THE OMBUDSMAN

*For Short-Term Insurance*

# *Annual Report*

# 2016

# Key Figures

AS AT 31 DECEMBER 2016

**10 175**
FORMAL COMPLAINTS RECEIVED

**4 741**
PRELIMINARY COMPLAINTS RECEIVED

**8 631**
FORMAL COMPLAINTS CLOSED

**99 139 593**
AMOUNT RECOVERED

**91 DAYS**
AVERAGE TURNAROUND TIME

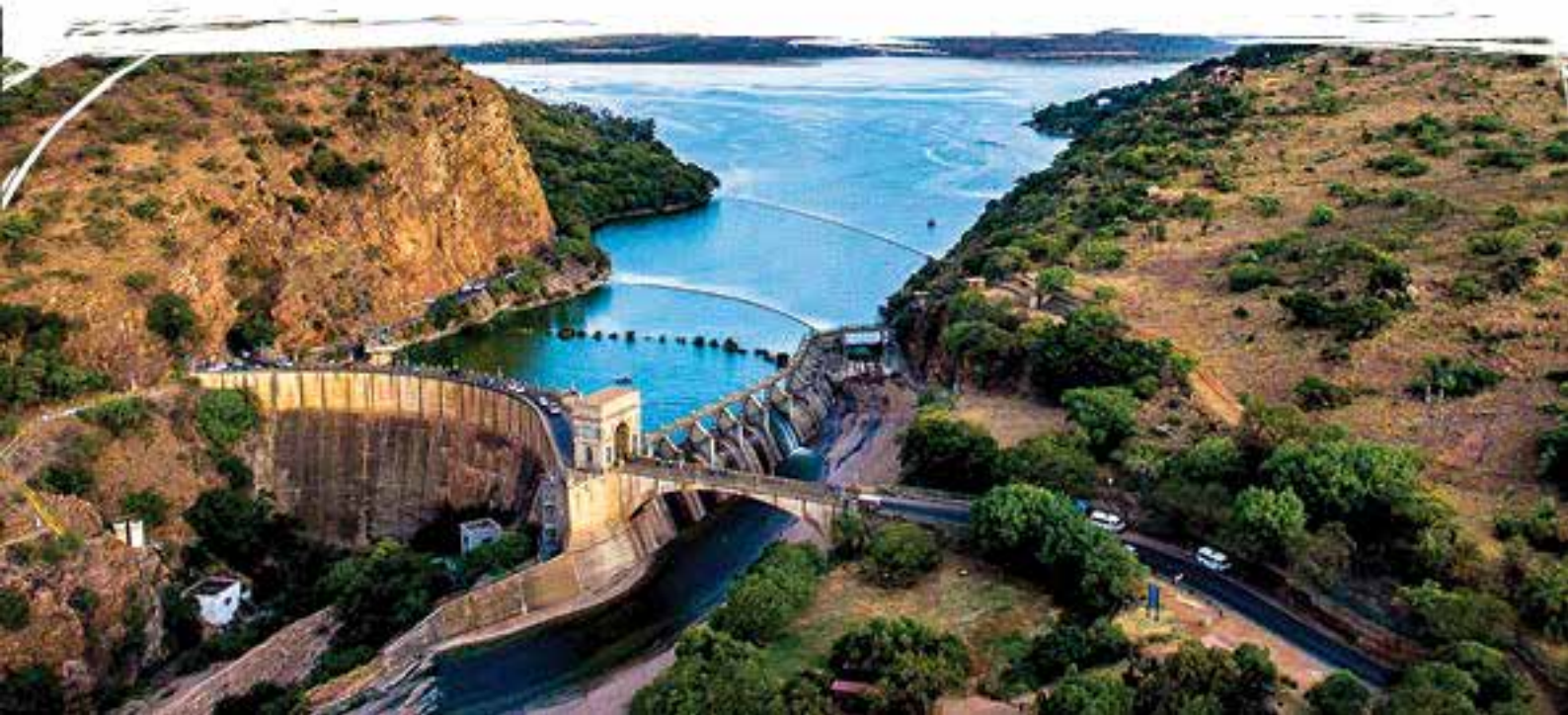
**71 005**
CALLS RECEIVED BY CALL CENTRE

# Mission

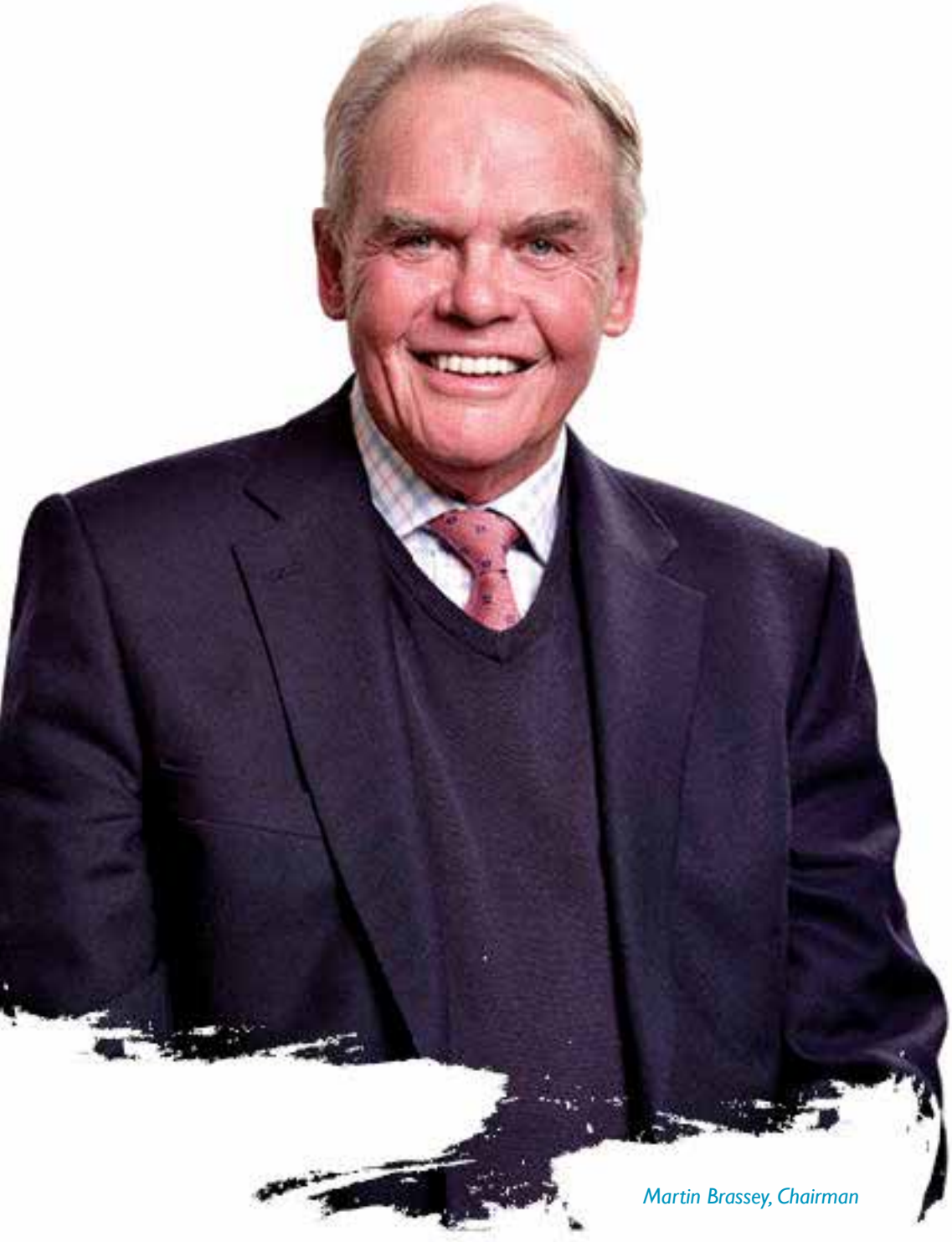
To resolve short-term insurance complaints fairly, efficiently and impartially.

# Contents





# *Report by the* CHAIRMAN



*Martin Brassey, Chairman*

When I presented last year's report, I recorded that the organization was under new leadership. My tenure of the chair was recent and the Ombudsman, Deanne Wood, had only just taken up her position.

Deanne's credentials (comprising good academic qualifications and a successful legal career) plus her energetic and engaging personality made her the Board's unanimous choice for the job.

In selecting her, the Board was conscious of her limited experience in the corporate milieu (a condition common to all advocates, who are required to operate as sole practitioners) but believed she would, by building on the sound foundation created by her predecessor, be able to deploy her considerable talents to enhance the standard of the organization's work.

Our faith in her determination to initiate change has not been misplaced. Deanne has significantly reorganized the way in which decisions are made by subjecting them all to a process of internal review. The feedback OSTI has received suggests that the resulting improvement in the standard of determinations has been palpable.

Change comes at a price, however. The more exacting systems now in place have led to a drop in staff morale and significant delays in turn-around times. Conscious of this problem, the Board has retained an expert in change management and corporate culture to take the pulse of the organization and provide OSTI's management with guidance and direction. Her appointment is paying real dividends.

On top of this intervention, the Board is carefully monitoring the proposals being made to ensure that turn-around times improve. I have every reason to believe that the innovations will bear fruit in the medium term at least.

Beyond parochial concerns are developments that will have a far-reaching impact on the organization. Soon OSTI will be subject to statutory scrutiny and regulation that will require a fundamental re-examination of our structures and modes of operation. OSTI's management and Board are of course monitoring the implementation of the legislation but we have yet to receive complete clarity on the State's expectations.

Our attitude, I think it is fair to say, is that we must seek to enshrine the best features of a voluntary Ombudsman structure within the framework of statutory regulation that is contemplated by the enactment. To meet this challenge, OSTI must ensure that office-bearers from top to bottom understand their roles and are happy to work in unison. Significant work needs to be done before we will achieve this happy result.

In short: much good is happening but there is no room for complacency and none is being exhibited. OSTI's Board and management confront the upcoming corporate year with zest and determination.

**Martin Brassey SC.**
**Chairman of the Board**
**April 2017**

# *Report by the* OMBUDSMAN

*Deanne Wood, Ombudsman*

If for nothing else, 2016 will be remembered by those closely associated with OSTI as a year of change. Any process of significant change is a bridge between how things were once done and how they will eventually be done. The first major change that OSTI faced in 2016 was my appointment as the new Ombudsman with effect from 1 March 2016. I succeeded Dennis Jooste who retired after four years at the helm. Dennis left behind an impressive legacy – an efficient and stable office with minimal backlogs and notable turn-around times.

As tempting as it was to invoke the adage "if it ain't broke, don't fix it",[1] the lessons learned and improvements made during Dennis's tenure left open for me the opportunity to consider other areas in which OSTI might improve the quality of the service that it offers to consumers and to its members because, after all, "if a job's worth doing, it's worth doing well."[2] I knew that, in order to achieve the right balance between efficient turnaround times and a job well done, OSTI had to change its approach to its work. In May 2016 OSTI embarked on another major change as it began its walk along the bridge that we, its leadership, hope will lead to consistently efficient resolution of complaints coupled with an assurance of high quality outcomes.

Quality outcomes are, in my assessment, essential to the proper functioning of an Ombud scheme. I say this in the belief that most consumers approach OSTI for assistance on the basis of their own strength of feeling in the outcome of their complaint. It is therefore important that, in addition to receiving efficient assistance in the resolution of their matters, consumers feel listened to, are given a clear and accurate explanation of the outcome of their complaint and feel that their matter has been addressed in a fair, comprehensible, correct and impartial way. Equally, insurers should feel confident that OSTI operates as an extension of their own quality assurance to their clients. In the same way as for complainants, insurers must also be heard and their reasoning and rationale properly considered. Where insurers' decisions are found by OSTI not to be justified, insurers should feel confident in OSTI's ability to make it right. Equally, where insurers have acted correctly, there are lessons to be learned and insurers should feel reassured by OSTI's endorsement of their decisions. OSTI should also seek to learn lessons from the complaints that it handles with a view to improving outcomes for future complainants and other stakeholders.

The quality control measures implemented at OSTI during 2016 have most certainly been felt by the micro community over which OSTI has influence. In this regard I refer most particularly to the committed group of people who staff OSTI's office and who dedicate their days to serving its objectives. Each one of them must be commended for the way in which they have walked OSTI's bridge to change during 2016. The changes at OSTI have also affected insurers who participate in the office and they too must be thanked for their positive approach to and acceptance of OSTI's infrastructural adaptations. Although these changes have affected OSTI's turnaround times and closure rates, we are confident that this is a temporary set-back and that, once fully over the transitional walkway, the statistics reported in previous years will again be an outstanding feature of this report. It is also our hope that the impact of the recent changes at OSTI have been felt by consumers who approach our office for assistance.

In addition to the operational changes that I have mentioned above, during 2016 OSTI also confronted and dealt with mooted changes to the statutory environment under which it is established, changes to its staff compliment and to its member composition. Below I first discuss OSTI's operational results and then turn to these other aspects of change that OSTI has confronted during 2016.

## Operational Results

During 2016 OSTI received 14 916 complaints of which 10 175 were registered as formal complaints. This reflects an increase in the number of complaints received in 2016 of 780 compared

1 Brett Lance, *Nation's Business* May 1977
2 Chinese Proverb

to 2015. The increase in complaints submitted coupled with the operational changes implemented during 2016 and the focus on quality outcomes resulted in 1 313 less complaints closed for 2016 than in the previous year. The average turnaround time per complaint remains within commendable levels at 91 days. As many as 34% of complaints were resolved in less than 60 days. Only 6% of complaints took longer than 180 days to resolve. Typically these long-standing complaints concern matters of significant complexity and the delay in their resolution can be explained by the intricacy of the evidence that must be obtained and evaluated during their investigation.

In 2016 OSTI recovered just short of R100million for consumers, just marginally less than in the previous year. This reduction in the rand recovery can be explained by the concomitant reduction in the number of files closed in 2016.

OSTI's overturn rate remains constant at 27%. The publication of the insurer statistics continues to attract much interest from OSTI's insurer members as well as the media, the regulator and consumer bodies. These statistics demonstrate which insurers attract a disproportionately high number of complaints when compared to their market share.

## Statutory changes

The National Assembly voted for the acceptance of the Financial Sector Regulation Bill ("the FSRB") on 6 December 2016. This followed the Standing Committee on Finance voting in favour of the Bill on 30 November 2016. Following the approval of the Bill by the National Assembly, it was then considered and debated by the National Council of Provinces on 14 February 2017. The Bill is now in its final stages of consideration and it is not unduly unrealistic to expect that it will be enacted within the course of this year. With its enactment will come a material shift in the way in which the financial industry, and so too, financial ombud schemes, operate. That the legislature views the ongoing role of financial ombud schemes as material to the operation of the new twin peaks model of financial regulation is evidenced by the continued engagement between National Treasury and the offices of the four voluntary financial ombud schemes both prior to and during 2016.

Governance of the financial ombud schemes under the new legislative regime is dealt with in chapter 14 of the Bill. On 3 May 2016 I, together with the Credit Ombudsman, Nicky Lala-Mohan, the Banking Ombudsman, Clive Pillay and the Long-Term Insurance Deputy Ombudsman, Jennifer Preiss, was invited to make a presentation on the workings of our respective offices and the potential impact of the Bill to the parliamentary standing committee on finance. During this presentation, the members of the committee engaged actively and vigorously with all of the ombuds present in an effort to understand the roles that each scheme plays in South Africa's financial landscape.

A study of the provisions of chapter 14 of the Bill reveals that the alternative dispute resolution role of the financial services ombudsmen is seen as important to the ordinary citizens of South Africa. This is evidenced by the sections in chapter 14 which compel financial services providers to belong to an ombud scheme, and which seek to promote public awareness of and access to ombud schemes and strive for greater coverage and jurisdictional application of the various schemes. One of the key differences between chapter 14 of the FSRB and the existing Financial Services Ombud Schemes Act is the introduction of the Ombud Council, headed by the Chief Ombud. Once established, the Ombud Council will be a full time operational body. It will set rules for all financial ombud schemes and will take steps to homogenise processes and procedures across all of the schemes. It will provide strategic oversight for the schemes and will establish a mechanism to monitor the performance of the schemes. Whether it will achieve its aims through the consolidation of the four voluntary schemes and the two statutory schemes into one collective financial services ombud scheme remains unclear. However, we have the assurance of National Treasury that whatever changes are made, they will be made gradually. We also have the commitment that this process will continue to unfold through negotiations, discussion and debates with the various ombud schemes.

## New staff and members

During 2016 OSTI welcomed the addition of two new members of its professional staff – Nadia Gamieldien who joined us from

Norton Rose attorneys and Kgomotso Molepo who previously worked at ABSA.

Two new members joined OSTI during 2016, namely Workerslife Insurance Limited and Professional Provident Society Short-Term Insurance Company Limited.

## Rulings

On 1 March 2016, my first official day in office, I was required to make final a provisional ruling made by Dennis Jooste during his last month in office against King Price. A final ruling is made when a recommendation made by this office to an insurer is not acted upon, adequately or at all. A final ruling is, subject to the appeal process, binding on the insurer. King Price initially appealed the ruling but later withdrew the appeal. OSTI welcomed the initiation of the appeal as it provided a much needed opportunity for it to test the effectiveness of the appeal process and to evaluate whether this process served its intended purpose. Although the appeal did not ultimately proceed to a hearing, significant steps were initiated to enable OSTI critically to evaluate the process and open discussions with the board about simplifying the appeal procedure.

I made a second final ruling against Mutual and Federal who, upon receipt of the ruling, abided by my decision.

## Finances

OSTI earns its income through fees charged per complaint. Although its revenue is collected at the inception of a complaint, it is only recognised in OSTI's book when a complaint is closed. In striving to improve the quality of its complaints' handling, OSTI closed fewer cases in 2016 than had been anticipated when the budget was prepared. For this reason, OSTI's financials reflect an accounting deficit (and a corresponding increase in deferred income) for the year. It is anticipated that this deficit will be reversed, if not in whole then at least substantially in part, during 2017.

## Board

OSTI's board consists of four insurer representatives, four consumer representatives, a nominee from the Financial Services Board and two independent directors, one of whom is the Chairman. I am extremely grateful to the board for their guidance and support during my first year in office. I am grateful too to the members of the risk and audit committee for their dedicated service and commitment to OSTI and for the careful and considered approach that they adopt in analysing potential threats to OSTI's security and viability.

## Consumer Education and PR activities

We continue to serve on the National Consumer Financial Education Committee under the auspices of the National Treasury and also serve on the SAIA Consumer Education Committee. We also make a direct contribution to consumer education in the form of our numerous public relations activities. General information about OSTI is regularly conveyed on our website and by way of regular Twitter feeds. Our relationship with the media remains on a sound footing as evidenced by the wide publicity given to the office, its activities and its rulings during the year. In 2016 we reached consumers by way of 15 newspaper articles, 13 magazine and on-line articles, 19 radio interviews, 3 TV interviews, 4 press releases receiving press coverage, 4 editions of the Ombudsman's Briefcase and responding to numerous media queries/requests.

## Seminars and Conferences

I, together with two senior ombudsmen, attended the annual insurance conference at Sun City. I also had the great privilege of attending the annual conference of the International Network of Financial Ombudsman Schemes in Armenia. This conference provided a wonderful opportunity for me to interact with ombudsmen from around the world and, more particularly, with the other financial sector voluntary ombudsmen and deputy ombudsmen – Nicky Lala-Mohan and Reana Steyn, the Credit Ombudsman and his deputy, Clive Pillay, the Banking Ombudsman and Jennifer Preiss, the Long-Term Insurance Deputy Ombudsman.

In closing I would like to thank all who participate in OSTI's activities for assisting me during my first year in office. Special thanks go to my Deputy Ombudsman, Edite Teixeira-Mckinon, without whose guidance, support and assistance I would not have been able to manage. I am also grateful for the sage advice and sound input of my Senior Assistant Ombudsmen, Darpana Harkison, Peter Nkhuna, Thasnim Dawood and Ayanda Mazwi.

**Deanne Wood**
**Ombudsman**
**April 2017**

# *Report by the*
# DEPUTY OMBUDSMAN

*Edite Teixeira-McKinon, Deputy Ombudsman*

The theme of our report, you would have noticed, is bridges.

A bridge can be a symbol for many things but for OSTI, during 2016, this image symbolises a crossing over, a passage from the past, old way of doing things to the future, to a new approach. A bridge it is both transitional, in enabling us to move from the old to the new, and connecting, by maintaining the connection between the past and the future. In essence, this year's theme symbolises the changes that OSTI has been through during 2016 and reminds us that bridges (both proverbial and actual) assist in getting us from where we are to where we need to be. A bridge also symbolises teamwork, without which change in an organisation cannot take place effectively. *"None of us, acting alone, can achieve success"* said the great Mr Nelson Rolihlahla Mandela. OSTI's staff can be commended for their teamwork during 2016 and for striving to achieve a unified and collective approach to the changes they have encountered.

The changes that have been made serve to ensure that OSTI's decisions are consistent in approach and represent the collective thinking of the organisation. They also strive to encourage greater accuracy in the outcomes of the recommendations made and to ensure that the quality of work produced is of the highest standard.

The operational changes that have been implemented at OSTI (and will continue to be implemented) following the appointment of Ms Deanne Wood, are not only to improve the quality of the service that we deliver but also in anticipation of the new regulatory framework that our office, along with the other voluntary Ombud Schemes, will eventually be operating under. It is difficult at this stage to understand the full extent of the impact that the Financial Sector Regulation Bill ("the Bill") will have on our office. The Bill, which has been approved by the National Assembly and is now at the National Council of Provinces for approval, will ensure that all of the voluntary financial Ombud Schemes will be answerable to the Ombuds Regulatory Council for the manner in which they handle complaints.

With increased accountability to the Regulator comes an increased responsibility to ensure that there is a consistent standard and approach at OSTI when recommendations are made by its assistant ombudsmen. The importance of high quality and consistent decision-making simply cannot be overlooked. Further areas of potential impact of the Bill include a more focused advancement in the co-operation between the various financial ombuds' offices and consistency in processes and requirements for all schemes. Under the Bill, all financial institutions providing financial products and services must be a member of an approved ombud scheme. The Bill also deals with quality control ensuring optimum service delivery by the ombud schemes and a widened jurisdiction of some of the ombud schemes' current jurisdictions requiring schemes to deal with service related complaints.

These are only some of the provisions that will change the way in which we operate. No doubt more will follow once the regulations that will ultimately be drafted under the Bill are promulgated. We will continue to engage closely with National Treasury and the Regulator in order to ensure that we understand what is expected of us and to ensure that we comply with the requirements set by the Ombudsman Council and the Chief Ombud.

The journey across a bridge is not always an easy one. But if OSTI is to remain effective, efficient and relevant, it is one we need to make perhaps now more than ever before.

**Edite Teixeira-McKinon**
**Deputy Ombudsman**
**April 2017**

# *Case Studies by*

# SENIOR ASSISTANT OMBUDSMEN

***Senior Assistant Ombudsmen:*** *Peter Nkhuna, Thasnim Dawood, Darpana Harkison and Ayanda Mazwi*

## 1. Obligations of the insured - proof of ownership – vehicle claim

**Alexander Forbes**

The complainant approached the office of the Ombudsman for assistance following the rejection of a claim submitted to the insurer for the theft of a motor vehicle on 6 July 2016. The vehicle was placed on cover on 1 June 2016 for an insured sum of R509 900.00.

During the validation of the claim, the complainant submitted that he purchased a used vehicle from Mrs. A in May 2016 for the total price of R495 000.00. According to the complainant, the parties agreed that he would make an initial cash payment of R190 000.00 in May with the balance consisting of a further cash payment upon the delivery of the Audi motor vehicle in December. The vehicle was registered in the complainant's name on 13 May 2016 after he paid R190 000.00 to Mrs A. The complainant was in possession of the registration certificate and attended to the deregistration of the motor vehicle after the theft.

The assessor appointed by the insurer to validate the claim discovered discrepancies in the registration of the vehicle. He found that the vehicle had originally been registered in the name of a vehicle rental company. The vehicle was subsequently registered to Salvage Management Disposal and then to Zurich Insurance.

Upon further investigation, the assessor found that the vehicle had been written off following a motor vehicle accident on 13 July 2015. A Natis audit trail revealed that the vehicle was deregistered and demolished on 17 September 2015. The vehicle salvage was purchased by a used spares proprietor and stripped for spare parts. The vehicle salvage was inspected by the assessor who confirmed from the chassis and VIN numbers that it was in fact the same vehicle on cover. At this stage, the insurer could not rule out the possibility that the insured vehicle had been cloned or did not exist. The assessor's report, including the Natis audit and photographs of the vehicle salvage were provided to the Ombudsman for consideration.

The insurer required the complainant to submit proof of purchase of the motor vehicle in light of the assessment findings. The complainant was not able to provide any proof that he paid Mrs. A the amount of R190 000.00, or that he owned an Audi motor vehicle that would have formed the balance of the payment. The complainant also failed to submit an agreement of sale or any service related documentation in respect of the vehicle. The contact details of Mrs. A were also not available. The insurer raised suspicion about the fact that the seller could not be located even though the complainant still owed her the balance of the purchase price.

**The insurer rejected the complainant's claim on two grounds:**

1. The complainant did not furnish true and complete information when submitting the claim. The general conditions of the policy provide that if the insured gives false information, wrong descriptions or fails to inform the insurer of any relevant information, the insured will not enjoy cover under the relevant section of the policy.

   The insurer argued that the complainant did not provide true and complete information regarding the purchase of the vehicle and the circumstances under which the vehicle was purchased.

   In considering this rejection reason, the Ombudsman held that the insurer had not established sufficient facts upon which to argue that the complainant had submitted false information.

2. The complainant failed to supply proof of ownership of the vehicle he was claiming for. This provision is set out under the general conditions of the policy relating to claims.

   The Ombudsman found that the insurer's request for proof of purchase was reasonable given the facts and circumstances of the claim. The complainant was not able to prove the purchase of the vehicle or provide any information which would enable the insurer to validate its existence.

The Ombudsman upheld the insurer's decision to reject the claim on the ground that the complainant failed to supply proof of ownership of the vehicle he was claiming for.

**Ayanda Mazwi**
**Senior Ombudsman**

## 2. Theft under false pretences

**Santam Insurance Limited**

Mr. G's vehicle, was stolen on 9 October 2016. The insurer rejected Mr. G's claim on the ground that the vehicle was stolen under false pretences and that the policy excludes cover under these circumstances.

**The insurer relied on the following wording in the policy:**

*"HIERDIE AFDELING DEK NIE DIE VOLGENDE NIE*

*1. Voertuig verlies of skade*

***Geen van die volgende word gedek nie, tensy andersins in die Bylae genoem:***

*1.7 verlies of skade wat ontstaan uit of wat verband hou met enige ruiltransaksie, kontant- of kredietverkoop transaksie, insluitende diefstal deur middel van valse voorwendsel en bedrog".*

Mr. G advertised his vehicle on a website and received a call from a potential buyer, Mr. X, who was interested in purchasing the vehicle. An arrangement was made to meet with Mr. X. Mr X. was to pay a R5 000 deposit and was to provide proof of payment to Mr. G.

An sms notification was received by Mr. G from Mr X.'s bank confirming that the deposit had been paid. Mr. G arranged to meet with Mr. X the following day at a shopping mall, where Mr. G would be provided with further proof of payment for the balance of the purchase price. Mr. G would then hand over the vehicle and the relevant documentation to Mr. X.

Before the meeting at the shopping centre, Mr. G received a further sms confirming that the outstanding amount had been paid into his account. However, Mr. G required further proof of payment and, on requesting such proof from Mr. X, he received an email attaching a bank transaction form.

Mr. G attended at the shopping centre in order to complete the transaction. He was approached by Mr. V who informed him that he would be collecting the vehicle on behalf of Mr. X as Mr. X was with his family and was unable to come to the centre. Mr. G attempted to call Mr. X's bank to determine whether the money had in fact been transferred but he was advised that only an account holder could enquire about payments. Mr. G obtained a copy of Mr. V's identity document and handed the vehicle over to him. The following day, Mr. G followed up with Mr X.'s bank and was told that he had been given false proof of payment. Further, he found that Mr. X's ID number did not exist.

Mr. G reported the loss as a theft to the police.

Mr. G submits that he did not hand over the keys to Mr. V voluntarily but that he was afraid for his and his wife's safety at the time. Mr. G said that Mr. V was accompanied by another male and that he felt that if he did not provide them with the vehicle, there might be "repercussions". Mr. G said that he felt threatened by Mr. V and his companion and therefore handed over the vehicle keys.

Mr. G also submitted that he did not receive the policy wording from the insurer and that he was unaware of the relevant terms and conditions. Further, he argued that his broker did not do enough to ensure that he was aware of the policy terms and conditions.

The insurer asserted that Mr. G's broker had indicated that the policy wording was furnished to Mr. G via registered post at the inception of the policy. The insurer also attached a welcome letter where it was stated that cover provided was subject to certain exclusions which should be perused by the insured. Proof that the documents had been sent by registered post was provided to this office by the insurer. A record of advice was also furnished from the insurer indicating that Mr. G was informed of important information contained in the policy including the policy exclusions.

The Ombudsman found that, based on the evidence, the loss fell within a policy exclusion, namely, theft under false pretences. Mr. G, even though he felt unsafe with Mr. V and his companion and was unable to confirm at that time that the funds had been transferred, handed over the keys to Mr. V, as he feared for his safety. It was apparent that Mr G. suspected at that stage, before handing over the keys and the vehicle that there was something wrong.

The Ombudsman found that as the policy excludes theft under false pretences, there was no cover for this loss.

The Ombudsman also found that there was sufficient evidence to prove that the policy wording was provided to Mr. G's broker and that Mr. G's broker advised that the policy terms and conditions were explained to Mr. G.

Consequently, the Ombudsman found that the insurer's rejection of the claim could not be faulted and the rejection was upheld.

Thasnim Dawood
Senior Ombudsman

## 3. Non-payment of premium

OUTsurance

In his details of complaint the insured advised that, during June 2016 he travelled to Zimbabwe to attend his father's funeral. On 15 June 2016, he was involved in an accident with a third party and a claim was submitted to the insurer. During the course of the claim's conversation, the insurer advised that the premium was not received for June 2016 but that it could still be paid following which the vehicle would need to be assessed. Subsequent to that conversation, the insurer rejected the claim due to non-payment of premium.

According to the insured, the insurer's rejection of his claim was contrary to the expectation it created during the claim's conversation where the insurer advised that it would assess the claim. This, the insured argued, constituted a verbal agreement to settle the claim. The insured further argued that the reason why the premium was not paid, on the due date and within the grace period, was because he was attending his father's funeral.

The insured argued that the insurer failed to comply with Outcome 3 of the Treating Customers Fairly doctrine when it first informed the insured that he could pay the premium but then revoked this later by stating that the claim was being rejected on the grounds that the premium was not received.

The insured requested the Ombudsman's assistance in compelling the insurer to comply with the verbal agreement entered into on 20 June 2016.

According to the insurer's comprehensive response, the insured's claim was rejected as the insured failed to pay the premium for the month of June 2016 and there was no cover for the loss. The policy wording which the insurer relied on in substantiation of its rejection of the claim is:

*"Your responsibilities*

*In order to have cover you need to:*

*Pay your premiums*

*Premiums not paid*

***If the premium is no paid on the payment date, you have a 15 day grace period after which we will automatically deduct the premium from the same account to ensure continuous cover. If this premium is also not paid you will have no cover for the period for which you did not pay. If your premiums are paid monthly, the grace period will only apply from the second month of cover."***

The insurer advised that, in order for the insured to have cover for June 2016, the insurer debited the premium on 30 May 2016, however, no premium was received. In compliance with the policy wording, the insurer re-debited the premium on 14 June 2016 and once again no premium was received. Therefore, the insured did not enjoy cover for the loss which took place on 15 June 2016 and the insured's claim was rejected.

**In his response to the insurer's comprehensive response, the insured advised that:**

- It is not in dispute that the premium was not paid for the month of June 2016;
- The insurer entered into a new agreement during the course of the claims conversation by telling the insured that it would send him the account details in order to enable him to pay the premium, which offer was accepted by the insured.
- The insurer was estopped from rejecting the claim as the insurer, despite being aware of the unpaid premium, went ahead with the assessment of the damages.

In response to the insured's reply, the insurer advised that it had notified the insured of the non-payment of the premium

during the claims conversation in order to ensure that the insured would be covered for the period following the loss. Further, the assessment of the damages was in order to establish the extent of the damages.

During its investigation of the complaint, the Ombudsman listened to the recorded claim's conversation. The recording revealed that the insurer notified the insured that the premium for the month of June 2016 had not been received and that arrangements would be made for the premium to be paid. The insurer did not make any undertaking to settle the claim in the event that the premium was received. Accordingly the Ombudsman found that no new agreement had been concluded and that the insurer was entitled to reject the claim on the grounds that the insured had failed to pay the premium. The Ombudsman was satisfied with the insurer's submission that the purpose of the assessment was to establish the extent of the damages and was not as an admission of liability.

**Darpana Harkison**
**Senior Ombudsman**

## 4. Lies, lies, darn lies... will compromise your claim

**Mutual & Federal Insurance**

The dispute relates to a motor vehicle hijacking claim for an incident reported to have occurred on the 26th of June 2016. The insurer rejected the insured's claim on the basis that the insured provided it with dishonest information with regards to the claim. The insurer also asserted that the insured had failed at the inception of the policy to disclose material information regarding his insurance history.

The insured advised the insurer that he had gone to visit a colleague who stays at Litha Park, which is situated five minutes away from his house. Whist driving home from the colleague's house, he gave an old man a lift to Harare. After dropping off the old man and before he could start the vehicle, he was approached by two men who beat him up and drove off with the vehicle. He walked to his cousin's home who stays close to where the vehicle was hi-jacked. According to the insured, the perpetrators had strangled him until he passed out. He later found himself dazed, walking in the rain not knowing how he got to his cousin's house. On arriving at his cousin, the insured alleged that he went to sleep. He did not contact the police or his wife. He further advised that his cell phone had been taken during the incident. The following day, his cousin assisted him to go to the police station and report the incident.

The insurer's assessor confirmed during the investigation that the insured did in fact visit his colleague in Litha Park. However, in contrast to what he had reported to the insurer, the insured told the assessor that he had given a lift to two old men. The insured thus provided the assessor with a version different from the one given to the insurer when the claim was submitted.

The insured vehicle was later found by the SAPS having been burnt down. The vehicle was found also to have sustained accident damage. It was also discovered that the insured had submitted an almost identical claim in 2014 which had been settled by the insurer.

The insurer argued that the insured had failed to inform it at the inception of the policy that he had two previous policies that had been cancelled by his previous insurers, Iwyze and Telesure.

The insurer further argued that, in its view, the insured had staged the hijacking. The insured apparently informed the insurer's assessor that he was on a call when the hijacking occurred and had a made a few calls prior to the hijacking. The insured's service provider confirmed that there were no calls made or received for at least six hours prior to the incident.

Having carefully considered all the submissions made, the Ombudsman was of the view that the insured had misrepresented his insurance history at the inception of the policy. It further appeared that the insured's loss had probably been staged, considering the conflicting versions provided by him and the various discrepancies in the factual circum-stances surrounding the alleged incident.

The insurer's decision to decline the claim was accordingly upheld.

**Peter Nkhuna**
**Senior Ombudsman**

# Words of WISDOM

If an insurer suffers a premium prejudice due to a material change in risk, but would still have accepted the risk, the insurer must consider a *pro rata* settlement of the claim.

- Adriaan Lombaard
**Assistant Ombudsman**

Premiums are determined by the insurer based on the information provided by the insured. The insured has a duty to disclose information that may affect the underwriting of the policy. Failure to disclose the required information will result in the insurer suffering prejudice by collecting an incorrect premium. This may affect the insured when a claim is submitted.

- Kgomotso Molepo
**Junior Assistant Ombudsman**

An insured bears the onus of bringing the claim within the ambit of the policy and must show that it falls under an insured peril. However, if the insurer wishes to rely on an exclusion, it bears the onus of proof.

- John Themnissen
**Assistant Ombudsman**

An insurer must create a duty of disclosure at the inception of a policy. Failure to do so will result in the insurer not being able to rely on a misrepresentation to void the policy.

- Hannes Bester
**Assistant Ombudsman**

When parties to a complaint rely on an expert report, they must ensure that the expert is suitably qualified to give opinion evidence and that the report does not contain speculation or conjecture.

- Johan Janse Van Rensburg
**Assistant Ombudsman**

As with any civil dispute, the Ombudsman's findings are based on a balance of probabilities taking into account all relevant facts and information provided by both parties. All the evidence is weighed up and the version that is most probable will succeed.

- Nadia Gamieldien
**Assistant Ombudsman**

Insurers must make certain that their policies make provision for a fifteen day period of grace for the deduction of premiums. This means that insurers may only issue a second debit against an insured's account on the 16th day following the first failed debit.

- Valerie Mngadi
**Assistant Ombudsman**

An insurer is required to prove a causal connection between a loss and a misrepresentation or non-disclosure before it can repudiate a claim.

- Anastatia Maimane
**Junior Assistant Ombudsman**

Remember, the Ombudsman's decision is not based solely on the law. The Ombudsman has the jurisdiction to also consider equity. The Ombudsman will try to find the most equitable outcome to the matter for both parties. Equity applies to both the insurer and the insured.

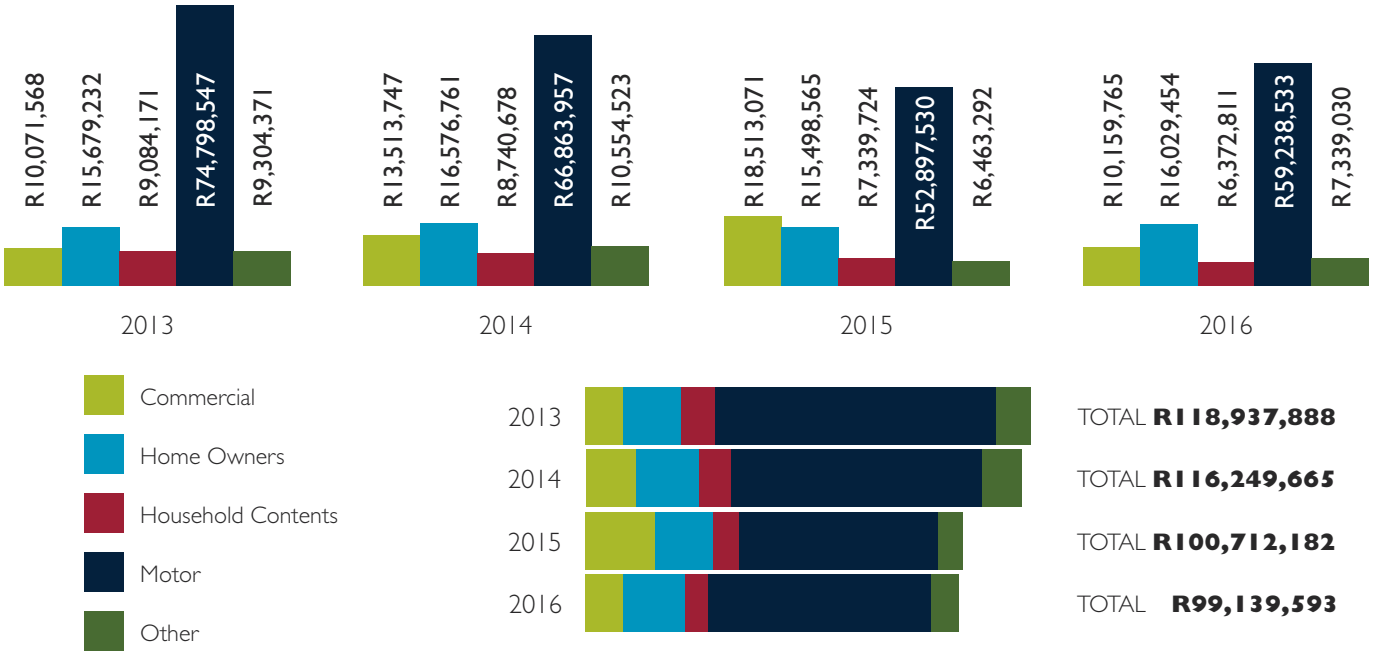
- Nosipho Mfeka
**Assistant Ombudsman**

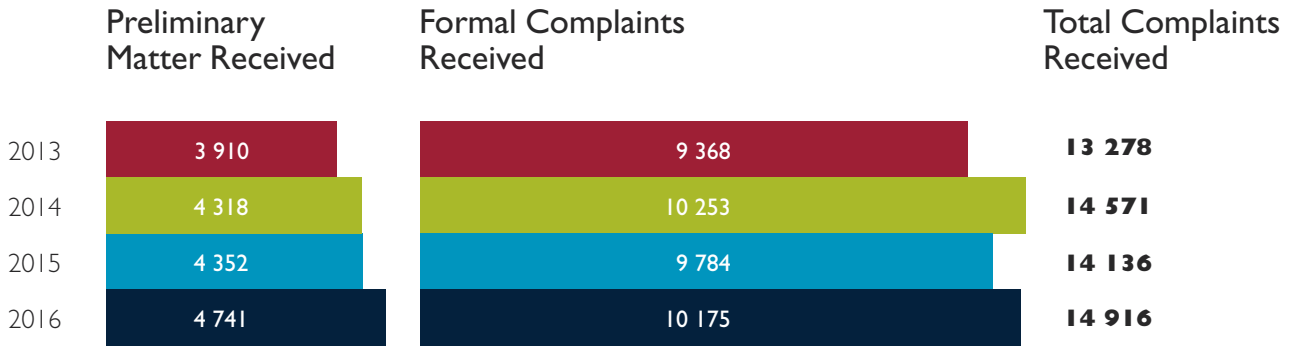
An investigator should not pose leading questions to a witness. The evidence elicited from a witness must be the witness' clear and independent account of his or her own observations.

- Sangeetha Sewpersad
**Assistant Ombudsman**

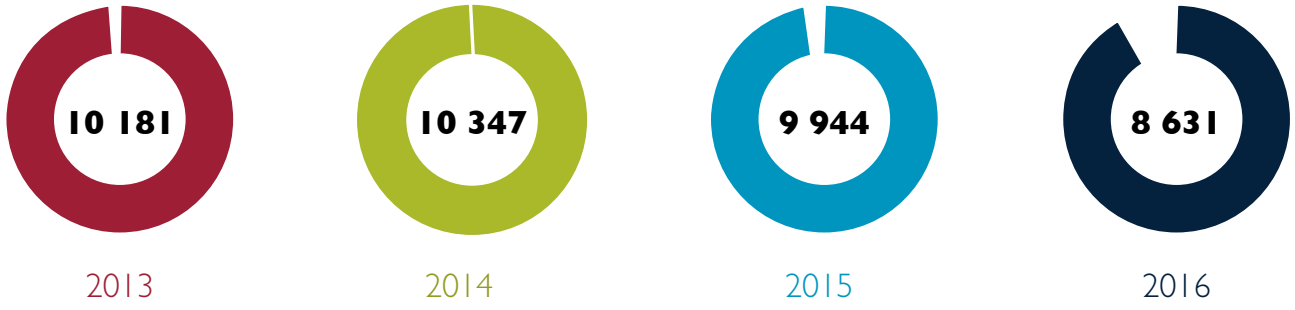
# Office STATISTICS

## Rand Value of Complaints Resolved in Favour of the Insured - Claim Type

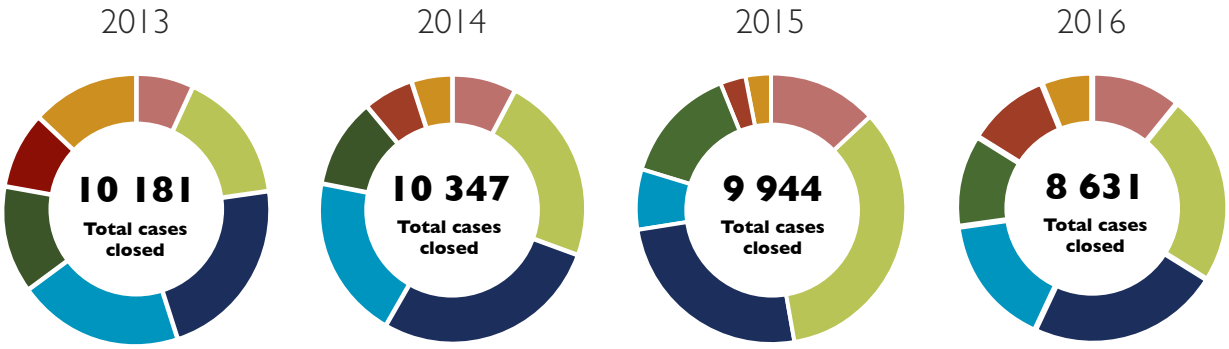



## Formal Complaints Closed

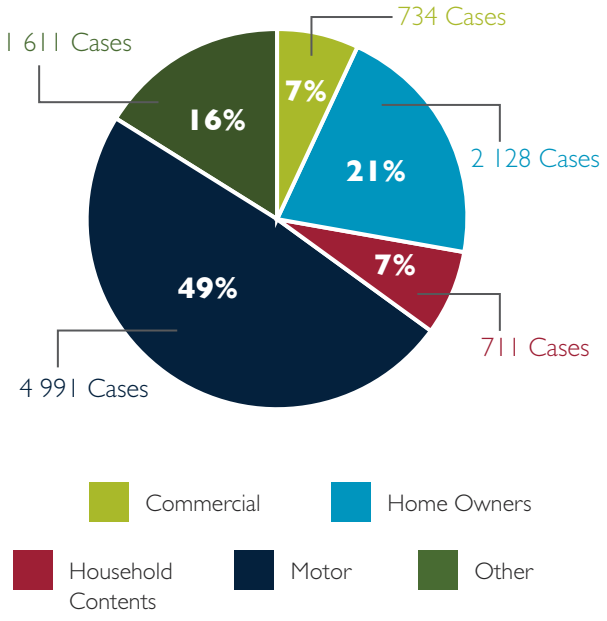


## Finalisation Period - Percentage of Closed Cases in Days




| Days | Number of cases | % | Number of cases | % | Number of cases | % | Number of cases | % |
|---|---|---|---|---|---|---|---|---|
| 0-30 | 672 | 7% | 836 | 8% | 1 264 | 13% | 972 | 11% |
| 30-60 | 1 649 | 16% | 2 363 | 23% | 3 382 | 34% | 1 958 | 23% |
| 60-90 | 2 213 | 22% | 2 862 | 28% | 2 529 | 25% | 2 018 | 23% |
| 90-120 | 2 081 | 20% | 2 033 | 20% | 731 | 7% | 1 383 | 16% |
| 120-150 | 1 362 | 13% | 1 114 | 11% | 1 394 | 14% | 933 | 11% |
| 150-180 | 892 | 9% | 614 | 6% | 331 | 3% | 854 | 10% |
| 180+ | 1 312 | 13% | 525 | 5% | 313 | 3% | 513 | 6% |

## Types of Complaints by Cases




## Claims Types Resolved Ratio

| Types of Complaints | Total Closed | Resolved | Ratio |
|---|---|---|---|
| Commercial | 577 | 150 | 26.00% |
| Home Owners | 1 748 | 494 | 28.26% |
| Household Contents | 679 | 215 | 31.66% |
| Motor | 4 207 | 1 314 | 31.23% |
| Other | 1 420 | 141 | 9.93% |
| **Total** | **8 631** | **2 314** | **26.81%** |

# *Explanatory Notes and* INSURER STATISTICS

## Explanatory Notes

1. The data must be understood in the correct context and it is therefore necessary to record some words of explanation in relation to these statistics.

## Ombudsman's limited jurisdiction

2. The office of the Ombudsman has limited jurisdiction over commercial lines policies and, in any event, has jurisdiction for personal lines business only up to R2 million, save for home owners claims where the jurisdictional limit is R4 million. The statistics therefore focus only on personal lines claims (statistics provided by the Financial Services Board) and personal lines complaints received by this office. Commercial lines complaints which are not reflected in the statistics, represent only about 7.0% of total complaints to the office of the Ombudsman.

3. No adverse conclusions should be drawn against any insurer based purely on the number of complaints against them received by this office. Larger insurers issue proportionately more policies which cannot form the basis of a complaint to this office due to our jurisdictional limits. Thus, for example, when considering the percentage of complaints received by this office against a large insurer, the large insurer, upon a superficial analysis, therefore appears to attract a relatively low number of complaints. What is the more important statistic is the proportion of personal lines complaints relative to an insurer's share of the total personal lines claims reported to the Financial Services Board. The clearest indicator of this is column 5, being the number of complaints to this office per thousand claims received by an insurer. Where an insurer receives a high number of complaints to this office per thousand claims, this may be an indicator that claims are dealt with unfairly by the insurer. However, this statistic should be considered in conjunction with column 8, being the overturn rate. The overturn rate is an indicator that the decision of the insurer with respect to a complaint was changed in some respect by this office with some additional benefit to the insured. Further comments on the overturn rate appear below.

4. Please note that a claim can be received by an insurer in year one and a complaint in respect of that claim may be received by OSTI only in year two, hence the number in column 3 may be greater than the number in column 1. The statistics record the numbers received by insurers and by OSTI respectively during 2016.

5. Also note that under column 1, certain insurers are shown by the FSB statistics as having received no claims during 2016. This may be explained on the basis of either the company issuing only commercial lines policies or that the company is dormant. We repeat that only personal lines statistics are included in the table as this is what has been received from the FSB (columns 1 and 2)

## Overturn Rate

6. The overturn rate per insurer as shown in the table is for personal lines claims only. It excludes commercial lines claims. However, the overall 27% overturn rate mentioned in the Ombudsman's report includes both types of claims. If a high overturn rate is registered, this may, but not necessarily, indicate that the insurer is not treating its customers as fairly as it should. However the overturn rate should be treated with considerable caution as a high overturn rate can also be indicative of a high degree of co-operation being received by the Ombudsman's office from a particular insurer in resolving a complaint to the satisfaction of the customer. The Ombudsman takes into account the following two circumstances in determining the Overturn Rate:

a) The decision of the insurer is overturned by the Ombudsman by way of a recommendation which is accepted or by way of a Final Ruling.

b) A resolution of the dispute has been mediated by the Ombudsman with the insured receiving a benefit which he/she would not have received without the involvement of the Ombudsman.

## General

7. Any media queries in relation to insurer statistics should be directed to the particular insurer.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Name of Insurer | Claims received by Insurers (FSB statistics) | Share of claims received by the particular insurer (FSB statistics) | Complaints received by OSTI | Share of the total number of complaints received by OSTI | Number of Complaints received by OSTI per thousand Claims received by Insurer | Complaints finalised by OSTI | Complaints finalised with some benefit to the insured | Overturn Rate |
| ABSA Insurance Co Ltd * | 169,800 | 5.30% | 964 | 10.23% | 5.68/1000 | 769 | 242 | 31.47% |
| Abacus Insurance Limited ** | 6,434 | 0.20% | 8 | 0.08% | 1.24/1000 | 9 | 6 | 66.67% |
| Chubb Insurance South Africa Limited ** | 652 | 0.02% | 6 | 0.06% | 0/1000 | 2 | 1 | 50.00% |
| AIG Insurance | 20,501 | 0.64% | 55 | 0.58% | 2.68/1000 | 48 | 18 | 37.50% |
| Alexander Forbes Insurance Company | 57,141 | 1.78% | 153 | 1.62% | 2.68/1000 | 108 | 15 | 13.89% |
| Allianz Global Corporate | 215 | 0.01% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| Auto & General Insurance Company | 103,420 | 3.23% | 311 | 3.30% | 3.01/1000 | 286 | 43 | 15.03% |
| Bidvest Insurance Limited | 15,523 | 0.48% | 64 | 0.68% | 4.12/1000 | 47 | 7 | 14.89% |
| Budget Insurance Company Limited | 66,266 | 2.07% | 232 | 2.46% | 3.50/1000 | 212 | 46 | 21.70% |
| Centriq Insurance | 61,280 | 1.91% | 165 | 1.75% | 2.69/1000 | 137 | 48 | 35.04% |
| Compass Insurance Company Limited | 1,130 | 0.04% | 34 | 0.36% | 30.09/1000 | 32 | 3 | 9.38% |
| Constantia Insurance Company Limited | 53,054 | 1.65% | 57 | 0.60% | 1.07/1000 | 44 | 5 | 11.36% |
| Corporate Guarantee | 0 | 0.00% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| Dial Direct Insurance Limited | 44,764 | 1.40% | 164 | 1.74% | 3.66/1000 | 146 | 30 | 20.55% |
| Discovery Insurance | 101,077 | 3.15% | 233 | 2.47% | 2.31/1000 | 189 | 53 | 28.04% |
| Emerald Insurance | 0 | 0.00% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| First for Women Insurance Company Limited | 43,308 | 1.35% | 126 | 1.34% | 2.91/1000 | 118 | 29 | 24.58% |
| Genric Insurance Company Limited | 31,973 | 1.00% | 49 | 0.52% | 1.53/1000 | 38 | 12 | 31.58% |
| Guardrisk Insurance Company Limited | 174,360 | 5.44% | 475 | 5.04% | 2.72/1000 | 442 | 213 | 48.19% |
| Hollard Insurance Company | 363,898 | 11.35% | 695 | 7.38% | 1.95/1000 | 596 | 202 | 33.89% |
| Indequity Specialised Insurance Limited | 2,385 | 0.07% | 7 | 0.07% | 2.94/1000 | 5 | 3 | 60.00% |
| Infiniti Insurance | 24,644 | 0.77% | 102 | 1.08% | 4.14/1000 | 70 | 24 | 34.29% |
| King Price Insurance | 54,836 | 1.71% | 431 | 4.57% | 7.86/1000 | 366 | 75 | 20.49% |
| Legal Expenses southern Africa Limited | 30,512 | 0.95% | 87 | 0.92% | 2.85/1000 | 63 | 12 | 19.05% |
| Lion of Africa | 7 | 0.00% | 1 | 0.01% | 0/1000 | 1 | 1 | 100.00% |
| Lombard Insurance Limited | 995 | 0.03% | 12 | 0.13% | 0/1000 | 11 | 6 | 54.55% |
| Lloyd's South Africa | 232 | 0.01% | 1 | 0.01% | 0/1000 | 1 | 0 | 0.00% |
| MiWay Insurance Limited | 111,553 | 3.48% | 516 | 5.48% | 4.63/1000 | 416 | 32 | 7.69% |
| Momentum ST Insurance Company Limited | 28,717 | 0.90% | 97 | 1.03% | 3.41/1000 | 70 | 3 | 4.29% |

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Name of Insurer | Claims received by Insurers (FSB statistics) | Share of claims received by the particular insurer (FSB statistics) | Complaints received by OSTI | Share of the total number of complaints received by OSTI | Number of Complaints received by OSTI per thousand Claims received by Insurer | Complaints finalised by OSTI | Complaints finalised with some benefit to the insured | Overturn Rate |
| Monarch Insurance Company Limited | 26,780 | 0.84% | 16 | 0.17% | 0.60/1000 | 16 | 12 | 75.00% |
| Mutual & Federal Insurance Co Ltd * | 168,793 | 5.26% | 630 | 6.69% | 3.73/1000 | 533 | 133 | 24.95% |
| Natsure Ltd | 0 | 0.00% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| Nedgroup Insurance Company | 62,563 | 1.95% | 212 | 2.25% | 3.39/1000 | 182 | 70 | 38.46% |
| New National Assurance Company Limited | 31,818 | 0.99% | 232 | 2.46% | 7.29/1000 | 223 | 66 | 29.60% |
| NMS Insurance Services (SA) Limited | 99,338 | 3.10% | 6 | 0.06% | 0.06/1000 | 5 | 3 | 60.00% |
| Oakhurst Insurance Company Limited | 25,540 | 0.80% | 216 | 2.29% | 8.46/1000 | 178 | 52 | 29.21% |
| Old Mutual Health Insurance Limited | 1,318 | 0.04% | 3 | 0.03% | 2.28/1000 | 5 | 2 | 40.00% |
| OUTsurance | 279,437 | 8.72% | 454 | 4.82% | 1.62/1000 | 404 | 47 | 11.63% |
| Regent Insurance | 44,322 | 1.38% | 135 | 1.43% | 3.05/1000 | 128 | 36 | 28.13% |
| Relyant Insurance Company Limited | 327 | 0.01% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| Renasa Insurance Company Limited | 61,773 | 1.93% | 116 | 1.23% | 1.88/1000 | 111 | 39 | 35.14% |
| RMB Structured Insurance Limited | 58,106 | 1.81% | 353 | 3.75% | 6.08/1000 | 279 | 62 | 22.22% |
| Professional Provident Society Short-term Insurance Company Limited | 177 | 0.01% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| SAFIRE Insurance Company Limited | 6,457 | 0.20% | 5 | 0.05% | 0.77/1000 | 6 | 0 | 0.00% |
| SAHL Insurance Company Limited | 24,026 | 0.75% | 90 | 0.96% | 3.74/1000 | 75 | 13 | 17.33% |
| Santam Limited | 368,545 | 11.49% | 617 | 6.55% | 1.67/1000 | 553 | 146 | 26.40% |
| SASRIA SOC LIMITED | 616 | 0.02% | 2 | 0.02% | 0/1000 | 2 | 1 | 50.00% |
| SaXum Insurance | 0 | 0.00% | 248 | 2.63% | 0/1000 | 272 | 104 | 38.24% |
| Shoprite Insurance Company Limited | 22,162 | 0.69% | 33 | 0.35% | 1.49/1000 | 26 | 18 | 69.23% |
| Standard Insurance Limited | 117,958 | 3.68% | 634 | 6.73% | 5.37/1000 | 538 | 159 | 29.55% |
| Sunderland Marine Africa | 0 | 0.00% | 0 | 0.00% | 0/1000 | 0 | 0 | 0.00% |
| Unitrans | 2,922 | 0.09% | 2 | 0.02% | 0.68/1000 | 3 | 2 | 66.67% |
| Vodacom | 90,979 | 2.84% | 36 | 0.38% | 0.40/1000 | 42 | 26 | 61.90% |
| Western National Insurance Limited | 12,110 | 0.38% | 170 | 1.80% | 14.04/1000 | 109 | 32 | 29.36% |
| Workerslife Insurance Limited | 8,745 | 0.27% | 15 | 0.16% | 1.72/1000 | 12 | 9 | 75.00% |
| Zurich Insurance Company Limited | 122,768 | 3.83% | 153 | 1.62% | 1.25/1000 | 127 | 36 | 28.35% |
| TOTAL | 3,206,257 | 100.00% | 9,423 | 100% | 2.94/1000 | 8,055 | 2,197 | 27.27% |

*Please Note:*

* The Statistics for ABSA Insurance Co Ltd include statistics for ABSA Idirect and ABSA Insurance Risk Management Services Limited.
* The Statistics for Mutual & Federal Insurance Co Ltd include statistics for IWyze and Mutual & Federal Risk Financing.

*FSB Legend*

** Insurer change name during the 2016 period

# *Report by the* GENERAL MANAGER

*Miriam Matabane, General Manager and Azeht du Plessis, Office Manager*

## Finance Matters

### 2016 Annual Financial Statements

PricewaterhouseCoopers Inc. audited the Annual Financial Statements for the year ended 31 December 2016. OSTI has once again enjoyed a clean audit report as no significant audit findings were identified.

To enable easy access to OSTI's financial statements, and mindful of the environmental and financial costs of an overlong report the approved and detailed audited annual financial statement are available at: **http://www.osti.co.za/financials.html**

A copy of our Annual Financial Statements will, in addition, be emailed to all our stakeholders.

### Financial Position

The financial position of OSTI remains sound with all member insurers save for saXum Insurance settling what was owed by them for the financial year ended 31 December 2016.

The revenue of the company depends solely on fees levied against new complaints received. The fee per complaint increased from R3 200 in 2015 to R3 500 for the year under review.

As a non-profit organisation, OSTI's objective is to cover annual expenses and to have sufficient reserves to cover any unanticipated expenditure. Costs are monitered carefully to ensure that we have sufficient resources to run OSTI's operations.

### Liquidation of saXum Insurance Company

SaXum Insurance was liquidated on 28 October 2016. According to our Memorandum of Incorporation, on liquidation of an insurer member, the agreement between the insurer and OSTI ceases to exist. According, with effect from this date, saXum ceased to be a member of OSTI. As at 31 December 2016, a provision for bad debts was raised to cater for this loss in revenue.

### New Membership

During 2016 we welcomed two new members namely Professional Provident Society Short-term Insurance Company Limited and Workerslife Insurance Limited. At year end our membership totalled 55, the list of member companies is enclosed in this report.

**Miriam Matabane**
**General Manager**
**April 2017**

# *Board of* DIRECTORS

***Standing from left:*** *Leila Moonda, Farzana Badat, Leigh Bennie, Martin Brassey, Gail Walters, Richard Steyn*
***Seated from left:*** *Gerhard Genis, Thuli Zungu, Paul Cranksaw, Dianne Terblanche, Collin Molepe*

# Staff of the

***Seated:*** *Valerie Mngadi, Louisah Letlhabe, Selinah Phakoe, Edite Teixeira-Mckinon, Deanne Wood, Miriam Matabane,*

***Middle:*** *Mariam Khampepe, Deola Matsimela, Ayanda Mazwi, Aadielah Human, Candace Fourie, Refilwe Mokoena, Sangeetha Sewpersad, Gadija Fisher, Darpana Harkison, Azeht du Plessis, Jo-Anne Goqo*

***Back:*** *Joanne Sergel, Anastatia Maimane, Johan Janse van Rensburg, Hannes Bester, Lebo Morokolo, Adriaan Lombard,*

# OMBUDSMAN

*Marilize Blignaut, Marinda Nolte, Melissa van Zyl, Terry Freemantle*

*Claudia Kampmann, Mavis Mabaso, Nosipho Mfeka, Leonie Budricks, Nadia Gamieldien, Jolene Prinsloo,*

*John Theunissen, Kgomotso Molepo, Karinien Kok, Janine Schultz, Katia Lo Drago, Thasnim Dawood, Peter Nkhuna*

# *Terms of* REFERENCE

## 1. Preamble

1.1 The Ombudsman is appointed to serve the interest of the insuring public and all short-term Insurers registered under the Short-term Insurance Act and including Lloyds. The Ombudsman provides, free of charge, an accessible, informal and speedy dispute resolution process to Policy Holders who have disputes with their Insurers where those disputes fall within the Ombudsman's jurisdiction.

1.2 The Ombudsman acts independently and objectively in resolving disputes and is not under instructions from anybody when exercising his or her authority. The Ombudsman resolves disputes using the criteria of law, equity and fairness. These Terms of Reference define the powers and duties of the Ombudsman.

1.3 The services rendered by the Ombudsman are not the same as those rendered by a professional legal advisor and are confined purely to resolution in terms of clause 3.1 below or mediation or conciliation in an attempt to settle complaints.

## 2. Definitions

**In these terms of reference the following expressions have the following meanings:**

2.1 "the Board" means the Board of Directors of the Ombudsman for Short-term Insurance NPC ;

2.2 "Commercial Lines Policy" means a policy (a) issued to a person who is not a natural person, or (b) if issued to a natural person is intended to indemnify such a natural person in respect of a commercial enterprise conducted by the natural person for his or her own benefit.

2.3 "the Complainant" means any Policy Holder who makes a complaint to the Ombudsman in respect of any insurance services provided by their Insurer;

2.4 "Ruling" means, with respect to a complaint, a written directive issued by the Ombudsman which is binding on the Insurer and which is based either in law or equity;

2.5 "the Ombudsman" means the Ombudsman for Short-term Insurance appointed from time to time by the Board of the Ombudsman for Short-term Insurance NPC ;

2.6 "Ombudsman's office" means the office of the Ombudsman established to perform the functions set out in these terms of reference;

2.7 "Policy" means a short term insurance Policy issued by an Insurer to a Policy Holder; with the Policy benefits under a Policy;

2.8 "Policy Holder" means the person entitled to be provided with the Policy benefits under a Policy;

2.9 "Insurer" means a short-term insurer registered as such in terms of the Short-term Insurance Act of 1998;

## 3. The Ombudsman's

### Powers and Duties

3.1 The Ombudsman shall:

3.1.1 act within these terms of reference;

3.1.2 receive complaints relating to the provision within the Republic of South Africa of insurance services by an Insurer to a Policy Holder;

3.1.3 resolve such complaints, relating to the provision of insurance services, by agreement or by the making of a ruling or by such other means as may seem expedient, subject to these terms of reference.

3.2 The Ombudsman should advise the public on the procedure for making a complaint to the Ombudsman's office and should take such steps as are reasonably possible conducive to client and industry education and training. The Ombudsman shall in his annual report referred to in clause 3.9 below provide details of steps taken in this regard.

3.3 On receipt of a complaint in the prescribed format, the Ombudsman will notify the Insurer of the complaint by providing the details of the complaint to the Insurer, and the Insurer shall then be obliged to give all relevant information and assistance required (including documentation requested by the Ombudsman) to enable the Ombudsman to assess fully the merits of the complaint.

3.4 During any period in which the Ombudsman is unable to exercise his duties owing to absence, incapacity or death or in a situation where a conflict of interest may arise, the Board may appoint a deputy or acting Ombudsman to act in place of the Ombudsman.

3.5 The Ombudsman shall have the overall responsibility for the conduct of the day to day administration and business of the Ombudsman's office. The Ombudsman may appoint an Administrator to be responsible to him for day to day matters of administration of the Ombudsman's office.

3.6 The Ombudsman shall have the power on behalf of the Ombudsman's office to appoint and dismiss employees, consultants, legal experts, independent contractors and agents and to determine their salaries, fees, terms of employment or engagement.

3.7 The Ombudsman shall have the power to incur expenditure on behalf of the Ombudsman's office in accordance with the current financial budget approved by the Board.

3.8 The Ombudsman shall give the Board any information and assistance which it reasonably requires, including the making of recommendations to the Board on any issues which the Ombudsman believes requires the Board's attention.

3.9 The Ombudsman shall publish an annual report on the activities of the office, which shall be published by 30 May of each year. Such report will be available to the public.

## 4. The Jurisdiction of the Ombudsman

4.1 The Ombudsman shall only consider a complaint made to him if he is satisfied that:

4.1.1 the complaint is not the subject of existing litigation;

4.1.2 the complaint is not the subject of an instruction to an attorney in contemplation of litigation against the relevant Insurer except where the attorney has simply assisted the Policy Holder in bringing the application to the Ombudsman;

4.1.3 the complaint does not involve a monetary claim in excess of the amount determined by the Board from time to time and that in respect of Commercial Lines Policies the annual turnover of the Complainant does not exceed the amount determined by the Board from time to time. *

*The limits are currently as follows namely, (a) R4 million for house owner's claims; (b) R2 million for all other claims provided that (c) in respect of Commercial lines policies, the turnover of the insured entity must not exceed R25 million per annum

4.1.4 the complaint is made by a Policy Holder or a duly authorised representative of the Policy Holder to whom or for whom the insurance services in question were provided;

4.1.5 the complaint relates to any dispute in regard to a Policy and/or any Claim or Claims thereunder or any dispute in regard to insurance premiums, or any dispute on the legal construction of the Policy wording relating to a particular complaint complying with the requirements of this clause 4.1;

4.1.6 the complaint is being pursued reasonably by the Complainant and not in a frivolous, vexatious, offensive, threatening or abusive manner, as the Ombudsman may decide in his or her sole discretion;

4.1.7 the complaint has not become prescribed in terms of the Prescription Act, 1969 or any enforceable time bar provisions contained in the Policy, provided that in relation to any enforceable time-bar provisions in the policy

4.1.7.1 the Ombudsman shall have the power to condone non-compliance therewith upon good cause shown, and

4.1.7.2 the provisions of any enactment which provides for the extension of any period contained in such time-bar provision shall be given effect to.

4.2 Should a complaint be lodged with the Ombudsman's office and thereafter the Complainant refers such dispute to an attorney for the further conduct of the dispute and/or direct correspondence with the Insurer, or for litigation, then the Ombudsman will immediately withdraw from the matter.

4.3 With the written consent of an Insurer and at his discretion the Ombudsman may investigate a complaint which exceeds his jurisdiction and make a recommendation or a Ruling in relation thereto.

4.4 A Complainant may at any time terminate the Ombudsman's adjudication of the complaint and resort to litigation.

## 5. Limits on the Jurisdiction of the Ombudsman

Subject to these terms of reference, the Ombudsman shall have the power to consider a complaint made to him and make a recommendation or Ruling in regard thereto except:

5.1 Where the Ombudsman determines that it is more appropriate that the complaint be dealt with by a court of law or through any other dispute resolution process;

5.2 Where the matter is already under the consideration by the person appointed to adjudicate disputes in terms of the Financial Advisory and Intermediary Services Act.

## 6. Time Barring Provisions

6.1 Any enforceable time bar clauses in terms of a Policy shall not run against a Complainant and shall be interrupted during the period that the complaint is under consideration before the Ombudsman. In particular, the Insurer waives and abandons all or any rights to rely in subsequent litigation on any time barring provisions in the Policy applying to the commencement of litigation after rejection of a claim, or after the happening forming the subject of the claim or after notification of the claim. In the event of the complaint being finalised in the office of the Ombudsman the Complainant shall have 30 (thirty) days or the remaining period of the time bar provision of the relevant policy, whichever is the longer, within which to institute proceedings against the relevant Insurer, provided however, that the Claim had not already become time barred in terms of the Policy when the complaint was received by the Ombudsman and the Ombudsman has not condoned the late receipt of the complaint as is envisaged in clause 4.1.7

6.2 For the purposes of clause 6.1, the time during which a matter is before the Ombudsman shall (provided that the complaint is accepted for adjudication) commence on the day that it is lodged with the Ombudsman's office to the time that the Ombudsman dismisses the complaint or makes a Ruling.

6.3 Save as may be otherwise provided in the Financial Services Ombud Schemes Act 37 of 2004 as amended or in any other legislation relating to or governing the Ombudsman, the lodging of any complaint with the Ombudsman shall in no way affect the running of prescription in terms of the Prescription Act, 1969 in respect of such complaint.

## 7. Rulings

7.1 When all the material facts are agreed or the facts have been established to the Ombudsman's satisfaction on a balance of probabilities, the Ombudsman may make a Ruling.

7.2 Rulings shall be based on the law and equity.

7.3 Where a material fact cannot be established or cannot be resolved on a clear balance of probabilities the Ombudsman may not make a Ruling. In such cases the Ombudsman shall advise the Complainant that the complaint is not one on which he or she can assist and that alternative recourse may be sought through the courts.

7.4 Any Ruling made by the Ombudsman shall be binding on the Insurer concerned save where an appeal against such Ruling is noted as is provided in Clause 8 below.

## 8. Right of Appeal against Rulings or Findings of the Ombudsman

8.1 Any party affected by any formal ruling or finding on the part of the Ombudsman may appeal against the ruling or finding of the Ombudsman, either in part or in whole. In this context a "Ruling" shall mean, in relation to a complaint received, "a written directive issued by the Ombudsman which is binding on the insurer and which is based either in law or equity and fairness or a combination of law and equity". "Finding" shall mean, with respect to a complaint, "a written directive issued by the Ombudsman in relation to the complaint received in terms of which the Ombudsman has dismissed the complaint or declined to intervene in a dispute between the complainant and insurer".

8.2 No appeal against the ruling or finding of the Ombudsman shall be considered by any Appeal Tribunal, unless the Ombudsman shall have granted the applicant leave to appeal against such ruling or finding.

8.3 The Ombudsman shall only grant leave to appeal to any appellant where he is of the opinion that:

8.3.1 There is a reasonable prospect that the appeal, either in whole or in part, if prosecuted, will succeed; and

8.3.2 The matter is one of complexity or difficulty; or

8.3.3 The ruling or finding in question involves issues or considerations which are of substantial public or industry interest or importance or It is in the interest of justice or public policy that the ruling or decision be considered by an Appeal Tribunal; or

8.3.4 The ruling or decision involves principles of law where the law may be considered to be uncertain or unsettled; or

8.3.5 The matter in dispute involves the jurisdiction of the Ombudsman to entertain the dispute; or

8.3.6 The issues are of such a nature that the judgment or order sought by the appellant will not be of academic relevance only and will have a practical effect or result.

8.4 The power to grant leave to appeal as contemplated in this section shall not be limited by reason only of the value of the matter in dispute, or the amount claimed or awarded by the Ombudsman, or by reason only of the fact that the matter in dispute is incapable of being valued in money.

8.5 Notice of any intention to appeal against any ruling or finding of the Ombudsman shall be filed with the Ombudsman within a period of 30 calendar days of the handing down of any ruling or finding and shall state whether the appellant appeals against the whole or part of the ruling or finding of the Ombudsman, the findings of fact and/or ruling of law appealed against and the grounds upon which the appeal is founded. The notice of intention to appeal shall be accompanied by an application for leave to appeal.

8.6 A Notice of Cross-Appeal shall be delivered within 15 calendar days after delivery of the Notice of Appeal, or within such other period of time as may, upon good cause shown, be permitted by the Ombudsman. The provisions of these rules with regard to appeals shall equally apply to cross-appeals. A "cross-appeal" shall mean a process by which the respondent in any appeal proceedings, having been advised by the Ombudsman of receipt of a notice of intention to appeal, wishes in turn to appeal against the terms of the ruling or finding made by the Ombudsman in relation to the complaint submitted to the Ombudsman.

8.7 Where an appeal has been noted, or an application for leave to appeal has been made, the operation and execution of the ruling or finding of the Ombudsman shall be suspended, pending the decision of the Appeal Tribunal on the matter, unless the Ombudsman, on the application of a party and on good cause shown, otherwise directs.

8.8 Upon receipt of a Notice of Appeal the Ombudsman shall within a period of 5 business days thereafter notify every other party to the dispute that a Notice of Appeal has been received.

8.9 All documentation in connection with any appeal proceedings including the notice of intention to appeal and the application for leave to appeal, shall be served upon the office of the Ombudsman by hand or alternatively by way of registered post or by e-mail save where the Ombudsman shall have expressly consented to any other method of service. Documentation served upon the Ombudsman shall be in A4 format and shall be clearly legible and capable of being photocopied. Wherever possible, original documents should form the subject of any appeal proceedings but copies of documents shall be acceptable subject to the provisions of these terms of reference.

## Applications for Leave to Appeal

8.10 Any party who desires to appeal against any ruling or finding of the Ombudsman shall, within 30 calendar days of the handing down by the Ombudsman of any final ruling or finding, serve upon the Ombudsman as provided for herein, a Notice of intention to Appeal, together with an Application for Leave to Appeal which shall set out the basis for the proposed appeal as contemplated in Clause 8.5 above, together with reasons why Leave to Appeal against

such ruling or finding should be granted by the Ombudsman. The granting of leave to appeal shall be a pre-requisite for the prosecution of any appeal.

8.11 Failing receipt by the Ombudsman of any Notice of Appeal within the time period referred to in paragraph 8 above, the final ruling or finding by the Ombudsman shall become final and binding upon the parties and shall be carried into effect without further delay.

8.12 Any late filing of a Notice of Appeal or an Application for Leave to Appeal shall be null and void save where accompanied by an application for condonation for the late filing of the appeal. Any application for condonation must set out in full the reasons why condonation should be granted, the reasons for any non-compliance and that the matter is one worthy of consideration.

8.13 The Ombudsman, after considering any application for condonation, may grant or refuse such application in his discretion.

8.14 Where leave to appeal against any ruling or finding of the Ombudsman is refused by the Ombudsman, the unsuccessful party may, within 15 business days of notification of such refusal, petition the Chairman of the Appeal Tribunal, to review the decision of the Ombudsman not to grant leave for appeal. The same provision shall apply mutatls mutandis to any application for condonation for the late filing of an appeal.

8.15 Any such request shall be addressed to the Chairman of the Appeal Tribunal via the Ombudsman who shall convey such request to the Chairman of the Appeal Tribunal. The Chairman of the Appeal Tribunal shall within a reasonable period of time but in any event not later than a period of 15 calendar days of the receipt of any such petition, either confirm or amend the decision of the Ombudsman not to grant leave to appeal or refusal to condone any application for the late filing of an appeal. The Ombudsman shall thereafter within a period of 5 business days, inform the parties accordingly.

## Appeals

8.16 An appeal against the ruling or finding of the Ombudsman shall be heard by an Appeal Tribunal who shall consider the matter as if it were the Ombudsman and shall include the consideration of procedural as well as substantive matters pertaining to the objection raised by such party to the decision of the Ombudsman.

8.17 The Appeal Tribunal may, where it considers it necessary or in the interests of justice, permit the leading of evidence or new evidence on any matter, even if the Ombudsman himself did not hold a hearing, or receive evidence on any matter prior to making a finding on any complaint referred to him.

8.18 Where the Appeal Tribunal decides to permit, or calls for the leading of evidence, or evidence is led on material that was never considered by the Ombudsman, the tribunal may decide, in its sole discretion to invite the Ombudsman to consider the matter in the light of such evidence and to canvass the views of the Ombudsman on the matter. The Ombudsman should be invited to comment on the new material in the manner and on such terms as it may regard to be fair to both parties.

8.19 Save where the Appeal Tribunal permits or calls for the leading of evidence, no evidence shall be led and the matter shall be decided by the Appeal Tribunal on the basis of the record of appeal furnished to it by the Ombudsman, including the documentation filed by the parties in connection with the appeal.

8.20 The record of appeal shall, save where in the opinion of the Ombudsman additional documentation is required, consist of the following:-

8.20.1 The complainant's Application for Assistance form and supporting documentation;

8.20.2 The insurer's response to the complaint;

8.20.3 The complainant's reply to the insurer's response to the complaint;

8.20.4 The Ombudsman's finding in relation to the complaint and any reasons furnished by the Ombudsman for any ruling or finding; and

8.20.5 The submissions or representations made by the parties to the Appeal Tribunal in connection with the appeal.

8.21 The Ombudsman may, in his discretion, when submitting the documentation to the Appeal Tribunal in connection with any appeal, make representations to the Appeal Tribunal by way of explanation or elaboration of his earlier determination and shall be entitled in such representations to deal with such matters as policy, industry practices and the approach followed by him in regard to equity. In addition the Ombudsman may furnish the Appeal Tribunal with such other information as he may consider to be of assistance or guidance to the Appeal Tribunal, save that the parties shall be afforded an opportunity to respond to any such additional material thus placed before the Appeal Tribunal.

8.22 Save as aforesaid, the Ombudsman shall not participate in the appeal process save where he should be asked to do so by the Appeal Tribunal itself on such terms and in such manner as may be determined by the Tribunal.

## Composition of the Appeal Tribunal

8.23 The Chairman of the Board, in consultation with the Vice-Chairman, must appoint the members of the Appeal Tribunal from the persons nominated by the Ombudsman.

8.24 The Appeal Tribunal must consist of a Chairperson and at least two members appointed for a minimum period of two years.

8.25 The Chairman of the Board must appoint the Chairperson of the Appeal Tribunal and such Chairperson must either be a retired Judge or a practicing Attorney or Advocate, or a person who formally practiced as an Attorney or Advocate, with at least ten years' experience and with appropriate experience in Insurance Law.

8.26 The Chairperson of the Appeal Tribunal is responsible for assigning matters for adjudication, taking into consideration the nature and complexity of the dispute or any special circumstance, to a panel of two or more members of the Appeal Tribunal who are suitably qualified to decide on a particular matter.

8.27 The Chairman of the panel must be the Chairperson of the Appeal Tribunal.

8.28 The person's nominated by the Ombudsman must be:

8.28.1 Practicing Attorneys or Advocates or persons who formerly practiced as an Attorney or Advocate, with at least ten years' experience and with appropriate experience in Insurance Law, and may include retired Judges; or

8.28.2 Persons with extensive experience in relation to the insurance industry and who by virtue of their knowledge, training and experience are able to perform the functions of a member of the Appeal Tribunal; or

8.28.3 Academics with the particular knowledge of specific areas of the law or persons of specific knowledge, skill or training whose expertise as an expert in any particular field may be appropriate.

8.29 The Chairman of the Appeal Tribunal may, in consultation with the Chairman of the Board and the Ombudsman, appoint a person who is not a member of the Appeal Tribunal to serve on the panel if in the opinion of the Chairperson of the Appeal Tribunal such appointment is merited or deemed desirable.

## The Hearing of Appeals

8.30 The Ombudsman shall be in charge of all practical or administrative matters preceding and relating to the hearing of an appeal and shall be responsible for the preparation of the record, the giving of notices and the making of arrangements for the hearing of an appeal, the recording of evidence, if any, and all such other matters incidental to the hearing or disposal of the appeal.

8.31 The Appeal Tribunal shall determine its own procedure both prior to and during the course of the hearing, including the hearing of oral evidence.

8.32 Appeals shall be heard at such place and time and in such manner as the Appeal Tribunal shall determine from time to time.

8.33 Not later than 10 business days before the hearing of an appeal, the appellant shall deliver to the Ombudsman a concise and succinct statement of the main points which he intends to argue on appeal, as well as the list of legal authorities (if any) to be tendered in support of each point to be raised. Not later than 5 business days before the hearing of an appeal, the respondent shall deliver a similar statement.

8.34 The Chairman of the Appeal Tribunal may, after consultation with the Ombudsman, direct that a contemplated appeal be dealt with as an urgent matter and that the appeal be prosecuted at such time and in such manner as the Chairman of the Appeal Tribunal deems appropriate.

8.35 The Appeal Tribunal should approach the matter on appeal put forward as if it were the Ombudsman determining the complaint. The Appeal Tribunal shall take into account the balance of probabilities and its finding shall be based on the criteria of law, equity and fairness.

8.36 The Appeal Tribunal shall deliver its judgment on the matter in writing to the Ombudsman within one calendar month of the conclusion of the hearing. The Ombudsman shall in turn deliver a copy thereof to the parties within a period of 10 business days.

## Representation

8.37 Any party to any appeal shall have the right to be represented at the hearing but, wherever possible, the parties should confine their submissions in regard to matters before the Appeal Tribunal to written submissions contained in a statement of case including, where appropriate, heads of argument.

8.38 Any party who employs a representative to represent their interest before the Appeal Tribunal shall be personally responsible for any fees and expenses associated with such representation.

## The Effect of the Decision and Order of the Appeal Tribunal

8.39 Where a complainant appeals against the ruling or finding of the Ombudsman, such person shall abide by the decision of the Appeal Tribunal and the order of the Appeal Tribunal shall be final and binding in relation to the proceedings before the office of the Ombudsman. The complainant shall however be entitled, if so desired, to thereafter pursue the matter further in any court of law.

8.40 An unsuccessful appellant insurer shall have no further right of recourse or action and shall be bound by the terms of the order of the Appeal Tribunal save that nothing contained herein shall in any way affect the right of an insurer to review any ruling made by the Ombudsman or the Appeal Tribunal in a court of law.

## Precedent

8.41 In recognition of the requirement that rulings made by the Ombudsman shall not establish any precedent in the Ombudsman's office, the decisions of the Appeal Tribunal shall not be accorded any formal status or regarded as creating binding precedents, but may serve as guidelines for future cases. Such findings or orders may however, serve as strong persuasive value for the Ombudsman and any other Appeal Tribunal in which the same dispute may be raised so as to ensure consistency in the decisions of the office of the Ombudsman.

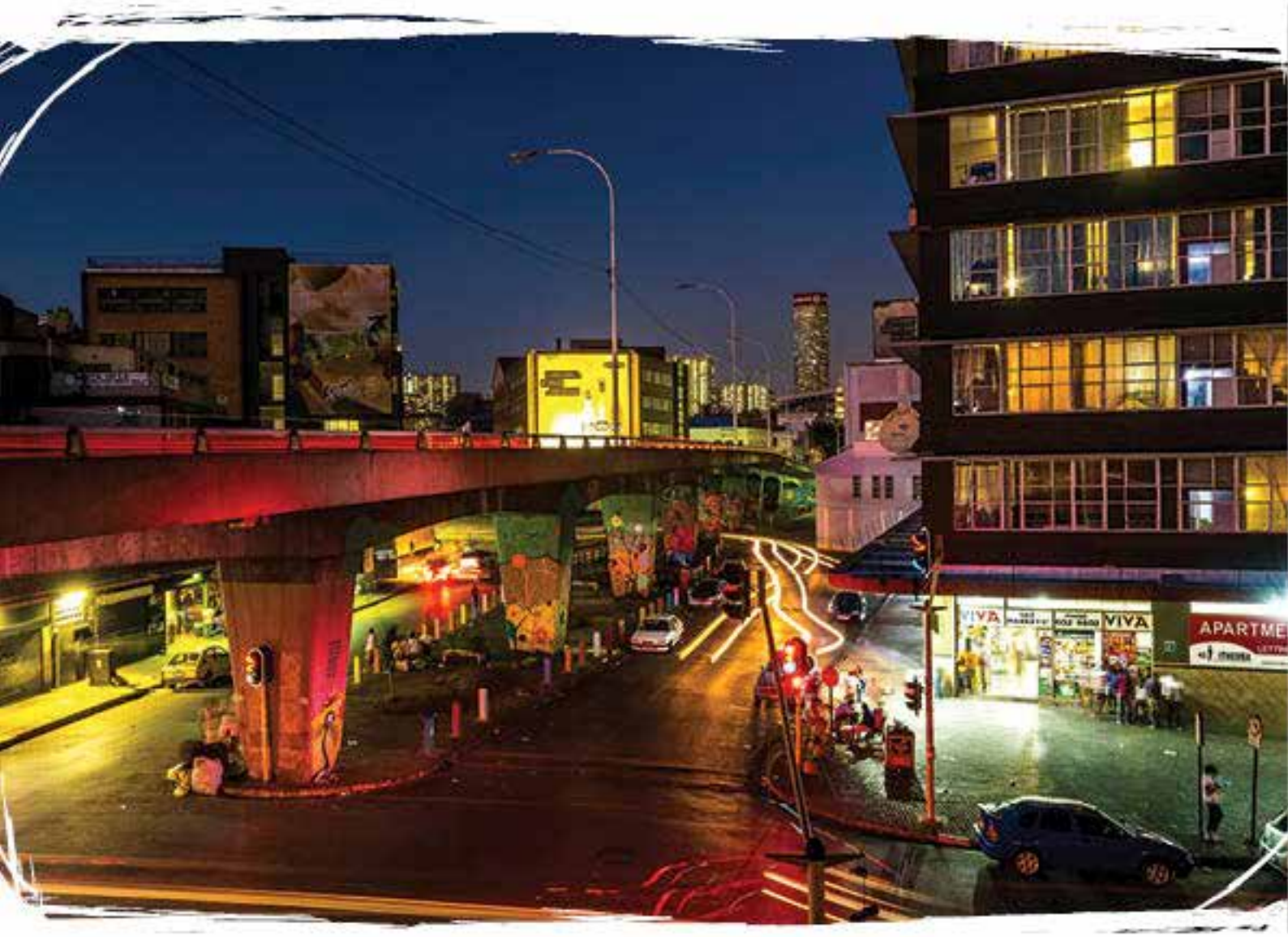
## Cost to the Parties to Appeals

8.42 Where an insurer notes an appeal against any final ruling of the Ombudsman and is not, in the opinion of the Chairman of the Appeal Tribunal, successful with such appeal, it shall defray the cost of such appeal incurred by the Ombudsman in connection with the appeal proceedings.

8.43 Where the insurer is the appellant in any proceedings, save where the Chairman of the Appeal Tribunal may direct otherwise, the cost to be paid by the insurer in relation to any appeal proceedings may be determined by the Board of the Ombudsman for Short-term Insurance, from time to time.

8.44 Where the complainant is the appellant in any appeal proceedings the Ombudsman may, in his discretion and taking into account, inter alia, the amount of the claim, the complexity of the issues and the complainant's personal circumstances, call upon such party to pay a deposit in an amount determined by the Ombudsman which deposit shall be refunded to the appellant should the appellant be successful in the appeal. In the event that the appeal fails, the deposit shall be forfeited to the office of the Ombudsman and shall constitute the only liability on the part of the complainant for the costs of the appeal proceedings. If the appeal is, in the view of the Appeal Tribunal, successful, the amount paid by the appellant shall be refunded to the appellant.

8.45 In no case shall the Appeal Tribunal award costs in favour of a successful party and in no case shall a losing party to an appeal be ordered by the Appeal Tribunal to pay costs to the other party, save where the Chairman of the Appeal Tribunal considers that, having regard to the presence of exceptional circumstances, a punitive order as to costs against any party is merited.



## 9. Policyholder/Complainant's Rights

The Policy Holder/Complainant's rights to institute proceedings in any competent court of law against the Insurer shall not be affected by any of the provisions of these terms of reference provided that, if the Policy Holder/Complainant institutes proceedings while the complaint is under investigation by the Ombudsman, the provisions of clause 4.2 shall apply.

## 10. Precedents

Rulings shall not establish any precedent in the Ombudsman's office.

## 11. Confidentiality

11.1 The Ombudsman shall as far as possible, maintain confidentiality unless the parties concerned expressly exempt him or her from that duty and the duty shall continue after the termination of his or her services. The duty of confidentiality shall however, not prevent the Ombudsman from:

11.1.1 Publishing details of rulings made by him or her.

11.1.2 Reporting on details of rulings or furnishing statistical information in connection with the workings of the office to the South African Insurance Association (SAIA), the Financial Services Board (FSB), the National Treasury or any other body or organisation which may be entitled to receive such information from the Ombudsman in connection with his/her activities and/or which may have a legitimate interest in such information, having regard to its statutory mandate, role as an industry association or otherwise.

11.1.3 Publishing statistics and related information in the Annual Report of the Association concerning complaints received by the Ombudsman against members of the Association as approved by the Board of the Ombudsman for Short-term Insurance from time to time.

11.1.4 Filing, either on behalf of the Company, or any complainant from whom a complaint is received, a complaint with SAIA in connection with any Code of Conduct applicable to or adopted by that organisation and which may be applicable to any member of the Company.

11.2 The Insurer and the Complainant shall not be entitled to make use of any information which comes to their knowledge as a result of the intervention of the Ombudsman during the course of any investigation by him or her.

11.3 A complaint will be regarded as confidential as between the Policy Holder, the Insurer and the Ombudsman and it is for the Ombudsman to decide what should be disclosed to the Insurer and/or the Policy Holder.

11.4 Documents brought into being as a result of any approach to the Ombudsman shall not be liable to disclosure or be the subject of a discovery order or subpoena in the event of any legal proceedings between the Complainant and the Insurer.

11.5 The Ombudsman or any member of his staff will not be liable to be subpoenaed to give evidence on the subject of a complaint in any proceedings.

## 12. Complaints not settled in defined period

The Ombudsman shall report to the Board all complaints, which have not been completed in one or way or another within a time, laid down by the Board. This time period shall initially be set at 6 (six) months calculated from the date that a complaint became an accepted complaint.

# *Members of the* OMBUDSMAN SCHEME

- Absa Insurance Company Limited
- Abacus Insurance Limited
- Chubb Insurance South Africa Limited
- AIG Insurance Company
- Alexander Forbes Insurance Company
- Allianz Global Corporate
- Auto & General Insurance Company
- Bidvest Insurance Limited
- Bryte Insurance Company Limited
- Budget Insurance Company Limited
- Centriq Insurance
- Compass Insurance Company Limited
- Constantia Insurance Company Limited
- Corporate Guarantee
- Dial Direct Insurance Limited
- Discovery Insure
- Emerald Insurance
- First for Women Insurance Company Limited
- GENRIC Insurance Company Limited
- Guardrisk Insurance Company Limited
- Hollard Insurance Company
- Indequity Specialised Insurance Limited
- Infiniti Insurance
- King Price Insurance
- Legal Expenses southern Africa Limited
- Lion of Africa
- Lloyds South Africa
- Lombard Insurance Limited
- MiWay Insurance Limited
- Momentum ST Insurance Company Limited
- Monarch Insurance Company Limited
- Mutual & Federal Insurance Company Limited
- Natsure Ltd
- Nedgroup Insurance Company
- New National Assurance Company Limited
- NMS Insurance Services (SA) Limited
- Oakhurst Insurance Company Limited
- Old Mutual Health Insurance Limited
- OUTsurance Insurance Company Limited
- Regent Insurance
- Relyant Insurance Company Limited
- Renasa Insurance Company Limited
- RMB Structured Insurance Limited
- Professional Provident Society Short-term Insurance Company Limited
- SAFIRE Insurance Company Limited
- SAHL Insurance Company Limited
- Santam Limited
- SASRIA SOC LIMITED
- Shoprite Insurance Company Limited
- Standard Insurance Limited
- Sunderland Marine (Africa) Limited
- Unitrans
- Vodacom
- Western National Insurance Limited
- Workerslife Insurance Limited

# *Useful Information*

# ABOUT OTHER OFFICES

## 1. Ombudsman for Long-Term Insurance

Private Bag X45, Claremont 7735
Telephone: 021 657 5000
Sharecall: 086 010 3236
Fax: 021 674 0951
E-mail: info@ombud.co.za
Website: www.ombud.co.za

## 2. Financial Advisory and Intermediary Services Ombud

PO Box 74571, Lynnwoodridge, 0040
Telephone: 012 470 9080
Sharecall: 0860 324 766
Fax: 012 348 3447
E-mail: info@faisombud.co.za
Website: www.faisombud.co.za

## 3. The Ombudsman for Banking Services

PO Box 87056, Houghton, 2041
Telephone: 011 712 1800
Sharecall: 0860 800 900
Fax: 011 483 3212
E-mail: info@obssa.co.za
Website: www.obssa.co.za

## 4. Credit Ombud

P O Box 805, Pinegowrie, 2123
Call Centre: 0861 662 837
Tel: 011 781 6431
Fax: 086 683 4644
E-mail: ombud@creditombud.org.za
Website: www.creditombud.org.za

## 5. Motor Industry Ombudsman of South Africa

Suite 156, Private Bag X025,
Lynnwood Ridge, 0040
Telephone: 010 590 8378
Call Centre: 086 116 4672
Fax: 0866 306 145
E-mail: info@miosa.co.za
Website: www.miosa.co.za

## 6. Consumer Goods and Services Ombud

Association House, Bond Office Park,
Cnr Bond and Kent, Randburg
Telephone: 011 781 2607
Call Centre: 0860 000 272
Fax: 086 206 1999
E-mail: info@cgso.org.za
Website: www.cgso.org.za

## 7. Public Protector

Private Bag X677, Pretoria, 0001
Telephone: 012 366 7000
Toll free number: 0800 11 20 40
Fax: 012 362 3473
E-mail: registration2@pprotect.org
Website: www.pprotect.org

## 8. Pension Funds Adjudicator

P O Box 580, Menlyn, 0063
Telephone: 012 346 1738
Fax: 086 693 7472
E-mail: enquiries@pfa.org.za
Website: www.pfa.org.za

## 9. National Credit Regulator

P.O. Box 209, Halfway House,
Midrand 1685
Telephone: 011 554 2600
Call Centre: 0860 627 627
Fax: 011 554 2871
E-mail: complaints@ncr.org.za
Website: www.ncr.org.za

## 10. City of Johannesburg Ombudsman

Wildsview II, Isle of Houghton
36 Boundary Road, Houghton Estate
Call Centre: 087 980 0058
Website: info@joburgombudsman.org.za

## 11. Financial Services Board

PO Box 35655, Menlo Park, 0102
Telephone: 012 428 8000
Toll-free: 0800 110 443 or 0800 202 087
Fax: 012 346 6941
E-mail: info@fsb.co.za
Website: www.fsb.co.za

## 12. National Consumer Commission

Private Bag X84, Pretoria, 0001
Tel: 012 761 3200
Fax: 086 758 4990
E-mail: complaints@thencc.org.za
Website: www.nccsa.org.za

## 13. S.A. Military Ombudsman

Private Bag X163, Pretoria 0046
Telephone: 012 676 3800
Toll free: 080 726 6283
E-mail: intake@miliombud.orh

## 14. National Consumer Tribunal

Private Bag X110, Centurion, 0046
Telephone: 012 683 8140 / 012 742 9900
Fax: 012 663 5693
E-mail: Registry@thenct.org.za

## 15. Office of the Tax Ombud

P.O. Box 12314, Hatfield 0028
Telephone: 012 431 9105
Call Centre: 0800 662 837
Fax: 012 452 5013
E-mail: complaints@taxombud.gov.za

## Ombudsman Central Helpline

Share call: 0860OMBUDS/0860 662837

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Facsimilie: 011 726-5501
Email: info@osti.co.za
Website: www.osti.co.za

**Ombudsman Central Helpline**
Share call: 0860OMBUDS/0860 66283