occurrence of an insured event, or the decision being taken, lest they forfeit their rights to claim or to contest decisions taken by insurers.

Peter Nkhuna
Senior Assistant Ombudsman
because i said so…

Thasnim Dawood
Senior Assistant Ombudsman

**Insurer:** My house was damaged by a storm.
**Insured:** But you haven’t proved your case why should we pay your claim?
**Insurer:** Because I said so……..

**Insurer:** We cannot pay your claim because you were driving under the influence of alcohol.
**Insured:** But you haven’t proved your case why would you not pay my claim?
**Insurer:** Because I said so……..

In many cases that come before OSTI, one of the parties to the dispute does not provide substantial or any evidence to prove their case. When a matter is considered by OSTI, the evidence and submissions by both parties are considered in order to arrive at a decision. Our courts have repeatedly said that he who alleges must prove.

It is often found that the one party expects a decision in their favour despite the fact that they have not presented any substantial evidence or submissions to prove their case or disprove the other party’s case.

When a matter is considered at OSTI the evidence and submissions are weighed and considered on a balance of probabilities. This is because insurance related matters fall within the ambit of civil law (as opposed to criminal law where the standard of proof is beyond a reasonable doubt). Civil law determines which party bears the onus (or burden of proof) in a matter. In insurance law the onus rests on the insured to prove that a claim is payable or that an insurer is liable under the policy. For example, when seeking payment for damage to a house under subsidence cover, an insured must prove that the cracks to the house were caused by subsidence. Mere say-so will not be enough. The insured must provide substantial evidence of this fact. This evidence can be in the form of an expert such as a structural engineer. Once the insured has provided sufficient evidence to demonstrate its case, the burden will shift to the insurer to refute that evidence. The insurer will equally be required to provide substantial evidence to refute the insured’s case.

In circumstances where there is no dispute about an ordinarily covered event, but the insurer avoids liability because of an exclusion or exception in the policy, the general rule is that the onus will lie with the insurer to prove this fact. For example, where an insurer alleges that an insured was driving under the influence of alcohol and rejects the claim on that basis, the insurer would have to prove its case by way of substantial evidence. The evidence and submissions of both parties will be considered and if the insurer fails to provide substantial evidence, then the insurer will be said to have failed to discharge its onus or to prove its case on a balance of probabilities.

Each party is responsible for providing the evidence they wish to rely on to OSTI. OSTI does not and will not gather evidence on behalf of any of the parties nor liaise with any third party who is not a party to the dispute.

Before approaching OSTI complainants should be aware that there may be evidence from both parties which create a dispute of fact or where material facts cannot be established or cannot be resolved on a clear balance of probabilities. In such cases, our Terms of Reference state that OSTI may not make a ruling but instead must advise the parties that the complaint is not one in which OSTI can assist and that alternate recourse may be sort through the courts.

Ultimately, a decision cannot be made in favour of a party without the party proving its case on a balance of probabilities, by providing substantial evidence. A party who alleges must prove its case.

Thasnim Dawood
Senior Assistant Ombudsman
“Change is the law of life and those who look only to the past or present are certain to miss the future.” - John F. Kennedy

2018 was a year of change for OSTI. Changes in OSTI’s physical and IT environment and are just two of the major changes experienced by OSTI’s staff and stakeholders. Following on what was reported in our 2017 Annual report, we are pleased to announce that we have upgraded our telephone system, internet line, updated and upgraded our CRM system and OSTI is now in the cloud. All these enhancements paved the way for a paperless environment.

As a result of the above enhancements, OSTI has already seen savings in equipment, paper and stationary expenditure. However, the ultimate goal is increased efficiency in the handling of complaints. The paperless environment has allowed for automation of certain processes in order to reduce turnaround times. Complainants are now able to complete their application forms online and submit supporting documentation. This reduces the possibility of human error in data capturing and the time taken to capture complaints manually.

With big change comes big challenges. OSTI acknowledged the shortcomings of the new system by hosting a workshop with insurers at the beginning of 2019 where the new process was introduced to the insurers. A comprehensive question and answer session helped in identifying and resolving the challenges being experienced by insurers. In addition, OSTI is engaging its staff on a regular basis to receive feedback, provide training and identify recurring issues and areas for new development.

As we look to the future, we are enhancing and optimizing our system to support new processes.

Darpana Harkison
Senior Assistant Ombudsman
Intervening insured perils: an application of equity

Insurance is commonly referred to as a grudge purchase. You calculate your monthly instalment on your new car and you can just afford it. You arrive at the dealership and you are presented with a finance agreement that contains a number of additional costs, such as finance charges. You start sweating and doing quick calculations in your head. Just as you breathe a sigh of relief when you estimate that your budget will JUST make it, you are told that you have to have insurance before driving the vehicle off the dealership floor, thus stretching your budget even further. It is no wonder that motorists loath paying a premium for something that they may never even use.

In truth, an insurance policy is the financial safety belt or airbag for savvy consumers. Without insurance, many buyers of high value vehicles understandably would not feel comfortable with the transaction, taking into consideration the risk of driving the vehicle on South African roads. The devastation experienced by policyholders when a claim is seemingly arbitrarily rejected based on an obscure technical point, is therefore understandable.

This was exactly what occurred when an insured purchased a used high price vehicle from the manufacturing dealer. A mere couple of hours after the insured collected the newly purchased vehicle, he was involved in an accident and a total loss of the expensive vehicle was incurred. It was common cause that the accident occurred as a result of the vehicle’s wheels separating from its chassis. This implied a latent defect in the construction of the vehicle and that the damage to the vehicle was as a result of mechanical failure.

A particular exclusion applies to damage that results from mechanical failure, which was evidenced to be the proximate cause of the damage in the matter under discussion. Proximate cause was defined in the case of Pawsey v Scottish Union & National Insurance Company (1908) as “the active and efficient cause that sets in motion a train of events which brings about a result, without the intervention of any force started and working actively from a new and independent source”. This would be the nearest cause and not a remote cause.

While OSTI agreed that damages resulting from mechanical failure are excluded from cover and that mechanical failure was the proximate cause of the some of the damage incurred, there was a subsequent accident which resulted in damage. Accident damage is an insured peril in terms of the policy.

OSTI, in applying its equity jurisdiction, found that a clear distinction had to be drawn between damage resulting from an accident and damage resulting from mechanical failure. The damage resulting from mechanical failure was limited to the wheel separating from the chassis. All damage that occurred before the accident and which may be termed “mechanical failure” would be excluded from cover in terms of the exclusion in the policy wording. Any damage resulting from the accident was an insured peril and had to be settled.

It is the view of OSTI that if a peril based policy provides cover for an event, the entire claim may not be excluded by a general exclusion if the insured event did occur causing further damage. The insured event must therefore be applied in the manner of a novus actus or new cause of damage. Thus, damage arising from mechanical failure may be excluded, but damage arising from an accident, which is an insured peril, must be settled by the insurer.

It was recommended that the insurer settle all accident related damage and exclude damage which resulted from the latent defect/mechanical failure up to the point of the accident. In the alternative, the insurer was to settle all damages and claim back from the manufacturing dealer. The insurer accepted the recommendation of the OSTI and it decided to settle all accident related damage only.

John Theunissen
Assistant Ombudsman
Mr N insured his household contents and submitted a claim to his insurer following a burglary at his home in April 2018. The insurer rejected the claim and its rejection letter noted the repudiation reason as: “Material change in Risk”, referred to in his policy schedule. Mr N advised the insurer that he had changed his address in December 2017 but had failed to inform the insurer of this change.

The insurer argued that household contents cover is a “premises-based” cover and therefore Mr N was only covered at the noted risk address. In this regard the insurer submitted that the household contents cover provided to Mr N was for the risk address in Klipfontein View, Midrand, whilst the loss occurred in Sagewood, Midrand.

Despite the rejection reason noted in its own rejection letter being “Material change in Risk”, the insurer maintained that it did not view this as a change in risk, but simply as an issue of no cover. It argued that the insured’s new address is a completely new risk which it needed to underwrite before assessing acceptability and the governing terms and conditions therein.

According to the policy wording, the policy holder has a responsibility to inform the insurer immediately of any information about the risk that has changed or that is no longer true and complete. The insurer argued that Mr N had a duty to inform the insurer of the change in risk address as soon as it happened to enable the insurer to assess the risk and determine its acceptability. The insurer maintained that it was not provided with an opportunity to underwrite Mr N’s new address and assess its acceptability on cover, and therefore there could be no cover.

Whilst OSTI agreed that Mr N was under a duty to notify the insurer of the change to the risk address, there was no evidence presented to suggest that Mr N intentionally failed to disclose this information to the insurer in order to pay a lower premium. There was also no evidence on record that suggested that the insurer would not have accepted the risk had it been advised of the new address. In light of all the submissions made by the parties to the dispute, OSTI was of the view that the insurer’s response to this office was disingenuous as its rejection letter acknowledged this to indeed be a change in risk due to Mr N’s failure to notify the insurer that he had changed the address where his contents were kept. OSTI’s view was that essentially the insured failed to notify the insurer of a change in the risk.

Section 53 of the Short-term Insurance Act precludes an insurer from declining a claim as a result of a non-disclosure or failure to disclose unless the insurer can establish that it would “have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any renewal or variation thereof.”

The insurer has a duty to prove that a policy holder’s non-disclosure is material and the insurer needs to show how it has been prejudiced by the policy holder’s breach.

OSTI referred the insurer to Pillay v South African National Life Assurance Co Ltd 1991 (1) SA 363 (D) where the court referred to the “Didcott principle” and held that if the insurer would still have issued the policy, albeit at a higher premium – even if the information withheld materially affects the assessment of the risk by the insurer – then it would not be fair for the insurer to repudiate the claim.

It was accordingly the recommendation of this office that the insurer settle this claim on a proportionate basis if it could show that it suffered a premium prejudice, alternatively, if it could not, then it had to settle the claim in full.

The insurer accepted our recommendation and settled Mr N’s claim in full.

Regina Chindomu
Assistant Ombudsman
Standing from left:
Leigh Bennie, Paul Crankshaw, Farzana Badat, Viviene Pearson, Collin Molepe and Magauta Mphahlele

Seated from left:
Gerhard Genis, Richard Steyn, Haroon Laher, Thuli Zungu and Gail Walters

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Clerical
Mavis Mabaso
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Clerical Assistant/Cleaner
Mariam Khampepe
1. Preamble

1.1 The Ombudsman is appointed to serve the interest of the insuring public and all short-term Insurers registered under the Short-term Insurance Act and including Lloyds. The Ombudsman provides, free of charge, an accessible, informal and speedy dispute resolution process to Policy Holders who have disputes with their Insurers where those disputes fall within the Ombudsman’s jurisdiction.

1.2 The Ombudsman acts independently and objectively in resolving disputes and is not under instructions from anybody when exercising his or her authority. The Ombudsman resolves disputes using the criteria of law, equity and fairness. These Terms of Reference define the powers and duties of the Ombudsman.

1.3 The services rendered by the Ombudsman are not the same as those rendered by a professional legal advisor and are confined purely to resolution in terms of clause 3.1 below or mediation or conciliation in an attempt to settle complaints.

2. Definitions

In these terms of reference the following expressions have the following meanings:

2.1 “the Board” means the Board of Directors of the Ombudsman for Short-term Insurance NPC;

2.2 “Commercial Lines Policy” means a policy (a) issued to a person who is not a natural person, or (b) if issued to a natural person is intended to indemnify such a natural person in respect of a commercial enterprise conducted by the natural person for his or her own benefit.

2.3 “the Complainant” means any Policy Holder who makes a complaint to the Ombudsman in respect of any insurance services provided by their Insurer;

2.4 “Ruling” means, with respect to a complaint, a written directive issued by the Ombudsman which is binding on the Insurer and which is based either in law or equity;

2.5 “the Ombudsman” means the Ombudsman for Short-term Insurance appointed from time to time by the Board of the Ombudsman for Short-term Insurance NPC;

2.6 “Ombudsman’s office” means the office of the Ombudsman established to perform the functions set out in these terms of reference;

2.7 “Policy” means a short term insurance Policy issued by an Insurer to a Policy Holder;

2.8 “Policy Holder” means the person entitled to be provided with the Policy benefits under a Policy;

2.9 “Insurer” means a short-term insurer registered as such in terms of the Short-term Insurance Act of 1998;

3. The Ombudsman’s Powers and Duties

3.1 The Ombudsman shall:

3.1.1 act within these terms of reference;

3.1.2 receive complaints relating to the provision within the Republic of South Africa of insurance services by an Insurer to a Policy Holder;

3.1.3 resolve such complaints, relating to the provision of insurance services, by agreement or by the making of a ruling or by such other means as may seem expedient, subject to these terms of reference.

3.2 The Ombudsman should advise the public on the procedure for making a complaint to the Ombudsman’s office and should take such steps as are reasonably possible conducive to client and industry education and training. The Ombudsman shall in his annual report referred to in clause 3.3 below provide details of steps taken in this regard.

3.3 On receipt of a complaint in the prescribed format, the Ombudsman will notify the Insurer of the complaint by providing the details of the complaint to the Insurer, and the Insurer shall then be obliged to give all relevant information and assistance required (including documentation requested by the Ombudsman) to enable the Ombudsman to assess fully the merits of the complaint.

3.4 During any period in which the Ombudsman is unable to exercise his duties owing to absence, incapacity or death or in a situation where a conflict of interest may arise, the Board may appoint a deputy or acting Ombudsman to act in place of the Ombudsman.

3.5 The Ombudsman shall have the overall responsibility for the conduct of the day to day administration and business of the Ombudsman’s office. The Ombudsman may appoint an Administrator to be responsible to him for day to day matters of administration of the Ombudsman’s office.

3.6 The Ombudsman shall have the power on behalf of the Ombudsman’s office to appoint and dismiss employees, consultants, legal experts, independent contractors and agents and to determine their salaries, fees, terms of employment or engagement.

3.7 The Ombudsman shall have the power to incur expenditure on behalf of the Ombudsman’s office in accordance with the current financial budget approved by the Board.

3.8 The Ombudsman shall give the Board any information and assistance which it reasonably requires, including the making of recommendations to the Board on any issues which the Ombudsman believes requires the Board’s attention.

3.9 The Ombudsman shall publish an annual report on the activities of the office, which shall be published by 30 May of each year. Such report will be available to the public.

4. The Jurisdiction of the Ombudsman

4.1 The Ombudsman shall only consider a complaint made to him if he is satisfied that:

4.1.1 the complaint is not the subject of existing litigation;

4.1.2 the complaint is not the subject of an instruction to an attorney in contemplation of litigation against the relevant Insurer except where the attorney has simply assisted the Policy Holder in bringing the application to the Ombudsman;

4.1.3 the complaint does not involve a monetary claim in excess of the amount determined by the Board from time to time and that in respect of Commercial Lines Policies the annual turnover of the Complainant does not exceed the amount determined by the Board from time to time. *

*The limits are currently as follows namely, (a) R4 million for house owner’s claims; (b) R2 million
for all other claims provided that (c) in respect of Commercial lines policies, the turnover of the insured entity must not exceed R25 million per annum

4.1.4 the complaint is made by a Policy Holder or a duly authorised representative of the Policy Holder to whom or for whom the insurance services in question were provided;

4.1.5 the complaint relates to any dispute in regard to a Policy and/or any Claim or Claims thereunder or any dispute in regard to insurance premiums, or any dispute on the legal construction of the Policy wording relating to a particular complaint complying with the requirements of this clause 4.1;

4.1.6 the complaint is being pursued reasonably by the Complainant and not in a frivolous, vexatious, offensive, threatening or abusive manner, as the Ombudsman may decide in his or her sole discretion;

4.1.7 the complaint has not become prescribed in terms of the Prescription Act, 1969 or any enforceable time bar provisions contained in the Policy, provided that in relation to any enforceable time-bar provisions in the policy

4.1.7.1 the Ombudsman shall have the power to condone non-compliance therewith upon good cause shown, and

4.1.7.2 the provisions of any enactment which provides for the extension of any period contained in such time-bar provision shall be given effect to.

4.2 Should a complaint be lodged with the Ombudsman's office and thereafter the Complainant refers such dispute to an attorney for the further conduct of the dispute and/or direct correspondence with the Insurer, or for litigation, then the Ombudsman will immediately withdraw from the matter.

4.3 With the written consent of an Insurer and at his discretion the Ombudsman may investigate a complaint which exceeds his jurisdiction and make a recommendation or a Ruling in relation thereto.

4.4 A Complainant may at any time terminate the Ombudsman's adjudication of the complaint and resort to litigation.

5. Limits on the Jurisdiction of the Ombudsman

Subject to these terms of reference, the Ombudsman shall have the power to consider a complaint made to him and make a recommendation or Ruling in regard thereto except:

5.1 Where the Ombudsman determines that it is more appropriate that the complaint be dealt with by a court of law or through any other dispute resolution process;

5.2 Where the matter is already under the consideration by the person appointed to adjudicate disputes in terms of the Financial Advisory and Intermediary Services Act.


6.1 Any enforceable time bar clauses in terms of a Policy shall not run against a Complainant and shall be interrupted during the period that the complaint is under consideration before the Ombudsman. In particular, the Insurer waives and abandons all or any rights to rely in subsequent litigation on any time barring provisions in the Policy applying to the commencement of litigation after rejection of a claim, or after the happening forming the subject of the claim or after notification of the claim. In the event of the complaint being finalised in the office of the Ombudsman the Complainant shall have 30 (thirty) days or the remaining period of the time bar provision of the relevant policy, whichever is the longer, within which to institute proceedings against the relevant Insurer, provided however, that the Claim had not already become time barred in terms of the Policy when the complaint was received by the Ombudsman and the Ombudsman has not condoned the late receipt of the complaint as is envisaged in clause 4.1.7.

6.2 For the purposes of clause 6.1, the time during which a matter is before the Ombudsman shall (provided that the complaint is accepted for adjudication) commence on the day that it is lodged with the Ombudsman's office to the time that the Ombudsman dismisses the complaint or makes a Ruling.

6.3 Save as may be otherwise provided in the Financial Services Ombud Schemes Act 37 of 2004 as amended or in any other legislation relating to or governing the Ombudsman, the lodging of any complaint with the Ombudsman shall in no way affect the running of prescription in terms of the Prescription Act, 1969 in respect of such complaint.

7. Rulings

7.1 When all the material facts are agreed or the facts have been established to the Ombudsman's satisfaction on a balance of probabilities, the Ombudsman may make a Ruling.

7.2 Rulings shall be based on the law and equity.

7.3 Where a material fact cannot be established or cannot be resolved on a clear balance of probabilities the Ombudsman may not make a Ruling. In such cases the Ombudsman shall advise the Complainant that the complaint is not one on which he or she can assist and that alternative recourse may be sought through the courts.

7.4 Any Ruling made by the Ombudsman shall be binding on the Insurer concerned save where an appeal against such Ruling is noted as is provided in Clause 8 below.

8. Right of Appeal against Rulings or Findings of the Ombudsman

8.1 Any party affected by any formal ruling or finding on the part of the Ombudsman may appeal against the ruling or finding of the Ombudsman, either in part or in whole. In this context a “Ruling” shall mean, in relation to a complaint received, “a written directive issued by the Ombudsman which is binding on the insurer and which is based either in law or equity and fairness or a combination of law and equity”. “Finding” shall mean, with respect to a complaint, “a written directive issued by the Ombudsman in relation to the complaint received in terms of which the Ombudsman has dismissed the complaint or declined to intervene in a dispute between the complainant and insurer”.

8.2 No appeal against the ruling or finding of the Ombudsman shall be considered by any Appeal Tribunal, unless the Ombudsman shall have granted the applicant leave to appeal against such ruling or finding.

8.3 The Ombudsman shall only grant leave to appeal to any appellant where he is of the opinion that:

8.3.1 There is a reasonable prospect that the appeal, either in whole or in part, if prosecuted, will succeed; and

8.3.2 The matter is one of complexity or difficulty; or

8.3.3 The ruling or finding in question involves issues or considerations which are of substantial public
or industry interest or importance or it is in the interest of justice or public policy that the ruling or decision be considered by an Appeal Tribunal; or

8.3.4 The ruling or decision involves principles of law where the law may be considered to be uncertain or unsettled; or

8.3.5 The matter in dispute involves the jurisdiction of the Ombudsman to entertain the dispute; or

8.3.6 The issues are of such a nature that the judgment or order sought by the appellant will not be of academic relevance only and will have a practical effect or result.

8.4 The power to grant leave to appeal as contemplated in this section shall not be limited by reason only of the value of the matter in dispute, or the amount claimed or awarded by the Ombudsman, or by reason only of the fact that the matter in dispute is incapable of being valued in money.

8.5 Notice of any intention to appeal against any ruling or findings of the Ombudsman shall be filed with the Ombudsman within a period of 30 calendar days of the handing down of any ruling or finding and shall state whether the appellant appeals against the whole or part of the ruling or finding of the Ombudsman, the findings of fact and/or ruling of law appealed against and the grounds upon which the appeal is founded. The notice of intention to appeal shall be accompanied by an application for leave to appeal.

8.6 A Notice of Cross-Appeal shall be delivered within 15 calendar days after delivery of the Notice of Appeal, or within such other period of time as may, upon good cause shown, be permitted by the Ombudsman. The provisions of these rules with regard to appeals shall equally apply to cross-appeals. A “cross-appeal” shall mean a process by which the respondent in any appeal proceedings, having been advised by the Ombudsman of receipt of a notice of intention to appeal, wishes in turn to appeal against the terms of the ruling or finding made by the Ombudsman in relation to the complaint submitted to the Ombudsman.

8.7 Where an appeal has been noted, or an application for leave to appeal has been made, the operation and execution of the ruling or finding of the Ombudsman shall be suspended, pending the decision of the Appeal Tribunal on the matter, unless the Ombudsman, on the application of a party and on good cause shown, otherwise directs.

8.8 Upon receipt of a Notice of Appeal the Ombudsman shall within a period of 5 business days thereafter notify every other party to the dispute that a Notice of Appeal has been received.

8.9 All documentation in connection with any appeal proceedings including the notice of intention to appeal and the application for leave to appeal, shall be served upon the office of the Ombudsman by hand or alternatively by way of registered post or by e-mail save where the Ombudsman shall have expressly consented to any other method of service. Documentation served upon the Ombudsman shall be in A4 format and shall be clearly legible and capable of being photocopied. Wherever possible, original documents should form the subject of any appeal proceedings but copies of documents shall be acceptable subject to the provisions of these terms of reference.

Applications for Leave to Appeal

8.10 Any party who desires to appeal against any ruling or finding of the Ombudsman shall, within 30 calendar days of the handing down by the Ombudsman of any final ruling or finding, serve upon the Ombudsman as provided for herein, a Notice of intention to Appeal, together with an Application for Leave to Appeal which shall set out the basis for the proposed appeal as contemplated in Clause 8.5 above, together with reasons why Leave to Appeal against such ruling or finding should be granted by the Ombudsman. The granting of leave to appeal shall be a pre-requisite for the prosecution of any appeal.

8.11 Failing receipt by the Ombudsman of any Notice of Appeal within the time period referred to in paragraph 8 above, the final ruling or finding by the Ombudsman shall become final and binding upon the parties and shall be carried into effect without further delay.

8.12 Any late filing of a Notice of Appeal or an Application for Leave to Appeal shall be null and void save where accompanied by an application for condonation for the late filing of the appeal. Any application for condonation must set out in full the reasons why condonation should be granted, the reasons for any non-compliance and that the matter is one worthy of consideration.

8.13 The Ombudsman, after considering any application for condonation, may grant or refuse such application in his discretion.

8.14 Where leave to appeal against any ruling or finding of the Ombudsman is refused by the Ombudsman, the unsuccessful party may, within 15 business days of notification of such refusal, petition the Chairman of the Appeal Tribunal, to review the decision of the Ombudsman not to grant leave for appeal. The same provision shall apply mutatis mutandis to any application for condonation for the late filing of an appeal.

8.15 Any such request shall be addressed to the Chairman of the Appeal Tribunal via the Ombudsman who shall convey such request to the Chairman of the Appeal Tribunal. The Chairman of the Appeal Tribunal shall within a reasonable period of time but in any event not later than a period of 15 calendar days of the receipt of any such petition, either confirm or amend the decision of the Ombudsman not to grant leave to appeal or refusal to condone any application for the late filing of an appeal. The Ombudsman shall thereafter within a period of 5 business days, inform the parties accordingly.

Appeals

8.16 An appeal against the ruling or finding of the Ombudsman shall be heard by an Appeal Tribunal who shall consider the matter as if it were the Ombudsman and shall include the consideration of procedural as well as substantive matters pertaining to the objection raised by such party to the decision of the Ombudsman.

8.17 The Appeal Tribunal may, where it considers it necessary or in the interests of justice, permit the leading of evidence or new evidence on any matter, even if the Ombudsman himself did not hold a hearing, or receive evidence on any matter prior to making a finding on any complaint referred to him.

8.18 Where the Appeal Tribunal decides to permit, or calls for, the leading of evidence, or evidence is led on material that was never considered by the Ombudsman, the tribunal may decide, in its sole discretion to invite the Ombudsman to consider the matter in the light of such evidence and to canvass the views of the Ombudsman on the matter. The Ombudsman should be invited to comment on the new material in the manner and on such terms as it may regard to be fair to both parties.
8.19 Save where the Appeal Tribunal permits or calls for the leading of evidence, no evidence shall be led and the matter shall be decided by the Appeal Tribunal on the basis of the record of appeal furnished to it by the Ombudsman, including the documentation filed by the parties in connection with the appeal.

8.20 The record of appeal shall, save where in the opinion of the Ombudsman additional documentation is required, consist of the following:-

8.20.1 The complainant’s Application for Assistance form and supporting documentation;
8.20.2 The insurer's response to the complaint;
8.20.3 The complainant’s reply to the insurer's response to the complaint;
8.20.4 The Ombudsman's finding in relation to the complaint and any reasons furnished by the Ombudsman for any ruling or finding; and
8.20.5 The submissions or representations made by the parties to the Appeal Tribunal in connection with the appeal.

8.21 The Ombudsman may, in his discretion, when submitting the documentation to the Appeal Tribunal in connection with any appeal, make representations to the Appeal Tribunal by way of explanation or elaboration of his earlier determination and shall be entitled in such representations to deal with such matters as policy, industry practices and the approach followed by him in regard to equity. In addition the Ombudsman may furnish the Appeal Tribunal with such other information as he may consider to be of assistance or guidance to the Appeal Tribunal, save that the parties shall be afforded an opportunity to respond to any such additional material thus placed before the Appeal Tribunal.

8.22 Save as aforesaid, the Ombudsman shall not participate in the appeal process save where he should be asked to do so by the Appeal Tribunal itself on such terms and in such manner as may be determined by the Tribunal.

Composition of the Appeal Tribunal

8.23 The Chairman of the Board, in consultation with the Vice-Chairman, must appoint the members of the Appeal Tribunal from the persons nominated by the Ombudsman.

8.24 The Appeal Tribunal must consist of a Chairperson and at least two members appointed for a minimum period of two years.

8.25 The Chairman of the Board must appoint the Chairperson of the Appeal Tribunal and such Chairperson must either be a retired judge or a practicing Attorney or Advocate, or a person who formally practiced as an Attorney or Advocate, with at least ten years' experience and with appropriate experience in Insurance Law.

8.26 The Chairperson of the Appeal Tribunal is responsible for assigning matters for adjudication, taking into consideration the nature and complexity of the dispute or any special circumstance, to a panel of two or more members of the Appeal Tribunal who are suitably qualified to decide on a particular matter.

8.27 The Chairman of the panel must be the Chairperson of the Appeal Tribunal.

8.28 The person's nominated by the Ombudsman must be:

8.28.1 Practicing Attorneys or Advocates or persons who formerly practiced as an Attorney or Advocate, with at least ten years' experience and with appropriate experience in Insurance Law, and may include retired Judges; or

8.28.2 Persons with extensive experience in relation to the insurance industry and who by virtue of their knowledge, training and experience are able to perform the functions of a member of the Appeal Tribunal; or

8.28.3 Academics with the particular knowledge of specific areas of the law or persons of specific knowledge, skill or training whose expertise as an expert in any particular field may be appropriate.

8.29 The Chairman of the Appeal Tribunal may, in consultation with the Chairman of the Board and the Ombudsman, appoint a person who is not a member of the Appeal Tribunal to serve on the panel if in the opinion of the Chairperson of the Appeal Tribunal such appointment is merited or deemed desirable.

The Hearing of Appeals

8.30 The Ombudsman shall be in charge of all practical or administrative matters preceding and relating to the hearing of an appeal and shall be responsible for the preparation of the record, the giving of notices and the making of arrangements for the hearing of an appeal, the recording of evidence, if any, and all such other matters incidental to the hearing or disposal of the appeal.

8.31 The Appeal Tribunal shall determine its own procedure both prior to and during the course of the hearing, including the hearing of oral evidence.

8.32 Appeals shall be heard at such place and time and in such manner as the Appeal Tribunal shall determine from time to time.

8.33 Not later than 10 business days before the hearing of an appeal, the appellant shall deliver to the Ombudsman a concise and succinct statement of the main points which he intends to argue on appeal, as well as the list of legal authorities (if any) to be tendered in support of each point to be raised. Not later than 5 business days before the hearing of an appeal, the respondent shall deliver a similar statement.

8.34 The Chairman of the Appeal Tribunal may, after consultation with the Ombudsman, direct that a contemplated appeal be dealt with as an urgent matter and that the appeal be prosecuted at such time and in such manner as the Chairman of the Appeal Tribunal deems appropriate.

8.35 The Appeal Tribunal should approach the matter on appeal put forward as if it were the Ombudsman determining the complaint. The Appeal Tribunal shall take into account the balance of probabilities and its finding shall be based on the criteria of law, equity and fairness.

8.36 The Appeal Tribunal shall deliver its judgment on the matter in writing to the Ombudsman within one calendar month of the conclusion of the hearing. The Ombudsman shall in turn deliver a copy thereof to the parties within a period of 10 business days.

Representation

8.37 Any party to any appeal shall have the right to be represented at the hearing but, wherever possible, the parties should confine their submissions in regard to matters before the Appeal Tribunal to written submissions contained in a statement of case including, where appropriate, heads of argument.

8.38 Any party who employs a representative to represent their interest before the Appeal Tribunal shall be personally responsible for any fees and expenses associated with such representation.
The Effect of the Decision and Order of the Appeal Tribunal

8.39 Where a complainant appeals against the ruling or finding of the Ombudsman, such person shall abide by the decision of the Appeal Tribunal and the order of the Appeal Tribunal shall be final and binding in relation to the proceedings before the office of the Ombudsman. The complainant shall however be entitled, if so desired, to thereafter pursue the matter further in any court of law.

8.40 An unsuccessful appellant insurer shall have no further right of recourse or action and shall be bound by the terms of the order of the Appeal Tribunal save that nothing contained herein shall in any way affect the right of an insurer to review any ruling made by the Ombudsman or the Appeal Tribunal in a court of law.

Precedent

8.41 In recognition of the requirement that rulings made by the Ombudsman shall not establish any precedent in the Ombudsman’s office, the decisions of the Appeal Tribunal shall not be accorded any formal status or regarded as creating binding precedents, but may serve as guidelines for future cases. Such findings or orders may however, serve as strong persuasive value for the Ombudsman and any other Appeal Tribunal in which the same dispute may be raised so as to ensure consistency in the decisions of the office of the Ombudsman.

Cost to the Parties to Appeals

8.42 Where an insurer notes an appeal against any final ruling of the Ombudsman and is not, in the opinion of the Chairman of the Appeal Tribunal, successful with such appeal, it shall defray the cost of such appeal incurred by the Ombudsman in connection with the appeal proceedings.

8.43 Where the insurer is the appellant in any proceedings, save where the Chairman of the Appeal Tribunal may direct otherwise, the cost to be paid by the insurer in relation to any appeal proceedings may be determined by the Board of the Ombudsman for Short-term Insurance, from time to time.

8.44 Where the complainant is the appellant in any appeal proceedings the Ombudsman may, in his discretion and taking into account, inter alia, the amount of the claim, the complexity of the issues and the complainant’s personal circumstances, call upon such party to pay a deposit in an amount determined by the Ombudsman which deposit shall be refunded to the appellant should the appellant be successful in the appeal. In the event that the appeal fails, the deposit shall be forfeited to the office of the Ombudsman and shall constitute the only liability on the part of the complainant for the costs of the appeal proceedings. If the appeal is, in the view of the Appeal Tribunal, successful, the amount paid by the appellant shall be refunded to the appellant.

8.45 In no case shall the Appeal Tribunal award costs in favour of a successful party and in no case shall a losing party be ordered by the Appeal Tribunal to pay costs to the other party, save where the Chairman of the Appeal Tribunal considers that, having regard to the presence of exceptional circumstances, a punitive order as to costs against any party is merited.

9. Policyholder/Complainant’s Rights

The Policy Holder/Complainant’s rights to institute proceedings in any competent court of law against the insurer shall not be affected by any of the provisions of these terms of reference provided that, if the Policy Holder/Complainant institutes proceedings while the complaint is under investigation by the Ombudsman, the provisions of clause 4.2 shall apply.

10. Precedents

Rulings shall not establish any precedent in the Ombudsman’s office.

11. Confidentiality

11.1 The Ombudsman shall a far as possible, maintain confidentiality unless the parties concerned expressly exempt him or her from that duty and the duty shall continue after the termination of his or her services. The duty of confidentiality shall however, not prevent the Ombudsman from:

11.1.1 Publishing details of rulings made by him or her.

11.1.2 Reporting on details of rulings or furnishing statistical information in connection with the workings of the office to the South African Insurance Association (SAIA), the Financial Services Board (FSB), the National Treasury or any other body or organisation which may be entitled to receive such information from the Ombudsman in connection with his/her activities and/or which may have a legitimate interest in such information, having regard to its statutory mandate, role as an industry association or otherwise.

11.1.3 Publishing statistics and related information in the Annual Report of the Association concerning complaints received by the Ombudsman against members of the Association as approved by the Board of the Ombudsman for Short-term Insurance from time to time.

11.1.4 Filing, either on behalf of the Company, or any complainant from whom a complaint is received, a complaint with SAIA in connection with any Code of Conduct applicable to or adopted by that organisation and which may be applicable to any member of the Company.

11.2 The Insurer and the Complainant shall not be entitled to make use of any information which comes to their knowledge as a result of the intervention of the Ombudsman during the course of any investigation by him or her.

11.3 A complaint will be regarded as confidential as between the Policy Holder, the Insurer and the Ombudsman and it is for the Ombudsman to decide what should be disclosed to the Insurer and/or the Policy Holder.

11.4 Documents brought into being as a result of any approach to the Ombudsman shall not be liable to disclosure or be the subject of a discovery order or subpoena in the event of any legal proceedings between the Complainant and the Insurer.

11.5 The Ombudsman or any member of his staff will not be liable to be subpoenaed to give evidence on the subject of a complaint in any proceedings.

12. Complaints not settled in defined period

The Ombudsman shall report to the Board all complaints, which have not been completed in one way or another within a time, laid down by the Board. This time period shall initially be set at 6 (six) months calculated from the date that a complaint became an accepted complaint.
As OSTI’s legal interns we have observed that consumers of insurance products generally lack an understanding of the basics of insurance law. Common to our observation is how consumers understand what the specific features of their policies are but not how the cover will be applied. This discussion looks at some of these problems and general misunderstandings of how insurance works and endeavours to explain some of these concepts to the consumer in the simplest terms.

“Why am I paying monthly premiums if the insurer is not going to honour my claim?”

Consumers often assume that paying premiums monthly is the catchall prerequisite for a valid claim. What they require from the Ombudsman is an explanation as to why their claims are being rejected when they have complied with the monetary obligations of the contract by making regular payment of their premiums. In addition to paying premiums, the consumer must comply with the terms and conditions of the relevant policy in order for their claim to be valid. To illustrate, where it is a condition of the policy to install a tracking device in a motor vehicle for theft and hijacking; failure to comply with this condition will result in the repudiation of the claim in the event of theft or hijacking of the vehicle notwithstanding the fact that premiums are up to date.

“My policy was cancelled, I want a refund of my premiums since inception of the policy because I have never claimed under the policy.”

There is also another perception held by consumers that because no loss or damage occurred which the insurer was called upon to settle during the subsistence of the policy the insurer is not entitled to retain the premiums collected during this period once a policy is cancelled. Short term insurance policies provide cover on a monthly basis. The parties agree that the insured’s exposure to the risk of loss of or damage to property will be transferred to the insurer in exchange for the payment of a premium. If the risk materializes, the insurer will indemnify the consumer provided that the terms and conditions are also met. If no risk materializes the insurer will still be entitled to retain the premium for that period. This is because the premium is payment for the exposure to the risk and not payment for an actual loss.

“I was not informed that my premiums were in arrears now my claim is rejected on the ground of non-payment of premiums.”

Another detrimental assumption made by consumers is that it is the duty of the insurer to inform them when premiums are not paid. It must be understood by consumers that the most important undertaking by an insured is the undertaking to pay premiums to the insurer for carrying the risk on his or her behalf. Accordingly it follows that it remains the consumer’s duty to ensure that premiums are paid.

(Relebohile Tsagae, Vuyisile Ramakoaba and Respect Masuku)

“I have insurance for damage or loss to property, why is the insurer now refusing to pay my claim?”

Often the type of policy sold to consumers contributes to the misunderstanding held by consumers. Consumers assume that the type of cover they have covers every event that they may suffer or that all of their loss will be recovered from the insurer. The terms and conditions of these policies will set out in detail what is covered and what is not covered, under what circumstances the damage or loss will be covered, the procedures to follow to enjoy cover and the amount of compensation that can be recovered from the insurer.

For example, All Risk Cover refers to insurance cover for losses arising from any unforeseen event except for events that are specifically excluded. The policy will list what is excluded from cover. It is therefore something of a misnomer to use the term “All Risks Cover” as not every risk is covered under the policy. Typical exclusions are wear and tear, mechanical failure or breakdown, gradual deterioration and the like.

(Relebohile Mashego)

Conclusion

We have observed that the major contributing factor to consumer misunderstanding is that consumers assume that insurers inform them of the terms and conditions of the policy. It remains incumbent on the insured to read and understand the terms of the policy and to seek clarity where there is uncertainty. We urge consumers to read their policies and request the insurers to clarify any issues they might have.
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<tr>
<th>members of the ombudsman scheme</th>
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<td>Abacus Insurance Limited</td>
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<td>Alexander Forbes Insurance Company</td>
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<td>Allianz Global Corporate</td>
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<td>Auto &amp; General Insurance Company</td>
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<td>Bryte Insurance Company Limited</td>
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<td>Dial Direct Insurance Limited</td>
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<td>Discovery Insure</td>
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<td>First for Women Insurance Company Limited</td>
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<td>GENRIC Insurance Company Limited</td>
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<td>Guardrisk Insurance Company Limited</td>
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<td>Hollard Insurance Company</td>
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<td>Indequity Specialised Insurance Limited</td>
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<td>King Price Insurance Company Limited</td>
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<td>Legal Expenses Southern Africa Limited</td>
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<td>Lion of Africa Insurance Company Limited</td>
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<tr>
<td>Lloyd’s South Africa (Pty) Limited</td>
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<td>Lombard Insurance Limited</td>
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## Useful Information About Other Offices

<table>
<thead>
<tr>
<th>Office</th>
<th>Address</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td><strong>Ombudsman for Long-Term Insurance</strong></td>
<td>Private Bag X45, Claremont 7735</td>
<td>Telephone: 021 657 5000, Sharecall: 086 010 3236, Fax: 021 674 0951, Email: <a href="mailto:info@ombud.co.za">info@ombud.co.za</a>, Website: <a href="http://www.ombud.co.za">www.ombud.co.za</a></td>
</tr>
<tr>
<td><strong>Financial Advisory and Intermediary Services Ombud</strong></td>
<td>546 Jochemus Street, Erasmus Kloof, Kasteel Park 2nd Floor</td>
<td>Telephone: 012 470 908/012 762 5000, Fax: 012 674 0951, Email: <a href="mailto:info@faisombud.co.za">info@faisombud.co.za</a>, Website: <a href="http://www.faisombud.co.za">www.faisombud.co.za</a></td>
</tr>
<tr>
<td><strong>The Ombudsman for Banking Services</strong></td>
<td>34 - 36 Fricker Road, Ground Floor, Ilovo, Johannesburg</td>
<td>Telephone: 011 712 1800, Fax: 011 483 3212, Email: <a href="mailto:info@obssa.co.za">info@obssa.co.za</a>, Website: <a href="http://www.obssa.co.za">www.obssa.co.za</a></td>
</tr>
<tr>
<td><strong>Credit Ombud</strong></td>
<td>P O Box 805, Pinegowrie, 2123</td>
<td>Call Centre: 0861 662 837, Tel: 011 781 6431, Fax: 011 388 8250, Email: <a href="mailto:ombud@creditombud.org.za">ombud@creditombud.org.za</a>, Website: <a href="http://www.creditombud.org.za">www.creditombud.org.za</a></td>
</tr>
<tr>
<td><strong>Motor Industry Ombudsman of South Africa</strong></td>
<td>Suite 156, Private Bag X025, Lynnwood Ridge, 0040</td>
<td>Telephone: 010 590 8378, Call Centre: 086 116 4672, Fax: 0866 306 145, Email: <a href="mailto:info@miosa.co.za">info@miosa.co.za</a>, Website: <a href="http://www.miosa.co.za">www.miosa.co.za</a></td>
</tr>
<tr>
<td><strong>Consumer Goods and Services Ombud</strong></td>
<td>292 Surrey Avenue, Ferndale, Randburg, 2194</td>
<td>Telephone: 011 781 2607, Call Centre: 0860 000 272, Fax: 086 206 1999, Email: <a href="mailto:info@cgso.org.za">info@cgso.org.za</a>, Website: <a href="http://www.cgso.org.za">www.cgso.org.za</a></td>
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<tr>
<td><strong>Ombudsman Central Helpline</strong></td>
<td>Share call: 0860 OMBUDS/0860 662837</td>
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<tr>
<td><strong>Pension Funds Adjudicator</strong></td>
<td>P O Box 580, Menlyn, 0063</td>
<td>Telephone: 012 346 1738, Fax: 086 693 7472, Email: <a href="mailto:enquiries@pfa.org.za">enquiries@pfa.org.za</a>, Website: <a href="http://www.pfa.org.za">www.pfa.org.za</a></td>
</tr>
<tr>
<td><strong>National Credit Regulator</strong></td>
<td>127, 15th Road, Randjespark, Midrand</td>
<td>Call Centre: 0860 627 627, Email: <a href="mailto:complaints@ncr.org.za">complaints@ncr.org.za</a>, Telephone: 011 554 2600, Fax: 087 234 7822, Website: <a href="http://www.ncr.org.za">www.ncr.org.za</a></td>
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<tr>
<td><strong>Public Protector</strong></td>
<td>Private Bag X677, Pretoria, 0001</td>
<td>Telephone: 012 366 7000, Fax: 012 362 3473, Toll free number: 0800 11 20 40, Email: <a href="mailto:registration2@pprotect.org">registration2@pprotect.org</a>, Website: <a href="http://www.publicprotect.org">www.publicprotect.org</a></td>
</tr>
<tr>
<td><strong>National Consumer Commission</strong></td>
<td>Private Bag X84, Pretoria, 0001</td>
<td>Tel: 012 761 3200, Fax: 086 758 4990, Email: <a href="mailto:complaints@thencc.org.za">complaints@thencc.org.za</a>, Website: <a href="http://www.nccsa.org.za">www.nccsa.org.za</a></td>
</tr>
<tr>
<td><strong>City of Johannesburg Ombudsman</strong></td>
<td>48 Ameshoff Street, Braamfontein Sappi Building</td>
<td>Call Centre: 010 288 2800, Website: <a href="mailto:info@joburgombudsman.org">info@joburgombudsman.org</a></td>
</tr>
<tr>
<td><strong>National Consumer Tribunal</strong></td>
<td>Menlyn Corner, 2nd Floor, 87 Frikkie De Beer Street, Menlyn, Pretoria, 0187</td>
<td>Telephone: 012 341 9105, Call Centre: 0800 662 837, Fax: 012 452 5013, Email: <a href="mailto:complaints@taxombud.gov.za">complaints@taxombud.gov.za</a></td>
</tr>
<tr>
<td><strong>Office of the Tax Ombud</strong></td>
<td>Private Bag X110, Centurion, 0046</td>
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<tr>
<td><strong>S.A. Military Ombudsman</strong></td>
<td>Private Bag X163, Pretoria 0046</td>
<td>Telephone: 012 676 3800, Toll free: 080 726 6283, Email: <a href="mailto:intake@miliombud.org">intake@miliombud.org</a></td>
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