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. 3 of 2013

IN THIS ISSUE:

NO COVER (ABSA INSURANCE COMPANY LTD)

The Facts:

The insured was the body corporate of a sectional title scheme. The insured claimed from the insurer for the theft of an intercom, for the units in the complex and the SIM card used to operate the intercom system.

The insurer accepted the claim. Thereafter an agreement of loss form was signed by the insurer and the broker, purportedly on behalf of the insured. However, it was later discovered that the SIM card had been used by the thieves, who incurred expenses of over R30 000 on the particular SIM card. A further claim was then lodged for the unlawful use of the SIM card.

This claim was declined by the insurer on the grounds that consequential loss was excluded in terms of the policy. The insurer further argued that the policy wording did not provide cover for the type of loss incurred, in that it only provided for "loss or damage" to the insured property. The insurer also argued that, in any event, the matter had been settled in full in terms of the signed agreement of loss form.

The insured responded by arguing that the broker had acted on behalf of the insurer in signing the agreement of loss form and that the agreement was therefore invalid.

The Ombudsman's View:

In considering this matter, the Ombudsman pointed out to the insured that he did not have a further claim against the insurer in that the policy wording did not provide cover for losses incurred due to the unlawful use of the SIM card. Therefore, it was not necessary to consider the validity of the agreement of loss as he did not have cover for the second claim in any event.

The insurer's decision was upheld.

MISTAKE: NOT FRAUD (OUTSURANCE)

The Facts:

The complainant's burglary claim was rejected by the insurer on the basis of fraud and/or dishonesty. The complainant disclosed, when reporting the claim to the insurer, that she believed that the bangles which had been stolen were 18 carat and not 9 carat gold. She supported her answer with the estimated price that had been paid when purchasing the bangles. The insurer further relied on the condition of some items that had been stolen and later recovered, in that some items were not in working order and this had not been disclosed to them at claim's stage. Finally, for their repudiation, the insurer relied on an alleged confession to fraud made by the complainant during an interview with the assessor.

The Ombudsman's View:

In the Ombudsman's view the alleged confession was nothing more than an admittance by the complainant to having possibly made a mistake in relation to the gold content of the bangles.

It was found that while the complainant may have incorrectly disclosed that the bangles were made from 18 carat gold, she had provided a value to the insurer which was in line with the price of 9 carat gold bangles. In the Ombudsman's view the claim was not intentionally inflated and the incorrect description of 18 carat could not be attributed to anything but a genuine mistake.

It was pointed out that fraud is a serious allegation and that no intention to defraud the insurer had been proven by the insurer. The insurer had only managed to prove a mistake, which, in any event, did not prejudice the insurer.

The Ombudsman recommended that the claim be settled and the insurer complied. The insurer also reinstated the policy which had been cancelled on the basis of the alleged fraud.

MATERIAL MISREPRESENTATION: PREVIOUS INSURANCE HISTORY (MUTUAL & FEDERAL INSURANCE COMPANY LTD.)

The Facts:

The complainant was involved in a motor vehicle accident and submitted a claim to the insurer for the vehicle damages. The complainant's claim was repudiated by the insurer on the ground that the complainant had misrepresented material facts of his previous insurance history during underwriting.

The complainant's policy was underwritten telephonically. The insurer argued that the complainant misrepresented the number of years he had enjoyed '*uninterrupted comprehensive vehicle insurance*'.

Assessment findings at claims stage revealed that the complainant had only had 3 months of uninterrupted comprehensive vehicle insurance. His cover with insurer A was in fact a 'top-up' cover policy only and not comprehensive vehicle insurance. The insurer also found that there were breaks in cover with another insurer, insurer B. The complainant therefore did not have 7 years of uninterruped comprehensive vehicle insurance as alleged by the complainant at underwriting stage.

The insurer argued that the complainant had intentionally misrepresented the facts and not acted in good faith. The insurer repudiated the complainant's claim, voided his policy and refunded all premiums received from the inception of cover.

The Ombudsman's View:

The recording of the underwriting sales conversation was reviewed. The Ombudsman noted that the sales consultant did not ask the relevant underwriting questions correctly as required by the Policyholder Protection Rules. In fact, it appeared that the consultant drew the incorrect conclusion that the complainant had enjoyed uninterrupted comprehensive vehicle insurance for 7 years and then noted this on the policy.

While the sales consultant questioned the complainant on his previous insurance history, the line of questioning was limited to where the complainant was previously insured and for how long. The sales consultant neglected to include the critical words '*uninterrupted*' and '*comprehensive vehicle insurance*'. The Ombudsman was of the view that it therefore could not be expected of the complainant to have understood that the insurer wanted to know for how long he had enjoyed "*uninterrupted comprehensive vehicle insurance*".

The insurer's attention was drawn to the specific requirements of the Policyholder Protection Rules, which are to be adhered to in every aspect. The most important rules, in relation to the context of the complaint, were:

Rule 4.1 (a) requires a direct marketer to, at all times, render services honestly, fairly and with due care, skill and diligence.

Rule 4.1 (b) requires the insurer to, in making contract arrangements and in all communications and dealings with the policyholder, act honourably, professionally and with due care to the convenience of the policyholder.

Rule 4.1 (c) requires representations and information provided to the policyholder to be factually correct, to be provided in plain language, to avoid uncertainty or confusion and not to be misleading.

Representations and information provided by the insurer must also be adequate and appropriate, taking into account the level of knowledge of the policyholder. The insurer must therefore ensure that the questions asked at underwriting stage will illicit the correct answers which are required for the correct assessment of the risk. Therefore, the questions must not be ambiguous or contradictory but concise and precise in order to extract the correct and specific information required by the insurer for purposes of its underwriting. The onus lies with the insurer to clarify all pertinent issues, to explain the purpose of the questions and their possible consequences.

In the circumstances the insurer had failed to show that the complainant intentionally gave the incorrect information to benefit from a lower premium.

The Ombudsman was therefore of the view that the insurer's decision to repudiate the complainant's claim as a result of a misrepresentation of previous insurance history was not justified. The insurer agreed to settle the complainant's claim.

STORAGE AND RELEASE CHARGES (RMB STRUCTURED INSURANCE)

The Facts:

The complainant was involved in a motor vehicle accident and instead of phoning the insurer's dedicated towing line, he authorised a towing truck that happened to pass the scene of the accident to tow his vehicle. The claim was submitted to the insurance company. The insurer did an assessment of the damage and informed the complainant of the quantum and the excess to be paid. The complainant stated that it had taken him approximately five months to save for the excess and when authorisation for repairs had been given, the panel beater informed the complainant that they would repair the vehicle but he would need to pay storage charges of approximately R40,000.00. The complainant then lodged a complaint with this office complaining about the release fee charged by the panel

STORAGE AND RELEASE CHARGES (RMB STRUCTURED INSURANCE) CONTINUED...

beater as he felt he should not be held liable for those charges.

The Insurer:

The insurer responded to the complaint by showing that soon after receipt of the claim an assessment was done on the damage to the vehicle. The policy required the complainant to pay the excess amount over to the insurance company. The complainant only paid this amount five months after the date of loss. Only when the insurer received the said amount was authorisation for the repairs given to the panel beater. When the complainant queried the storage fees charged by the panel beater with the insurance company, the insurance company made contact with the panel beater who informed them that they were willing to reduce the storage amount from approximately R40,000.00 to R30,000.00. The insurer confirmed that had the complainant phoned the correct telephone number known to the insured, as he was supposed to have done, a towing company of the insurer's choice would have been authorised to uplift the vehicle and that no towing or storage fees would have been payable by the complainant.

The Ombudsman's View:

After considering the facts the Ombudsman advised the complainant that he was indeed liable for the storage charges as he had not followed the correct procedure as per the policy terms and conditions. He had entered into an agreement with the towing company directly when he authorised them to tow his vehicle and the insurance company could therefore not be held liable for the storage fees.

It was suggested to the insurer that the claim be settled on a cash in lieu basis and the complainant could then negotiate with the panel beater for a fair resolution of the storage fees. The suggestion was accepted by both parties and the matter was thus settled by way of a mediated settlement.

BUILDINGS COVER: NO PERIL (OUTSURANCE)

The Facts:

The insured noticed a crack on the retaining/boundary wall and had registered a claim with the insurer for damage to the wall. The insurer had rejected the claim on the grounds that the loss or damage had not been the result of an insured peril.

In supporting their rejection, the insurer had relied on a report which stated that the damage had been the result of one or more of the following:

1. The wall was a retaining wall which had originally been designed with weep holes to allow water to escape, which had subsequently been blocked by plugging the holes with a cement mixture.
2. There had been a large tree on the neighbouring property which had exerted pressure on the wall.

According to the insurer there was no liability on their part as no insured peril had operated.

The insured had then lodged a complaint with the Ombudsman, contending that the policy provided comprehensive cover covering all causes of damage and that there was no specific clause in the policy which excluded cover. According to him, this therefore entitled him to have the claim paid.

It was his further contention that he had requested that the insurer inspect the property to ensure that the property was insured for the correct amount and that the insurer had failed to do this. He submitted that this also entitled him to have the claim paid.

The Ombudsman's View:

The Ombudsman pointed out to the complainant that although the policy provided comprehensive cover, it was clearly a listed perils policy. This meant that only the listed perils would be covered.

It was further pointed out that in this specific instance, the policy had excluded cover, albeit by implication, for damage due to defective design and construction. The blocking of the drainage/weep holes had rendered the construction or design defective.

It was also pointed out to the complainant that the evaluation to ascertain the correct insured value would not have had any relevance on the extent of cover provided by the policy. It was also not the insurer's (or even the bank's) responsibility to advise on the property's structural or other shortcomings or the sum insured.

The Ombudsman accordingly found in favour of the insurer.

LET'S HEAR IT FOR OSTI

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

"Thank you for having promptly dealt with my case. I was pleasantly surprised by the level of communication and professionalism. Please do keep this up.

.....

Thank you for your efficient assistance. Payment has already been received on 23/08 and I have handed my van over to the panel beater. He promised to have it ready by the weekend. My claim would not have been successful without your intervention.

.....

Please allow me to say thank you for your efficient service through my trying time. It is good to know that there are still good people out there. Thank you for hearing me out.

.....

Thank you very much for having followed this case. I very much appreciated your highly useful service, and hope many others in similar situations may benefit from your work.

.....

My case was dealt with promptly and professionally by your office and to my complete satisfaction."

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.

Our address:
Sunnyside Office Park, 5th Floor, Building D
32 Princess of Wales Terrace
Parktown