



THE OMBUDSMAN

For Short-Term Insurance

To resolve
short-term
insurance
complaints
fairly

efficiently &

impartially

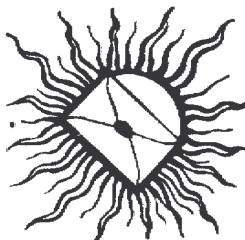
OMBUDSMAN FOR SHORT-TERM INSURANCE

H A N D B O O K

January 2008

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MESSAGE FROM THE OMBUDSMAN



A very warm welcome to our Workshop for the Short Term Insurance Industry. Thank you to all participants for taking the time out from your busy and demanding schedules to participate in this event. I trust that you will find today's proceedings to be both informative, interesting and I hope you will also leave this event with a greater understanding of the workings of the Office of the Ombudsman and in particular our application of the principles of equity and fairness in the resolution of complaints.

There is increase in pressure on this Office from the public at large to resolve complaints as quickly as possible and in terms that the lay person can identify with as being fair and equitable. To achieve this objective the active and enthusiastic participation of the Industry is vital. The Office seeks to promote the image and reputation of the Insurance Industry to serve the interests of both Consumers and the Industry.

Our target is to resolve 75% of complaints referred to the Ombudsman within a period of six months. Our target turn around time for the resolution of complaints is 90 days. This can be difficult to achieve in practice. Our Board, chaired by Mr. Moses Moeletsi, is provided with a list of all matters outstanding in excess of six months and good reason should exist why a matter is not resolved within this timeframe. We ask for your co-operation and participation in the adjudication process to achieve these goals. We also hope that the Office of the Ombudsman will serve as an example to other Ombud Schemes and regulatory bodies. We believe that a strong, independent and pro-active Ombudsman for the Industry is one of the best ways of defeating ever increasing government intervention in the Industry demonstrating that the interest of the Consumer are best protected by the Industry itself.

You are invited, indeed encouraged, to communicate with us at any time to discuss issues of concern or interest and to develop a key partnership with the Office serving the needs of Consumers who have placed their trust and confidence in the Industry to assist them in times of need.

Brian Martin
Ombudsman for Short-Term Insurance

COMMUNICATION WITH THE OFFICE

PREFERRED METHODS OF COMMUNICATION



The key to the process being a success is efficiency in responding to correspondence and the complaints themselves. To speed up communication between our offices and Insurers respectively, we encourage the use of email, which is quick and expeditious.

Emails can be forwarded to our offices at the following email addresses:

| Contact Person | Email Address |
|--|--|
| Brian Martin Ombudsman | brian@osti.co.za |
| Karinien Kok Secretary to the Ombudsman | karinien@osti.co.za |
| Hendrik Viljoen Deputy Ombudsman | hendrik@osti.co.za |
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| Johan Janse van Rensburg Assistant Ombudsman | johan@osti.co.za |
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| Thasnim Dawood Assistant Ombudsman | thasnim@osti.co.za |
| Vantera Joseph Secretary to the Assistant Ombudsman | vantera@osti.co.za |
| Miriam Matabane Operations Manager | miriam@osti.co.za |
| Azeht du Plessis Office Manager & Bookkeeper | azeht@osti.co.za |

The advantage of email besides the speed is the fact that it can also accommodate a number of attachments (with in some instances limitations on the size of the attachment allowed), and attachments in a variety of formats, which could be:

- a. word documents;
- b. scanned documents;
- c. photographs;
- d. copies of voice recordings; etc.

Fax

The following fax number can also be utilised (011) 726-5501

Snail mail

This method is still utilised to some extent, with the distinct disadvantages of the delay involved, and of course the eternal question mark concerning the competence and efficiency of the S.A. Postal Services.

Telephonic contact

Often one deals with a complex matter that is easier to discuss verbally than by the written medium. Our offices encourages the discussion of current matters with our offices, provided that what was discussed is later reduced to writing and attended to as verbally agreed / undertaken.

Meetings

Our offices from time to time invite Insurers to discuss outstanding matters at meetings held at our offices. The meeting provides a valuable opportunity to interact with each other on a face-to-face basis, and often one finds that matters are more easily and speedily resolved at such meetings. Meetings are as and when the need arises. In this regard reports are prepared on a monthly basis to reflect all outstanding matters per Insurer which are older than 4 and 6 months respectively, which reports often reflect which Insurers necessitate meetings with.

Technical issues

Voice recordings are sent to this office in a number of formats, most of which are accessible by our offices. Where however it is not possible to access the recording, a request would then be made for same to be sent on a disc or on tape.

System issues

Our office has just gone through the process of upgrading our database software (CRM) to enable us to keep more efficient and effective records, provide statistics and reports so as to ensure a minimum of delay in the processing of the complaint as well as to speedily allow us to identify worrying trends with Insurers in general or with any particular Insurer/s.

The software already grants insurers limited access to our database in order for them to monitor and track the number of complaints received for that Insurer, the number of outstanding complaints for that Insurer and depending upon systems and security issues also access to determine the status of such outstanding complaints.

Any queries regarding the system can be directed to Miriam Matabane, email miriam@osti.co.za

Newsletters

Our office produces a quarterly newsletter entitled “ *The Ombudsman’s Briefcase* “ which contains useful articles on recent developments in the office and insurance law in particular. Also contained in such newsletters are records of case studies from actual matters dealt with by our offices, and which are useful for gauging our views on matters. However please note that these are not to be regarded as precedents of any sort, as each matter received in the office is dealt with on its own individual merits.

In the event that you do not currently receive our newsletter and would like to join our mailing list, kindly furnish Edite Texeira-McKinon, our Editor, with your contact details. Edite can be reached on 011 726 8900 or email edite@osti.co.za.

Website (www.osti.co.za)

- Our website is fairly comprehensive and contains detail on the history of the office, our staff and board of directors. It also contains copies of our memoranda which contain our views on matters ranging from motor claims to utilising of the Small Claims Court to attempt recovery of the Insured’s excess where the Insurer has not /can not recover same.
- The website also contains copies of our annual reports, frequently asked questions newsletters and has a newsroom section that contains all of our media releases.
- The website also contains links from our site to most member insurance companies and other organisations such as the Financial Services Board etc.

GENERAL AND SPECIFIC RESPONSES

GENERAL RESPONSES

The purpose of a workshop with Insurers:

- With consumers’ greater awareness of the services offered by our office, Complainants have specific expectations of us and we in turn, have specific expectations of Insurers when addressing complaints registered with the office of the Ombudsman by consumers.
- To facilitate efficient complaints resolution, Insurers must all respond to complaints in a general form / manner.
- If the initial response provided by Insurers properly meets all the requirements, the response should, in most matters, be capable of providing complete complaints resolution, without further unnecessary delays and assist Insurers with meeting the accepted 90 day turn-around time.

ACKNOWLEDGEMENT

In the interest of all parties (Complainant/Insurer/Ombudsman), it is advisable that Insurers immediately acknowledge receipt of every complaint in standard format. The Insurer’s acknowledgement assists with the reconciliation of their record of complaints, avoids turn-around-time being unnecessarily extended and should confirm:

- Receipt of all documents contained in the Complaint.
- That the complaint is allocated and billed to the correct Insurer.
- The details of the specific individual responsible for handling the complaint.
- The accuracy of reference / claim / policy numbers.

INSURER'S DETAILED RESPONSE

In order for an Insurer to adequately address a complaint, the dedicated individual should have the proper knowledge of the principles of insurance, undertake a thorough review of each matter and be capable of arguing and supporting the merits upon which the Insurer's decision was made. One must bear in mind that if the claim was properly addressed at claims stage, Insurers' should be able to provide a comprehensive response, which meets the following requirements:

- Insurer's response must demonstrate a complete understanding of the facts giving rise to the complaint.
- The representative should have conducted enough research into the circumstances surrounding the loss and obtained all the necessary supporting documentation/material prior to responding.
- The response itself must be comprehensive and conclusive to enable the Ombudsman to formulate a ruling/decision.
- The grounds for Insurer's decision (declinature) need to be justified and supported, not merely quoted as an extract from the policy wording.
- The decision to decline liability by an Administrator should be formally supported by the Insurer and not merely be the subject of a "copy and paste" exercise by the Insurer when responding to a complaint (see "1A" attached).
- Insurer's may not base their decision to decline liability solely on a technicality but should have considered 2 very important principles i.e. materiality and prejudice, before standing by a decision to reject the claim.
- The response must have addressed all issues/concerns raised in the "Details of Complaint" form completed by the Complainant.

OTHER RESPONSES

A general response may not be required when:

- The complaint has already been addressed and resolved by the Insurer by the time it has been registered with the Ombudsman's office.
- The initial decision to decline liability is overturned.
- Insurers have proposed a (revised) settlement offer to the Complainant subsequent to acknowledging the complaint.
- A specific response is required to adequately address the complaint.

SPECIFIC RESPONSES

In certain instances, an Insurer would rely on the results of investigations from a variety of experts / assessors / investigators etc., to substantiate their stance with regard to the acceptance or rejection of claims. In order to evaluate the merits of complaints lodged with our office, the Ombudsman would require copies of the reports relied upon where an Insurer:

- Relies on confidential/sensitive information; or
- Relies on expert opinion

Confidential / sensitive information

An Insurer may be reluctant to provide copies of documentation they have on file, as it may contain e.g. discriminatory comments or confidential information which the Insurer would rely on in the event of an Insured taking legal action.

In terms of Schedule 4 of the Association Agreement entered into by the Insurer and the Ombudsman, provision is made that the Ombudsman may decide what documentation should be disclosed to an Insurer or Insured.

The Ombudsman's office will as far as possible, concede to an Insurer's request not to disclose confidential or sensitive information. Documents of this nature must however be clearly marked with:

- *"For your eyes only", or*
- *"In confidence"*

When a request for confidentiality is received by the Ombudsman, the Insurer must however provide adequate information which can be relayed to the Insured. The Ombudsman can only support an Insurer's stance if sufficient detail can be relayed to an Insured.

Often, it is found that there is no particular reason why a supporting document cannot be forwarded to an Insured. Reports containing mere facts of the claim are labelled, "for your eyes only", by Insurers.

Insurers are encouraged to advise their panel of experts to report on the facts and to refrain from stating derogatory remarks or relying on hearsay. It is ultimately in the interest of all parties concerned when reports are made available to an Insured. A report supporting the Insurer's stance will add credibility to the Insurer and the Insured can see that his claim was comprehensively investigated.

A request for confidentiality should be an exception to the rule.

EXPERT OPINION

Insurers rely on expert opinion, when dealing with more technical claims. Examples include:

- Homeowners claims – subsidence, fire (forensic & loss adjuster reports); or
- Motor claims – smooth tyres, driving under the influence; or
- Household claims – damage to electronic equipment, underinsurance

In instances where an Insurer has relied on the submission of an expert's report, a copy of the report should be attached to the initial response to the Ombudsman's office.

Copies of expert reports are sent to the Insured in support of the Insurers' stance. The Ombudsman allows the Insured the opportunity to obtain an independent expert's report, in the event that they differ with the Insurer's expert. On receipt of the Insured's independent report, a copy will be sent to the Insurer for their comment.

RESOLUTION:

- If the Insured's expert concurs with the Insurer's expert, the matter is resolved in favour of the Insurer; or
- If the Insurer or its expert concur with the Insured's expert, the matter is resolved in favour of the Insured; or
- Should the experts not reach agreement, the Ombudsman may declare a Dispute of Fact and the file will be closed.

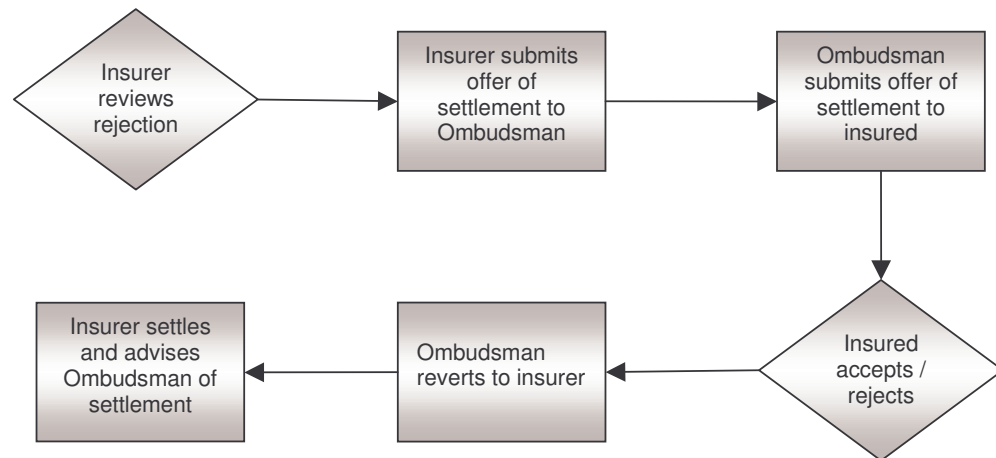
ADMISSION OF CLAIMS

The mission of the Ombudsman's office is:

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

In order for the Ombudsman's office to achieve our mission, it is imperative to resolve complaints as soon as possible. The Ombudsman therefore appeals to the insurance industry, when it is evident that a claim should have been admitted, that the Insurer does not submit the reasons for the initial rejection of the claim. The Insurer is requested, in these instances, to respond that the claim has been admitted.

Offer of settlement (partial or full settlement) - process flow



Following receipt of the offer of settlement, payment should be made by the Insurer within a reasonable time. Penalties can be awarded to the Insured, should the Ombudsman find that payment has been unduly delayed.

EQUITY

SCHEDULE 4 TERMS OF REFERENCE 7.2 STATES THAT 'RULINGS SHALL BE BASED ON THE LAW AND EQUITY'.

WHAT IS EQUITY?

It is the quality of being fair and impartial based on natural justice, and used when existing laws would be unfair or inappropriate. Natural justice is based on two principles.

- **Audi alteram partem**, hear the other side and all affected should be given a hearing.
- **Nemo debet esse iudex in propria sua causa**, no one shall be the judge in his own case and the decision reached should be reached on nothing either than the merits of the case. Preconceived opinions, vested interest or personal involvement should not colour the judgement.

The Ombudsman's office gives a hearing to both parties that is the Insured and Insurer and is independent of either of the parties, even though the Insurers pay the fee, it is in their interest not to have a legal battle that goes on for a long time and is very costly.

PROCEDURAL FAIRNESS

- Sufficient detail should be provided for the respondent to prepare a response and the response should provide enough detail to ensure that a fair resolution can be reached.
- Only evidence which is relevant, reliable, logically valid and capable of being tested should be admitted.
- Opportunity should be given to correct or contradict statements which may be prejudicial.
- Quick Resolution.
- Rules, principles and documents used to reach resolution should be disclosed to both parties.

It is easier to understand and to some extent judge whether the above has been satisfied except for the last one which needs to be explained. There are two major principles used by the office to determine the fairness or otherwise of the action of an Insurer; Materiality and Prejudice.

PREJUDICE

The action of the Insured should have prejudiced the Insurer in some way for the Insurer to be justified to reject a claim.

An example would be where the Insured does not maintain his vehicle in a good condition and due to such condition of the vehicle, say for instance unroadworthy brakes, the Insured suffers a loss which could easily have been avoided had the brakes been in a good condition. The difficulty is to determine whether the accident was in fact avoidable as alleged. This is where Procedure number two helps; the evidence should be logical and capable of being tested or verified.

The most common example is where the Insured declares an incorrect fact, which is to say there are misrepresentation(s) and/or non disclosure(s). The non-disclosure should be such that Insurer suffered prejudice in that a higher premium would have been charged or the policy accepted with different terms and conditions or not accepted at all. There is a few scenarios, one where the Insurer would have asked for a higher premium, not given a discount, asked the Insured to improve the risk, restricted the cover, changed the excess' or other conditions.

MATERIALITY

The common application of materiality in insurance is to test whether the breach of the term(s) or condition(s) is material to the risk, that is, had the true facts been declared what would the Insurer have done differently and all the underwriter has to prove then is that a reasonable underwriter would have found the facts withheld or misrepresented by the Insured material in the assessment of the risk. The courts support the foregoing which has led Insurers to hold on to the principle even where the consequences may seem inappropriate.

An example is where the vehicle may be unroadworthy but was collided into by a third party while it was parked. There are even better examples like where the Insured has failed to install a security gate in his house but the house was occupied at the time of the loss.

The Ombudsman takes the matter further by applying the principle to the claim rather than the risk. For instance, the fact that the son of the Insured was the regular driver of the vehicle may prejudice the Insurer and is material to the risk regardless of how the claim occurred, but where the vehicle was parked at the Insured's house when it was stolen, the misrepresentation is not material to the loss. We then ask the Insurer to settle the claim, which is a fair result.

INSURERS' RESPONSES

The Insurer, in defending the decision to reject a claim should address the two principles adequately.

- The Insurer should give the background to what happened; policy inception date, date of loss, description of loss and evidence collected.
- How was the Insurer prejudiced? Show by actual premium calculation or condition what would have been imposed save for the breach of term(s) and/or condition(s).
- Materiality: On a balance of probabilities, how would the outcome been different had there been no breach of the term, condition, non-disclosure or misrepresentation?
- Argue the case why you believe the decision is fair to the Insurer, Insured, other policyholders and society.

THE PRINCIPLE OF PROPORTIONALITY

Traditionally, in the Insurance Law a principle of "all or nothing" has been followed. In other words, the insurer is either liable for the entire claim or for nothing at all. This approach can work hardship and is not always fair or equitable due to its inflexibility and harshness of the result that it can occasion. In many jurisdiction, notable France the courts have accordingly developed a doctrine of proportionality. This doctrine seeks to compensate for the harshness of the "all or nothing" approach. It recognizes that the

insurer may have been prejudiced by the conduct of the insured, but that there are extenuating circumstances which should be taken into consideration.

This office favours the principle of proportionality and I am happy to report that an increasing number of insurers have accepted this principle when considering complaints. On this basis an enquiry is conducted into the specific circumstances giving rise to the prejudice suffered by the insurer. Instead of simply rejecting the entire claim for any technical breach. The principle which is favoured is that the parties should perform their respective obligations pro-rata to the loss or harm suffered. Where for example an insurer has suffered premium prejudice through the insured having, on account of ignorance, not having notified the insurer of a change in risk or other pertinent information, the insurer will settle the claim pro-rata to the percentage of premium actually received. The insured is accordingly penalized for his failure to have strictly adhered to the terms of the contract but he is not deprived the benefits of the entire claim.

The principle of proportionality is now applied by Ombudsmen in many other countries and is achieving more and more international acceptance. This issue was discussed extensively at the International Ombudsman Conference held in London this year and it is hoped that all Short Term Insurers in South Africa will embrace this principle.

FRAUD

Sadly, we live in a country which is plagued by crime and the Insurance Industry has not been exempted from the affects of this scourge. It is thus understandable that the Industry is sensitive about the issue of fraud and in particular the problem of fraudulent claims. Various devices have been resorted to in an endeavour to reduce the impact of fraud and to penalise those that engage in fraudulent practices. However, the Industry has tended at times to overreact to the problem of fraud and to regard any incorrect statement, representation or conduct as fraud, when this is clearly not so.

Part of the difficulty lies in the fact that different notions and definitions of fraud are applied. Before a statement can be said to be fraudulent it must be made intentionally with knowledge of its falsehood and with the intention that the Insurer may act or rely upon it to its detriment. A common example of a fraudulent claim would be a claim made by an Insured who has himself intentionally destroyed the property Insured or brought about an Insured peril, with the intention of obtaining a benefit under the policy. Mere exaggeration however is not by itself, evidence of fraud, particularly in relation to the value of items Insured as value is often a matter of opinion. It is been held, in English Law, for example, that exaggeration will amount to fraud if it is dishonestly made and so greatly in excess of the true value or amount so as to be incompatible with good faith.

In Roman Dutch Law the position was that an Insured could derive no benefit from a fraudulent claim. Consequently, an Insurer is not liable for an unfounded claim, or for the exaggerated part of a fraudulent claim but the Insurer will, despite the fraud, remain liable for the genuine part of an exaggerated claim as well as for the value of a valid claim merely accompanied by fraudulent means. In terms of our Common Law the Insured's

fraud does not entitle the Insurer either to avoid a contract as a whole or to avoid all liability for the claim in question, thereby penalising the Insured for his fraud. It is important to remember that fraud is a criminal offence and if punishment or sanction is to be imposed for the fraud, this is a matter for the Criminal Law and not for Law of Contract.

In an endeavour to modify the Common Law position, which is anti-penal in nature, it became common place for many Insurance Contracts to contain a provision dealing with the effect of fraud on the part of the Insured in connection with a claim. These clauses commonly provided that if any fraudulent means or devices were used to obtain any benefit under the policy then all benefits under the policy would be forfeited. When dealing with fraud in relation to Insurance Contracts it must also be borne in mind that a distinction exists between an Insured's fraudulent pre-contractual conduct, such as would arise with a false misrepresentation in connection with a proposal, and post-contractual fraudulent conduct. Where the Insured makes an intentional fraudulent misrepresentation with a view to inducing the Insurer to enter into a contract, the Insurer would be entitled to declare the contract void.

It should also be remembered that where an Insurer alleges fraud on the part of the Insured, the burden of proof rests upon the Insurer to establish such fraud on a balance of probabilities. Fraud will not likely be imputed to anyone and before the provisions of any clause dealing with fraud can be relied upon by the Insurer, the fraud alleged must be established.

When approaching claims alleged to be tainted with fraud, it is important to determine whether the claim itself is fraudulent or whether it is simply a case of the Insured having misrepresented the extent of the loss or damage suffered in a genuine claim covered by the policy, by inflating the value of the claim. Certain writers have described this enquiry as one involving a consideration as to whether there was "*incidental fraud*" or "*relevant or causal fraud*." Should the typical forfeiture clause stipulating that if any information provided in connection with the claim "*is not true*" then "*all benefits under this policy shall be forfeited and you shall be obliged to refund to us any amount paid to you and we shall not be obliged to pay any claim lodged before or after such fraudulent event*" be upheld?

The approach followed by the Office of the Ombudsman towards forfeiture clauses is in line with the Common Law. The practice is to examine the type of fraud involved and whether this may be termed "*incidental fraud*" (i.e. fraud causally unrelated to the occurrence, extent or coverage of the loss) or whether there was "*relevant or causal fraud*" (i.e. fraud causally linked to the occurrence, extent or coverage of the loss). Where a genuine claim has been filed, the provisions of a fraudulent claims clause will not be interpreted so as to mean that any false statement made after the lodgement of a valid claim, has the affect of tainting the claim with fraud and thereby entitling the Insurer to escape all liability. False and fraudulent evidence furnished in support of an already submitted valid claim is not considered sufficient to render the claim a false one, particularly if the Insurer has not suffered any prejudice thereby. This approach is in line with that followed in the case of *Ivanov v. Santam Limited 2006 JDR0714(W)*.

There must be a clear intention to deceive and defraud the Insurer by the obtaining of a benefit for which the Insured knew he was not entitled. In the Ivanov Case the Court pointed out that if it had to interpret a fraudulent claims clause so as permitting the Insurer to escape liability to indemnify the Insured by relying upon a "*insignificant incorrect statement which was not materially connected to the risk or the assessment of*

the claim" this would amount to the condoning of a breach of good faith on the part of the Insurer. The Court stated that *"an untrue or incorrect statement which does not amount to wrongful or material misrepresentation cannot be relied upon to exclude or limit liability simply on the fact of its unlawfulness"*. The approach followed in the case of ***Schoeman v. Constantia Insurance Company Limited 2004 (6) SA 3131(SCA)*** is also followed. In that case the Insured was alleged to have fraudulently increased the true quantum of the claim by adding on a margin of 10%. The Insurer argued that the effect of this was that the entire claim would be forfeited. The Court reaffirmed that our Common Law did not permit the imposition of a penal term and that the mere fact that an Insured's estimate of the value of a claim had been found to be exaggerated, did not prove fraud.

The Office of the Ombudsman believes that where the true value of a genuine claim can be established, even if certain aspects of the claim are tainted with fraud or misrepresentation, then the bad portion of the apple should be cut out so to speak and the Insurer should pay the true value of the claim. The Office follows the provisions of the **Conventional Penalties Act No. 15 of 1962**, having regard to fact that, by seeking to rely upon a forfeiture clause, an Insurer is seeking to impose a penalty on the Insured it could not otherwise impose under the Common Law. In terms of the Conventional Penalties Act a Court is empowered to reduce or even eliminate, a penalty imposed in terms of a contract if in the view of the Court the penalty is excessive and out of proportion to the harm or prejudice suffered. This principle is in line with the concept of equity and fairness which is applied by the Office of the Ombudsman. Our view is that in the case of a valid claim merely supported by fraudulently false evidence or information, the penalty of total forfeiture of the entire claim, is clearly excessive and should be avoided. Forfeiture should apply only to the exaggerated part and not the genuine part of the Insured's claim. There needs to be a balancing of interest between the Insured and the Insurer, having regard to the fact that the Insured has paid premium to the Insurer in good faith and in the expectation that if or when he suffers a loss covered by the policy, he will be fairly indemnified.

It is interesting to note that the principle of proportionality has also been embraced by the Constitutional Court when called upon to consider the application of forfeiture clauses embodied in statutes. In a case of ***Prophet v. National Director of Public Prosecutions 2007 (6) SA 169(CC)***, the Court was called upon to consider whether the forfeiture provisions contained in **Sections 48 and 50 of the Prevention of Organised Crime Act No. 121 of 1998** were valid. In terms of these provisions a Court is empowered to grant a forfeiture order declaring any property forfeited to the state where it was an instrumentality of a criminal offence. In this case the Plaintiff's property had been seized and declared forfeited as it had been used as a base for the manufacture of methamphetamine. The Court held that on the evidence presented it was beyond doubt that the property had been appointed, organised, furnished by, adapted and equipped to facilitate the accused's illegal activities. The property had been used in commission with criminal offences and was not merely incidental thereto. Nevertheless, and despite this finding, an enquiry of proportionality was required – a balancing was required between the severity of the interference with individual rights to property against the extent to which the property had been used in a commission of an offence. The Court held, on the facts, that the imposition of the forfeiture order had not been disproportional.

Contracts of insurance, like other contracts need to be considered against a background of public policy. Public policy imports notions of fairness, justice and reasonableness. Public policy precludes the enforcement of a contractual term if its enforcement would be unjust or unfair. Public policy has in fact been said to be *"the*

general sense of justice of the community, the boni mores, manifested in public opinion"
see *Barend Petrus Barkhuysen v. Ronald Steward Napier Case: CCT/72/05*

The office of the Ombudsman believes that public policy requires that Insurers recognise their responsibility and obligation to indemnify and compensate persons who have suffered loss in a fair, reasonable and equitable manner. Insurance requires good faith on both sides. It is not a game of cat and mouse or an exercise in bargaining such as would be found in a bazaar.

RULINGS

WHAT IS THE DIFFERENCE BETWEEN A RULING AND A RECOMMENDATION?

A ruling is binding on the Insurer whereas a recommendation is not. A ruling is made by the Ombudsman whereas recommendations are made by all other professional staff.

WHY IS A RULING BINDING ON THE INSURER?

The OSTI is a sec 21 company. An Insurer will only be bound by a ruling if they are a member of the company. The only way to become a member is to sign a Deed of Accession in terms of which the Insurer agrees to be bound by the Association Agreement.

WHERE DOES THE AGREEMENT SPECIFY WHEN A RULING CAN BE MADE AND THAT IT IS BINDING?

Schedule 4 provides as follows under the heading Rulings:

- 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.
- Rulings shall be based on the law and equity.
- 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.
- Any Ruling made by the Ombudsman shall be binding on the Insurer concerned.

IS THE RULING ALSO BINDING ON THE COMPLAINANT?

Schedule 4 provides specifically that the Insured is not bound by the Ombudsman's rulings. One has to bear in mind that the Insured is not a party to the Agreement.

DOES A RULING OR RECOMMENDATION CREATE PRECEDENT?

Again it is specifically stipulated in Schedule 4 that no precedent is created in the Ombudsman's office. The reason for this is because a ruling can be based on either law or equity. The facts of each case will thus dictate whether a ruling can be made. It is highly unlikely that two different matters will share exactly the same circumstances. Previous decisions made by the office are thus merely persuasive and not binding precedent.

IS A RULING FROM THE OMBUDSMAN SUBJECT TO APPEAL?

From the quote above it is clear that Schedule 4 provides that the rulings are binding on the Insurer without the right of appeal. In terms of our Constitution and common law however, Insurers do have the right to take a ruling on Judicial Review. It has to be born in mind though that a Review is solely concerned with procedural issues and not the merits of the ruling. Thus a court may examine whether the Rules of Natural Justice was followed by the Ombudsman and whether he applied his mind to the matter at hand but not whether he made the correct decision. The judge cannot second guess the Ombudsman on what would constitute equity. Review proceedings have to be launched within a reasonable time should an Insurer want to follow this route. Fortunately no ruling by this office has ever been taken on review and thus illustrates the excellent relationship that the office enjoys with most Insurers.

HOW OFTEN ARE RULINGS MADE?

Fortunately it is seldom necessary for this office to use the formal powers granted in terms of Schedule 4. In 2007 the office received in excess of 9000 complaints yet only 7 rulings were made. It is also the norm internationally for Ombudsman to resolve complaints by agreement. This is one of the major advantages of an Ombudsman scheme as it generally results in much speedier dispute resolution.

WHAT IS THE PROCEDURE WHEN A RULING IS MADE?

A letter is sent to the person dealing with the complaint at the Insurer. The letter will clearly indicate that this is a formal ruling and will at least be signed by the Ombudsman. A copy of this letter is sent to the managing director of the Insurer involved and is also reported at the next Board meeting of the Ombudsman.

WHAT IS A DEFAULT RULING?

Unfortunately certain Insurers don't give Ombudsman complaints the required attention that it deserves. This results in the office having to write numerous letters to follow up on why a response is outstanding. Last year we introduced the letter demanding a response within a time period. What this means is that if we feel that an Insurer is unduly delaying the finalisation of a matter, we will issue a letter giving the Insurer 10 working days to respond. If no response is received we will evaluate the merits based on the Insured's submission to decide whether a ruling can be made. The Insurer can off course approach us to request an extension if there are compelling reasons. We have to issue a word of warning that we will be making more use of this method going forward to try and resolve long outstanding matters and to try and clear the backlog that resulted due to the huge increase in volumes.

SALVAGE

WHAT IS SALVAGE?

Salvage is what is left over of the Insured item after the Insured event, or goods or property saved from destruction.

WHY IS THE INSURER ENTITLED TO RETAIN THE SALVAGE?

In terms of the Principle of Indemnity, the Insured may not be enriched as a result of the loss.

In order to prevent the Insured from being enriched, the law developed the Subrogation principle which provides that once the Insured has been indemnified, the Insurer is placed in the Insured's position and is therefore entitled to the Insured's rights and remedies against third parties. Analogously, the Insurer is also entitled to the salvage in the event of the vehicle being a total loss after the happening of an Insured event, but only once the Insurer has indemnified the Insured.

A partial settlement of the claims means that the Insurer has no right to retain the salvage.

DOES THE INSURED HAVE ANY RIGHT TO RETAIN THE SALVAGE?

In the event that vehicle is written off after the Insured event and the Insured wishes to purchase the wreck:

- If the vehicle is subject to a finance agreement, the Insurer must obtain the financier's permission to allow the Insured to purchase the salvage and repair the vehicle at his/her own cost. Once permission has been obtained, the Insurer's liability will be the maximum they would have allowed for the repairs to the vehicle.
- If the vehicle is not subject to a finance agreement, the Insured may approach the Insurer to purchase the wreck and the parties will negotiate the purchase price.

TOWING, STORAGE AND RELEASE FEES:

WHAT IS TOWING AND STORAGE?

Towing is the act of drawing or pulling a vehicle by means of a hitch or a rope or on back of a truck. Storage is the act of storing the Insured item either at a panel beater or a storage facility.

Scenario 1:

Where the insurance contract obliges the Insured to utilize the Insurer's Towing Company to remove the vehicle from the scene of the accident and the Insured fails to do so:

- If the Insured fails to utilize the Insurer's services and instructs another towing company to remove the vehicle either to a storage facility/the Insured's home, then the Insured may be held liable for the cost of this tow and any storage incurred in this regard. However, our offices do require Insurers to indemnify the Insured to the extent of their liability in the event that the Insured had utilized their services.
- If the Insured is injured or unable to contact the Insurer to remove the vehicle and the vehicle is removed from the scene on the instructions of the police or other persons present, then the Insurer should be liable for the reasonable towing and storage costs incurred as a result thereof.

Scenario 2:

Where the insurance contract does not oblige the Insured to utilize the Insurer's Towing services, and the Insurer is liable for towing and storage costs, then the Insurer is liable for the towing and storage costs.

Scenario 3:

Where the insurance contract limits the Insurer's liability in respect of towing and release fees, then the Insurer's liability will be to the extent of that limit, provided that the Insured has been made aware of this limitation. Any further towing or storage costs which the Insurer incurs in order to facilitate the assessment of the vehicle must be done with the Insured's permission: the Insurer must not spend the Insured's money without obtaining the Insured's permission.

Scenario 4:

The Insurer moves the vehicle from the scene of the accident or where it has been towed to after the accident to a storage facility/panel beater in order to assess the damage to the vehicle:

- If the claim is subsequently rejected, the Insurer must pay the cost of releasing the vehicle from the premises to which it requested the vehicle be moved to, and attend to the return of the vehicle to the Insured's premises, alternatively to the premises that the Insured elects.
- If the claim is settled, then the Insurer is not entitled to deduct these towing or storage costs from the settlement, as the Insurer is not allowed to spend the Insured's money. The Insurer must first obtain the Insured's permission prior to incurring any costs on his/her behalf.

FINANCIAL MATTERS

HOW IS THE OMBUDSMAN FUNDED?

FUNDING PROCEDURE:

The Ombudsman is funded by a fee charged per complaint received against Insurers. The cost is shared between the Insurers based on the estimated number of complaints received.

BOARD COMPRISES OF:

- 4 people representing consumers
- 4 people from the Industry
- 1 from the Financial Services Board

The Budget is examined and approved by the Board represented by senior officials from the Insurance Industry.

SURPLUS FUNDS

In the last few years, there has been a surplus of funds coming in due to:

- The rise in the number of complaints received over the estimated figure,
- Cost effective management of expenses.

This surplus is used to subsidise a lower fee for Insurers for the following year.

The board has approved that a cash surplus of 3 months worth of expenses be kept in reserve and that the balance thereafter be used to subsidise a lower fee.

An example of the reduction in the fee is illustrated:

In the year 2006, the fee was R1500.00. In 2008 we will charge a fee of R1300.00.

WHEN WILL A FEE BE RAISED?

- When we receive a complaint which falls within our jurisdiction.
- We have two types of files:
 - **Preliminary** files and
 - **Main** files

PRELIMINARY FILES

These are matters which lack vital information which prevent us from effectively dealing with the complaint.

Files where we are uncertain as to:

- A. What the complainant is complaining about or
- B. Who the Insurer is or
- C. What the claim or policy number is.

We don't charge for Preliminary matters **BUT** once these 3 items are adhered to, a **MAIN** file will be opened and a fee will be charged.

Prem files also include matters that fall outside our jurisdiction e.g. Life, banks etc. these are then referred to the correct office that would be able to help the client

TIME BARRING AND PRESCRIPTION

When a matter has become Time-Barred i.e. the Insured did not take legal action or formally report the matter to the Ombudsman within the period set out in the policy conditions (usually ninety days), we will still open a **Main File** and charge for the matter.

When a matter has **prescribed** i.e. the 3-year time period has elapsed since date of the incident, we will not open a main file and there will be no charge.

INVOICING AND PAYMENT TERMS

Invoicing:

- Invoices are generated on a monthly basis based on the number of complaints lodged against the Insurer for that month.
- Invoices are then sent out together with a list of complaints received.
- All invoices should be settled within 30 days after receipt.

Interest:

- Interest is charged on long outstanding payments, that is payments outstanding for 90 days and longer.

Payments:

- Payments should be made directly into the Ombudsman's bank account, the banking details can be found on the bottom left hand corner on the invoice.
- Please ensure that the company name or invoice number is reflected when the payment is made.
- Payment requests are sent out on a weekly basis and any queries should be forwarded to the accounts department.

Remittance advice or Proof of payment:

- A remittance advice should specify the reference numbers and the amounts that are being paid to ensure that the payments are allocated to the correct invoices.
- A remittance advice should be forwarded to the accounts department as soon as a payment has been made.

Credit notes:

- Credit note requests should be forwarded to the person (e.g. Assistant Ombudsman) dealing with the file. Confirmation will be forwarded before a credit note will be processed.

Debtors reconciliations:

- Debtors' reconciliations will be sent out on request.

UNDER WHAT CIRCUMSTANCES CAN AN INSURER ASK FOR A FEE TO BE REVERSED?

1. If the matter is outside our jurisdiction.
2. Reallocation from one Insurer to the other.
3. Duplication.

RECOGNITION



OMBUDSMAN'S OFFICE LAUNCHES PRESTIGIOUS "UKUSIZANA" AWARD TO RECOGNISE INSURERS' COMMITMENT TO CONSUMER EXCELLENCE

In September 2007 the Ombudsman's Office announced the launch of a brand new initiative aimed at recognising Insurers' efforts and commitment to consumer excellence.

CRITERIA OF THE AWARD:

- Speed of response
- Thoroughness of response
- Level of cooperation with the Office
- Application of equity and fairness
- Turnaround Time

The first adjudication process has begun this month. A short-list of three finalists has been determined and the overall winner, second place and third place will be announced at the launch of the Ombudsman's Annual Report in March 2008. The winner will be presented with an exclusive floating trophy designed by well-known Kwazulu Natal artist, Sarah Richards and will receive a Certificate of Achievement.

Ombudsman's Challenge to Insurers: Do you have what it takes to be No. 1?

Ombudsman's Handbook
Update: January 2008

TERMS OF REFERENCE OF THE SHORT-TERM INSURANCE OMBUDSMAN

PREAMBLE

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.

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.

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 0 below or mediation or conciliation in an attempt to settle complaints.

DEFINITIONS

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

- "the Board" means the Board of Directors of the Ombudsman for Short-term Insurance (Association Incorporated under Section 21);
- "the Complainant" means any Policy Holder who makes a complaint to the Ombudsman in respect of any insurance services provided by their Insurer;
- "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;
- "the Ombudsman" means the Ombudsman for Short-term Insurance appointed from time to time by the Board of the Ombudsman for Short-term Insurance (Association Incorporated under Section 21);
- "Ombudsman's office" means the office of the Ombudsman established to perform the functions set out in these terms of reference;
- "Policy" means a short term insurance Policy issued by an Insurer to a Policy Holder;
- "Policy Holder" means the person entitled to be provided with the Policy benefits under a Policy;
- "Insurer" means a short-term Insurer registered as such in terms of the Short-term Insurance Act of 1998;

THE OMBUDSMAN'S POWERS AND DUTIES

The Ombudsman shall:

- act within these terms of reference;
- receive complaints relating to the provision within the Republic of South Africa of insurance services by an Insurer to a Policy Holder;
- 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.
- 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 below provide details of steps taken in this regard.
- 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
- 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.
- 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.
- 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
- 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.
- 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.
- 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.

THE JURISDICTION OF THE OMBUDSMAN

- The Ombudsman shall only consider a complaint made to him if he is satisfied that:
- the complaint is not the subject of existing litigation;
- 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;
- the complaint does not involve a monetary claim in excess of R800 000, but the Insurer concerned may agree in writing to this limitation being exceeded. This R800 000 limit shall be subject to review on an annual basis;
- 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;
- 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 □;
- the Complainant has tried unsuccessfully to resolve the dispute through approaches to the Insurer's management or its internal complaints handling section;
- 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;
- the complaint has not become prescribed in terms of the Prescription Act, 1969 or any enforceable time bar provisions contained in the Policy.
- 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.
- With the written consent of an Insurer and at his discretion the Ombudsman may investigate a complaint which exceeds his jurisdiction.
- A Complainant may at any time terminate the Ombudsman's adjudication of the complaint and resort to litigation.

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 except:

- 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;
- 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

TIME BARRING PROVISIONS

- 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.
- 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.
- Save as may be otherwise provided 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.

RULINGS

- 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.
- Rulings shall be based on the law and equity.
- 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.
- Any Ruling made by the Ombudsman shall be binding on the Insurer concerned.

POLICY HOLDER/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 □ shall apply.

PRECEDENTS

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

CONFIDENTIALITY

- The Ombudsman shall as far as possible, maintain secrecy 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 secrecy shall not prevent the Ombudsman in his or her annual report from setting out the facts of any case though he or she shall refrain from mentioning names in his or her report.
- 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.
- 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.
- 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.
- 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.

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.