The burden of proof

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Myra Knoesen

We summed up some case studies from the Ombudsman for Short Term Insurance's (OSTI) briefcase, which we thought would be interesting for our readers… there is failure to bring claims within the ambit of policy wordings.

Proving permanent and total disablement

Mr M sustained injuries to his right leg and ankle, and left elbow after he fell off a truck whilst on duty. The incident occurred on 28 October 2010. Mr M approached his insurer shortly after the accident; however, he was not permanently and totally disabled at that stage.

In 2017, Mr M approached the insurer again. He was advised that because he was not permanently and totally disabled within a 24-month period, as stipulated in the policy, he did not enjoy cover and, further, that his claim had prescribed. It was after the rejection in 2017 that Mr M approached OSTI for assistance.

The insurer's rejection of the claim was upheld by OSTI. However, Mr M requested that OSTI's decision be reconsidered on the grounds that he was able to demonstrate that he was permanently and totally disabled already in 2011.

In favour of the insurer

Mr M referred to the Sweeper Clause in the policy. The matter was reviewed by the Escalation Committee, who were tasked with determining whether Mr M was permanently and totally disabled as required by the policy, whether he complied with the 24 month time limitation and, if so, whether his claim against the insurer had become prescribed.

The Committee stated it was clear that the permanent and total disablement must be diagnosed within 24 months of the event giving rise to the disability.

A medical report from Mr M's doctor dated 28 February 2011 stated that Mr M *"will have pain for a long time and might develop a deformity."* The report also stated that Mr M first became unable to carry out his occupation on 28 October 2010 (being the date of the incident), however, Mr M was able to resume his occupation on 4 April 2011. The Committee also considered a medical report of the incident prepared for the Department of Labour dated 28 January 2017. In this report, a different doctor confirmed that Mr M had been fit for normal work since 22 May 2012.

The Committee noted that the claim form submitted to the insurer in 2017 confirmed, firstly, that Mr M was still employed at the time and, secondly, that his occupation and work description before the loss was exactly the same as that during February 2017 with the exception of Mr M not lifting heavy objects. Therefore, even if Mr M was able to overcome the 24-month time limitation, he had failed to bring his claim within the ambit of the policy wording by demonstrating that he was permanently and totally disabled.

The Committee also mentioned that, in view of the conclusions drawn above, the issue of prescription did not arise for consideration. Mr M's complaint was dismissed.

A stolen cellphone

Mrs N claimed for a cell phone that was stolen from her bag. Mrs N stated that she had placed her phone in her bag and left her bag on the side of the netball court whilst she was playing netball.

The insurer relied on the provision in the policy to reject her claim: "*The Insured shall take all reasonable steps … ensuring that the equipment is: not left exposed...*" The insurer argued that the cell phone was not safeguarded, and it had been left in a vulnerable situation where easy access could be gained to Mrs N's bag.

OSTI stated that the ordinary grammatical meaning of the word "exposed" is not "covered or hidden; visible". Since the phone was in Mrs N's bag, it was not exposed. OSTI recommended that the insurer settle the claim and the insurer agreed to do so.

The case of stolen luggage

In August 2018, Mrs G and her husband were catching a train from Paris to Disneyland in France. On boarding, Mrs G found herself surrounded by a group of young teenage girls. When the girls exited the train, Mrs G noticed that her luggage had been tampered with and certain items within the bag had been stolen.

Mrs G and her husband lost several high-end items, including a camera and cash, among other belongings. After reporting the incident to the police, Mrs G and her husband were informed that the girls, more than likely, belonged to an organised crime ring.

The insurer rejected Mrs G's claim on the basis that Mrs G had failed to take the necessary measures to ensure the safety of her personal baggage. The insurer based this assessment on the wording of Mrs G's statement on her insurance claim, as well as the wording the French police had used to describe the robbery. The insurer said that the police report notes the cause of loss as 'Vol a la tire' which translates to 'robbery' and not 'pickpocketing'.

A final point the insurer made was that the items could not possibly have been pick pocketed from Mrs G's bag without her noticing.

OSTI noted that the most common translation for 'vol a la tire', based on the information provided, was pickpocketing; a crime that typically takes place in the presence of crowds, making it difficult for the victim to notice the theft. Mrs G only noticed the loss once the girls had disembarked from the train. This indicated that Mrs G was on the train and had her bag with her at the time, said OSTI.

OSTI found that Mrs G had demonstrated on a balance of probabilities that the items were stolen from her bag. OSTI recommended that Mrs G be paid out in full for her loss to which the insurer agreed.

The case of Mr B

Mr B had claimed for legal assistance with a dispute between himself and his employer.

The insurer advised that Mr B's instruction to it was that he was short paid R1 600 for work done. The insurer issued a letter of demand to Mr B's employer for R1 600 in line with the instructions given by Mr B.

The insurer provided OSTI with a letter addressed by Mr B to the insurer in which Mr B stated that other people, who he was working with, were paid R9800 while he was paid R8220. The insurer also referred to the policy wording which contained restrictions and limitations to the cover.

Mr B disputed the insurer's submissions stating that his instruction to the insurer was that he was short paid R10 151. The insurer claimed that Mr B's version was untrue. The insurer denied receiving any instructions other than those contained in the letter, that it had acted on.

OSTI noted that, in his application for assistance to its office, Mr B stated that he was claiming an amount of R3000. After considering Mr B's application for assistance, the contents of Mr B's letter to the insurer, the submissions made by the insurer and by Mr B, OSTI found that there was an irreconcilable dispute of fact about the alleged "mandate" given by Mr B to the insurer.

In light of the dispute of fact, it could not be determined whether Mr B had proven the breach of contract by the insurer on which he relied, nor did he prove the extent of the damage that he had allegedly suffered. On the face of it, the insurer had acted on the instructions given to it in the letter from Mr B. Mr B's complaint was dismissed.

Writer's thoughts:

It makes sense to regularly review policy wordings and ensure that each of your clients is informed of whether any exclusions apply, especially as circumstances change. There are many potential pitfalls in the area of cover, as evidenced by these case studies published. Do you agree with this? If you have any questions please comment below, interact with us on Twitter at @fanews_online or email me - myra@fanews.co.za