THE OMBUDSMAN'S BRIEFCASE

Official Newsletter of the Ombudsman for Short-Term Insurance

THE OMBUDSMAN
For Short-Term Insurance

Mission

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

Issue No. 2 of 2013

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OMBUDSMAN LAUNCHES HIS ANNUAL REPORT FOR 2012

OMBUDSMAN LAUNCHES HIS ANNUAL REPORT FOR 2012.

The Ombudsman, Mr Dennis Jooste, launched his Annual Report for 2012 to guests at a function held on 22 May 2013 at the Johannesburg Country Club. The function was well attended by the insurance industry and media representatives. It has become customary for the Annual Report to feature a different theme each year and utmost good faith between insurers and policyholders was chosen as the theme for the 2012 report.

Statistics were published and included in the report. The complete Annual Report is available on the Ombudsman's website: www.osti.co.za

LEGAL COSTS INSURANCE (ZURICH INSURANCE CO. SA LTD)

The Facts:

The complainant consulted an attorney in 2009 in respect of a labour matter, namely unfair dismissal. The claim was subsequently dismissed at the CCMA. The insurer paid the legal costs incurred to the attorney. The complainant was then not satisfied with the outcome and wanted to take the matter on review. He was referred to another attorney who succeeded with the said review and the CCMA decision was set aside. The matter was again heard at the CCMA and the case was again dismissed.

The complainant was still not satisfied and unbeknown to the insurer, consulted with another attorney in respect of the review and paid the attorney from his own pocket. He then claimed for these costs from the insurer. The insurer declined liability.

The Insurer:

The insurer argued that the complainant had, unbeknown to them and without written authorisation, consulted with his attorney and was therefore in breach of a policy condition (Claims Procedure 13.5), which stated that: *"You may not appoint an attorney to act on your behalf unless you received our written authority to do so"*.

The insurer further based its reasons for the rejection of the claim on Clause 11, which stated that: "Appeal or Review Procedure":
"We will not be liable to indemnify you in respect of an appeal or review proceeding following the outcome of a covered matter, unless written authority to proceed with the proposed proceeding has first been obtained from us. Such authority shall not be granted unless the attorney representing you has given a statement, confirmed in writing by an Advocate of the High Court of not less than five years standing, that the proceedings have a reasonable prospect of success".

The insurer stated that to give the complainant the benefit of the doubt, they had referred him to two different attorneys, one of them being an expert in labour matters, and both had concluded that there was no prospect of success in the matter.

The Ombudsman's View:

The Ombudsman indicated to the complainant that the policy was clear with regard to the review and appeal procedure as the insurer would cover the cost only if there was a reasonable prospect of succeeding with the appeal.

The Ombudsman upheld the decision of the insurer.

PRE-EXISTING DAMAGE (AIG INSURANCE CO. LTD)

The Facts:

The Complainant's insurance policy incepted on 5 March 2011.

On the 25th of August 2009, the complainant noticed water ingress into her apartment through her ceiling which caused damages. The complainant, noting that the source of the water leak was from one of the units above her unit, instructed a repairer to rectify the problem. The owner of the upstairs unit determined that the bath outlet pipe was fitted incorrectly causing it to leak onto the complainant's apartment below. The problem was aggravated by additional water leaking through a rusted air vent in the roof of the block of apartments.

The complainant now lodged a claim for the damages suffered which was declined by the insurer due to the fact that the damages existed before the inception of the policy.

The Ombudsman's View:

On the facts, the Ombudsman found that the complainant was aware of the damage to the upper premises in 2009 but had failed to inform her previous insurer and the current insurer. When the insurer came on risk, the damages had not been repaired and apart from the specific exclusion against pre-existing damages in the policy, it was neither fair nor equitable to expect the insurer to accept liability for the damages.

The Ombudsman supported the repudiation of the claim by the insurer.

PREVIOUS INSURANCE HISTORY (TELESURE)

The Facts:

The complainant had placed a vehicle on cover. This vehicle previously belonged to her father, who had enjoyed comprehensive cover with another insurer in his name. The daughter was however the primary or regular driver of the vehicle on her father's policy. This was conveyed to the current insurer, and the complainant was allocated a No Claim Bonus of 4 years based on the aforementioned information. The daughter was involved in an accident whereafter she submitted a claim to the current insurer for the damages sustained, to what was now her vehicle.

The Insurer:

In their validation of the claim, the current insurer contacted the previous insurer. It came to light that the previous insurer did not have any record of the daughter

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PREVIOUS INSURANCE HISTORY (TELESURE) (CONTINUED)...

being the primary or regular driver of the vehicle at any stage. The current insurer subsequently declined the claim on the grounds that the complainant was unable to provide the necessary information to support the fact that she was previously comprehensively insured, stating further, that they had been denied the opportunity to correctly assess the risk at the inception of the policy.
In response, the complainant subsequently established that the previous insurer did not stipulate or mention a regular driver on their risk profile when such a person was under the age of 25 years. However, in reality the daughter had been the regular driver of the vehicle at the time. This could not be refuted by the current insurer.

The Ombudsman's View:

The Ombudsman recommended that, since there was no clear intention on the part of the complainant to gain an "unfair financial benefit" at the cost of the insurer, that the claim be settled. The insurer would in any event still have accepted the risk albeit at an increased premium of approximately 17%. It was recommended that the insurer deduct the actual prejudice suffered in premium received, from the settlement.

The insurer agreed and settled this claim as recommended.

GRADUALLY OPERATING CAUSES (ACE INSURANCE)

The Facts:

The complainant, being a unit owner in a sectional title complex, submitted a claim on behalf of the body corporate, being the insured under the policy.

The claim submitted was for water damage to the complainant's unit. The complainant advised the insurer that she had noticed damp in the kitchen when she had taken occupation of the unit in July 2012.

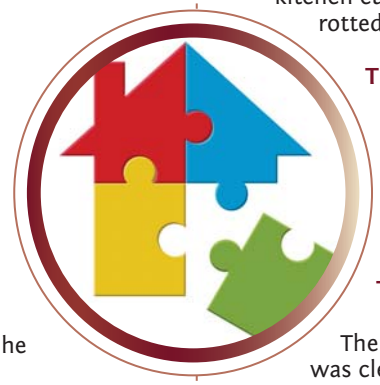
She advised that she had painted the unit as she had assumed that the damp was due to poor maintenance or ventilation.

The damp was noticed again in January 2013 at which point she decided to submit a claim to the insurer.

The insurer rejected the claim on the basis that the damage had occurred over a long period of time and was not sudden or unforseen as is required by the terms of the policy.

The Insurer:

During the assessment of the claim it was found that the kitchen cupboards as well as the wooden floors had rotted due to a leak in the corner of the kitchen area.



The Complainant:

The complainant advised that the leak had not been disclosed to her when she had purchased the unit and, further, that she could not be held liable for the actions or lack thereof the previous owner.

The Ombudsman's View:

The Ombudsman advised the complainant that it was clear from the documents submitted that the damage had occurred prior to the complainant purchasing the unit which also meant that the damage had occurred for at least a year prior to July 2012 when the claim was first sumbitted to the insurer.

It was explained to the complainant that it was not the purpose of this insurance contract to cover damage which had been left unattended over long periods of time and which was pre-existing and was not sudden or unforseen.

The Ombudsman upheld the insurer's rejection.

WHAT CONSTITUTES "PHYSICAL DAMAGE"? (HOLLARD INSURANCE CO. LTD)

The Facts:

The complainant, a specialist medical practitioner, claimed for damage to a highly sophisticated and technically complex medical instrument, known as a 'scope'. The scope was owned by him and had been used for the diagnosis of the medical condition of a severly ill patient who was diagnosed as having an infectious disease. The use of the scope, on the particular patient, led to the scope being rendered unusable in terms of the relevant medical regulations, it having been irretrievably contaminated by the body fluids of the ill patient. The contamination was so severe that the scope could never be sterilized or cleaned properly and could never again be safely used in medical examinations.
The insurer rejected the claim on the basis that the loss did not constitute "physical loss or damage" as required by the policy. The insurer also relied on other grounds for repudiation which were without merit and which will not be further commented upon.

WHAT CONSTITUTES "PHYSICAL DAMAGE"? (HOLLARD INSURANCE CO. LTD) (CONTINUED)...

The Insurer:

The insurer submitted that the basis of the repudiation was that the contamination did not constitute "physical loss of or damage to the property". The insurer submitted further, that in order to constitute physical loss or damage, there is a requirement that there needs to be a visible change in the physical condition of the item.

The Ombudsman's View:

The Ombudsman rejected the insurer's contentions and recommended that the claim should be paid. The Ombudsman found that "physical loss or damage" was not limited to obvious and visible changes but could also involve contamination whereby the essential nature of the item had permanently changed to the degree that it could not be used for the purpose for which it was designed. There had been an alteration in the pre-existing physical state of the scope and this, in the Ombudsman's view, constituted "physical damage" for the purposes of the policy.

Upon the Ombudsman's recommendation that the claim be paid, the insurer agreed to settle the matter in full.

POLICY INTERPRETATION: APPLICATION OF THE CONTRA PROFERENTUM RULE (MUTUAL & FEDERAL INSURANCE CO. LTD)

The Facts:

The complainant enjoyed comprehensive building cover for his residential home. On 10 April 2012, he submitted a claim for the theft of copper water pipes from the insured building. The pipes were cut and wrenched off the external walls of the building. Forcible entry was gained into the property through a palisade fence. There was no actual entry into the building or any items stolen from inside the building.

The Insurer:

The Buildings Combined Section of the policy provided cover for theft "*accompanied by forcible and violent entry into or exit from the building*". The insurer argued that, although forcible and violent entry was gained into the property through the palisade fence, this was insufficient and did not constitute forcible and violent entry into or exit from the building as required by the policy. The insurer also argued that the removal of copper piping from the exterior walls of the building did not constitute forcible and violent entry into or exit from the building. The insurer concluded that the complainant's claim did not fall within the ambit of the theft cover provided in the policy and rejected the claim.

The Ombudsman's View:

The nature and location of the copper water pipes on the property did not necessitate entry into the building. Therefore the policy condition relied upon by the insurer did not find application in the present circumstances.

After reviewing the insurer's policy terms and conditions, the Ombudsman noted that there was no other clause in the policy which would support the repudiation of this claim. In fact, the policy was silent on the terms and conditions relating to theft on the outside of the building.

The insurer then argued that as the policy was silent on the theft of fixures and fittings from outside the building, theft cover was therefore restricted to fixtures and fittings inside the building. The Ombudsman informed the insurer that, if this is what the underwriters had intended when drafting the policy, they were required to set out the exception in clear terms, which they had not done. The Ombudsman noted further that the insurer's definition of "*building*" provided in the policy wording included all fixtures and fittings and did not exclude the circumstances under consideration.

In the Ombudsman's view it was the insurer's duty to make it clear regarding which particular risks it wished to exclude. Consequently, the extent to which the insurer's liability was limited must be plainly spelled out. The Ombudsman applied the contra proferentum rule to this matter. This Latin/legal phrase explains that where there is doubt about the meaning of the contract, the words will be construed against the party who is responsible for drafting the clause. The contra proferentum rule found application in cases where there was any ambiguity in the wording. Any provision in a policy of insurance which purports to place a limitation upon a clearly expressed obligation to indemnify must be restrictively interpreted, ***French Hairdressing Salon Limited VS. National Employers Mutual General Insurance Association 1931 (AD60)***. An exemption clause is interpreted against the insurer because it purports to limit what should otherwise be a clear obligation to indemnify.

In applying the above principle to the facts of the present matter, the Ombudsman found that the complainant had demonstrated that an event covered by the policy had arisen, namely the theft of fixtures and fittings from the insured building.

The insurer's repudiation of the claim was overturned and the claim was settled in full.

NEW APPOINTMENTS AT THE OFFICE

Candace Fourie *Secretary to John Theunissen, Assistant Ombudsman*

Candace joined the office in January 2013.

Candace has a diploma as a Management Assistant. She has worked in the Medical Scheme environment from 1999 to 2012 and has gained a wealth of experience in the Medical Schemes Industry.

Candace enjoys art and reading. She has a daughter of 8 years old, who is the light of her life.

LET'S HEAR IT FOR OSTI

What a few of our complainants have had to say about OSTI recently:

"The service was superior, to be honest I really think this is one of the most under-rated services, yet brilliant in dealing with big corporates that take advantage of consumers that are helpless... Many thanks.

.....

Service was excellent. If I only knew you guys were so helpful, I would have put in a complaint when my car was stolen 3 years ago, and insurance declined. I am still paying for the car :(Keep up the excellent work.

.....

You guys are awesome. You sorted our problem out in a month. We really appreciate it. THANK YOU.

.....

Thank you very much for your assistance in resolving my problem. Your performance was professional and beyond expectation. Your level of committment has given me hope to the future of this country for it is not often for one to find such service. I really thank you."

WHAT DOES THE OMBUDSMAN DO?

The Ombudsman for Short-Term Insurance resolves disputes between Insurers and consumers in an independent, impartial, cost-effective, efficient, informal and fair way.

The Ombudsman is appointed to serve the interests of the insuring public and the short-term insurance industry. The Ombudsman acts independently of the insurance industry in all complaints. All members of the South African Insurance Association conducting personal lines and commercial lines business have voluntarily agreed to accept the Ombudsman's formal recommendations.

If you want to lodge a complaint or require assistance please contact the Ombudsman's Office by calling 0860 726 890 or visiting our website at www.osti.co.za where application forms can be downloaded.

CONTACT US

If you would like to be added to our mailing list, please contact us on:
Tel: 011 726-8900 Fax: 011 726-5501 or email: info@osti.co.za
For more information on our activities, please visit our website at **www.osti.co.za**.
We welcome any feedback or comments you may have.

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