THE OMBUDSMAN'S BRIEF CASE.

THE OMBUDSMAN'S BRIEF CASE

(Newsletter of the Ombudsman for Short-Term Insurance)

Å (011) 726-8900 **Issue no. 01/2005**

[Developments in the office](#)
[Ombudsman's Advice](#)
[Insurance Fraud](#)
[Avoidance & Cancellation](#)
[Formal Ruling](#)
[Contact details](#)

Rounded Rectangle: The Ombudsman's Briefcase now available via e-mail
Kindly be advised that should you wish to receive this newsletter via e-mail, please contact the Ombudsman's Office on telephone (011) 726-8900, Fax (011) 726-5501 or e-mail. info@osti.co.za

Bevel: COPYRIGHT WARNING NOTICE Copyright subsists in this Newsletter. No part of the Newsletter may be reproduced, transmitted or downloaded in any form or by any means, without the permission of The Ombudsman for Short-Term Insurance.

& **For more information contact Mr Naresh Tulsie**
y **info@osti.co.za / naresh@osti.co.za**

DEVELOPMENTS IN THE OFFICE

- **A proposal was put forward to extend the jurisdiction of this office to handle limited commercial insurance complaints.**
- **The Financial Services Ombudsman Schemes Bill (FSOS Bill) was passed by parliament and awaits the signature of the President to be passed as Law.**
- **A proposal was put forward to merge our Council and Board in order to streamline the organizational structure of the Ombudsman's Office.**

OMBUDSMAN'S ADVICE

1. Take proper care and precaution to prevent loss or damage

-

* The insured, who was resident in Margate, was leaving early in the morning to make arrangements for his father-in Law's funeral. To ensure that he did not leave any documents behind, he locked his wallet, which contained his driver's licence, R5000 in cash, his firearm licence, bank and medical aid cards in the cubbyhole of his bakkie.

* The immobilizer jack plug could no longer be tied to his key ring because of a worn out holder, and was kept in his wallet. He engaged the gear lock and locked the vehicle, which was parked in his premises. That night the vehicle was stolen. The insurer repudiated liability on the grounds that the insured had failed to take reasonable precautions to prevent the loss.

* The Ombudsman pointed out that in terms of the decision of *Santam Limited versus CC Design* 1999 (4) SA 199C, there was an onus on the insurer to establish whether the conduct of the insured was such that one would conclude that s/he recognized the danger to which s/he was exposed, and deliberately courted them by taking measures which s/he knew were inadequate to avert them, or about the adequacy of which s/he simply did not care. The insurer conceded that it could not discharge this onus and then admitted the claim.

2. Double debit has the effect of the insurer giving credit for the preceding month

-

* The insured's policy incepted on 1 June 2003, and four days later his mag wheels were stolen. The insurer repudiated liability because the insured had failed to pay the premium due on the 1 June 2003.

* The Ombudsman pointed out that subsequent to the return of the debit order for 1 June 2003 due to insufficient funds, the insurer had lodged a double debit on 1 July 2003 and it duly received the money. He also pointed out that the insurer had accordingly given credit to the insured for the preceding month and that he was consequently covered as at date of the loss, i.e.4 June 2003. The insurer agreed and settled the claim.

3. Honesty is the best policy

* During the period August to September 2003, the insured noticed that his cell phone and a hand chain belonging to his wife had gone missing. He deliberately did not claim for these items because of the excess that would be applicable. On 25 November 2003, his house was burgled and a number of items of jewellery were stolen. The insured then included in the list of stolen items, the cell phone

as well as the hand chain. The insurer, upon becoming aware of the inclusion of these two items, repudiated the entire claim on the grounds that the insured had used fraudulent or dishonest means to claim a benefit to which he was not entitled.

* The Ombudsman agreed with the insurer that in view of the insured's dishonesty, the insurer was entitled to maintain its repudiation.

4 Failure to notify change of risk address - motor insurer

* On 16th July 2004, the Insured's Honda Ballade was stolen while parked in Vause Road, Berea, Durban. The Insurer repudiated liability because the insured had changed his address from an address in Natal to an address in Johannesburg and had not informed the Insurer of this change of address.

Ombudsman's response

* The Ombudsman established that the Insured often visited the area where the theft took place. The change of risk address did not increase the risk factor, as it was not material to the loss. The Insurer accepted the point made and settled the claim.

& **For more information contact Helm van Zijl**

y info@osti.co.za / **helm@osti.co.za**

INSURANCE FRAUD

-

Insurance fraud has always been a controversial issue, and Insurance companies have correctly clamped down on all fraudulent claims.

But are insurance companies too quick to repudiate claims where fraud is merely "suspected"? The office of the Ombudsman looks at this issue, and evaluates the merits of the declinature.

The onus rests on the Insurer to prove "on a balance of probabilities" that fraud exists on a claim. Knowing, or strongly suspecting, that a claim is fraudulent is one thing. Proving the same in a court of law on a balance of probabilities (civil case), let alone "beyond all reasonable doubt" (in a criminal prosecution), is a different matter altogether.

As there is no presumption of fraud, the insurer must clearly establish fraud on the part of the insured. The insurer must prove not only that the insured knew he was making a false statement with the intention of defrauding the insurer.

Professor J.P Van Niekerk of UNISA cites 3 different types of fraudulent insurance claims:

1. Fabricated claims: This type of fraudulent claim involves the fabrication of a loss or a cause of loss to enable the insured to institute a claim. Here, the insured suffers no actual loss or a loss not covered by the insurance contract, and fabricates the loss, often by causing it.

For example: The owner of a motor vehicle, hearing or seeing an approaching storm, parks his dilapidated but insured vehicle in the open so that it may be damaged by hail and falling branches which would allow him to claim on his policy and have his car repaired.

The Ombudsman will not tolerate claims such as these, as the fraudulent act is intentional, material and prejudicial to the insurer.

2. A Valid loss accompanied by fraudulent means: This second type of fraudulent claim is the least serious. Here, the insured suffers a genuine loss covered by his insurance contract, and claims no more than he is entitled to. However, in an attempt to ensure that the insurer does not take a technical point or delay the claim, he/she gives false information. The advantage gained is not of a direct financial nature as the actual claim is valid but is supported by fraudulent means.

For example: A claim for an injury under a Personal Accident policy where there is no dispute that the injury is covered and that the insurer is liable under the contract. The insured discovers that the medical practitioner accidentally failed to sign the accompanying medical report. The insured then forges the signature on the report and submits the claim.

Clearly, the action of the insured has not prejudiced the insurer, nor is it material to the claim. The Ombudsman would, in the absence of any other defence available to the Insurer, ask the Insurer to admit these claims.

3. Exaggerated claims: The third type of fraudulent claim involves an exaggeration of a loss to enable the insured to claim more from the insurer than would otherwise have been possible.

This is the most prevalent type of fraudulent claim and the most difficult to prove.

For example: An insured house owner suffers a burglary at his house. His loss is covered by his insurance contract. However, when completing the claim form, he includes a number of items which were either not stolen from his house but which he lost earlier; or which he never in fact had. This type of fraud is generally not premeditated but rather a spontaneous act by the insured, acting upon an opportunity that has presented itself.

An exaggerated claim is, according to case law, considered to be fraudulent in the following circumstances:

- Where the insured clearly intended to defraud the insurers;
- Where the exaggeration of loss is so excessive as to lead to the inference that the insured cannot have made the claim honestly, but must have intended to defraud the insurer.

In the matter of Schoeman v Constantia which was dealt with in a previous newsletter, Issue 03/2003, the court awarded the value of the actual loss proven by the insured and did not regard the inflated amount of the claim to justify upholding the repudiation of the entire claim.

Materiality is one of the guidelines applied by the Ombudsman in making fair decisions.

To illustrate this concept, one can look to the case of Pereira v Marine & Trade. Here, the insured falsely denied he had a passenger in the vehicle at the time of the collision. The court found that this was not material to the accident, loss and damage. Notwithstanding the fact that the insurer proved there was a passenger in the vehicle at the time of the collision, the insurer could not avoid liability.

The case of Strydom v Certain Underwriting Agencies is another good example of materiality and how it is applied. Reference to this case can be found in a previous newsletter.

In conclusion:

1. Insurers must bear in mind that an allegation of fraudulent conduct is a serious one. It is an area of law where there are no "black and white" guidelines.

2. Fraud must be the most readily apparent and acceptable inference that can be drawn under the circumstances. Often insurers suspect fraud but are not able to prove it. They may, and often do, rely on a number of technical defences as well as speculation and theories based on various "assessor's reports". This is not sufficient.

3. An over-estimate *per se* does not constitute fraud. In other words, if there is a valid claim but the insured unintentionally inflates his claim by overstating the value of those items that were lost, the insurer remains liable for the valid part of the claim.

4. An excessive claim must be looked at together with other relevant circumstances. If the insurer can establish that the Plaintiff has *deliberately* exaggerated his claim, this may well establish the Plaintiff's fraudulent intent.

(Please note that reference has been made to Professor J.P van Niekerk's article on insurance fraud in the above article)

& **For more information contact Paul van Onselen**

y **info@osti.co.za / paul@osti.co.za**

AVOIDANCE & CANCELLATION

AVOIDANCE & CANCELLATION OF INSURANCE POLICIES AND THE REJECTION OF INSURANCE CLAIMS

1. INTRODUCTION

Word Usage

i. "Void" : Refers to a policy that never existed as a lawful contract so that no rights and obligations came into being;

ii. "Cancellation": Is a term appropriately used for policies cancelled on the breach of a material term or in terms of a cancellation clause in the policy;

iii. "Rejection" : Is the suggested term for the rejection of a claim to an indemnity under a valid policy; and

iv. "Repudiation" : Has a specific contractual meaning and should only be used in that regard.

2. CANCELLATION OF POLICY ON BREACH

-

2.1. An Insurer may cancel a policy for breach of a term of the policy, where that term is so material or essential that a breach thereof clearly entitles it to cancel the contract. For instance; the insured commits fraud when submitting a claim or during the processing thereof; there has been a material change in risk; or where the policy expressly stipulates that the term (for example, a duty to take reasonable care and precautions against loss) is a material term, the breach of which creates a right of cancellation.

2.2. Method of Cancellation

2.2.1. An Insurer bears the onus of proving the breach and must decide, within a reasonable time after the breach came to its knowledge, whether to cancel the policy. Furthermore, it is crucial that the Insurer not do anything, in the meantime, which amounts to the waiver of the right to cancel (for example, continue to deal with the claim). When cancelling the policy, the Insurer must cancel the policy from the moment that the breach occurred (which may be the inception date) and give clear notice of cancellation to the insured. A refund of all premiums collected after the date of cancellation must be tendered and all valid claims arising prior to the cancellation date must be paid. Payments of claims that arose after the cancellation date can be recovered from the insured.

2.2.2. It is possible to cancel only a portion of the policy, which may be divisible from

the rest (for instance, in the case of a motor and household policy, where a term of the motor policy was breached, the household policy does not have to be cancelled).

3. AVOIDANCE OF A POLICY

3.1. A policy is void (i.e. never gave rise to rights and obligations) if, for instance, the object is illegal (for example the insured insures stolen goods); or on the grounds of a material misrepresentation or non-disclosure; or where the risk would not have been acceptable on moral grounds

3.2. Method of Declaring a Contract Void

3.2.1. A void agreement gives rise to no contract at all and no formal act is required to declare the "contract" void. An Insurer bears the onus, when contending that the policy is void, of proving this assertion;

3.2.2. The fact that the "contract" is void, should be communicated to the insured;

3.2.3. Save in the case of illegal policies where special rules may apply, an Insurer must repay any premium received and the insured must repay any claims paid. The one may be set off against the other; and

3.2.4. An act by an Insurer inconsistent with treating the "contract" as void after the fact has come to it's knowledge, may prevent it from enforcing the consequences of the policy being void and therefore the policy must be treated as void without delay and without waiver of rights.

4. REJECTION OF A CLAIM

4.1. A claim is rejected where an Insurer denies liability under a contract, the existence of which is admitted.

4.2. Examples of situations where a claim may be rejected are: the insured fails to perform a duty that is a condition of liability, for example, failure to report the loss to the SAPS within a required period of time; the insured fails to perform a material obligation, which is not a warranty under the contract; where the insured lacks insurable interest in the property damaged or destroyed at the time of the loss.

5. OMBUDSMAN'S APPROACH

The Ombudsman's office deals with the above methods of declinature by looking at both the legal position, which would include reference to Section 53 of the Short Term Insurance Act 1998 as amended, relevant case law as well as on the basis of fairness and equity. An Insurer will therefore need to show that the breach was material to the loss and that the Insurer has suffered prejudice as a result thereof.

Therefore, even if a breach has taken place, an Insurer may still be asked to entertain the claim if the breach is not material and/or an Insurer has not, in some way, been prejudiced by the breach.

6. PRACTICAL EXAMPLES

6.1. **Non-Compliance with time periods**

As a result of a storm, the insured's roof sustained damage and her property also sustained water damage. However, she only reported the claim to her Insurer five months later. Her Insurer rejected the claim because of her failure to report the claim within 30 days of the event.

Ombudsman's Response

The Insurer acknowledged that it had not been prejudiced but for the cost of reinstatement and agreed to accept the claim, although legally the claim could have been declined.

6.2. **Immobiliser Required**

By virtue of a clause obliging the insured, within 14 days of inception of the policy, to furnish the Insurer with a certificate to the effect that the insured vehicle in question was equipped with an approved immobiliser, the Insurer could avoid theft cover on the policy in question. The insured had the vehicle equipped with the required immobiliser, obtained the required certificate from the dealer and arranged for it to be sent to the Insurer. The Insurer allegedly did not receive the certificate within the required time but continued to accept premiums in terms of the policy from the date when the certificate should have been supplied.

When the vehicle was subsequently stolen, the Insurer refused to accept the insured's claim and avoided the policy on the ground that the immobiliser certificate had not been furnished within the required period, although it was in fact furnished when the insured submitted his claim. It was not in dispute that the vehicle was equipped with the immobiliser at the time of the theft.

Ombudsman's Response

The Ombudsman made a formal recommendation that the claim should be met, because there was no prejudice to the Insurer whatsoever, and in addition to that, because the Insurer had waived its rights to rely on a technicality of this nature by continue to accept monthly premiums and not advising the insured that the certificate had not been received within the required period.

6.3. **Failure to advise the insurer of an increase in risk**

The insured resided in a secure complex and on a Friday night between 23h00 and 10h00 on Saturday, he visited his girlfriend, who did not live in the same complex. When he returned to his residence on the Saturday, he found that he had been burgled. The Insurer paid out for his laptop computer, which was covered by All Risks insurance, but refused to pay out the balance of the claim covered under the Household risk.

At the time, when the insured took out the insurance, he enjoyed a discounted premium because he resided in a secure complex. The complex decided to do away with the 24hr guard and it was during this period that the theft took place. During the same period at least three thefts took place from units within the complex and as a result, the guards were reinstated. The Insurer stated that in the absence of the security guards at the time of the theft, the risk was dramatically altered and this change was not notified to the Insurer.

Ombudsman's Response

The Ombudsman could not assist the insured because it is an integral principle of insurance that if the risk changes materially during the period of insurance, the Insurer is to be informed thereof. The Insurer was accordingly entitled to stand by its rejection.

& **For more information contact Mrs Noa Kraut**

y **info@osti.co.za / noa@osti.co.za**

FORMAL RULINGS

Formal Ruling No 17:

1. On 2nd May 2003, the Insured purchased a Toyota Corolla and Comprehensive Insurance was arranged by the sales person employed by Imperial Motors. In confirmation of the cover, a schedule titled "Toyota Comprehensive Insurance Schedule" which was underwritten by a registered Insurer in terms of the Insurance Act of 1998 was handed to the Insured. Almost a year later, a claim was submitted for damages sustained in a collision. The claim was admitted by the Insurer, which advised that an Excess of R7 250.00 was applicable as set out in the Policy wording. The Insured did not receive a Policy wording despite repeated requests. The Insurer was unable to show from its records that a Policy wording had in fact been sent out, which would have alerted the Insured to the Excesses payable in the event of a claim. The Insurer was also not able to demonstrate that the Excesses were drawn to the Insured's attention and merely relied on the fact that the Policy clearly showed the applicable Excesses.

2. The ruling in terms of the Ombudsman's Terms of reference was made on the following issues.

a. Despite repeated requests, the Insured was not placed in possession of a fully claused Policy wording showing the applicable Excesses.

b. The Insured was not given the opportunity of either accepting or rejecting the terms of the Policy, as these were not explained at the time of the taking out of the Policy.

c. It is probable that a lower Excess would have been applicable had the Insured been given the opportunity of sourcing a Policy with some other Insurer on better terms.

The Insurer did not concede and stated that the full Excess as per its Policy be paid. The Ombudsman exercised his rights in accordance with the principal of equity and ruled that the Excess be reduced to 5% of the claim, resulting in a decrease of the Excess by R5 200.

Comment:

The ruling was made based on the facts presented to the Ombudsman. The excess amounts were found to be excessive (ie an exorbitant amount) and unusual (as compared to excesses normally applied in the insurance industry) as the amount was based on a percentage of the Sum Insured rather than as a percentage of the amount claimed or a fixed excess amount. The Insurer couldn't prove to the Ombudsman that the Insured was informed of the excess amount applicable and therefore a ruling was made.

& **For more information contact Mr Helm van Zijl**

y **info@osti.co.za /**

CONTACT DETAILS

POSTAL ADDRESS	**E-MAIL ADDRESS:**	**info@osti.co.za**
P O Box 32334	**WEBSITE:**	**www.osti.co.za**
Braamfontein	**TEL:**	**(011) 726-8900**
2017	**FAX:**	**(011) 726-5501**

Home | **History** | **What we do**| **Staff** | **Submit a Dispute** | **Annual Report** |**Common Problems**|

How to Complain | **Contact Us** | **Members** | **Code of Practice** | **News** | **Links** | **FAQ'S**