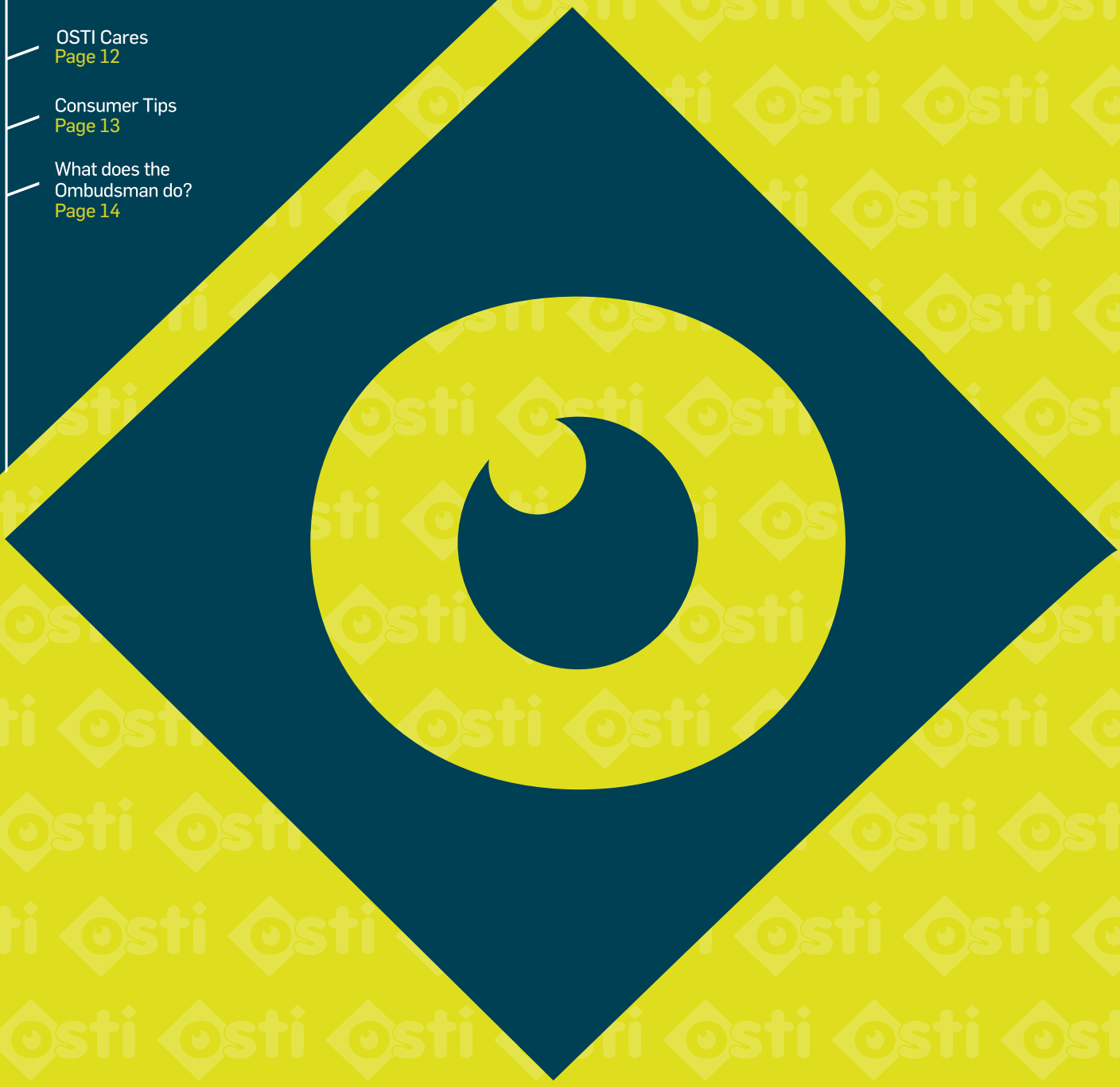
THE OMBUDSMAN'S BRIEFCASE

Issue No4 of 2019

ombudsman for short-term insurance



FROM THE EDITOR'S DESK

At the end of December 2019 OSTI will bid farewell to its Ombudsman, Deanne Wood. We take this opportunity to thank Ms Wood for her valued contribution and dedication to OSTI. We wish her every success for the next chapter of her journey.

We wish you a safe and prosperous festive season. Please read our "Consumer Tips" section for advice over the festive period. Happy Holidays!

NEWS AND EVENTS

JOINT OMBUDSMAN FOR THE OFFICE OF THE OMBUDSMAN FOR LONG-TERM INSURANCE AND THE OFFICE OF THE OMBUDSMAN FOR SHORT-TERM INSURANCE

The insurance industry will have a single Ombudsman from 1 January 2020. He is retired Judge, Mr Justice Ron McLaren who brings with him a wealth of judicial experience and knowledge in dealing with and resolving insurance disputes.

As from 1 January 2020, the short-term (non-life) and long-term (life) insurance industries will have a single Ombudsman when retired Judge McLaren, the current Ombudsman for Long-term Insurance, in addition takes over the adjudicative role in the office of the Ombudsman for Short-term Insurance. Deanne Wood, the current Ombudsman for Short-Term Insurance, will be leaving the office on 31 December 2019. Edite Teixeira-Mckinon has been appointed by the Board of the office of the Short-term Insurance Ombudsman as Chief Executive Officer of the office of the Ombudsman for Short-Term Insurance and will head up all operations.

For some time, National Treasury has advocated a self-rationalisation process for the four statutorily recognised voluntary financial services ombudsman schemes, namely long-term insurance, short-term insurance, banking and credit.

Against the backdrop of changes in the policy and insurance environment, the Boards of both insurance ombudsman schemes made an in-principle decision to enter into a shared services agreement and have a single Ombudsman for the adjudication of both short-term and long-term insurance complaints.

The office of the Ombudsman for Short-term Insurance and the office of the Ombudsman for Long-Term Insurance will remain in existence and continue to operate separately within their current defined jurisdictions.

Judge McLaren said there will be a single port of entry for complainants who are uncertain at which office to lodge a complaint. This will go live on 1 February 2020. Complainants of both life and non-life insurance can also continue to use the existing entry points. If a complaint needs to be transferred to the other office it will be a seamless process.

Judge McLaren was admitted as an attorney in 1968 and practised until 1978 when he joined the Pietermaritzburg Bar. He became a Senior Counsel in 1984 and left the Bar in 1990 when he was appointed as a Judge, which position he held for more than 20 years.

On 1 June 2013 he was appointed as Ombudsman for Long-term Insurance, which position he will continue to hold as the joint Ombudsman.

ABOUT THE OFFICES

The Ombudsman for Short-Term Insurance will continue to have jurisdiction over all types of short-term insurance products, including motor, house owners (buildings), householders (contents), cell phone, travel, disability and credit protection insurance, and commercial insurance for small businesses and sole proprietors.

The Ombudsman for Long-Term Insurance will continue to have jurisdiction over complaints about long-term insurance products such as life insurance, funeral, long-term disability, credit life and health insurance policies.

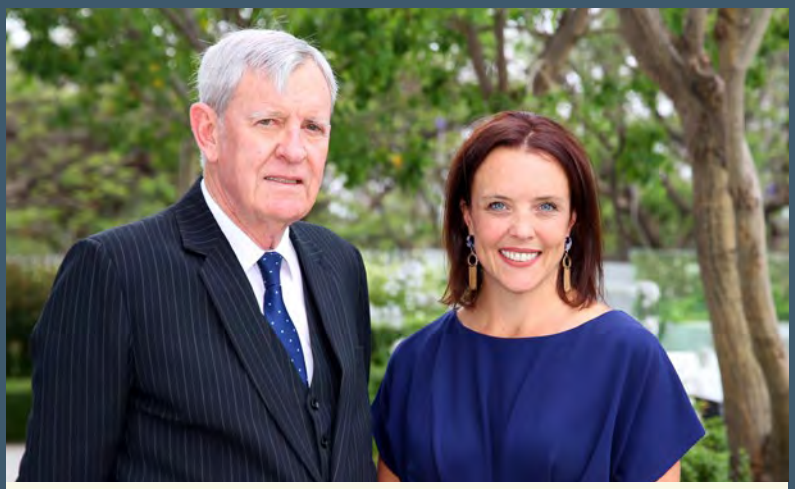
The offices of both the Ombudsman for Short-Term Insurance and the Ombudsman for Long-Term Insurance will continue to provide the insuring public with a free, efficient and fair dispute resolution mechanism through an alternative dispute resolution process, applying the law and principles of fairness and equity.

FOR THE OMBUDSMAN FOR SHORT-TERM INSURANCE,

visit website www.osti.co.za or call 0860 726 890 or email info@osti.co.za.

FOR THE OMBUDSMAN FOR LONG-TERM INSURANCE,

visit website www.ombud.co.za or call 0860 103 236 or email info@ombud.co.za.



Judge Ron McLaren, Ombudsman for Long Term Insurance and Deanne Wood, Ombudsman for Short Term Insurance

ANNUAL MOOT COURT COMPETITION WINNER

Assistant Ombudsman, Latoya Masango

Osti's Assistant Ombudsman, Latoya Masango participated in the first Annual Moot Court Competition hosted by the Student Litigation Society during 4 -7 December 2019. There were 40 registered teams, made up of 100 individual participants. Ms Masango's team originally comprised of 2 members, however owing to external factors, her team member had to withdraw at the preliminary rounds. Ms Masango was permitted to continue the competition as a single member team where she advanced to the finals. Ms Masango won the final round and was awarded competition winner and overall best speaker. Osti congratulates Ms Masango on her achievements.

CASE STUDIES

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

FAILURE TO PROVE DISHONESTY OR DRIVING UNDER THE INFLUENCE OF ALCOHOL

Mr M was involved in a motor vehicle accident around 22h00 on 8 August 2018. He reported that a friend, Ms S was the incident driver. The incident description provided by both Mr M and Ms S was that a third party driving a Toyota Corolla skipped a stop street and collided into the insured vehicle.

The insurer asserted that Mr M breached his obligations in terms of the contract of insurance by failing to provide true and complete information relating to the circumstances of the loss. The insurer submitted further that a breathalyzer test conducted on Ms S at the accident scene indicated that she was under the influence of alcohol. It was on these two grounds that the insurer rejected the claim.

1. Mr M's alleged failure to provide true and complete information to the insurer.

The contract of insurance provides:

"Be honest
Always provide us with true and complete information. This also applies when anyone else acts on your behalf."

"You need to give us:
True and complete information to us and the authorities. We act on the information you provide, therefore any information which is misleading, incorrect or false will prejudice the validity of your claim."

The insurer appointed an assessor to validate the claim. The assessor interviewed Mr M and Ms S on 14 October 2018. The insurer submitted that Mr M had to disclose his whereabouts before the accident and provide further details in respect of the accident.

Mr M stated that he was at work from 07h30 to 14h30. Thereafter, he went to assist a student with school work. Mr M stated that he left the student's place around 18h00 and visited a friend, Mr P. They later drove to a 'chesanyama'. He stated that they ate liver and drank coke. Mr M advised the assessor that they had left the 'chesanyama' around 19h00 with several passengers inside his vehicle. He stated that they have driven to Ms S's home and spent some time there. Mr M informed the assessor that the accident occurred on the way to drop off another friend named Mr O. He stated that he had asked Ms S to drive the vehicle because she knew how to get from her place to Mr O's home. Mr M submitted that he did not consume any alcohol the entire day.

During the assessment conversation, Ms S confirmed that she was the incident driver. She also corroborated Mr M's version regarding the circumstances of the loss. Ms S was asked whether she had, had anything to drink before the incident. She submitted that she had consumed two Millers earlier that day, before 17h00. The assessor found a receipt for a bottle of Russian Bear vodka inside the vehicle during his inspection. According to the receipt, the alcohol was purchased at Tops Liquor, Katlehong at 15h25. The assessor confirmed from Mr M's bank records that he had made this purchase.

The insurer submitted that the evidence of the transaction at Tops Liquor contradicted Mr M's timeline concerning his whereabouts between the time he had visited the student and Mr P. According to the insurer, when confronted with these findings, Mr M only advised the assessor that the alcohol was purchased for his friend Mr O. In his submissions to OSTI, Mr M stated that he had informed the assessor that he was not really keeping track of the time. Mr M advised that he merely estimated the timeline provided during the assessment interview.

The insurer submitted further that Mr M's bank statement reflected a transaction at "Lizzy's" for R200.00. It stated that Mr M could not provide any detail of what he had purchased.

The assessor also interviewed two witnesses at the accident scene. The insurer submitted that, according to these witnesses, the incident driver was male. They identified Mr M on an ID photograph presented by the assessor as having been the incident driver. They also stated that Mr M was injured by an airbag in the accident. The witnesses also informed the

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assessor that a woman, who was a passenger at the back of the vehicle, submitted that she was the incident driver. They stated that she did so as she was the only vehicle occupant who was not drunk.

The assessor interviewed another witness named Mr X. The insurer submitted that Mr X confirmed that a woman identified herself as the incident driver. He was however not convinced that this was the case. Mr X stated that he believed that the incident driver was an injured male who was lying outside the vehicle. Mr X also stated that the vehicle occupants were all drunk.

The assessor also interviewed the towing operator who uplifted Mr M's vehicle. He stated that the vehicle smelled of alcohol. He also found alcohol bottles in the boot. The towing operator stated further that, in his view, all of the vehicle occupants were under the influence of alcohol because they smelled of alcohol. The insurer also submitted that assessment notes were made that the vehicle interior smelled of alcohol and had spillage marks. The towing operator also stated that Ms S told him that she was driving the vehicle.

Mr M argued that he could not have been the person identified by the witnesses as lying down as he was busy communicating with the insurer telephonically and with the towing operator at the scene. According to Mr M, Mr O was the person lying down at the accident scene. He stated that Mr O was seated on the back seat without a seatbelt. The impact of the accident lunged him into the windscreen. Mr M submitted that he was seated on the front passenger's seat and had minor injuries. Mr M also denied that all of the passengers inside the vehicle were drunk as two of his friends inside the vehicle did not drink alcohol at all.

The insurer argued that the assessment findings indicated that Mr M gave false and misleading information with regards to his whereabouts before the accident, the identity of the incident driver and the consumption of alcohol. According to the insurer, there was sufficient circumstantial evidence on which it could prove that Mr M was the incident driver and that he was under the influence of alcohol at the time of the accident. It further argued that the discrepancies noted in the assessment prejudiced its right to validate the claim. Mr M submitted recorded telephone conversations with a police officer. According to Mr M, the police officer and the investigating officer agreed to assist him with CCTV footage from nearby cameras to prove that he was not the driver. Mr M was however not able to obtain the footage.

As this is a civil matter (as opposed to a criminal one), the insurer is not required to prove the facts beyond a reasonable doubt but on a balance of probabilities. The insurer bears the onus of proving that Mr M submitted false information regarding his whereabouts before the accident, the identity of the incident driver and the consumption of alcohol. If this onus was discharged by the insurer, then OSTI had to decide whether the insurer was able to determine its liability for the claim based on the information provided by Mr M.

The receipt from Tops Liquor was the only evidence the insurer relied on to challenge Mr M's submissions with regard to his whereabouts before the accident. It proved that Mr M left the student's home before 18h00. This evidence, however, could not be considered in isolation. OSTI had to consider the evidence and facts of this matter as a whole before determining the materiality of this discrepancy.

OSTI considered Mr M's submission that the timeline provided during the assessment was an estimate. Mr M did not conceal the alcohol he had purchased. When OSTI listened to the recorded assessment interview provided by the insurer, OSTI noted that Mr M was asked if he had purchased any alcohol on the day of the accident. He disclosed having purchased the bottle of vodka.

The transaction at Lizzy's was in the amount of R84.00, not R200.00 as submitted by the insurer. OSTI confirmed that Mr M informed the assessor, during a subsequent recorded assessment conversation submitted by the insurer, that this was what he had paid at the 'chesanyama'.

OSTI also listened to the assessment recordings with the two witnesses at the accident scene. In OSTI's view, their submissions were merely speculative and could not be relied upon without proven objective facts.

The witnesses at the accident scene concluded that Mr M was the incident driver without having witnessed the accident take place. Their statements did not indicate that they had seen Mr M driving the vehicle, or seated on the driver's seat, or exiting the vehicle from the driver's side. What they had said was that, if a driver was drunk, the sober person will always claim to be the driver.

One of the witnesses had stated that the woman could not have driven the vehicle because she was not injured. He had said that he had also seen her seated on the back seat. In the same conversation, the other witness (who was assisting the assessor with translations) mentioned that the witness was drunk on the night of the accident and had not seen properly. This other witness also mentioned that the man who allegedly drove the vehicle suffered injuries because of the airbags. According to Mr M, he was seated on the front passengers' seat. He could, therefore, have been hit by the airbag from that seat. The assessment photographs had shown that both airbags deployed. The witnesses also submitted that Mr M referred to the vehicle as his. This did not conclude that he was the incident driver.

The witnesses at the accident scene referred the assessor to Mr X. They stated that Mr X was the person who had best seen the accident. According to his recorded statement to the assessor, Mr X arrived at the accident scene after all of the vehicle occupants had exited the vehicle. He therefore, could not confirm the identity of the incident driver.

Further to the above, the Metro Accident Report made no mention of any issues with regard to the identity of the incident driver. Apparently, none of

the insurer's witnesses raised this with authorities who attended the accident scene. The statement of the towing operator regarding the presence or use of alcohol was too general and did not take the matter further.

In light of the above, OSTI found that the evidence submitted by the insurer did not support the allegations made against Mr M. The insurer failed to prove that Mr M had submitted false information regarding his whereabouts before the accident, the identity of the incident driver and the consumption of alcohol. The insurer was therefore not justified in declining liability on this ground.

2. Driving under the influence of alcohol

The insurer had submitted that if Ms S was the incident driver, the evidence indicated that she was under the influence of alcohol. Ms S admitted to consuming alcohol before the accident. The insurer advised further that a metro police officer conducted a breathalyzer test on Ms S at the accident scene. The test results showed a breath alcohol content of 0.14mg per 1,000ml.

The contract of insurance provides;
"You're not covered for driving under the influence
If the person who drives the car:

- *Is under the influence of alcohol or drugs*
- *Has a concentration of alcohol in their blood exceeding the legal limit or fails a breathalyzer test.*
- *Is under the influence of medication used contrary to a practitioner's or the manufacturer's instructions.*
- *Refuses to give either a breath or blood sample."*

The policy entitled the insurer to decline liability where the incident driver was under the influence of alcohol, or had a blood-alcohol level exceeding the legal limit, or failed a breathalyzer test.
Ms S's blood-alcohol levels were never tested. The legal limit of a breathalyzer test is 0.24mg per 1,000ml. Therefore, Ms S did not fail the breathalyzer test.
The issue which had to be determined, therefore, was whether Ms S was, on a balance of probabilities, under the influence of alcohol at the time of the accident. In this regard, the insurer bears the onus of proving that Ms S did, in fact, consume alcohol on the day of the incident. This was not in dispute. The consumption of alcohol alone, however, was not the end of the matter. The insurer further bears the onus of proving that Ms S was influenced by such consumption resulting in the accident.

It is trite that a driver will be found to be under the influence of liquor when *"the skill and judgment normally required of a driver in the manipulation of a vehicle was diminished or impaired as a result of the consumption of alcohol. The judgment of a driver will be impaired not only when his vision is dulled or his judgment is blunted or his muscular reactions to communication from his brain made sluggish, but also when the consumption of liquor has induced an exuberant over-optimistic frame of mind which causes him to take risks which he would not have taken but for the liquor he has consumed."* - **Swart v Mutual & Federal Insurance Co. Ltd (10352/2004) [2009] ZAWCHC 107 (4 August 2009).** The court in **Swart** stated further that the inference to be drawn must be based on objective facts, not conjecture and speculation. It was under these circumstances that the onus of proof would shift to Mr M. According to an affidavit deposed to by the metro police officer who attended the accident scene, Ms S's alcohol consumption did not exceed the legal limit. The third party, on the other hand, was found to have been three times over the legal limit. The incident description confirmed in the accident report pointed to the third party's culpability. None of the insurer's witnesses described Ms S's demeanour as that of a person whose mental faculties or driving ability were affected by alcohol to the extent that she was incapable of driving the vehicle with the required skill, care or judgment.

The insurer therefore had not demonstrated sufficient evidence to prove that Ms S was influenced by the consumption of alcohol or that it had contributed to the accident. In light of this, the insurer was not justified in its decision to decline liability on the basis that the incident driver was under the influence of alcohol.

Accordingly, OSTI recommended that the insurer settle the claim. The insurer agreed to settle the claim. The dispute was therefore resolved in Mr M's favour.

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CONSEQUENTIAL LOSS

Mr B submitted a motor vehicle accident claim to his insurer on 10 October 2017. According to the information provided, there were significant delays in processing and finalizing the claim. An assessor was appointed to validate the claim on 20 November 2017. The insurer submitted that, with the beginning of the festive season, there were further delays in the repair of the vehicle.

Mr B's policy provided cover for a rental vehicle during the claims period. Mr B was provided with a Ford Fiesta through a vehicle rental company. The insurer submitted that the class of rental vehicle provided was in line with the 'car hire option' agreed to at the inception of cover and set out in the policy schedule.

On 2 February 2018, Mr B's rental vehicle was broken into. Various items of value were stolen from the boot. According to the information provided, there were visible signs of forced entry into the vehicle, namely that the key cover on the driver's door handle had been removed. Mr B submitted a claim under the All Risks section of the policy for the replacement of the stolen items.

Mr B claimed a total sum of R67 250.00. The claimed items included a 13" Apple MacBook for the replacement value of R19.600.00. According to the insurer, this item was specified under the policy for R14 000.00. This was, therefore, the maximum limit of cover. Mr B also claimed for various items under the Unspecified All Risk cover. The insurer pointed out that the limit of cover under the unspecified All Risks section of the policy was 25% of the sum insured, per individual item and the claimed incident. The sum insured was R12 900.00, less a basic excess of R250.00.

The insurer offered to settle Mr B's total claim in the amount of R25 270.00 calculated as, R14 000 in respect of the 13"Apple MacBook and R11 270 for the total unspecified items less, the excess of R250.00. The settlement offer was declined by Mr B.

The insurer had substantiated its settlement offer based on the following provisions in the insurance contract:

"Section 3 – All Risks

This Section covers items that you decide to insure, against a wide range of risks (including loss and accidental damage). These items are also covered when they are removed from your home."

"Details of cover we provide

1. We will compensate you

- *when any of your insured property is lost or damaged,*
- *compensation will be based on the current new replacement cost, but limited to the sum insured."*

"Specific Exclusions

(your All Risks cover is limited in the following ways)

Loss or damage is NOT covered for:

- *more than R1 000 or 25% of the sum insured, whichever is the greater, for any one article, pair or set (other than clothing); this limit is not extended by any of the sub-limits that follow. (For cover up to the full amount of any of the sub-limits, you should ensure that your "General" Sum Insured is 4 times the sub-limit that is important to you);"*

"Procedures and requirements when making a claim

- *You must supply proof of both ownership and value of any item that you are claiming for."*

Mr B stated that his claim was not based on the insurer's contractual obligation. He submitted that the insurer should be held responsible for the full loss due to the admitted delays in the administration of the vehicle claim as this had 'real-world consequences' for him.

Mr B argued that the incident would never have occurred with his vehicle, a 1990 Jaguar XJ40. He submitted that, according to the car rental company and the media, the Ford Fiesta is notoriously vulnerable to this type of theft. Mr B stated that he would not have been driving the Ford Fiesta in February 2018 had it not been for the inefficient service and claim delays on the part of the insurer.

Mr B argued further that the insurer's initial offer should be reconsidered as it had been made during the tenure of the insurer's CEO whose employment was subsequently terminated on issues relating to dishonest conduct.

The insurer submitted that it had already exercised good-will by going

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beyond the terms and conditions of the policy. The insurer advised that it waived the policy requirement for proof of ownership in respect of the unspecified claimed items. The insurer further offered an additional R5 000.00 as compensation for the inconvenience suffered by Mr B as a result of its delay in the administration of the vehicle claim.

Mr B declined the amended settlement offer. He submitted a counter-offer that the insurer settle the unspecified laptop in the amount of R10 775.00. The insurer did not accept the counter-offer.

The insurer, in its response to the details of the complaint, maintained that the settlement offer was reasonable and fair. It acknowledged its delay in appointing the assessor and apologized for the poor claims experience. The insurer submitted however that it could not be held responsible for the theft. It stated that this would be unfair because theft incidents in South Africa occur daily. The insurer explained that the additional R5 000.00 settlement offer was made in goodwill, as an ex gratia payment. It stated that there was no scientific calculation behind it. The insurer added that the basic excess was also subsequently waived.

The relief sought by Mr B required OSTI to determine whether the insurer's liability in respect of the theft claim could extend beyond the scope of the cover provided in the insurance contract on account of its delay in processing the vehicle claim.

The following terms are stipulated under the vehicle section of the insurance contract;

"SPECIFIC EXCLUSIONS
(your Motor cover is limited in the following ways)
Limitations on cover for loss or damage

We do NOT cover:

- consequential loss from any cause (except car hire cover as it is insured in this Section);"

Consequential loss arose from a special circumstance. It was the indirect financial loss suffered by Mr B following an insured peril. The financial loss is usually not foreseeable or within the contemplation of the parties when entering into the contract. Consequential loss is often excluded in short-term insurance policies thereby limiting the insurer's liability. Consequential loss may be recoverable in terms of a damages claim - a delictual loss. In order to make out a valid claim for delictual loss, Mr B would need to establish a breach of contract of a legal duty and demonstrate that the loss was reasonably foreseeable as a probable consequence of the breach. The aforementioned claim falls beyond the scope of the insurance contract and therefore outside of OSTI's jurisdiction.

Mr B's theft claim had been accepted by the insurer in line with the cover provided. An additional amount was offered as a gesture of good-will for the significant delays experienced by Mr B. The ex gratia settlement offer was made as a business decision. How the insurer determined this offer fell within its domain, not OSTI's. OSTI also does not have the mandate to award penalties against the insurer for gaps in the service it provided to Mr B.

The termination of the services of the insurer's employee was irrelevant to the claim. There was no evidence which indicated that the alleged dishonest conduct of the insurer's employee was related to Mr B's claim in any way.

OSTI's view was that the insurer's settlement offer was reasonable, fair and in line with the contract of insurance. OSTI therefore upheld the insurer's settlement of the claim and the matter was resolved in favour of the insurer.

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MATERIAL MISREPRESENTATION AND DISHONESTY

Mrs V's policy incepted with her insurer on 26 November 2018. She enjoyed "All Risks" cover for portable possessions.

Mrs V submitted a claim to her insurer in respect of the theft of her laptop and camera out of the boot of her motor vehicle, which occurred on 2 April 2019. The laptop and camera were specified under the policy. Mrs V also had cover for her motor vehicle and household contents under the policy.

According to the insurer's rejection letter dated 11 April 2019, it declined liability for the claim on the following grounds:

1. Fraudulent Claim: Misrepresentation / True and Complete Information.
2. Non-Compliance: Lack of Reasonable Proof of Ownership.

During the underwriting of the policy, Mrs V was asked to disclose any losses she had suffered in the preceding three years, being 26 November 2015 – 26 November 2018. According to a copy of the recorded underwriting conversation provided by the insurer, Mrs V disclosed a burglary which occurred in November/ December 2017 to the value of approximately R20 000.00.

Following Mrs V's alleged loss, an assessor was appointed to validate the claim. The insurer advised that the underwriting information provided by Mrs V was incorrect. The insurer stated that Mrs V failed to disclose additional claims submitted to her previous insurer during the relevant three year period. The insurer submitted a TransUnion Claims Enabler Report and a copy of a recorded telephone conversation held with the previous insurer to substantiate these claims. The TransUnion Claims Enabler Report recorded 12 claims. The total value of the claims were approximately R291 499.00.

During the telephone conversation with the previous insurer, the assessor was informed that Mrs V had three separate policies under the financial services group. She submitted a total of seven claims relating to household contents and portable possessions between 18 February 2017 and 15 November 2018. The previous insurer also advised that the policy was cancelled in November 2018 based on an 'unfavourable claims history'. In light of the assessment findings, the insurer rejected the claim and voided the risk based on material misrepresentation and dishonesty.

The rejection letter further stated that Mrs V informed the assessor that her laptop and camera were previously stolen in 2013. She stated that they were both subsequently replaced and never stolen again until the reported incident. According to the rejection letter, the assessor discovered that Mrs V claimed for the same/similar items with her previous insurers after 2013 and was compensated for that loss. The insurer argued that Mrs V intentionally provided misleading information relating to the claimed items. However, the insurer did not provide OSTI with a copy of the assessment conversation held with Mrs V.

In her details of the complaint, Mrs V informed this office that she had decided to change her insurer in November 2018 because her previous insurer had treated her unfairly after a home burglary claim. Her response to the previous losses was that the South African crime rate was notoriously high and that was why she insured her valuables.

Mrs V did not provide reasons for not disclosing the previous losses to her insurer during the underwriting of her policy.

The insurer cited the following relevant sections of the policy wording as the basis for the rejection of this claim:

"THE CONTRACT
The policy wording and your policy schedule is a legal contract between you and us.

The contract is based on the information you gave us when you applied for insurance, either by speaking to us or on any document.
Our duty is to provide the cover explained in this policy wording subject to the terms of the policy and the specific rules in your schedule for those sections which are shown on your policy schedule and for the insurance period set out on the same schedule.

Your duty in terms of the contract is to follow the rules explained in this policy wording and your schedule. If you do not carry out your duty in terms of the contract, we may increase your premium, cancel your policy or we may not pay your claim."

"DISHONESTY
We may refuse to pay a claim under this policy or cancel the policy from the date on which you have deliberately or dishonestly tried to take advantage of us.

For example, if you dishonestly exaggerate (overstate) the amount of your claim to get an inflated claims payment under your policy or if you give incorrect information to either get cover at a reduced premium or hide the fact that you did not comply with policy terms and conditions, all benefits under this policy will be lost, the policy may be invalid and you may not be entitled to a refund of premium (our emphasis). We may also take legal action against you. If this happens, you will have to repay all amounts which we previously paid towards your claims under this policy."

"OWNERSHIP
You are not covered under any section in this policy if you are unable to prove ownership or if you are not the legal owner of the item.

When you want to claim, you must:
3) Always give us true and complete

information. All documentation and information which you provide as evidence or support of any claim must always be true and correct."

The following provision was also noted on Page 8 of the Policy wording;

> ***"CHANGES IN YOUR CIRCUMSTANCES***
> *It is very important that you give us honest and accurate information at all times. This is what determines your risk profile and whether we accept your policy and what your premium should be. If you give us false or incorrect information, your policy may be invalid or you may not be covered in full or in part."*

The insurer argued that Mrs V had a duty in terms of the policy to disclose all material facts truthfully, so that it could properly assess the risk. It submitted that by failing to disclose the additional losses, Mrs V misrepresented material facts relating to her risk profile. This created an unacceptably high risk according to its underwriting guidelines. The insurer submitted that it would not have agreed to conclude a contract of insurance with Mrs V had it been aware of her insurance loss history.

The Ombudsman's findings

Short-term insurance contracts are entered into in good faith. Under common law, a policyholder when requesting cover must make full disclosure of all matters material to the insurer's assessment of the risk. This principle is founded on the insurer's legal right to be informed of all the material facts to enable it to properly assess the risk. An insurer has the right to avoid a contract of insurance if the proposer has misrepresented a material fact.

The Supreme Court of Appeal conveyed the common law principles applicable to misrepresentations in **Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality 1985 (1) SA 419 A,** as follows:

> *"There is a duty on both insured and insurer to disclose to each other prior to the conclusion of the contract of insurance every fact relative and material to the risk (periculum or risicum) or the assessment of the premium. This duty of disclosure relates to material facts of which the parties had actual knowledge or constructive knowledge prior to conclusion of the contract of insurance."*

In terms of section 53(1) of the Short-term Insurance Act 58 of 1998, (STIA), an insurer has the right to avoid a contract of insurance if the proposer misrepresented information which was *"likely to 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 test for materiality is then prescribed as follows;

> *"1) B. The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the short-term insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk."*

The court in **Oudtshoorn Municipality** also remarked that the test for materiality is whether the notional reasonable person would have considered that the information should have been disclosed to the insurer.

In OSTI's' view a 'reasonable person' in the position of Mrs V would consider that the additional losses and claims may influence the insurer's assessment of the risk and should, therefore, be disclosed.

The following was a transcription of the relevant portion of the underwriting conversation;

> ***Advisor:*** *Have you had any losses in the past 3 years?*
> ***Insured:*** *I have had a burglary yes. Last year. December last year. November somewhere around there.*
> ***Advisor:*** *You had one last year, okay. And how much did the loss amount too?*
> ***Insured:*** *R20 000.00.*
> ***Advisor:*** *R20 000.00 - otherwise any other losses in the last three years?*
> ***Insured:*** *No.*
> ***Advisor:*** *Okay.*

OSTI was satisfied that the underwriting questions relating to Mrs V's loss history were clear. OSTI also confirmed that Mrs V was advised at the commencement of the underwriting conversation that the information she provided must be true and complete. She was also informed that incorrect information may affect the outcome of her claims.

The policy documents were also sent to Mrs V on 5 November 2018, before the commencement of cover.

Having regard to the facts in the matter and the ordinary application of the law on the relevant issue, OSTI found that Mrs V misrepresented material facts relating to her risk profile. This misrepresentation materially affected the insurer's assessment of the risk. The insurer was induced into concluding an insurance contract that it would not otherwise have entered into had Mrs V's claims history been fully disclosed. OSTI therefore found that the insurer was within its right to void the cover and reject the claim.

Mrs V informed OSTI that the insurer continued to collect the insurance premiums from her bank account notwithstanding the cancellation of the policy. This was addressed with the insurer and it confirmed that the relevant department was instructed to void the policy in April 2019. It appeared that, due to an oversight, this instruction was not carried out. The insurer rectified this on 11 November 2019. The policy remained void and Mrs V was refunded all premiums collected since 2 April 2019.

Osti's view was that the insurer was justified in its decision to avoid the risk on the ground of a material misrepresentation. The rejection of Mrs V's claim was therefore upheld.

The insurer's second rejection reason on the ground that Mrs V failed to provide reasonable proof of ownership for the items claimed was not adequately addressed in its response to the complaint. In her correspondence to this office, Mrs V provided two invoices for a camera and laptop dated July 2015 and September 2015 respectively. In reviewing the conversation between the assessor and Mrs V's previous insurer, OSTI noted that she submitted three claims for similar items between February 2017 and June 2018. It was therefore not clear if the invoices provided were in respect of the current loss. Nevertheless, given the finding OSTI made concerning the insurer's first rejection reason and the voidance of cover, the rejection of the claim stood despite Mrs V having provided proof of ownership and quantum.

Osti was unable to assist Mrs V and the matter was resolved in favour of the insurer.

DRINKING AND DRIVING – DO NOT BE A STATISTIC

The December month is referred to as "the festive season" for good reason. It is a time when festive activities such as year-end functions, office parties and social gatherings are the order of the day. As we approach this season, insureds must remain mindful of complying with their insurance policy conditions regarding the operation of a vehicle whilst under the influence of alcohol, to avoid the risk of having a claim rejected by their insurer or the risk of causing harm to other parties.

Some insurers have introduced options in their policies that provide insureds with the benefit of alternative transportation after they have consumed alcohol or are over the legal limit. Insureds are encouraged to educate themselves on their policy options and make use of the benefits available to them in order to avoid the possibility of a rejected claim on the grounds of driving under the influence of alcohol.

Insureds are reminded that insurance claims are civil matters and not criminal matters.

In a criminal case the state is required to prove beyond a reasonable doubt that a driver was driving under the influence of alcohol. The onus in civil matters is different as the insurer is only required to prove on a balance of probabilities that a driver was driving whilst under the influence of alcohol. What this means for an insured is that an insurer does not require blood or Breathalyzer tests to support a rejection of a claim on the grounds of driving under the influence of alcohol. An insurer may rely on, for example, independent witness statements describing the driver's demeanour, the amount of alcohol consumed by the driver prior to the incident, the manner in which the vehicle was driven and the manner in which the accident took place, to support the insurer in discharging its onus.

Some insurers elect to reject a claim on the grounds of driving under the influence of alcohol coupled with a secondary rejection reason for example:

- *where the insured provides dishonest information to the insurer;*
- *where the driver leaves the scene of an accident unlawfully after an accident;*
- *an insured's failure to exercise due care and or speeding;*
- *an insured's failure to comply with the insurer's reasonable request/s for beacon and billings or other information.*

The above list is not exhaustive but is an indication of the most common issues that are usually related to claims rejected for driving under the influence of alcohol.

Where an insurer suspects that the driver was under the influence of alcohol at the time of the incident, an investigation is likely to take place to verify the incident driver's activities before, during and after the accident. Insureds must be aware that should they try to conceal facts or circumstances surrounding the incident by providing incorrect information or withholding relevant information from the insurer, this in itself may provide the insurer with additional grounds upon which to deny liability on a claim. This is because most policies exclude cover for claims where the insured materially misrepresented the circumstances surrounding the loss.

In a dispute dealt with at this office, the insurer interviewed several witnesses who were present at the accident scene and who confirmed that the driver had been highly intoxicated. Further, the insured's tracker report indicated that the vehicle had been travelling at a speed of 124km/h in a 100km/h zone and had been travelling at speeds of 174km/h mere minutes before the accident. The insurer rejected the claim on the grounds of driving under the influence of alcohol and failure to exercise due care. OSTI upheld both rejection reasons.

Some insureds approach OSTI to dispute their insurer's request for

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additional information. Examples of such information often requested by an insurer are the beacons and billings for all cell phones registered to the insured, the insured's bank statements for the incident date or contact details of any person who could verify the insured's version of the circumstances surrounding the accident.

A common argument from insured's in this regard is that the requested information is irrelevant to the actual loss or that the information is private and sensitive and thus cannot be provided to the insurer. An insured should be mindful of their duties in terms of their policy requirements which often state that an insured is to comply with the insurer's reasonable request for information. An insured has to prove that their claim is valid in terms of the policy. The insured has a contractual duty to provide the insurer with all the necessary information and documentation to enable the insurer to validate the claim.

Insurers have structures in place to facilitate the investigation of a claim and to verify the information provided by an insured before accepting liability for the loss. A common misconception of insureds is that if all premiums are paid timeously, then an insurer is bound to accept a claim and provide the cover it undertook to provide. We reiterate, that a policy is a contract and the payment of premiums is not the only duty placed on an insured. Insureds must also comply with the provisions of cover and bring their claims within the ambit of the policy.

Where an insurer has proven on a balance of probabilities that the claim falls within the policy exclusions relating to driving under the influence of alcohol or that there was non-compliance with the provisions of cover, OSTI may uphold the insurer's decision to decline liability on a claim.

Therefore OSTI's advice over the festive period is - do not be a statistic and do not drink and drive.

OSTI CARES

SANTA SHOEBOX

Supporting the Santa Shoebox project has become a favourite annual event at OSTI. OSTI and its staff pledged a total of 43 boxes this year. We hope these gifts bring as much joy to the children as OSTI had in preparing the boxes.

CONSUMER TIPS

1. Do not drink and drive.

2. If you are going on a road trip this holiday, make sure that your vehicle and tyres are in roadworthy condition.

3. With the holiday season upon us, ensure that your assets are properly protected and that your home is secure. Remember to test your home alarm system to ensure that it is in working condition.

4. Having an accident is extremely stressful. Keep your insurer's and roadside assistance numbers on you at all times. They can help you when you need it most.

5. Buying gifts this holiday? Keep invoices, valuation certificates and receipts in a safe place. You will need to prove the existence and value of any item for which you claim.

6. If you are travelling check carefully what is on offer when taking out travel insurance. Remember to read the terms and conditions of the cover you purchase.

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WHAT DOES THE OMBUDSMAN DO?

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

MISSION

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

ABOUT US

We resolve disputes between consumers and short-term insurers:

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

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

WHAT TO DO IF YOU HAVE A COMPLAINT?

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

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

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

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

011 726 8900 or 0860 726 890

or download our complaint form via our website at

www.osti.co.za, click on Lodge a Complaint and then follow the prompts.

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We welcome your feedback and/or comments.