THE OMBUDSMAN'S BRIEFCASE

Official Newsletter of the Ombudsman for Short-Term Insurance

THE OMBUDSMAN
For Short-Term Insurance

Mission

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

Issue No. 4 of 2012

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OMBUDSMAN'S ADVICE:
CASE STUDIES

DUAL INSURANCE

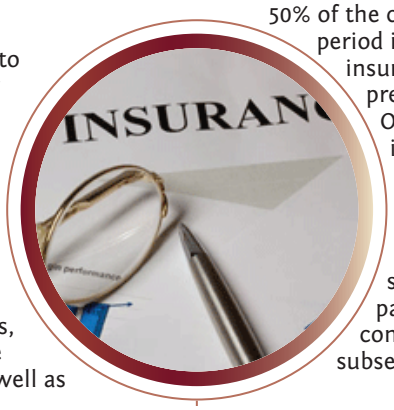
Details of Claim:

The complainant's vehicle was written off in an accident on 25 December 2011. He submitted a claim against his insurer (A). This claim was duly authorised and settled for the full retail value less the excess applicable to the policy.

Whilst conducting an audit on his monthly bank statement, the complainant noticed that debit orders were being raised for insurance premiums in respect of the same vehicle by another insurer (B). The complainant then proceeded to submit a claim against insurer B for damages to the motor vehicle resulting from the accident on 25 December 2011. Insurer B repudiated the complainant's claim, based on the following reasons;

- Non-disclosure of material facts pertaining to the regular driver and the risk address, and
- Late notification of the claim.

The complaint related to insurer B's decision to repudiate the claim. The complainant further argued that, since insurer B had received insurance premiums to cover the motor vehicle, they were therefore liable to cover the damages in the same way as insurer A, in addition to the settlement already received from insurer A.



In its response to the complaint, insurer B argued its rejection of the claim on the merits, providing the Ombudsman with a copy of the underwriting and assessment recordings, as well as relevant policy documents.

The complainant's policy with insurer B incepted prior to his policy with insurer A. It was further pointed out that the complainant had not cancelled his insurance policy with insurer B after securing cover with insurer A. The complainant did not dispute this. Without any notice of cancellation, insurer B continued deducting its premium in the normal course.

The Ombudsman's View:

Whilst this office could not fault insurer B's decision to repudiate the complainant's claim on the merits, the Ombudsman further advised the complainant that he no longer had a claim against insurer B. The Ombudsman pointed out that the complainant had been indemnified, in full, for damages associated with the motor vehicle accident on 25 December 2011 by insurer A. The complainant cannot be indemnified twice in respect of the same loss and therefore did not have a valid claim against insurer B.

The Ombudsman did however call upon insurer B to refund 50% of the complainant's insurance premium for the period in which he was dually insured. In this case, insurer B had also continued to collect insurance premiums after the date of loss. The Ombudsman therefore further called upon insurer B to refund all insurance premiums collected after 25 December 2011, in full, as the risk had been written off in the accident and ownership of the salvage had been transferred to insurer A, after the claim was settled. This premium was calculated and paid to the complainant accordingly. The complainant's policy with insurer B was subsequently cancelled.

NON-DISCLOSURE OF FINANCIAL HISTORY

Details of Claim:

The complainant submitted a complaint against his insurer in respect of a claim which had been rejected due to his "non-disclosure of material facts pertaining to his credit worthiness." The complainant's vehicle was damaged as a result of an accident which took place on 16 December 2011. The accident took place when the third party collided with the rear of the complainant's vehicle.

The policy incepted in March 2009. The vehicle was financed and the insurance policy incepted shortly after the purchase of the vehicle. During the course of the sales conversation, the complainant was asked the following questions:

Agent: Have either you or your wife ever been liquidated or sequestrated?
Insured: No no-no
Agent: Ever been placed under administration?
Insured: No
Agent: Do either of you have any judgements, defaults or are blacklisted?
Insured: No-no

The policy wording stated as follows:

Non-disclosure, misdescription or misrepresentation

Should any of the information supplied to us be found to be incomplete, inaccurate or untruthful, we have the right to declare the policy null and void and/or decline your claim.

The insurer rejected the claim and voided the policy due to the non-disclosure of a judgement in the sum of R1500.00 which was captured on the complainant's credit record on 01 February 2008, prior to the inception of the policy.

The insurer was asked to furnish us with their underwriting guidelines in order to confirm that the insurer would not have accepted the risk in light of the fact that the non-disclosure was for a very small amount.

The underwriting guidelines were provided. However, they did not state that the insurer would not have accepted the risk had the complainant disclosed this judgement. The

NON-DISCLOSURE OF FINANCIAL HISTORY (CONTINUED)

underwriting guidelines provided that the risk would have been referred to management to determine the acceptance of the risk and, if accepted, on what terms and conditions.

The Ombudsman's View:

The complainant's defence was that he had paid the premiums diligently and the insurer should have checked his credit records before accepting the risk.

Considering the quantum of the undisclosed judgement and the manner in which the accident took place, the Ombudsman requested the insurer to settle the claim.

The insurer offered to settle the claim which offer was accepted by the complainant.

USE WITHOUT CONSENT

The Facts:

The complainant's son, accompanied by his girlfriend, drove the insured vehicle to a social event. In the early hours of the next morning, the vehicle was involved in a single vehicle accident. Although the complainant's son averred that he was the incident driver, it was later established that his unlicensed girlfriend was in fact driving the vehicle at the time and that the complainant's son was under the influence of alcohol.

The claim was rejected on the basis that the incident driver, at the time, was not licensed. The complainant contested the rejection averring that the complainant's son did not give permission to the incident driver to drive the vehicle which constituted use without consent. The complainant refused to lay criminal charges for use without permission against the incident driver.

The Ombudsman's View:

It is common cause that the complainant's son was severely intoxicated and the incident driver was unlicensed at the time of the accident.

The issue in contention was whether there was sufficient evidence to prove that the complainant's son had authorised his girlfriend to drive the vehicle.

Both individuals provided directly contrasting statements, the incident driver alleging that she had permission and the complainant's son denying it. It was found that although it is not a requirement in terms of the policy to lay charges of use without permission, the complainant's adamant refusal to do so in itself lent more weight to the version of the incident driver than that of the insurer.

It was therefore found that on a balance of probabilities, the incident driver had been given the consent to drive the vehicle and that because she was not licensed, there was no cover for the loss.

Outcome:

The insurer's repudiation was upheld.

PREMIUM PAYMENT / POLICYHOLDER PROTECTION RULES

The insured had agreed with the insurer that premiums would be paid by way of debit order on the 25th of each month. In the relevant month this day had fallen over a weekend. The insurer had then, without discussing this with the insured, decided to bring forward the date of the debit order to the 23rd of the month.

The insured's salary had been paid into his account on the 23rd and would accordingly have been available on the 25th for the debit order. The funds had however not been in the account at the time of the early debit order and the debit order had been unsuccessful. The insured had been advised via SMS and voicemail on the 26th that the debit order had been unsuccessful, and that he needed to pay the premium within 15 days. The SMS had stated that he could do a direct deposit to remedy the situation, and gave relevant account details into which the deposit could be made.

The insurer had however raised a second debit order on the 27th (only four days after the initial debit order submission).

The insured had on the same day withdrawn funds from the account for monthly groceries as he allegedly always did on this day of the month.

The second debit order had also been unsuccessful.

Arguments:

It was the insured's argument that it was the insurer's first debit order on the incorrect date that resulted in the insufficient funds. (This did not appear to be the case, as the debit order was unsuccessful.)
The insurer disputed this argument by arguing that the erroneous debit order did not result in insufficient funds; but that it was the insured's own withdrawal of the funds that had caused the deficit.

The Ombudsman considered the following:

PREMIUM PAYMENT / POLICYHOLDER PROTECTION RULES (CONTINUED)

1. Whether the first debit order of the 23rd had been in line with the agreed terms and conditions of the contract?
2. Whether the insurer had wrongfully caused or created the problematic situation by debiting on the incorrect date?
3. Whether the insurer could rely on its own wrongful act to avoid liability?
4. Whether the insurer had allowed the 15 day grace period required in terms of the Policyholder Protection Rules (PPR)?
5. If the insurer's first debit had not been erroneous, but in line with the agreed terms and conditions, then the insurer, in any event, would have been obliged to allow a fifteen days grace period, as required by the Policyholder Protection Rules, which it did not.

The Ombudsman's View:

1. The insurer had erred in moving the debit order date without notifying the insured. This had been a unilateral change to the terms and conditions of the contract which was in breach of the contract.
2. The insurer had wrongfully created the situation.
3. The insurer could not therefore rely on its own wrongful act to the detriment of the insured.
4. The second debit order submission, only four (4) days after the first one, had also not been compliant with the requirements of the Policyholder Protection Rules.
5. The insurer was accordingly asked to settle the claim and to deduct the outstanding premium from the settlement. The insurer complied with the Ombudsman's request.

NEW APPOINTMENTS AT THE OFFICE

Dee Keys

Secretary to Dharmita Jogee, Assistant Ombudsman

Dee has worked as a Private Secretary as well as a Personal Assistant for approximately 30 years. She has reported to Executive Directors, a Chairman, National Sales Managers, Financial Managers, Project Managers as well as the Principal of an Estate Agency. Dee also previously worked as a secretary to an Assistant Ombudsman at the Offices of the Ombudsman for Short Term Insurance when she left to join an Insurance Adjuster.

Dee returned to the Office of the Ombudsman in 2012 and is currently holding a position as a secretary to Assistant Ombudsman, Dharmita Jogee.

Dee's hobbies are watching internationl sport on television, as well as sewing and embroidery. She also enjoys visiting "the bushveld" when on holiday.

Linda van der Vyver

Secretary to Peter Nkhuna, Senior Assistant Ombudsman

Linda's first job was that of a typist. She was promoted after a year to Senior Clerk also presenting software courses to internal staff members.

Thereafter, Linda worked as a secretary at a company and then as a senior secretary to a Managing Director. Following this she was a Human Resource Assistant, also assisting with payroll. During this time Linda obtained a National Diploma in Office Management and Technology through UNISA.

Prior to joining the Ombudsman for Short Term Insurance, she worked as an Office Administrator at an Accounting firm. She was responsible for all the administrative and secretarial functions of the practice.

YEAR END AND FESTIVE WISHES FROM THE OMBUDSMAN

We have reached yet another end of year at the office of the Ombudsman for Short-Term Insurance. I would like to thank all of those who have contributed to the successful year, including in particular, the staff of the office.
This year, like other years, has been busy and challenging. The end of this year also marks the end of the first year in my term as Ombudsman of this office. The year has been pressurized but rewarding.

From myself and the staff at the office of the Ombudsman for Short-Term Insurance, I wish you a peaceful, safe and restful festive season as well as a happy and prosperous new year.

Regards,

DENNIS JOOSTE
OMBUDSMAN FOR SHORT-TERM INSURANCE

LET'S HEAR IT FOR OSTI

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

"Thanks for being such a tremendous help to us in giving us the fair chance to state our case and that the outcome of the dispute was successful. You've got no idea what it means to us. Million thanks to people like you who look after us, the consumers and for giving us the peace of mind that our rights will be dealt with in the most professional, fair and efficient way.

.....

I would certainly recommend the Ombudsman to all I come into contact with. Once again thank you for the professional input and assisting me with this matter. It means the world to me and your efforts have certainly scored points.

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I'm in agreement and thank you very much for your undivided support and services rendered. This service I rate it as true professionalism towards vulnerable clients.

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Thank you for your assistance and impeccable service.

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I was pleasantly surprised & impressed by your quick turnaround time. I was truly not expecting the case to be resolved so easily and hassle-free from my side; especially considering that your services are free."

WHAT DOES THE OMBUDSMAN DO?

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

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

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

CONTACT US

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

Our new address:
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Parktown