Policy wording – Disappointing outcome for client

by Janine Geldenhuys on 3 December 2020 0

Policy wording and its interpretation at claim time received increased airtime in the last few months as a result of various Business Interruption insurance claims. Although the courts have thus far ruled in favour of the insureds, with some appeals still pending, policy wording in terms and conditions have in many other cases also been a bone of contention as it is quite often misinterpreted by the insured.

Each year, the consequences of misinterpreting terms and conditions are highlighted in the annual report of the ombudsman for short-term insurance as well as in various published case studies.

In Ombudsman's Briefcase: Issue 3 of 2020, one of the case studies deal with cover around personal accident cover, focusing on the rejection of a claim based on the policy wording.

Background

Mr M sustained injuries to his right leg and ankle, as well as left elbow after he fell off a truck whilst on duty on 28 October 2010. He approached his insurer shortly after the accident for a disability claim, but as he was not permanently and totally disabled it was rejected. In May 2011, the insurer settled a claim for hospitalization, but he was still not permanently and totally disabled, and that portion of the claim was, once again, rejected.

In 2017, he approached the insurer once more and 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. Mr. M then approached OSTI for assistance.

The insurer relied on the following policy wording to substantiate its rejection of the claim:

"Definitions

– Permanent Total Disablement means total and absolute disablement which entirely prevents the Insured from engaging in or giving attention to his/ her usual occupation or any occupation for which the Insured Person is qualified or has received specialised training in and which will in all probability be lasting and continuous for the lifetime of the Insured Person.

The diagnosis and determination of the Permanent Total Disablement must be made by a physician and must be continuous and permanent for at least 24 consecutive months from the onset of the disablement.

Documented evidence of the incident that caused the Permanent Total Disablement is required. The degree of Permanent Total Disablement will be determined immediately after it is established or as soon as it can reasonably be assumed that there will be no further improvement or worsening of the Insured Person's condition in consequence of the Accident, but not later than 24 months from the Date of Loss.

– Permanent and Total Loss means in reference to an arm or a leg or a hand or a foot or fingers or toes – the loss by physical severance or the total and permanent loss of use of said member.

– Sweeper Clause means in the event of a Permanent Disability not being listed under Partial Disability Insured Events in the Table of Benefits, [X] will indemnify the Insured Person up to a maximum of 50% of the Permanent Total Disablement Benefit."

Although the insurer's rejection of the claim was also upheld by OSTI, 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.

Findings

The matter was reviewed by the Escalation Committee, which comprised the Ombudsman, the Deputy Ombudsman and four Senior Assistant Ombudsmen 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.

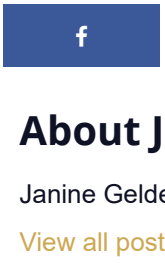
The Committee reviewed various medical reports, including one prepared for the Department of Labour. The Committee further noted that the claim form submitted to the insurer in 2017 confirmed, firstly, that Mr M was still employed at the time and, secondly, that his occupation and work description before the loss was exactly the same as that during February 2017 with the exception of Mr M not required to lift 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. Similarly, in order to enjoy cover under the Sweeper Clause, Mr M would have needed to demonstrate that he was permanently disabled which Mr M could not do,” according to the Committee.

The Committee also found that, in view of the conclusions drawn above, the issue of prescription did not arise for consideration. As a result, Mr M’s complaint was dismissed.

Click here to download the case study.

This case study emphasises the important role of the advisor in working through the terms and conditions of a policy with the client, especially with regards to material terms such as special clauses, provisions, or exclusions.



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