THE OMBUDSMAN'S BRIEF CASE.

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(Newsletter of the Ombudsman for Short-Term Insurance)

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DEVELOPMENTS IN THE OFFICE

OMBUDSMANS ADVICE

1. FAILURE TO COMPLY WITH SECURITY REQUIREMENTS

Following a visit, the insured returned home at approximately 21:05. She locked the car doors (but did not engage the gear-lock) and went inside her house to give her husband the car keys so that he could lock the car in the garage. She met her husband at the front door and they spoke for about four to five minutes while her son went out of the gate to unlock the garage, but by this time the car had been stolen. The insurer repudiated the claim on the basis that the insured did not activate the gearlock at the time of the theft.

It was a requirement of the policy that the vehicle be fitted with a VESA Level 3 or 4 or SAIA approved immobiliser, or VESA or SAIA approved lockable gearlock. Although the insured did have an approved gearlock, she on her own admission did not activate the gearlock at the time of the theft. The insurer was accordingly entitled to maintain its repudiation.

2. INSURABLE INTEREST

The insured was a life insurance broker and operated his business through a CC in which he had a 90% interest. His wife owned 5% and his domestic help owned the remaining 5%.

During May 2001 his CC acquired a new BMW 325 at a cost of R233 000. He instructed his short-term broker to insure it comprehensively in his personal name for private and professional use. Three months later, the vehicle was involved in an accident and damaged beyond economical repair. The insurer repudiated liability on two grounds:

a. The insured did not have an insurable interest in the vehicle.
b. The vehicle was not used in accordance with the description of use clause in the policy.

The Ombudsman referred the insurer to the decision *Lynco Plant Hire & Sales BK vs Univem Versekerings Makelaars BK 2002 (5) SALR 85 (T),* and to articles by JR Midgley *'Spouses and Shareholders —Insurably Interested?'* (1985) 102 SALJ 466 and JP van Niekerk — Juta's Insurance Law Bulletin, Volume 5 No. 3 202, Page 92. It was pointed out that the South African law regarding insurable interest require the insured to suffer a loss of an appreciable commercial value if the insured item were damaged, destroyed or lost. Clearly the insured as the virtual sole member of the CC would suffer a substantial commercial loss if the vehicle owned by the CC were destroyed.
The insurer abandoned the second repudiation reason as it was not material to the loss. Under threat of a ruling the insurer ultimately admitted the claim.

3. ADMINISTRATIVE ERROR ON THE PART OF INSURER

On 6 April 2001, a Spoornet employee at Empangeni purchased a Toyota Corolla and insured it through brokers. More than a year later he went to Absa Bank in Empangeni to withdraw cash. While he was busy at the ATM two armed men approached the Toyota Corolla, forced his wife and child out of the vehicle and drove off with it. He lodged a claim with his insurer who repudiated the claim on the ground that he had cancelled his policy from 1 July 2001.
Notwithstanding a letter from the Ombudsman the insurer persisted in its repudiation. The insured then pointed out that on 6 April 2001 the policy had been revised and the Toyota Corolla which he had bought was added to the policy. At the end of May 2001, he noticed that the premium on the Toyota Corolla was high and telephonically informed the insurer that the policy was to be revised. The only property to be insured was the Toyota Corolla and that everything else was to be deleted. His monthly premium was then reduced for the next month. The insurer ultimately conceded that *"an administrative error has occurred and the whole policy* was *lapsed instead of just being revised as per the insured's instructions".* The insurer then admitted the claim in full.

4. FAILURE TO GIVE PROPER NOTICE OF CHANGE IN EXCESS AMOUNT

When the insured purchased a cell-phone in Johannesburg, she was advised of the option of insuring the cellphone at a certain premium and an excess of risk. She completed the application form and before actually receiving a policy document, she noticed that debits were being presented against her account, which was the only proof she had that the policy was in force. On 21 February the cellphone was stolen whilst she was shopping. After she had lodged the claim, the insurer informed her that the claim would be admitted, but that the excess had been increased from R150 to R500. When she asked why it had been increased without notification, she was informed that she had been notified by SMS on 11 September 2002 of the change. She denied that she had received the SMS.
The Ombudsman pointed out to the insurer that an SMS is merely an 'electronic medium' as referred to in Part 1 Rule 3(l)(c) of the Policyholder Protection Rules. An SMS could never be regarded as a written confirmation of disclosure as referred to in Rule 3 (1) (d). In the absence of a written confirmation regarding the increase in the excess, the insurer was persuaded to effect payment to the insured of the shortfall of R350.

5. POLICY CONDITIONS NOT CONVEYED TO INSURED

According to the policy documentation furnished to the insured, she was required to have burglar bars on all opening windows, safety gates in front of all doors and safety pins in the sliding door. On 19 July 2002, her house was burgled.
The insurer repudiated liability on the ground that the insured did not have an activated alarm.
The Ombudsman pointed out to the insurer that according to the policy conditions furnished to the insured, no mention was made of a burglar alarm that had to be activated if the property was left unattended. The insurer confirmed that the underwriting manager was unable to provide any valid policy wording, or endorsement thereto containing a provision that the alarm should be activated at all times when the premises were left unoccupied. The insurer conceded that it had no alternative but to settle the claim.

6. REPAIRS EFFECTED BY A MEMBER OF PANEL OF SERVICE PROVIDER

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At 15:45 one afternoon, a pipe burst under the floor or inside a wall of the insured's property. He promptly called his plumber, who he had used for about 15 years. The plumber immediately responded, opened the tiles and some bricks and switched off the mains, returned the next day and finished the job. When the insured lodged his claim the insurer repudiated liability because the insured had not followed the correct procedure, i.e. to call the toll-free number which would have referred him to a panel of service providers. The insurer pointed out that it had written to about 300 000 clients advising them of the new arrangement, providing insureds with the toll-free number and a paragraph drawing their attention to the necessity of calling the Claims Centre and that in the event of not doing so, the possibility existed for the claim to be repudiated.
The Ombudsman pointed out to the insurer that the insured was very clear in his recollection that after he telephonically reported the loss to the insurer, he was at no stage asked to abort his instruction to his own plumber. The insurer accepted the proposal of the Ombudsman that they pay the amount, which they would have paid had a service provider nominated by the insurer carried out the repair.

7. FAILURE TO REPORT ACCIDENT TO POLICE WITHIN 24 HOURS

It was not a happy Friday 13th for the insured, a chef at a hotel in Saxonwold. At 20:00 he was on his way home along Jan Smuts Avenue, Johannesburg, and on one of the many turns he noticed a group of pedestrians crossing the road. While avoiding them, he overcorrected and collided with a light pole. He lost consciousness and woke up the following day in the Milpark Hospital. He was discharged on Saturday at 15:30 and his wife took him home, gave him medication and put him to bed. He spent the whole of the Sunday in bed, and although still shaky and in a lot of pain, reported the accident to the Randburg Police Station on Monday. He lodged a claim for the repairs of his car with the insurer, which repudiated the claim on the ground that he had failed to report the collision to the SA Police within 24 hours. The insurer alleged that it was not given the opportunity to verify and confirm the incident with the Police and there was also no blood test conducted to confirm the possible use of alcohol. As a result of the Ombudsman's intervention, the insurer admitted the claim and paid out to the insured R44 095,17, being the pre-accident value of his vehicle.

8. INCORRECT REASON TO REPUDIATE

The insured was resident in Strubens Valley and according to the policy his Opel Corsa was kept

at this address. On 17 June 2002 in Honeydew, his car was damaged beyond economical repair. When he completed his claim form, he wrote on the claim form his new address in Honeydew where he was intending to stay. The insurer promptly repudiated liability because the insured had supposedly changed his address without informing the insurer. The Ombudsman pointed out to the insurer that at the time of the collision, the insured had not physically changed his address and furthermore, and in any event, because the vehicle was involved in a collision, the change in his address was of no legal significance. The insurer then admitted the claim.

9. **ALTERATION OF THE RISK**

On 16 November 2001, the insured acquired a Tazz for his son and quite correctly noted his son as the regular driver of the vehicle. Three and a half months later the insured contacted the insurer to add a further vehicle to the policy. He then also enquired as to why the premium on the Tazz was so high. He was informed that it was because of the fact that his son was the regular driver. The insured instructed the insurer to change the regular driver of the vehicle to himself. The insured accordingly paid a premium of R222,56 per month on the Tazz, but had his son been recorded as the regular driver, the premium would have been R715,15 per month. Eight months later the Tazz was stolen while parked on Main Road, Woodstock, Cape Town, outside a club. The insured's son was the last person to use the vehicle and both the insured's wife, who submitted the claim, as well as the son, confirmed that the son used the vehicle most often and more frequently than any other person for the last nine months. The insurer repudiated the claim and in the Ombudsman's view it was entitled to do so.

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PERSONAL LINES - A HARDER LINE?

Recently, in response to an article in the Cover Magazine, as to whether Insurers were taking a harder line on claims, we published our observations regarding recent **articles** on the above subject are as follows:

The targeted readers of COVER are members of the insurance industry at large i.e. insurers, underwriting managers, brokers, intermediaries, outsource managers, and claims administrators etc. Bearing this in mind, if regard is had to the cases reported from the Ombudsman's office, most reflect instances where the Ombudsman was able to convince the insurer to reconsider the claim for various reasons ranging from strict legal interpretation to fairness and equity.
Within this context, what also has to be borne in mind is not just the volumes of complaints being received by the Ombudsman's office, but the type of complaint, the reasons for rejection and the insurer against whom such complaint has been lodged.

A perusal of our Annual Reports for the last few years certainly reflects an increase in the number of complaints being received by this office. However, a mere comparison of gross volumes does not paint a complete picture. By analysing the complaints received in comparison to past years the following become apparent:

- Ø the number of complaints has increased across the board for all insurers, and not just in respect of any particular insurer/s;
- Ø The type of complaint received has remained fairly consistent in the sense that the vast majority pertain to motor, followed closely by householders, homeowners, and then cellphone, travel, disability and medical expenses;
- Ø Statistics of the complaints received are reviewed on a monthly, quarterly, hi-annual, and annual basis to identify potential problem areas, worrying trends, conduct of particular insurers

(in the sense of the type and number of complaints received for a particular insurer);

- Ø This constant analysis has clearly identified that the increase in volume can certainly not be attributed to any 'harder line' being adopted by any insurer/s, or that more claims are in fact being rejected;
- Ø Constant meetings with insurers, to discuss differences of views on complaints are encouraged, where 'tricky' complaints through mutual discussion can be effectively, amicably and speedily resolved;
- Ø The low number of rulings this office has been required to make during its term of existence has, on average, remained consistent. In 2002, a total of 18 rulings were made, mainly as a result of non-cooperation by two insurers.

I might add that these matters were immediately rectified by the insurers concerned. The year to date reveals no rulings having had to be made against insurers. This however, does not appear to have affected the amounts paid out to complainants as a result of the intervention of this office, which is in line with amounts recovered in previous years;

- Ø From an analysis of the statistical data available, no particular insurer/s has been identified as either inappropriately rejecting claims, or for that matter, identified as inappropriately rejecting a greater number of claims than in the recent past;
- Ø Distribution of our quarterly newsletter to insurers which, in most instances, is being filtered through to staff at claims handling level, is raising awareness on the insurers part as to the Ombudsman's views, on both fairness and equity, as to particular types of claims and complaints; and
- Ø Distribution of printed material in the form of bookmarks, frequently asked questions, as well as the launch of the Ombudsman's website (***www.osti.co.za***) earlier in the year,
- Ø has raised awareness not only of the office itself, but also as to the manner and functioning of the office.

Thus whilst there certainly has been an increase in the volumes of complaints received over recent years, no particular problem areas are identifiable. The increase, whilst still a cause for concern, could be attributable to one or more of the following:

- Ø greater public awareness of the Ombudsman's office as an alternative to litigation;
- Ø the impact of the Policyholder Protection Rules and statutory notices accompanying policy documentation;
- Ø A vast majority of insurers encouraging referral of disputed claims to the Ombudsman's office in their letters of repudiation and in verbal communication with dissatisfied insureds; and
- Ø More effective marketing of the Ombudsman's office.

In conclusion, if we lived in an ideal world and if the Ombudsman's office was absolutely effective, there should be no complaints. However, in reality and bearing in mind the human error factor, the fact that a large number of the insured public either do not read and/or understand, or query their rights and obligations in the insurance contract, there are bound to be complaints, whether justified or unjustified.

Looking at the broader picture and drawing comparisons with the functioning, not just of the other voluntary schemes in this country but also to the functioning of Ombudsmen's offices internationally (in particular United Kingdom, Australia, Canada, New Zealand), all of which reflect increases in the volumes of complaints received, the increase in this office does not appear to be out of the ordinary. It is however, hoped that with constant awareness, education of the parties to the insurance contract as to their rights and obligations, as well as constant interaction and feedback, the near future will ultimately reflect a lesser volume of disputed claims, and perhaps even the lesser involvement of the Ombudsman.

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BETTERMENT

The basic principle underlying Insurance is the insurers obligation, in return for payment of the premium by the insured, and on the occurrence of the event insured against, to put the insured in the position that he was before the loss (i.e. indemnity). The insured cannot make a profit arising from such insurance claim, nor can he receive an amount greater than his loss. However on an insurer electing to reinstate or settle by means of a cash payment, different views emerge regarding the issue of the deduction for betterment by the insurer.

Insurers are sometimes of the view that betterment should be deducted as the insured is put in a better position than he was before the accident by only looking at the cost of that particular component that was replaced, in comparison to the damaged one. Most frequently this arises where as a result of an insured event the vehicles engine requires repairs / overhauling, or tyres require replacement.

However this loses sight of the fact that what is in fact being insured is the vehicle itself as a unit, and not the individual components, i.e. the engine, tyres, bonnet etc. The test, in our view, should be to compare the value of the insured property before the loss and after the loss, and only if it can be objectively demonstrated that the market value of the property has been increased, then only should the insurer be entitled to effect a deduction for betterment. It is difficult to postulate that the market value of a vehicle would in fact be so increased by for example the vehicle now having an overhauled engine, or new tyres.

In practice also what has to be borne in mind, is the fact that where the claim is for example, for an insured vehicle which is written off, i.e. a total loss, the insurer in determining a settlement amount rarely, if ever, increases its offer to include an amount for the written-off vehicle having new tyres, or a repaired engine, the argument being that this has not increased the market value of the vehicle. Furthermore Mead & Macgruthers in determining market value take into account, the mileage, condition and extras to the vehicle. No direct authority has to date been available in support of the contention that new tyres or an overhauled engine increases the market value of a vehicle.

The deduction may only be made where the insurer proves the monetary value of the compensating advantage. It must show an actual benefit to the patrimony of the insured. **Reynolds & another v Phoenix Assurance Company Ltd & others** (1978) 2 LLR 440.

In **Reinecke, van der Merwe, et al, General Principles of Insurance Law (2002)**, at 326, footnote 43, the view has been expressed that, " *If the object is as a consequence of the restoration worth more than before the accident, the insurer has no claim against the insured.*" However no direct authority is cited in support of the statement.

In conclusion I would thus reiterate that:

1. Insurers would be entitled to effecting a deduction for betterment, however only in instances where it can objectively demonstrate an increase in the value of the insured property.

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FORMAL RULINGS

FORMAL RULING NO. 10
(Ombudsman's Reference H111/01T)

The complainant lodged a complaint with this office following difficulties she experienced in pursuing a claim in terms of a Travel Insurance Policy.

The complainant has free cover as per her Credit Card purchases of air tickets as well as the Optional Added Benefit. The Application form handed to the complainant indicates that cover exists for persons up to the age of 75 years. During the telephone conversation when the Optional Added Benefit Policy was acquired, the complainant did advise Insurers that her husband was aged 70 years. The complainant was not advised as to any additional limitations of cover. The documentation furnished to her makes reference to a Master Policy, which she has not had sight of and which despite her requests, she has still not received.

During the Easter weekend the complainant's husband travelled to the UK. The Optional Added Benefit cover was obtained subsequent to his flight and Insurers were made aware of the fact that the complainant's husband had already flown to the UK.

Shortly thereafter, the complainant was telephonically advised that her husband had been admitted to hospital after having suffered a mild Myocardial Infarct. The Insurer was contacted and advised of the claim. The complainant further indicated that she would have to travel to the UK and enquired as to whether this would qualify as an "Emergency Travel situation" as set out in the document furnished to her by Insurers . Insurers indicated that the complainant's travel to the UK would fall to be covered as an Emergency Travel situation.

Insurers later repudiated the claim on the basis of the husband's alleged pre-existing condition. The documents furnished to the complainant make no reference to any Exclusions for pre-existing conditions. The only reference is to the fact that cover is subject to the Terms and Conditions Exceptions as fully as described in the Master Policy document, of which the complainant was never furnished a copy.

The complainant's claim is not for the medical expenses as a result of her husband having been hospitalised, but only in respect of the Emergency Travel situation benefit, when she was required to the travel to the UK to attend to her husband.

Thus far, no supportable information has been provided to uphold the Insurer's decision to decline the claim, and I a ruling was therefore made in terms of Schedule 5 of the Association Agreement, that you the claim be settled .

FORMAL RULING NO. 11
(Ombudsman's Reference F30/02Z)

The complainant alleges that when she took out the Insurance, she pointed out to Insurers that she was travelling to the U.S.A. to visit her daughter, and she was assured at the time that she was fully covered if she was delayed for any reason.

Whilst the complainant was with her daughter in U.S.A., the complainant's two-year old granddaughter suddenly became ill and required major surgery. Whilst the parents of the two-year old granddaughter had to stay at the hospital, the complainant had to look after her three-year old granddaughter. Both her granddaughters are profoundly deaf.

The complainant's daughter telephoned Insurers to advise of complainant's delayed return from the U.S.A. and she was informed that complainant was covered by the Insurance. Complainant went ahead and changed her departure .

Insurers later repudiated the claim on the basis that the grandchild was not resident in South Africa. The Policy Schedule and Summary of Benefits did not set out the Terms and Conditions of the cover. It is not acceptable to state that "the Master Policy is available at travel agents or any of the Insurer's offices".

A ruling was therefore made against the Insurer in terms of the provisions of Schedule 5 of the Association Agreement.

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