ANNUAL REPORT

2020

OMBUDSMAN
FOR LONG-TERM INSURANCE

ombudsman
for short-term
insurance

CONTENTS

APPENDICES

OTHER USEFUL INFORMATION ONLINE

- ● Rules www.ombud.co.za
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- ● Summary of income and expenditure www.osti.co.za/news-room/#financials

● **Ombudsman for Long-term Insurance**
● **Ombudsman for Short-term Insurance**
○ **Both offices**

unity

noun

noun: unity; noun: unity of time; noun: unity of place; noun: unity of action

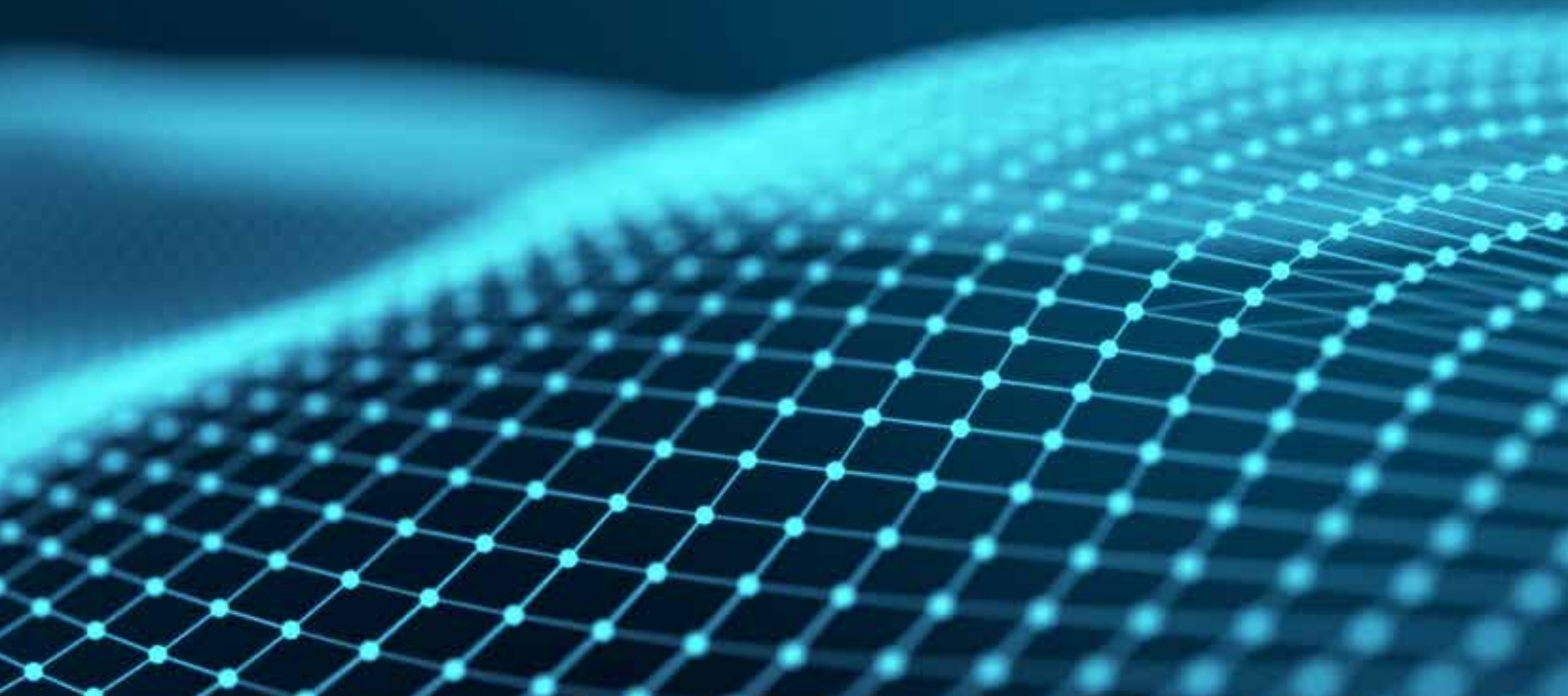
1. the state of being united or joined as a whole.

disruption

noun

noun: disruption; plural noun: disruptions; noun: digital disruption

1. disturbance or problems which interrupt an event, activity, or process.



KEY FIGURES

OMBUDSMAN
FOR LONG-TERM INSURANCE

Written requests for assistance received
- 14 198

Full cases finalised
- 3 624

Chargeable complaints received
- 6 756

Percentage of cases finalised within six months
- 90%

Cost per standard case
- R4 387

Compensation granted
- R817 970
(in 208 cases)

R177.9m

AMOUNT RECOVERED in lump sums

Total expenses for the year
- R30.761m

Transfers settled in favour of complainants
- 1 373

Percentage of cases resolved wholly/partially in favour of complainants
- 31.73%

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Complaints received
- 14 479

Formal complaints registered
- 11 095

Formal complaints closed
- 10 805

Average turnaround time in days
- 136 days

Calls received
- 72 880

Percentage of complaints finalised within six months
- 69%

R119m

RAND VALUE OF BENEFIT TO CONSUMERS

FOREWORD BY THE **CHAIRPERSON OF THE OMBUDSMAN'S COUNCIL**

The office's Annual Reports play an important role in recording its history, which includes the coming and going of people in the office and those who serve on its Council.

In history, 2020 will undoubtedly be remembered as the year when the worldwide catastrophic COVID-19 pandemic fully manifested itself. Much has been written about the wide-ranging disastrous effects of the disease on almost every aspect of human life. I am not going to add anything to that body of literature, but I will rather refer to the positive outcomes which the pandemic brought for the office, including the revelations about the people who make it up. What COVID-19 taught us about them forms an integral part of our history and I use this opportunity to record it.

The office did not simply cope with COVID-19, in the sense that it managed to carry on despite the pandemic. Under the most challenging circumstances, which impacted on all facets of life in the home, office and community environments, the office grew in its reputation and stature, and increased the volume and quality of the work which it performed.

The office's ability to better serve consumers and its subscribing members and to do more work in 2020 than it did in, for instance 2019, is the direct result of the dedicated efforts by the staff and the following attributes which they consistently displayed:

- Adaptability and organisational capabilities.
- Courage and tenacity in the face of adversity.
- Encouragement and support for one another.
- Emotional and mental well-being.
- Loyalty to the office.

The positive outcomes to which I referred also served to better prepare the office to overcome the continuing ravages of the pandemic which are anticipated for 2021.

On behalf of the Council I thank every staff member who made it possible for me to record this episode of the office's history.

Independent review

Every three to five years an Independent Review is commissioned to ensure that the office is performing in accordance with its mission. Mr Dennis Jooste, a former Ombudsman for Short-term Insurance, was tasked to carry out the review. His report will be available in 2021 and will then be published.

During the year we welcomed the following new members on the Council:

- Ms M L Phala CA (SA) is a member of the Audit and Risk Committee of the Ombudsman for Short-term Insurance and has experience in the short-term/non-life insurance industry.
- Mr A Woolfson previously served as a member of the Council's Audit and Risk Committee and in his capacity as former Chairperson of the Ombudsman's Committee he was an **ex officio** member of the Council.

I am pleased to say that Ms Phala and Mr Woolfson also serve on the Council's Audit and Risk Committee.

In terms of section 10(1)(b) of the Financial Services Ombud Schemes Act, 37 of 2004 ("the Act"), the Council is obliged to "monitor the performance and independence of the Ombud … the continued compliance by the scheme with its constitution, the provisions of the scheme and this Act".

In the performance of its corporate governance oversight function the Council met three times during 2020. At these digital meetings the Council received a comprehensive overview of the office's activities from the management team.

The Council is satisfied that in 2020 the office fulfilled its mission, complied with its obligations under the scheme's rules and under the Act, and maintained its independence, which is vital to its function.

I thank the members of the Council and the office's management team for their continued support and valued contributions during 2020. A special word of thanks goes to Judge Ron McLaren and Ms Jennifer Preiss for their leadership during these troublesome times and in the amalgamation with the Ombudsman for Short-term Insurance.

Leona Theron

MEMBERS OF THE COUNCIL

Justice Leona Theron (Chairperson)
Justice of the Constitutional Court

Adv Moses Moeletsi
Independent consultant;
Formerly Chairperson of the Board of the Ombudsman for Short-term Insurance

Mr Desmond Smith
Chairperson of Reinsurance Group of America (South Africa); Director of companies

Ms Mpho Lekala
Chief Operations Officer: Consumer Financial Education Foundation

Mr Alan Woolfson
Director of companies

Ms Lumka Phala
Head of Finance
Short-term Insurance
(Africa Regional Offices)
Absa Group Limited

Ms Thandiwe Zulu
Regional Manager of the Black Sash

Ms Jackie Huma *(ex officio)*
Head of Department: Micro and Access Product
Institutions Supervision
Financial Sector Conduct Authority

Mr Glenn Hickling *(ex officio)*
Head of Legal Department: BrightRock Life Limited
Chairperson of the Ombudsman's Committee

Judge Ron McLaren *(ex officio)*
Ombudsman

FOREWORD BY THE **CHAIRPERSON OF THE BOARD**

During the year under review, it became clear that the office's greatest asset is its staff. The board's COVID-19 Crisis Committee had numerous meetings with the staff, and we referred to the "three baskets", which are the closely interwoven objectives of ensuring the health and well-being of the staff, the operational functionality of the office and its financial stability.

During the pursuit of those objectives there was close and frequent personal interaction between the board and the staff, which is unprecedented in the office's history. OSTI's staff demonstrated strong resiliency in a difficult and challenging time for everyone, managing to perform at the high level expected as part of its service mandate. I was touched by the staff's fortitude in adversity and by their unwavering loyalty to the office. For me, the close and personal interaction with the staff during this difficult and trying time was an enriching experience, which was, unfortunately, marred by the passing away of the much-loved Ms Mary Tshabalala, who served the office for many years.

The reports by the Chief Executive Officer and the General Manager on, respectively, pages 14 to 17 and 38 to 39 of this Annual Report bear eloquent testimony of the resounding success which the office achieved in relation to the other two baskets. They were, by way of speaking, filled to overflowing.

The quick response of the COVID-19 Crisis Committee, and thoughtful actions of cash and expense management, has provided the foundation for OSTI to map its own *"next normal"*.

During 2020 the "soft" amalgamation of the office and the Ombudsman for Long-term Insurance continued to be implemented to their reciprocal benefit and for the good of consumers. The board also mandated the engagement by the office with the other three statutorily recognised financial ombudsman schemes in exploratory discussions about their amalgamation. More information about this and related matters appears on pages 8 and 9 of this Annual Report.

The board fulfilled its corporate oversight role and held four meetings during 2020. In addition, the board's Audit and Risk Committee met on the same number of occasions and its Executive Committee met twice during the year. In doing so, the board duly complied with section 10(1)(b) of the Financial Services Ombud Schemes Act, 37 of 2004 ("the Act"), which enjoins the board to "monitor the performance and independence of the Ombud … the continued compliance by the scheme with its constitution, the provisions of the scheme and this Act." On behalf of the board I confirm that during 2020 the office was fully compliant with the requirements spelt out in the Act.

It is my pleasure to thank the board members, the members of the COVID-19 Crisis Committee and, in particular, every member of the staff for their collective contribution to the positive tone of this Foreword.

I cannot end my report without speaking about the major effect that the COVID-19 pandemic has had on our lives. Many of us are facing challenges that can be stressful, overwhelming and cause strong emotions. Social distancing, a necessity to prevent the spread of COVID-19, can make us feel isolated and lonely – increasing stress and anxiety. In the South African context the prevalence of gender-based violence and substance abuse is high, and these are some of the major challenges that arise following isolation and reduced social contact. Poverty and lack of resources are also issues likely to result in people avoiding restrictions associated with the pandemic. To this end the COVID-19 Crisis Committee adopted several measures to enable staff to cope with stress, anxiety, grief and worry during the pandemic. I extend my thanks and appreciation for the participation, energy and contribution of every member of the COVID-19 Crisis Committee – Gail Walters, Edite Teixeira-Mckinon, Miriam Matabane, Gerhard Genis and Collin Molepe.

Having reviewed the main events of 2020, I am filled with optimism for the future, which I would like to share with you by expressing the belief that we will again fill the three baskets during 2021.

I end with this:

"When can we be free again?" asks Kedibone

"When the police arrest and imprison every germ in South Africa", says Mummy.

Haroon Laher

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BOARD OF DIRECTORS

Haroon Laher

Richard Steyn

Viviene Pearson

Makgompi Raphasha

Collin Molepe

Gail Walters

Gerhard Genis

Magauta Mphahlele

Paul Crankshaw

Leigh Bennie

Thuli Zungu

REPORT BY THE **OMBUDSMAN**

Our Annual Reports serve a number of important functions, including a recordal of the history of the offices. This purpose of the Annual Report stands out for 2020, which was the year of the "soft" amalgamation between the two offices and of the COVID-19 pandemic.

We refer to the "soft" amalgamation to indicate that there was not a complete merger of the offices into a single ombudsman scheme for the insurance industry. The principal reason why a unification of the offices did not take place is the absence of the regulatory mechanism to bring about such a merger. It is not necessary to explain this at any length. Suffice it to say that the Financial Services Ombudsman Schemes Council ceased to function some time ago.

Chapter 14 of the Financial Sector Regulation Act, 9 of 2017, finally came into operation on 1 November 2020. This chapter deals with the financial services ombudsman schemes, including the two offices. We are awaiting the outcome of the "Financial Ombud System Diagnostic" (the "Ombudsman's Diagnostic") which is a long-expected initiative of the National Treasury, funded by the World Bank Group. It started during the year when extensive questionnaires were submitted to the various Ombudsman offices. Two eminent international experts on ombudsman schemes were retained for the Ombudsman's Diagnostic by the World Bank Group. They are Mr D Thomas of the United Kingdom and Mr S Tregillis of Australia. Our offices had a cordial working relationship with the two experts and the representatives of the World Bank Group during the entire investigative process, which stretched over a period of many months and which required considerable effort and input from us. It is anticipated that the final report on the Ombudsman's Diagnostic will be released during 2021. It will be more appropriate to deal with the developments which follow the release of the relevant report in next year's Annual Report.

Now that Chapter 14 has come into operation, the offices have a period of up to 18 months to apply for recognition in terms of section 194 of Act 9 of 2017.

Towards the end of 2019 the two offices concluded a Shared Services Agreement ("the Agreement") of which clause 2 sets out its purpose:

"2.1 Following the promulgation of the Financial Sector Regulation Act, 2017 ('the FSR Act'), and the repeal of the Financial Services Ombud Schemes Act, 2004 ('the FSOS Act'), the OSTI and the OLTI wish to establish a joint industry ombudsman scheme, as contemplated in Chapter 14 of the FSR Act, to be known as the Office of the Insurance Ombudsman.

2.2 The Office of the Insurance Ombudsman, as a joint industry ombudsman scheme, is to be achieved by the establishment of a body corporate in the form of a new voluntary association under which the single Insurance Ombudsman will be appointed. The OLTI and the OSTI will, pending the coming into operation of Chapter 14 of the FSR Act, continue to operate as two separate entities under the umbrella of a single Insurance Ombudsman.

2.3 On the basis that the new voluntary association cannot be formally established until the commencement of Chapter 14 of the FSR Act, this Agreement is concluded in order to begin to provide the framework in terms of which the new voluntary association, to be established, will function.

2.4 The Parties record that acting in terms of this Agreement will provide a valuable opportunity for both the OLTI and the OSTI, as well as consumers and insurers, to learn from the shared services experience for the better implementation of the eventual new voluntary association to be established in terms of Chapter 14 of the FSR Act."

Clause 8 of the Agreement provides for the publication of this "Combined Annual Report".

During the year under review another related development took place, namely a project which was undertaken by the four voluntary financial services ombudsman schemes (the two offices, the Ombudsman for Banking Services and the Credit Ombud). The purpose of the project is to explore the possible amalgamation of these offices in a single ombudsman scheme. Extensive work has been done in connection with the project, which enjoys the support of the National Treasury and the Financial Sector Conduct Authority. At present our mandates are limited to participation in the exploratory discussions and our governing bodies are kept informed of all important developments on an ongoing basis. It is impossible to predict the future course of events, in which the Ombud Council could play a significant role.

In terms of the Agreement, I was appointed as the Ombudsman to both offices, with effect from 1 January 2020. On that date Ms E Teixeira-Mckinon became the Chief Executive Officer of the Ombudsman for Short-term Insurance.

This is an appropriate opportunity to record my sincere appreciation of and thanks for the following:

Adv D Wood SC, the previous Ombudsman for Short-term Insurance, for her sound advice about my new role and for facilitating a smooth handover of the reins at that office.

Ms J Preiss, the Deputy Ombudsman for Long-term Insurance, for the exemplary way in which she shouldered the additional workload and responsibilities at the office which resulted from my appointment.

Ms Teixeira-Mckinon for her invaluable support in my new position.

In consultation with them it was decided that the Deputy Ombudsman at each office will contribute to this publication, also by way of a Report which will concentrate on the operational aspects of the offices, and that I will deal herein with the regulation of the financial sector.

On 29 September 2020 the second draft of the Conduct of Financial Institutions ("COFI") Bill was published by the National Treasury for public comment, after it had received close to 800 pages of comments on the first draft published in December 2018. In its accompanying media statement the National Treasury said:

> *"The COFI Bill is a key pillar in government's Twin Peaks financial sector regulatory reform process that aims to entrench better financial customer outcomes in the South African financial sector. It is a financial institution-facing law that sets requirements for financial institutions to meet and outcomes to deliver.*
>
> *The Bill aims to significantly streamline the legal landscape for conduct regulation in the financial services sector, and to give legislative effect to the market conduct policy approach, including implementation of the Treating Customers Fairly (TCF) principles. These principles are currently not enforceable, and while customer outcomes may have somewhat improved, this has not been consistent across the sector. The COFI Bill will ensure that the TCF principles are legally binding and enforced on all financial institutions."*

During the year under review we experienced the devastating consequences of the COVID-19 pandemic on our society as a whole. This Annual Report pays tribute to the staff at the offices for the role which they played during the pandemic. Without their commitment, dedication and sheer guts we would not have survived the havoc caused by that disaster. I salute all of you in the words of A A Milne:

> *"You're braver than you believe, and stronger than you seem, and smarter than you think."*

Ron McLaren

REPORT BY THE **DEPUTY OMBUDSMAN**

2020 was a year filled with disruption, death, loss of all kind and illness. COVID-19 and the lockdown dominated our lives and work.

This reflected in our complaints and the work pressure we experienced. The graph on page 18 reflects the uneven inflow of complaints during the year. A similar trend was experienced by many ombudsman offices – with a slowdown in the initial lockdown period and an expected surge of complaints in the second half of the year. What was unexpected was the devastation of the second wave and its effect.

The challenges we faced were similar to those of other organisations:

- Adjusting to remote working and doing everything electronically during the hard lockdown.
- Dealing with grief and fear.
- Online communication fatigue and difficulties.
- Remaining positive and adjusting again when the second wave hit the country.

We opened our office with the necessary safety protocols and limited staff as soon as it was permitted. This allowed us to become fully operational and to receive walk-in complaints, couriered complaints and documents and, after a while, postal complaints when the postal service was functional.

Overview

We received 14 198 written requests for assistance in 2020 (compared to the 11 915 in 2019) which included 6 756 chargeable complaints. This is the highest number of written requests the office has ever received.

A total of 6 512 complaints were finalised. This included the 3 624 full cases that were finalised, of which 31.73% were resolved wholly or partially in favour of complainants, and the 2 888 Transfers finalised.

INFO

The International Network of Financial Ombudsman Schemes ("INFO Network") cancelled the annual conference which had been planned to take place in Kuala Lumpur in Malaysia during September 2020. This cancellation was due to the COVID-19 pandemic. In place of the conference there were webinars during the year which kept INFO Network members in touch with one another and which provided valuable insights and lessons from ombudsman offices all over the world as they dealt with the pandemic and lockdowns.

New subscribing members

Emerald Life (Pty) Limited
Merrit Insurance Limited

Outreach

In accordance with our obligation to raise public awareness of our existence and function we were involved in outreach initiatives. At the start of the year the emphasis was on making the public aware of the ''soft" amalgamation, the joint Insurance Ombudsman and the new Insurance Ombudsman portal for complaint submission. We also launched a joint social media presence as the Insurance Ombudsman and new posts with hints and information for consumers took place monthly.

We had to curtail some of our activities due to the lockdown, however we did release our 2019 Annual Report to subscribing insurers and the media on 6 May 2020 and the advertising value equivalent/AVE was R5.4 million in the following months.

Our main project in the second half of the year was to do outreach to advice offices. We sent our Annual Report, posters, brochures and fridge magnet handouts to advice offices.

A short video about the office was made and distributed to insurers together with an information brochure and this YouTube video was made available on our website www.ombud.co.za and will be sent to advice offices.

We also continued to interact with the media by way of articles and radio and television interviews to reach consumers.

The Cape Peninsula University of Technology

We continued the co-operation with this university which was first mentioned on page 6 of the 2019 Annual Report. In addition to the bursaries we provided, four final year para-legal students performed vacation work in the office. This developed into internships in 2021 for three of them. This is a mutually beneficial arrangement as the office benefits from their employment and the interns gain valuable work experience which should assist in their future careers.

Legal interns

Towards the end of 2020 we introduced a legal internship along the same lines as a programme that the Ombudsman for Short-term Insurance introduced in 2018. In co-operation with the Cape Bar we recruited applicants aspiring to become advocates, for legal internship positions in the office. They will acquire work experience which should enhance their applications for admission to the Bar. Two applicants were appointed to commence service in February 2021.

Tribute to staff

In line with the historically low staff turnover in our office, there were no staff departures in 2020.

In a very difficult year our staff adapted and performed above and beyond their duty. They did us proud and worked very hard under unfamiliar conditions with an unusually large workload. We were fortunate that despite some members of staff contracting the COVID-19 virus, there were no fatalities. Unfortunately, some staff members lost family and friends and had to deal not only with the grief but also with the fact that mourning could not take place in the usual way.

Denise Gabriels was appointed as Deputy Ombudsman Successor towards the end of the year and will take over that role after my retirement in 2021. We congratulate Denise on a well-deserved achievement.

Jennifer Preiss

OMBUDSMAN
FOR LONG-TERM INSURANCE

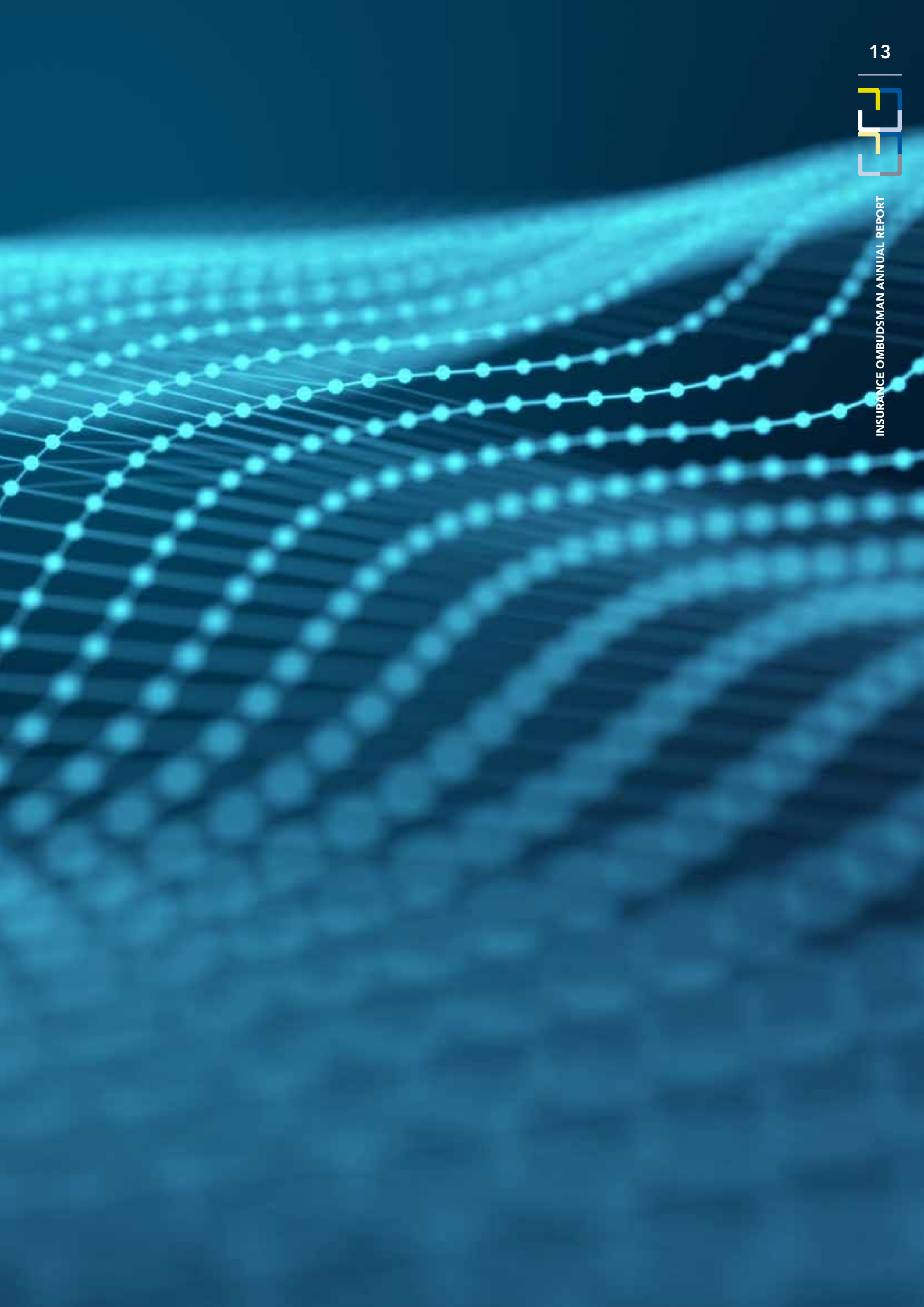
THE INDEPENDENT **EXTERNAL ASSESSOR**

During 2014 Judge R Cleaver was appointed in the above position to receive and to consider service complaints against the office by complainants and insurers. A service complaint is about the practical handling of a complaint by the office and it does not relate to the outcome of a complaint. A special procedure is provided for dealing with such service-related complaints.

Further information can be obtained on our website, www.ombud.co.za.

During 2020 Judge Cleaver dismissed all four complaints to him about the office and, in the concluding paragraphs of his rulings, he said the following:

- "In my view the complaint was dealt with in a perfectly reasonable and competent manner. The assessor dealing with the complaint merely sought information from the complainant as to whether she had any record of payments made during a stated period. It was the abusive and unreasonable tone of her reply that put an end to any further consideration of the complaint. In the circumstances the complaint to me cannot be sustained."
- "In my view the complaints were dealt with in a reasonable manner and in the result cannot be sustained."
- "In the circumstances it is not necessary to go through the complainant's grounds of appeal or re-assess her case, for all I am permitted to do is to establish, by reference to all the correspondence whether the office provided the complainant with a reasonable service in dealing with her complaint against the insurer. I am quite satisfied that the complainant was offered a reasonable service. Her complaint was fully and adequately put to the insurer and the latter's response was properly conveyed to her before the rulings were made by the Ombudsman. Accordingly her complaint to me cannot be sustained."
- "I am quite satisfied that the complainant was offered a reasonable service. His complaint was fully and adequately put to the insurer and the latter's response was properly conveyed to him before the rulings were made by the Ombudsman. In fact, the Office went so far as to facilitate the offer of settlement from the insurer which was accepted by the complainant. Accordingly his complaint to me cannot be sustained."



REPORT BY THE **CHIEF EXECUTIVE OFFICER**

As I start writing this report, it is almost one year, to the day, that the State President declared a national state of disaster in response to the coronavirus (COVID-19) pandemic in South Africa. In last year's Annual Report, I canvassed OSTI's response to COVID-19 and the accompanying lockdown.

It is also almost one year ago that our entire staff complement was forced into working from home. Despite the changes in the regulation levels of the national disaster, OSTI's Board of Directors and management have taken a considered decision to keep the office closed and operating online from home.

A COVID-19 Compliance Officer was internally appointed who, together with the Disaster Recovery Team, has been working on a plan to reopen the office, even if only on a partial basis. We continue to carefully monitor how COVID-19 evolves and the vaccine programme rolls out. We do not anticipate that there will be a rapid return to pre-pandemic norms any time soon, as many of the trends and routines that we have adopted over the last year will remain relevant, and several preoccupations and needs developed during the pandemic will persist long after aspects of pre-COVID-19 life resume.

The Board's COVID-19 Crisis Committee's and management's focus continued to be on ensuring the health and well-being of OSTI's staff, protecting OSTI's finances by preserving OSTI's cash reserves and liquidity, whilst maintaining OSTI's operational well-being by ensuring that productivity remained at acceptable levels.

There was an immediate recognition that leadership needed, more than ever, to support staff for staff, in turn, to support the business strategy. When the national state of disaster was declared, the primary focus was on addressing the COVID-19-related human need for information, including information on COVID-19 symptoms and prevention, and providing access to assistance and resources. When staff are supported, the business strategy is supported. Within OSTI, we saw clear evidence of cohesion, togetherness and empathy in response to the COVID-19 challenge and our operational performance during 2020 is testament to this.

OSTI's response to COVID-19 and the lockdown was communicated to all its stakeholders in March.

In 2020, OSTI registered 11 095 new complaints, 7% more than in 2019, and closed 10 805 complaints, 17.9% more than in 2019.

Of all the complaints registered in 2020, 786 complaints related to COVID-19, with 562 relating to business interruption insurance and 224 relating to travel insurance. COVID-19-related complaints comprised 7% of all the complaints registered in 2020. The highest number of COVID-19 complaints were registered during June, July and August. A new sub-category of complaints was added to our case management system to ensure total visibility of these complaints and a dedicated team of assistant ombudsmen was appointed to handle them in a timeous and consistent manner.

We started the year with an average turnaround time of 141 days and by the end of the year the turnaround time decreased to 136 days. The 6 Month List, which

is a list of complaints outstanding for six months and longer, decreased from 739 in January to 575 at the end of December.

OSTI recorded a monetary benefit and value to consumers in the amount of R119 548 901.55. The benefit/value to consumers who approached our office increased by approximately R22 million from 2019 to 2020. In addition to the new COVID-19 sub-category of complaints, a new closure reason was created to capture those amounts in which commercial offers, in line with the Financial Sector Conduct Authority's ("FSCA") and the industry's interim relief arrangement, were made by insurers and accepted by complainants. The total of these offers amounted to R5 490 182.16.

Despite going into a hard lockdown at the end of March, experiencing connectivity issues, overloaded networks, load-shedding, staff acclimatising to the lockdown and working from home, and everyone dealing with a worldwide existential crisis, as well as undergoing a change to the telephony platform, OSTI scored an overall customer experience rating of 76% out of a target of 80%. This rating increased by 1% from 2019.

As part of the "soft" amalgamation with the office of the Long-term Insurance Ombudsman ("OLTI"), a single website called The Insurance Ombudsman Portal was launched and went live on 4 February 2020. Engagement with the industry on the "soft" amalgamation took place during 2019 and engagement with OSTI's other stakeholders took place through a dedicated public relations campaign that ran from the end of 2019 to April 2020. This portal provides complainants with a single port of entry for all insurance complaints and enables the seamless transfer of telephone calls between the two offices. As at the end of the year, OSTI transferred 700 telephone calls to OLTI and received 974 telephone calls from OLTI and 514 e-mails from the portal.

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MISSION STATEMENT

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

ABOUT US

We resolve disputes between consumers and short-term insurers:

- **in a co-operative, efficient and fair manner;**
- **with minimum formality and technicality;**
- **as transparently as possible, taking into account our obligations for confidentiality and privacy.**

This involves understanding all aspects of a dispute without taking sides and making decisions based on the specific facts and circumstances of each dispute.

Land Bank Insurance Company (SOC) Limited became a member of OSTI and was its only new member in 2020.

The International Network of Financial Services Ombudsman Schemes ("INFO Network") conference, scheduled to take place in Kuala Lumpur in Malaysia at the end of September, was postponed but its Annual General Meeting was held online. The office also participated in surveys conducted by and webinars hosted by the INFO Network throughout the year.

OSTI's Internship Programme, started a few years ago, continued in 2020 with two new legal interns and one new administrative intern joining the programme and with three legal interns and three administrative interns proceeding to their second year of internship.

During the year, several engagements took place with the National Treasury, FSCA and South African Insurance Association, more especially around the industry's and OSTI's response to the COVID-19-related claims and complaints. A consumer workshop was hosted by OSTI in September and an industry workshop was hosted in December; both were hosted online.

Engaging with OSTI's external stakeholders meant being open to explore solutions to new challenges and being flexible to changing the way things have been done in the past and to accommodate new realities.

OSTI's community outreach during the pandemic in 2020 took the form of supporting new orphanages. In May we donated personal protective equipment and other essential items such as toiletries, stationery and non-perishable food to Kids Haven, a registered child and youth care centre. Thereafter, in July, we reached out to Door of Hope, a place of safety for abandoned babies, and donated personal protective equipment and necessities such as nappies, baby formula, baby puree and sterilising liquid. OSTI, in November, donated personal protective equipment and necessities to Abraham Kriel Bambanani, an organisation that provides residential and community care around Gauteng, with its main priority being to shelter, care for and rehabilitate children who have been subjected to trauma. Lastly, in December, we donated a tumble dryer, nappies and wet wipes to Princess Alice Adoption Home, a place of safety for babies who have been abandoned, consented for adoption, or orphaned.

The disruption to millions of people's lives and the economic damage caused by the COVID-19 outbreak has led to an increased sense of unity for all who work at OSTI. The enormous, and sometimes violent, interruption caused to people's lives by the pandemic has brought about an unprecedented togetherness at OSTI.

The senior leadership team at OSTI has taken more time and an active interest in the personal lives of staff. By taking a more personal approach and expressing empathy and compassion, genuine relationship building has taken place. This is not only good for everyone at OSTI but also good for OSTI.

Through the disruption we have built a sense of belonging in that people feel connected through their shared experiences and challenges, which leads to people being more engaged and motivated and which makes them feel emotionally and personally invested in OSTI.

We continue to lead and support everyone at OSTI through their personal experiences of isolation, uncertainty, anxiety and recovery from what has been

a traumatic, painful and stressful time. Going forward, there is a realisation that challenges in people's lives will not recede when the crisis does. There will be many ongoing challenges facing the workforce, such as mental health struggles and burnout, to name a few.

A flexible work schedule is key in an always-connected world and this can only happen if one trusts that staff will get their work done in a way that will not lead to burnout. Load-shedding and connectivity issues require flexible working arrangements. We all continue to learn how to communicate, collaborate and co-ordinate on virtual platforms.

When we realise that we are not going back to the way things used to be, we can open ourselves to new opportunities to modify our company culture and the work lives of staff for the better. Our office can be reimagined to accommodate a more hybrid workstyle tailored around in-person collaboration and engagement. The compartmentalisation of work and family is, to a large extent, a thing of the past.

For the first time this year, one of our senior assistant ombudsmen and one of our assistant ombudsmen successfully worked, for some time during the year, from outside of South Africa.

The role of a leader is not only to drive results and productivity but also to keep the company culture alive and serve as a lifeline to staff as they continue to navigate the many challenges of remote working.

As leaders we need to create an environment of both mental and physical safety, and trust. Trust is hard to win and easily lost. Having the humility to admit that, in dealing with a crisis such as the one inflicted by COVID-19, we, as leaders, do not have all the answers, goes some way to building this trust.

On 16 November we suffered the tragic loss of one of our staff members, Mary Tshabalala. Mary had been with OSTI since February 2004 and had occupied various roles within OSTI. Mary's passing was a shock to the entire OSTI team and was a harsh reminder of how fragile life is. Our deepest condolences go to Mary's family, friends and her work colleagues. May you rest in peace, Mary.

On behalf of everyone at OSTI, I express a word of deep appreciation to OSTI's Board of Directors and all the Board's subcommittees, including the Executive Committee, Audit and Risk Committee and COVID-19 Crisis Committee, for their advice, guidance and support.

I thank Miriam Matabane, our General Manager, for her unwavering support during an exceptionally challenging year. I thank the senior leadership team, and all who occupy managerial roles, for many robust discussions and for making possible all that needed to happen in the year to ensure that OSTI achieved its strategic goals.

The overall improvement in OSTI's operational performance in 2020 is testament to a committed, engaged, productive, positive and loyal workforce. I thank each staff member for their dedication, passion and hard work during a very difficult year.

Last, but certainly not least, I thank all of OSTI's stakeholders, including the non-life insurance industry and its customers, who, in turn, become OSTI's customers, for your ongoing support.

Edite Teixeira-Mckinon

STATISTICS

OMBUDSMAN FOR LONG-TERM INSURANCE

Requests for assistance received

We received 14 198 requests for assistance in 2020, which was an increase of 2 283 or 19% over the 11 915 received in 2019. Our jurisdictional assessment team had to work hard to keep up with this inflow.

6 756 were chargeable complaints which we accepted for further consideration – this was an increase of 10% over the 6 107 of 2019.

Transfers increased to 4 782 from the 4 051 in 2019. Insurers managed to settle 1 373 of these directly with complainants. This amounted to 28.7% which is consistent with 28.06% in 2019 and 28.6% in 2018.

Reviews increased to 1 342 from 1 293 in 2019.

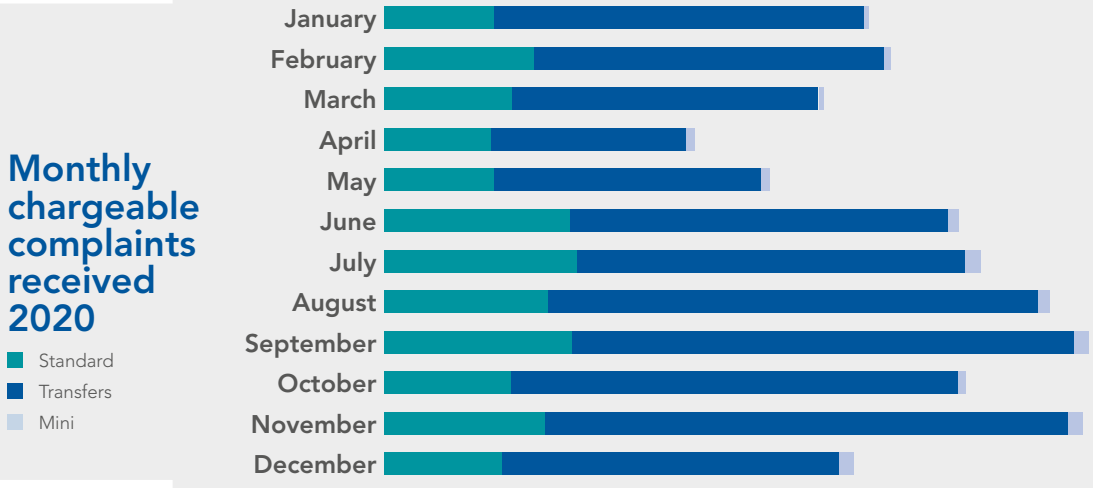
Description of chargeable complaints

MINI CASES – consist of simple complaints that are within the jurisdiction of the office, but which insurers can handle without the office's involvement. The complainant is always advised that if the matter is not resolved he/she can revert to us. There are also some complaints which have no prospect of success. The assessing staff dismiss these complaints and explain the reasons for the dismissal to the complainants. In these complaints the insurers are charged the reduced mini case fee.

TRANSFERS – these are complaints not previously seen by insurers and referred to them to try and resolve directly with the complainant. If not resolved and if the complainant, when contacted by the office, requests us to do so, they are taken up by the office as Reviews and handled in the same manner as Full Cases.

FULL CASES – these are complaints that have already been seen by insurers and they are handled by the office from inception to finalisation.

Monthly chargeable complaints received 2020



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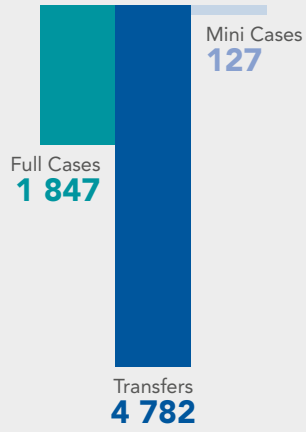

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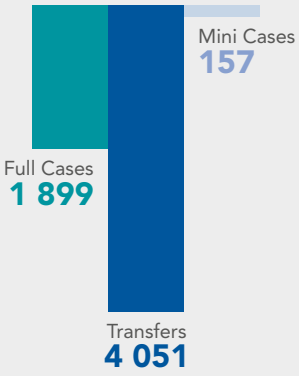
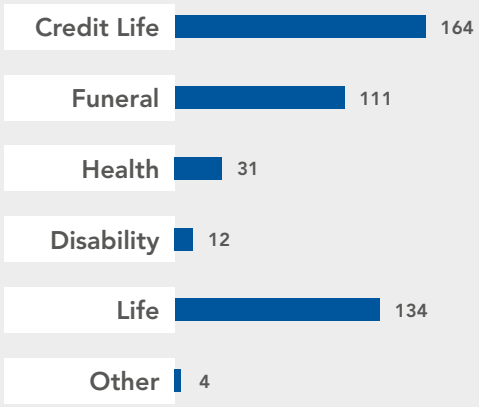


COVID-19 complaints: types of benefits

There were 456 complaints that were directly related to COVID-19 or to the lockdown. The majority of these (36%) were in respect of credit life benefits, which is a very different picture from our overall complaints where credit life benefits make up only 9% of cases. Claims for retrenchment and inability to earn an income caused the highest number of complaints, which is perhaps not surprising as the economy suffered, and these are also the more contentious claims – see page 24 of this Annual Report.



STATISTICS
> CONTINUED

OMBUDSMAN
FOR LONG-TERM INSURANCE

CASES FINALISED – cases finalised incorporate Full Cases as well as Reviews. These are the cases that the office considered and resolved during the year. In 2020 this amounted to 3 624, which is 66 more than the 3 558 in 2019. In total, including Transfers closed, 6 512 complaints were finalised in 2020.

CASE FEES – the office is funded by way of a levy, which amounts to 10% of our funding, and the rest is by way of case fees which are charged for cases handled by the office, irrespective of the outcome thereof. The benchmark Standard Case fee was R4 387.

As a result of an error detected when invoicing insurers for 2020/2021, the case fee for 2018 and 2019 had to be adjusted retrospectively. The 2018 adjusted standard case fee is R3 868 and the 2019 fee, R4 390. This error did not affect the financial accounts for the two years.

Finalised cases are categorised as follows for charging purposes:

STANDARD CASES – this term refers to the benchmark category of cases.

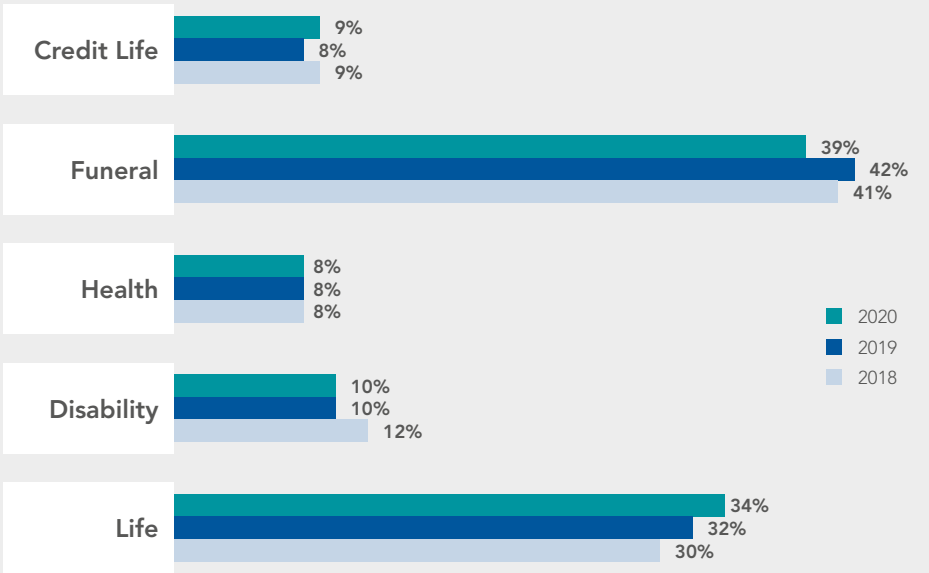
INCOMPETENT CASES – these are cases in which the insurer gave a late or an inadequate response. These cases are charged at either double or triple the Standard Case fee, depending on the extent of the incompetence.

COMPLICATED CASES AND COMPLICATED PLUS CASES – these cases are difficult to deal with because of complex legal, medical or financial issues or as a result of the complainant's persistence.

BASIC CASES – these are cases involving complaints about funeral policies issued by small insurers in which the complaint is resolved on the first response from the insurer. A reduced fee is charged for these cases.

Types of benefits

The benefit types were very similar to previous years, with only funeral benefits reducing slightly by 3% but still remaining as the highest category of finalised cases.



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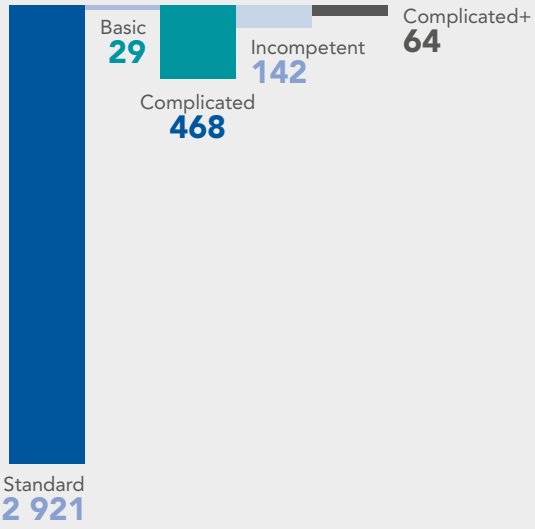

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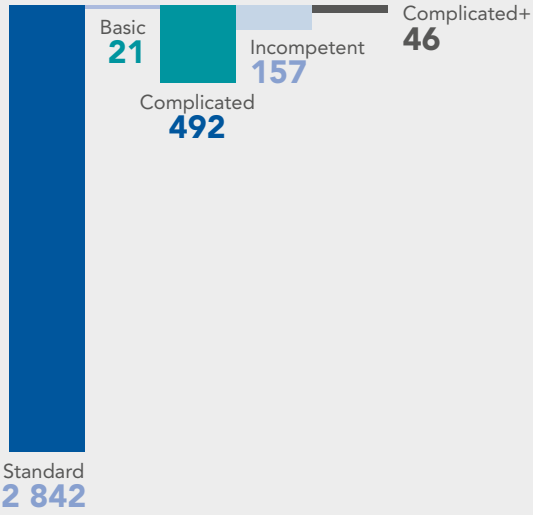


Finalisation period

It is gratifying that the percentage of complaints finalised within six months was 90%. This was despite the effect of the COVID-19 pandemic and lockdowns and the fact that some insurers were tardy in their responses as can be seen from the number of second reminders on page 34 of this Annual Report.

0 – 30 days	**38.40%**
31 – 60 days	**19.00%**
61 – 90 days	**12.20%**
91 – 180 days	**20.00%**
181 – 365 days	**9.00%**
Over 365 days	**1.40%**

STATISTICAL SUMMARY OF **FULL CASES FINALISED**

OMBUDSMAN FOR LONG-TERM INSURANCE

NATURE OF COMPLAINT	LIFE				DISABILITY			
	2019	W/P*	2020	W/P*	2019	W/P*	2020	W/P*
Poor communications/documents or information not supplied/poor service	504	37%	**527**	**31%**	37	35%	**46**	**35%**
Claims declined (policy terms or conditions not recognised or met)	437	27%	**502**	**28%**	273	37%	**333**	**35%**
Claims declined (non-disclosure)	101	24%	**88**	**22%**	54	19%	**39**	**28%**
Dissatisfaction with policy performance and maturity values	122	11%	**112**	**13%**	0	0%	**1**	**0%**
Dissatisfaction with surrender or paid-up values	59	10%	**55**	**13%**	0	0%	**0**	**0%**
Misselling	17	24%	**10**	**10%**	1	0%	**1**	**100%**
Lapsing	79	33%	**78**	**23%**	1	0%	**1**	**0%**
Miscellaneous	100	35%	**104**	**25%**	7	14%	**7**	**57%**
Total	**1 419**	**28.3%**	**1 476**	**26.3%**	**373**	**33.2%**	**428**	**34.3%**

* Resolved wholly or partially in favour of the complainant.

Nature of complaint

There were no material changes in the numbers or percentages of finalised cases in the different categories. Declined claims are still the biggest cause of complaints, with a slightly higher percentage of the total complaints than in 2019. The other categories are remarkably consistent with those of previous years.

The Treating Customers Fairly outcome categories as contained in the Policyholder Protection Rules ("PPR"), appear in the block alongside. There has also been very little change from 2019 in this categorisation.

PPR complaints categorisation

	%
Design of policy or related service	**6%**
Information provided to policyholders	**11.3%**
Advice	**0.4%**
Policy performance	**4.1%**
Service to policyholders	**12.9%**
Policy accessibility, changes and switches	**2.8%**
Complaints handling	**0.6%**
Insurance risk claims	**60.4%**
Other complaints	**1.5%**
Total	**100%**

HEALTH				FUNERAL				TOTALS				% OF TOTAL	
2019	W/P*	2020	W/P*	2019	W/P*	2020	W/P*	2019	W/P*	2020	W/P*	2019	2020
51	27%	31	32%	509	54%	460	49%	1 101	44%	1 064	39%	30.94%	29.36%
198	21%	226	29%	767	36%	753	31%	1 675	32%	1 814	30%	47.08%	50.05%
27	19%	29	14%	12	33%	5	40%	194	22%	161	22%	5.45%	4.44%
0	0%	0	0%	1	0%	1	0%	123	11%	114	12%	3.46%	3.15%
1	100%	0	0%	2	0%	0	0%	62	11%	55	13%	1.74%	1.52%
0	0%	0	0%	1	100%	6	67%	19	26%	17	35%	0.53%	0.47%
2	50%	4	25%	139	38%	163	35%	221	36%	246	31%	6.21%	6.79%
5	40%	6	67%	51	27%	36	39%	163	25%	153	30%	4.59%	4.22%
284	**22.5%**	**296**	**28.4%**	**1 482**	**42%**	**1 424**	**37%**	**3 558**	**34.0%**	**3 624**	**31.73%**	**100%**	**100%**

Resolved wholly or partially ("W/P") in favour of complainants

The percentage of cases resolved in favour of complainants decreased from 34.12% in 2019 to 31.73% in 2020. If we add the Transfers settled in favour of complainants, then the W/P percentage increases to 39%.

R177.9 million was recovered for complainants in the form of lump sums. This figure does not reflect the value of all benefits awarded in favour of complainants, such as recurring income or instalment benefits, annuities, the reinstatement of policies, etc.

The amount of compensation awarded to complainants in terms of Rule 3.2.5 amounted to R817 970 in 208 cases as compared to the R874 286 in 190 cases in 2019.

MATTERS OF INTEREST

Trends
COVID-19-related complaints

Credit life complaints

Given the impact of COVID-19 and the lockdown on employment and the economy, it is not surprising that there was an increase in complaints about retrenchment and loss of income benefits. These are events that are mostly covered by credit life policies – see page 19 of this Annual Report. We have been and are dealing with some new and difficult issues generated by claims being declined and the resulting complaints. One such issue is whether an insurer is obliged to pay a claim for benefits related to an inability to earn an income when an insured receives Temporary Employee/Employer Relief Scheme/ TERS payments. The office has not finally determined on this aspect. The following is an example of the relevant policy condition.

> *"Unable to Earn an Income" is defined as: Unable or Inability to Earn an Income means you are incapable of earning an income from any occupation, work, job or business for any reason other than Disability.*

Non-payment of premiums and lapsing

Many policyholders could not afford to pay premiums either as a result of loss of employment or income and this led to lapsed policies*. Although some insurers provided premium relief of one kind or another, this was not universal, and the relief packages were not all equally generous. It is unfortunate when a risk policy lapses but even more so during a pandemic when cover is so crucial.

* *Association for Savings and Investment South Africa ("ASISA") indicated in a press release that 10.2 million long-term insurance risk policies lapsed in 2020.*

Service-related complaints

Insurers, some more so than others, struggled with service delivery during remote working conditions. Consumers, and even this office, often had difficulty in contacting and communicating with insurers. This led to complaints, particularly when claimants were desperate to have claims paid, e.g. under funeral policies. The delays that were caused not only by insurers but also by some of our complainants, who had challenges with communication during the lockdowns, impacted on our turnaround times.

52% of COVID-19-related complaints were about declined claims.

OMBUDSMAN
FOR LONG-TERM INSURANCE

Other trends

Premium reviews on Universal Life policies

We have written about the problem with Universal Life policies in several previous Annual Reports. In the 2019 Annual Report on page 25 we mentioned the problem of premium reviews which led to complaints. This trend has continued and complaints are increasing as more reviews take place.

We issued a newsletter, Ombuzz No. 44, dealing with the problem. The topic was highlighted by the media and by two actuaries in a paper delivered at the Actuarial Society conference in 2020. We again raised the problem with the Financial Sector Conduct Authority and ASISA and this time also with the National Treasury. As a result further investigations into this issue will carry on. It is particularly problematic when elderly policyholders who are on pension are faced with high premium increases of up to a 100% or more. The policyholders have paid premiums for many years, sometimes amounting to even more than the sum insured. The reviews leave the policyholders with the difficult option of high premium increases or substantial reductions in cover. It is not a matter which can easily be resolved on an individual complaint basis, it requires an industry-wide solution if there is to be recourse for policyholders.

Accidental cover

We are receiving an increasing number of complaints where policyholders or beneficiaries were not aware or did not understand that the policy that was bought offered restricted cover, in that it only provided accidental cover. These policies are generally sold by means of direct marketing, without advice. Consumers buying life policies assume that they will be covered, whether the insured event is as a result of accidental or natural causes. If the sales process is not conducted in such a way that it is explained in easy-to-understand terms that the policy only provides accidental cover, and what that means, it can lead to disappointed expectations at claim stage.

There are also policies where the cover starts out for accidental and natural causes, but then reduces to only accidental cover because the life insured does not comply with the insurer's medical protocol or criteria.

We have posted on social media to caution policyholders to make sure what cover is provided by reading their policies.

In one complaint about a declined claim the beneficiary argued that death due to the COVID-19 virus is accidental. In the policy, accident was defined as:

> *"an uncertain future event which is caused solely and directly by violent, accidental, physical and visible means and independently of any other cause".*

She argued that the virus was not expected, so it was uncertain; contracting it was accidental; and the death it caused was violent because the deceased was unable to breathe.

We pointed out the following:

''Every element of the definition must be satisfied.

You are correct that the COVID-19 virus was unexpected and it causes a terrible death when somebody dies of not being able to breathe. We accept that contracting the virus was unexpected and we accept that your late husband did not intentionally contract the virus. These are two of the elements of an accident but not the only two.

*I point out that it is the **contracting of the virus**, i.e. the cause of death, which must also be violent and accidental and external and physical and visible. The effect of the COVID-19 virus on the patient's body is not the determining factor.*

To use an obvious example, a car crash is an accidental event because the event itself is uncertain, violent, accidental, external, physical and visible, not only the damage caused to a person's body or the death caused by the accident.

I also could not find any South African or English case law which supports the view that death as a result of contracting a disease (such as the COVID-19 virus) is an accident for insurance purposes. The legal text books that I consulted also do not provide support for such a position. The conclusion I draw from these text books is that contracting a disease is generally not regarded to be an accident."

Applications for leave to appeal

There is no automatic right of appeal against a final determination, but any party to a complaint may apply to the Ombudsman for leave to appeal in terms of Rule 6. During 2020 there were 29 applications for leave to appeal by complainants. Rule 6.3 provides as follows:

"Such leave to appeal shall be granted:

6.3.1 if the determination is against a subscribing member and involves an amount in excess of R250 000 or such other sum as the Council may from time to time determine; or

6.3.2 if the Ombudsman is of the opinion that the determination as such or the particular issue in dispute is of considerable public or industry interest; or

6.3.3 if the Ombudsman is of the opinion that the aggrieved complainant or subscribing member has a reasonable prospect of success in an appeal before a designated Appeal Tribunal."

No application fell within the ambit of Rule 6.3.2 and 27 were dismissed for failure to satisfy the requirement in Rule 6.3.3 of a reasonable prospect of success in the proposed appeal. One application was granted and thereafter the insurer paid the claim. The other application was granted, but leave to appeal was subsequently withdrawn for the reasons set out as follows in a letter to the complainant:

"It is clear that, since I granted leave to appeal to you on 27 August 2020, information was supplied which indicates that paragraph 18 of my letter, dated 27 August 2020, is incorrect and that the deceased received medical treatment in the 12 months before the policy started. This information means that there is no reasonable prospect of success in an appeal against the final determination.

In terms of our Rule 1.2.2 I must follow 'informal, fair and cost-effective procedures'. I am satisfied that the prosecution of an appeal against the final determination, dated 17 August 2020, will be a wasteful exercise in futility which will offend against Rule 1.2.2."

Case Report 44

Income disability benefits – frequency of medical reviews

The complainant received income disability benefits and complained to the office about the frequency with which Sanlam Life Insurance Limited ("the insurer" or "Sanlam") required medical reports from her, which she found distressing.

The insurer relied on the following policy provision to justify its requests for medical reports:

> *"After we have started making the income payments, we may from time to time ask for proof that the life insured is still disabled, and still has a loss of income. We may require the life insured to be medically examined for this purpose. We will cover the cost of such a medical reassessment only after the life insured has been disabled for at least one month."*

The matter was discussed at a meeting of the adjudicators in the office and the meeting agreed with the view expressed in a provisional ruling that the insurer is "entitled to obtain, at the very least, one report from each of Ms D's treating specialists annually". The finding of the meeting was expressed as follows:

> *"Having taken all the factors presented to us, the meeting was of the view that an annual review is reasonable. More frequent reports would not be reasonable in Ms D's circumstances."*

The insurer challenged this finding and referred extensively to the available medical reports before summing up its submissions as follows in support of a six-monthly review of the complainant's claim:

> *"We accept and acknowledge her burden of disease that she is currently unable to work hence we accept the validity of the income protector benefit claim for the next 6 months, following her last specialist's report.*
>
> *We require follow-up reports as part of her routine medical management as outlined by her treating team. And by requesting these reports, we must respectfully point out that this is already part of her routine medical management so it isn't unnecessary hardship, or unreasonable requirements on our part.*
>
> *There is still the principle of review and verifying optimal treatment, MMI and the prognosis."*

In the final determination the following was said in response to the insurer's submissions, including its reference to "maximum medical improvement (MMI)":

> *"The policy does not have a requirement for either MMI, as we have stated above, nor for optimal treatment, which is mentioned by Sanlam. In any event, this office has explained on previous occasions that it will not support a requirement of optimal treatment. The requirement is for reasonable treatment."*

The final determination reviewed the relevant reports which reflect the various medical conditions from which the complainant suffered, including the following prognosis:

> *"It is important to note that the neuropathy is a progressive and ongoing condition for which there is currently no cure."*

The concluding paragraphs of the final determination read as follows:

> *"Given the range of treatments Ms D has tried and the fact that she cannot recover from this condition, the probability that she would be able to return to work within a 6-month period is remote. In addition to the neuropathy, she suffers from bipolar disorder with major depression which is impacted by the painfulness of her neuropathy.*
>
> *In the latest report by Dr W she confirms this. The assessment of the complainant's impairment shows a marked (significant) impact on all areas of functioning….*
>
> *The recommendation for an assessment by an Occupational Therapist is noted, however, in our view it is not indicated in the present circumstances in the light of the evidence in the rest of the report and the complainant's other medical conditions. As Dr W points out, the prognosis is guarded in the short term and long term.*
>
> *The change in medication, e.g. eliminating the two pain controlling medications by Dr T, is unlikely to enhance the complainant's ability to return to work in the short term.*
>
> *The final determination is that Sanlam can request medical reports on an annual basis, but not more frequently than that. Requesting more frequent medical reports has an impact on the complainant's mental state and is likely to impede her recovery rather than improve her situation. If the medical evidence at the annual assessment indicates that there is an improvement in the complainant's pain control and mental condition, the frequency of requests for medical evidence can be reconsidered."*

Case Report 45

Compensation for poor service

In the complaint against Liberty Group Limited ("the insurer" or "Liberty") the office applied Rule 3.2.5, in terms of which we may, regardless of whether a complaint is otherwise upheld or dismissed, award compensation for "poor service". Such an award may be made up to an amount not exceeding R50 000.00 "for material inconvenience or distress or for financial loss suffered by a complainant as a result of error, omission or maladministration (including manifestly unacceptable or incompetent service) on the part of the subscribing member".

After the complaint about poor service had been considered by an ad hoc Compensation Committee, the following provisional ruling was made on 18 March 2020 in relation to the insurer's offer of R2 500.00 compensation:

"Ms W declined the compensation.

The R2 500 compensation is in our view far short of what should be paid in this matter. At a time when Ms W was stressed and ill Liberty's poor handling of her claim and complaint added to her distress. The often nonsensical and contradictory answers that Liberty gave to questions and requests added to Ms W's frustration. Right from the start, when Liberty refused to give her the OT report, Liberty has been unhelpful in the handling of her claim and the complaint.

The meeting was of the view that compensation of R15 000 should be paid to Ms W."

The insurer responded as follows to the provisional ruling:

"We acknowledge that the claim and complaint for Ms W was poorly handled. This was an oversight on our part, therefore, we sincerely apologise for the inconvenience caused.

We advise your office that we cannot adhere to your office's request to pay Ms W the amount of R15 000 as compensation. However, we are willing to pay Ms W an amount of R10 000 as compensation. We have attached the offer letter to be signed by Ms W, and we will proceed with payment once we receive the signed letter."

The complainant furnished extensive personal reasons for rejecting the insurer's increased offer of compensation.

Following the consideration of the matter at a meeting of the adjudicators in the office, a final determination was made in the following terms:

"6.1 When the matter was discussed at the adjudicator meeting the following points arose:

- *The provisional determination set out the sequence of events and reasons taken into account in arriving at a decision that R15 000 compensation was due. In response, Liberty offered no reason why it stated '… we cannot adhere to your office's request to pay Ms W the amount of R15 000 as compensation.' Without any reasoning as to why R15 000 was inappropriate or why Liberty could not adhere to the payment the meeting was accordingly not placed in a position to consider Liberty's stance. Liberty had also not responded to Ms W's further submissions as to why she could not accept their offer. The lack of reasons by Liberty for its non-adherence to the provisional determination is further evidence of the perfunctory handling of this complaint.*

- *The adjudicator meeting then went on to consider whether it was of the view that the R15 000 award was inappropriate. No grounds were found for altering the provisional determination. We have in the past explained the reason for Rule 3.2.5 which deals with compensation and how the office applies the rule. There is no formula for determining the amount of compensation but it is also not simply an arbitrary exercise to decide on an amount. The award is affected by many factors, including the extent of the poor handling of the claim and complaint, the extent of the inconvenience and distress caused, the extended period over which this occurred, and, that this occurred at a time when Liberty was aware of the fact that Ms W was ill and under stress.*

6.2 The inevitable conclusion is that Liberty was not complying with the Treating Customers Fairly Rules, in particular the following:

'(a) policyholders can be confident that they are dealing with an insurer where the fair treatment of policyholders is central to the insurer's culture;

...

(e) policyholders are provided with products that perform as insurers or their representatives have led them to expect, and the associated service is both of an acceptable standard and what they have been led to expect; and

(f) policyholders do not face <u>unreasonable</u> post-sale barriers to … submit a claim….'

6.3 The provisional determination that R15 000 compensation must be paid to Ms W is confirmed. This is a final determination."

See also the article, "Compensation for poor service", on page 20 of the 2018 Annual Report.

Case Report 46

Exclusion – evidence – insurer insists policyholder must provide documents

In this complaint AIG Life South Africa Limited ("the insurer" or "AIG") relied on the following policy provisions:

- *"No benefit will be payable if an insured event is as a result of, by, for or from diabetes."*
- *"The claim form and all supporting documentation as may be requested will be supplied at your own expense, and must be received by us within 180 days."*

The insurer challenged the correctness of the provisional ruling in favour of the complainant and submitted as follows:

"Our policy wording is clear around the onus of proof and the claims conditions refer to an insured providing all documentation at the insured's cost. In this instance the insured is a known Diabetic who was treated for cellulitis – we identify medically the causal link between diabetes and cellulitis….

As previously stated, we have not formally rejected the claim. Once the insured disputes our decision to reject based on the basis of an Exclusion (Diabetes), as our TCF guidelines, we hold back on the rejection and provide the insured/claimant with an opportunity to provide us with supporting clinical evidence in support of their dispute that, their admission was due to other conditions that are non-related to Diabetes.

Regrettably, the claim will remain closed until such time that required documents are submitted to enable us to conclude a medical review on the claim."

After the matter had been considered at a meeting of the adjudicators in the office a final determination was made, the concluding paragraphs of which read as follows:

"11. The evidence therefore shows that the complainant was admitted and hospitalised for Cellulitis and, as such, that her claim falls within the scope of insurance. The insurer has not alleged at any stage that the complainant's claim does not fall within the scope of insurance.

12. If AIG wishes to rely on the Diabetes exclusion, it has to obtain the evidence necessary to prove that the hospitalisation was 'as a result of, by, for or from' Diabetes. It cannot ask the complainant to provide that evidence.

13. It appears that AIG may be labouring under the following misconceptions:

- *That the clause in the policy under Claim Conditions means that the insured has to provide any documents the insurer requests. The clause only covers the claimant's duty to prove the claim and the documents to support the claims, which she has done.*
- *That clause cannot and does not shift the onus. The onus of proving that it can rely on the exclusion rests on the insurer. See **South Cape Corporation (Pty) Ltd v Engineering Services (Pty) Ltd** 1977 (3) SA 534 (A) at page 548. If the insurer makes out a **prima facie** case that it can rely on the exclusion only then does the claimant have the burden of adducing evidence in rebuttal. That has not happened as yet in this case. The evidence we have received does not equate to a **prima facie** case that AIG can rely on the exclusion.*
- *AIG appears to view the Diabetes Exclusion as having a wider ambit than what it states. Diabetes must be the direct cause of the hospitalisation in order for the clause to become operative. The fact that Diabetes is a condition from which the claimant suffers is not sufficient. Even if it is accepted that a claimant is more susceptible to Cellulitis because of Diabetes, that will not entitle AIG to rely on the exclusion if the hospitalisation was not as a result of, by, for or from Diabetes.*

14. The fact that the complainant is a 'known Diabetic who was treated for Cellulitis' is not sufficient to discharge that onus. AIG has not made out a prima facie case that the complainant was hospitalised as a result of, by, for or from Diabetes. The documentation reflects that she was hospitalised as a result of, by or for Cellulitis. The fact that she has an underlying condition of Diabetes does not bring her within the exclusion clause.

15. The meeting was satisfied that AIG cannot expect the complainant to provide the medical information it requested. It must obtain the information itself. Given the delays that the complainant has experienced in this matter, AIG has 30 days to obtain the information and make its claim decision known, or, it must pay the claim. This is a final determination."

Case Report 47

Claim declined due to pre-existing condition

In this complaint, Santam Structured Life Limited ("the insurer" or "SSL") disputed its liability for the payment of the policy benefit, following the death of one of the insured lives. In doing so, the insurer relied on a "pre-existing medical condition" exclusion ("the exclusion") in the application form; the policy schedule and the so-called Master Agreement.

The complainant averred that the exclusion was not explained to her at application stage. The insurer submitted that the policy was sold on a "non-advice" basis by a person who uses a script to provide information, but not advice.

The matter was discussed at a meeting of the adjudicators in the office and the principal findings in the provisional ruling were the following:

- *Having considered the application form and the script, the meeting was of the view that the policy may be seen as and assumed to be a funeral policy.*
- *On such assumption, it was found that the application of a pre-existing exclusion clause for the duration of the policy term, was unusual.*
- *The meeting held that in such circumstances, SSL's reliance on the policyholder familiarising himself/herself with the provisions of the policy, was not reasonable.*

The provisional ruling concluded thus:

> *"For the reasons set out above and considering the complainant's contention in point 8 above, the meeting was of the view that there had not been a meeting of the minds at application stage and as such no consensus regarding the terms of the policy, had been reached. The meeting unanimously agreed that the contract was to be considered as void and that all premiums contributed, were to be refunded."*

The insurer challenged the correctness of the provisional ruling and submitted that:

- *Any refund of premium should be limited to the "premium relating to the particular life assured who had a pre-existing condition because the insurer will have been on risk for every other life assured".*
- *"There is further not a lack of consensus in regard to all lives insured."*
- *"The insured does not contend that she would not have taken out the policy for the other lives who remained insured. This is not a basis for considering the contract void which would mean the other insured parties would have had free cover."*

Following the consideration of the matter at a further meeting of the adjudicators a final determination held thus:

> *"20. The complainant, by the completion of one composite application form, applied for one policy, covering multiple lives.*
>
> ...
>
> *24. The meeting, for the reasons set out above, unanimously confirmed its view as set out in point 15 above, that due to a lack of consensus at application stage, the contract was to be considered as void and that all premiums contributed, were to be refunded."*

It may be worth noting that the insurer paid R663.68 to the complainant in accordance with the final determination.

REPORT BY THE **CHAIRPERSON OF THE OMBUDSMAN'S COMMITTEE**

This has been a truly remarkable reporting period. The "soft" amalgamation between the offices of the Long-term Insurance Ombudsman and the Short-term Insurance Ombudsman was finalised, the details of which are more fully dealt with in the Ombudsman's report.

Suffice it to say that this initiative commanded the extensive attention of both the Ombudsman and Deputy Ombudsman who had to balance the demands of the amalgamation with those thrust upon the office by the COVID-19 pandemic. Of course, the COVID-19 pandemic brought not only considerable disruption, but also increased workloads for all the members and the office. Not only did we all have to cope with an influx of COVID-19-related claims and complaints, but we all had to adapt to a new way of working and interacting with the office.

Despite all of this the office continued to discharge its mandate seamlessly without let-up or hindrance. Our thanks and admiration go to all the staff at the office for their hard work and sacrifice during this time. Due to the lockdown restrictions the committee meetings were held via an electronic functionality and ran without any difficulties or objections. It seems that meetings will be held this way for the foreseeable future. The complaint volumes showed an increase from previous reporting periods – no doubt as a result of the pandemic. A heartening trend is that the W/P percentage of 31.73% is a decrease from the previous reporting period. The office received 14 198 written requests for assistance and 3 624 full cases were finalised. The office dealt with 456 COVID-19-related complaints.

Our members have again unanimously expressed their view that they enjoy a positive and constructive relationship with the office and that the well-considered and rigorous determinations they receive from the office are incorporated into their complaints handling processes. As always, I will end by saying on behalf of the committee that the office continues to provide the South African consumer with a world-class dispute resolution system. For this our thanks go to the Ombudsman and each and every member of his staff.

Glenn Hickling

OMBUDSMAN
FOR LONG-TERM INSURANCE

MEMBERS OF THE OMBUDSMAN'S COMMITTEE

Glenn Hickling (Chairperson)
BrightRock Life Insurance Limited

Corlene du Plessis
Sanlam Developing Markets Limited

Fathima Reddy
Nedgroup Life Assurance Company Limited

Hein Human
Discovery Life Limited

Shaun-Thomas Pringle
Santam Structured Life Limited

Nkukuleko Masondo
Workerslife Assurance Company Limited

Anna Rosenberg
ASISA

Shale Adams
Absa Life Limited

Martin van Wyk
Sanlam Life Insurance Limited

Mariza Schlusche
Metropolitan Life Limited

Russell Krawitz
Guardrisk Life Limited

Jacolien Potgieter
Assupol Life Limited

Jason Mey
Clientèle Life Assurance Company Limited

Sue du Plessis
Momentum Metropolitan Limited

Denvor Pillay
1Life Insurance Limited

Gaby Faltermair
Hollard Life Assurance Company Limited

Charlotte Sunker
First Rand Life Assurance Limited

Hazel Lerman
Liberty Group Limited

Lara du Plessis
Old Mutual Life Assurance Company (SA) Limited

COMPLAINTS DATA FOR **SUBSCRIBING MEMBERS**

The office will publish individual insurer complaints data for the period 1 January 2020 to 31 December 2020 on its website, www.ombud.co.za.

The publication is done in order to promote accountability and transparency. It will also encourage insurers to benchmark their standards of complaints handling against other insurers and to learn from insurers who appear to be better at complaints handling.

The information to be published on the website under the heading "Complaints Data" and herein, shows the number of complaints received; the number of cases considered; the number of cases finalised and the number of cases resolved in favour of the complainant, i.e. the W/P (Wholly or Partially) percentage. In addition, Table 2 on the website reflects the nature of the complaints.

The office does not interpret what any of the figures may mean. That is left to insurers, intermediaries and industry bodies, reporters and consumer organisations, as we are of the view that such interpretation and comment by us would not be consistent with our role in impartial dispute resolution.

Although there are a number of published reports reflecting market share in the long-term insurance industry, there is no single generally accepted measure for it and, therefore, this is not reflected in the published data. Another reason for not including market share is that the office does not hold the underlying data that could be used to determine market share and this makes it impossible for the office to verify its correctness. The only context is the individual insurer's complaints expressed as a percentage of the total complaints received.

Second reminders for responses

Where an insurer has more than five second reminders per year, the number of reminders is published with the complaints data. The names of the insurers and the number of the second reminders sent to them during 2020 appear alongside.

More than five second reminders 2020

3Sixty Life	**81**
Vodacom	**15**
Safrican	**14**
Workerslife	**8**
Real People	**6**
First Rand Life	**6**

OMBUDSMAN
FOR LONG-TERM INSURANCE

Wholly or Partially (W/P) in favour of complainants

A W/P classification applies whenever a case is resolved either wholly or partially in favour of a complainant, whether by settlement or determination. This includes so-called **ex gratia** settlements. The W/P classification is not limited to cases where the office issued a determination. The classification is also not limited to cases where a sum of money is paid to a complainant – it can apply to service complaints, reinstatement of policies, adjustment of benefits, etc.

We wish to caution against an over-emphasis of the W/P percentage, which should not be viewed in isolation. A low W/P percentage in favour of complainants is, by itself, not necessarily good or an indication that the insurer has exemplary complaints handling processes. Neither is a higher percentage necessarily negative or an indication that the insurer's complaints handling is poor.

Some insurers are more inclined than others to settle matters. Such insurers choose to settle matters, either wholly or partially, when there may, strictly speaking, be doubt about legal liability.

There may also have been a bulk case situation, i.e. a large number of cases on the same issue. This can "skew" the W/P percentage either up or down for one or more years. This effect is noticeable when an insurer's W/P percentage changes markedly from previous years.

Of course, if an insurer has a disproportionately high percentage of complaints and has had a high W/P percentage for a number of years, that would raise a question about its complaints management and other practices.

The complaints data should be used by intermediaries, consumers and others in conjunction with other measures, such as an insurer's claims ratio, its efficiency generally, its products, etc. to give a full picture of an insurer's performance.

The table overleaf shows:

Complaints received

This is the number of new complaints received in respect of an individual insurer. Some of these complaints will be sent to the insurer to deal with the complainants directly. If a complainant is not satisfied with the insurer's response we will then take up the case.

Percentage of total

This indicates the complaints received in respect of an individual insurer expressed as a percentage (to two decimal places) of the total number of complaints received by our office.

Cases considered

These are the complaints where case files are opened and complaints are investigated by our office.

Cases finalised

These are the cases finalised during 2020, some of which had been received in earlier years.

Percentage resolved W/P in favour of complainants

This refers to the percentage of cases which were resolved wholly or partially (W/P) in favour of the complainants. These cases are resolved by way of settlement, mediation, conciliation, recommendation or determination. The overall W/P percentage in favour of complainants was 31.73%.

COMPLAINTS DATA FOR SUBSCRIBING MEMBERS > CONTINUED

	Complaints Received	% of Total	Cases Considered	Cases Finalised	Resolved W/P in favour of Complainants
1Life Insurance Limited	199	2.95%	151	99	21.2%
3Sixty Life	131	1.94%	112	109	56.0%
Abacus Insurance Limited	36	0.53%	24	16	75.0%
Absa Insurance and Financial Advisers (Pty) Limited	1	0.01%	1	0	0.0%
Absa Life	222	3.29%	176	140	28.6%
Acsis Limited	0	0.00%	0	0	0.0%
AIG Life South Africa Limited	82	1.22%	71	77	27.3%
Alexander Forbes Investments Limited	0	0.00%	0	0	0.0%
Alexander Forbes Life Limited	16	0.24%	14	10	50.0%
Allan Gray Life Limited	7	0.10%	4	5	20.0%
Assupol Life Limited	219	3.25%	146	111	40.5%
AVBOB Mutual Assurance Society	139	2.06%	101	64	21.9%
Bidvest Life Limited	6	0.09%	6	0	0.0%
BrightRock Life Insurance Limited	74	1.10%	55	35	37.1%
Centriq Life Insurance Company Limited	193	2.86%	151	96	36.5%
Clientèle Life Assurance Company Limited	211	3.13%	172	129	51.2%
Constantia Life	11	0.16%	11	3	66.7%
Constantia Life & Health Insurance	5	0.07%	4	3	66.7%
Discovery Life Limited	244	3.62%	221	174	24.1%
Dotsure Life	1	0.00%	0	0	0.0%
Emerald Life	37	0.55%	32	0	0.0%
FedGroup Life Limited	2	0.03%	2	2	0.0%
First Rand Life	142	2.11%	112	58	32.8%
Guardrisk Life Limited	195	2.89%	110	73	27.4%
Hollard Life Assurance Company Limited	706	10.47%	533	334	37.1%
Hollard Specialist Life Assurance	59	0.87%	35	28	46.4%
Investec Life Limited	0	0.00%	0	0	0.0%

OMBUDSMAN
FOR LONG-TERM INSURANCE

	Complaints Received	% of Total	Cases Considered	Cases Finalised	Resolved W/P in favour of Complainants
Just Retirement Life	1	0.01%	1	0	0.0%
Liberty Group Limited	587	8.70%	490	371	26.4%
Merrit Life	1	0.01%	1	0	0.0%
Metropolitan	427	6.33%	336	219	30.6%
MMI Group Limited	292	4.33%	236	216	31.5%
Nedbank Limited	0	0.00%	0	0	0.0%
Nedgroup Life Assurance Company Limited	193	2.86%	159	119	35.3%
Nestlife Assurance Corporation Limited	16	0.24%	12	2	100.0%
New Era Life Insurance Company Limited	1	0.01%	1	2	50.0%
Ninety One Assurance Life	1	0.01%	0	0	0.0%
Old Mutual Alternative Solutions Limited	11	0.16%	2	3	33.3%
Old Mutual Life Assurance Company (SA) Limited	1 042	15.45%	743	445	25.8%
OUTsurance Life Insurance Company Limited	25	0.37%	21	13	30.8%
Professional Provident Society Insurance Company Limited	24	0.36%	21	24	33.0%
PSG Life	2	0.03%	2	2	50.0%
Real People Assurance Company Limited	4	0.06%	4	4	75.0%
Safrican Insurance Company Limited	182	2.70%	128	85	49.4%
SA Home Loans Life Limited	23	0.34%	18	9	0.0%
Santam Structured Life Limited	262	3.88%	181	90	41.1%
Sanlam Life Insurance Limited	311	4.61%	264	206	16.0%
Sanlam Developing Markets	264	3.91%	187	116	22.4%
Shield Life	0	0.00%	1	1	0.0%
Smart Life Insurance Limited	2	0.03%	1	0	0.0%
Viva Life Insurance Limited	4	0.06%	3	1	0.0%
Vodacom Life Assurance Company Limited	23	0.34%	21	19	42.1%
Workerslife Assurance Company Limited	104	1.54%	94	96	37.5%

REPORT BY THE GENERAL MANAGER – **FINANCE MATTERS**

Financial overview

2020 was an extraordinary year and we have all had to adapt to a new paradigm. The COVID-19 pandemic ("COVID-19") brought new challenges and uncertainties. OSTI implemented numerous measures to minimise the impact of COVID-19 and to ensure that it maintained a strong liquidity position in response to varying economic conditions. The continuous review of existing contingencies and recovery plans was necessary to ensure OSTI's operational efficiency.

OSTI continues to experience no disruptions to its operations as all staff members continue to work remotely. OSTI took appropriate measures to migrate all its information and communications technology systems onto a cloud platform to ensure secured access and business continuity. The rapidly changing and uncertain circumstances brought about by COVID-19 require great agility to mitigate and manage inherent post-COVID-19 risks.

2020 Annual Financial Statements

PricewaterhouseCoopers Inc. continued in office as auditors for the financial year ended 31 December 2020. The financial statements have been prepared in accordance with the International Financial Reporting Standards and the requirements of the Companies Act, 71 of 2008.

The 2020 Annual Financial Statements were prepared on a going concern basis. The Board of Directors and management have reviewed and assessed OSTI's liquidity and financial position to ensure that there is sufficient funding to sustain its operations, meet its financial obligations and execute its mandate. We are not aware of any material uncertainties related to events or conditions that may cast significant doubt on OSTI's ability to continue as a going concern.

Copies of the approved and audited 2020 Annual Financial Statements will be distributed to our members on request.

Operational change: current/present state of affairs

OSTI entered into a "soft" amalgamation with the office of the Long-term Insurance Ombudsman with effect from 1 January 2020. Both offices continue to operate as two separate entities and continue to be separately responsible for the collection of revenue and the discharge of costs incurred by each office as per the Shared Services Agreement.

Financial position

OSTI remains financially sound with all members settling their outstanding debts in full for the financial year ended 31 December 2020. We would like to extend our gratitude to all our insurer members for their continued support and contributions.

The debtors' collections are timeously monitored and we are not aware of insurer members whose businesses have been adversely impacted by COVID-19 causing an inability to settle their outstanding accounts.

OSTI identified measures for controlling its budget, such as increasing cost savings, which resulted in the actual expenditure for 2020 being below budget. OSTI's financial position at year-end was solid and it has no immediate financial concerns at this stage; it should be able to continue meeting its anticipated contractual and financial obligations in the foreseeable future.

Revenue

OSTI recorded a revenue of R48.0 million for the year, an increase of 6% compared to 2019 (R45.2 million). The favourable variance is mainly attributable to the increase in the fee income, the penalty income and the increase in the number of registered complaints.

The fee income is recognised over time based on when a complaint is closed or based on the three-year average time that it takes to close complaints. The annual fee per complaint increased from R4 300 in 2019 to R4 400 in 2020. The penalty fee of double the current fee is charged to insurers for delays in resolving matters.

A total of 11 095 complaints was registered in 2020, representing an increase of 7% compared to 2019 (10 367). COVID-19-related complaints account for 7% of all the complaints registered in 2020, that is a total of 786 complaints, with 562 relating to business interruption insurance and 224 to travel insurance.

Operating expenditure

OSTI recorded R41.7 million in operating expenditure against the annual budget of R46.5 million in 2020. The favourable variance is as a result of the implementation of cost-saving measures as some of the expenses were cancelled due to COVID-19 and the lockdown. A surplus of R7.1 million for the year was recorded compared to R3.5 million in 2019. OSTI's financial position has strengthened mainly due to reduced expenditure and to an increase in the revenue. We will continue with cost management measures to ensure that OSTI remains efficient and sustainable.

Cash and cash equivalents

The cash and cash equivalents increased to R29.6 million in 2020 compared to 2019 (R20.6 million). OSTI has various cash management procedures and processes in place. The capital structures of OSTI consist of debt, cash and cash equivalents and retained income as disclosed in the statement of financial position.

Cash flow scenario planning, with middle and end estimates, is in place to enable OSTI to adjust to changes in the environment that might evolve over time. We will continue to review our cash flow forecast and adjust to changes in the economic environment.

Board, Audit and Risk Committee

The Board and Audit and Risk Committee ensure that OSTI implements effective policies and plans for risk management to enhance its ability to achieve its strategic objectives. The management of risk and accompanying controls is monitored throughout the company to mitigate and maintain an acceptable level of risk.

The Board of Directors established a COVID-19 Crisis Committee to monitor the impact of COVID-19 on OSTI's operations, financial position and the health and well-being of staff. The Committee oversees and responds to emerging risks with the main objectives of ensuring OSTI's sustainability in serving its stakeholders and OSTI's relevance. The Committee continues to meet regularly and to strenuously debate issues with management and engage with staff.

The finance team would like to thank these committees for their valuable input and contributions during these challenging times.

New Membership

Land Bank Insurance SOC Limited's application for membership was approved in June 2020.

A list of member companies is enclosed in this report.

Miriam Matabane
General Manager

OFFICE STATISTICS

ombudsman for short-term insurance

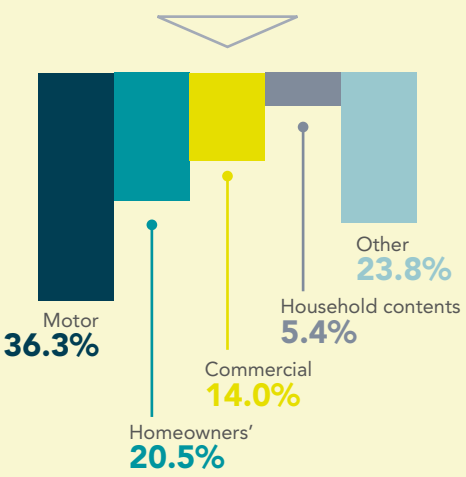
Complaint types resolved in favour of the insured

	Motor	Homeowners'	Commercial	Household contents	Other
2020					
Total closed	**4 305**	**2 100**	**1 231**	**618**	**2 551**
Resolved	**688**	**229**	**199**	**102**	**744**
Ratio	**15.98%**	**10.90%**	**16.16%**	**16.50%**	**29.16%**
2019					
Total closed	**4 492**	**1 843**	**723**	**551**	**1 558**
Resolved	**859**	**268**	**133**	**99**	**534**
Ratio	**19.12%**	**14.54%**	**18.40%**	**17.97%**	**34.27%**

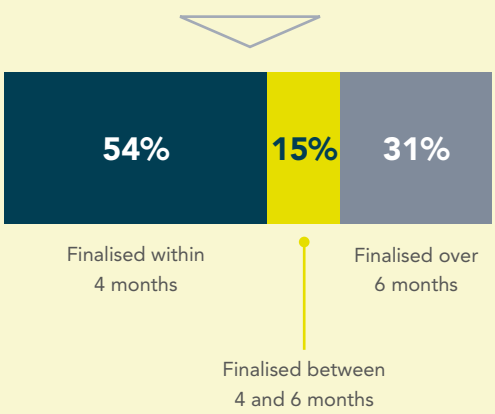
Complaint types – Rand value of complaints resolved in favour of the insured

	Commercial	Homeowners'	Household	Motor	Other	Total
2016	10 159 765.28	16 029 453.83	6 372 811.38	59 238 532.81	7 339 029.55	**99 139 592.85**
2017	17 622 893.50	10 438 651.39	4 023 243.71	39 488 281.91	4 706 791.94	**76 279 862.45**
2018	13 666 388.20	14 031 727.18	3 214 442.85	50 903 691.52	3 666 389.47	**85 482 639.22**
2019	18 255 299.01	14 653 628.32	2 958 039.99	47 701 385.68	11 366 537.68	**94 934 890.68**
2020	**38 909 691.15**	**15 703 055.02**	**3 782 112.41**	**48 908 741.25**	**12 245 301.72**	**119 548 901.55**

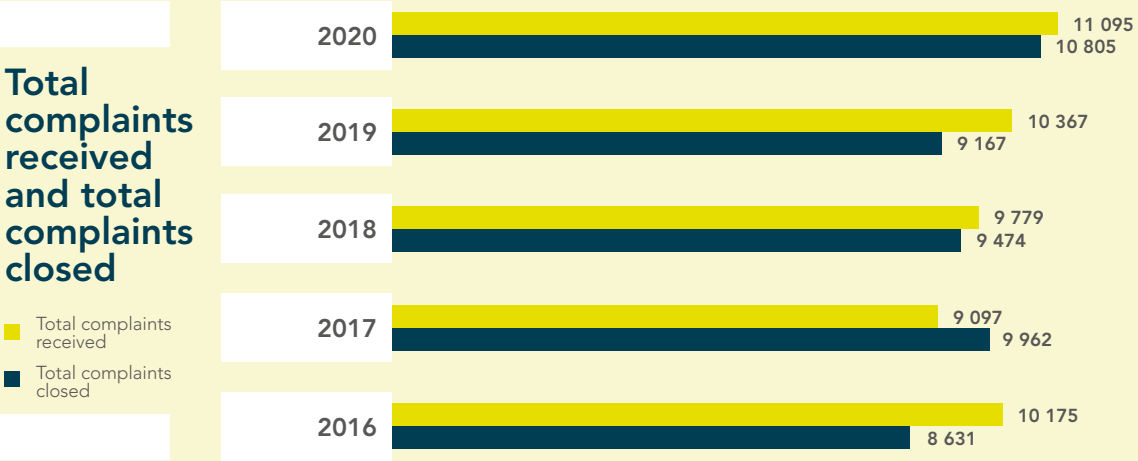
Types of complaints



Finalisation per period



Total complaints received and total complaints closed



A STATISTICAL ANALYSIS OF MATTERS CLOSED BY OSTI IN 2020

ombudsman for short-term insurance

During 2020 OSTI finalised a total of **10 805 formal complaints.** This was 1 638 more than in 2019.

The majority of these complaints, at **36%**, related to **motor vehicle** disputes. This was followed by **homeowners'/building disputes** at **21%, commercial** at **14%**, and **household contents** at **5%**. The balance of 24% is related to other types of cover and general policy queries.

The complaint trends in 2020 were influenced, in part, by the nationwide lockdown and government regulations set to combat the spread of the Coronavirus (COVID-19) in South Africa. For instance, the number of **motor vehicle-related complaints was 12% lower** than in 2019. It was the **lowest reported in the last five years**. Commercial complaints increased by 5%, with the majority relating to business interruption claims.

Below we have set out some of the complaint trends in relation to each category of insurance.

Motor vehicle insurance disputes

At **73%, accident-related claims** remained the highest number of complaints considered by OSTI in this category. **Warranty and mechanical breakdown** claims comprised **11%. Theft and hijack** claims comprised **7%**.

In OSTI's 2018 and 2019 Annual Reports, we pointed to a **downward trend** (15% and 13% respectively when compared to the previous years) in the number of complaints relating to accident claims rejected by an insurer on the ground that the incident driver was **under the influence of alcohol (DUI)**. This is attributed to several factors. The statistics in **2020** show a further **12% decline** when compared to 2019.

On the other hand, the predominance of claims rejected on what is referred to as the ***reasonable precautions clause*** is now apparent. The number of complaints relating to motor vehicle claims rejected on the basis of this clause increased substantially. In 2018 these types of complaints increased by 48% when compared to 2017. OSTI considered close to **300 complaints** on the issue and this number has remained more or less constant in 2020.

The reasonable precautions clause is a general exclusion to cover contained in most vehicle insurance policies. It refers to the insured's obligation to exercise due care concerning the insured vehicle and to prevent loss. Essentially, the clause excludes the insurer's liability for a claim arising from loss or damage caused by the insured's own actions. In many of the matters that we considered in 2020, the insurer's decision to decline liability was based on allegations that the insured was driving over the regulated speed limit.

In previous years, some insurers relied on insufficient circumstantial evidence to justify rejections based on DUI, in which case OSTI would overturn the insurers' decisions. The upward trend in insurers relying on the reasonable precautions clause, we believe, may have, in some measure, been influenced by this. We say this because when we review the merits of such a dispute, there is frequent mention of a suspicion that

the incident driver was under the influence of alcohol, however, the assessment of the claim by the insurer may not have yielded sufficient evidence to sustain a rejection on this ground.

Having said this, the insurers' reliance on the reasonable precautions clause has, in some cases, been incorrectly applied and/or unsubstantiated. In adjudicating these matters, OSTI has adopted the courts' approach. It generally recognises that the clause must be restrictively construed to ensure that it does not undermine the very purpose of having a policy of insurance, which is to cover an insured's negligence. An insurer may only successfully rely on the clause if it can prove that a driver acted recklessly, in a specific legal sense. Speed alone, for instance, does not amount to recklessness. Therefore, a claim cannot be invalidated by the insurer if it is, at best, established that the insured drove negligently at the time of the collision.

In 2020, 16% of the total number of motor vehicle disputes were resolved in favour of the insureds, and OSTI put **R48 908 741.25** back into their pockets.

Homeowners' insurance disputes

54% of complaints considered by OSTI under this category related to claims for damage caused by **acts of nature**, largely storm-related damage. With changes in the weather patterns, we anticipate that catastrophic storm-related claims will become prevalent.

OSTI considered a total of **2 100** homeowners' insurance disputes in 2020, **15% more** when compared to 2019. The **primary cause** for the complaints, at **47%**, was the rejection of claims based on policy exclusions for damage caused by **defective design, construction or workmanship, wear and tear, and lack of building maintenance**.

This cause for complaints **increased** by **17%** in 2020 and continues to be the main basis for consumer dissatisfaction in homeowners' insurance coverage.

Although many aspects of the above can be discussed, an issue we wish to highlight for the consumer concerns **homeowners' insurance policies issued under a home loan with the bank**. Often, an evaluation of the building is conducted by the bank at the time of the purchase. The purpose of this evaluation is to establish whether the property is of sufficient value to act as security for the loan. The evaluator does not inspect the property for insurance purposes. As such, the assessment does not warrant that the property is free from underlying structural defects, wear and tear or other maintenance-related issues that may affect the outcome of a future claim. Generally, an insurer is under no obligation to inspect the property before the commencement of an insurance policy since insurance contracts are entered into in good faith. It is the insured's responsibility to ensure that the building is properly maintained and structurally sound.

11% of homeowners' insurance disputes were resolved in favour of the insureds' complaint, with a recovery of **R15 703 055.02**.

Household content insurance disputes

Theft and burglary claims comprised **55%** of complaints considered by OSTI under this category. This was a **17% decline** compared to last year's figure. Complaints relating to damage caused by **power surges** increased from 3% in

A STATISTICAL ANALYSIS OF MATTERS CLOSED BY OSTI IN 2020 > CONTINUED

2018 to 6% in 2019. Last year **11%** of household contents disputes related to power surge claims. This cause of damage will remain a concern for consumers during periods of load-shedding. This event is excluded from the cover in some household content insurance policies.

16.5% of household content insurance disputes were resolved in favour of the insureds' complaint, with a recovery of **R3 782 112.41**.

Commercial insurance disputes

The total number of commercial complaints considered by OSTI in 2020 surged by **62% when compared to 2019. Motor vehicle** complaints comprised **21%**. This was a **12% decline** when compared to 2019. **Building complaints** also declined from **23% in 2019** to **18% in 2020**.

In our 2019 Annual Report we predicted an increase in complaints related to COVID-19, particularly around business disruption and travel. In 2020, **22%** of commercial insurance complaints related to business interruption claims. The majority of these, **15%**, concerned **COVID-19-related business interruption**.

Some of these complaints were submitted in circumstances where insurers had endorsed the business interruption cover to exclude claims related, directly or indirectly, to the COVID-19 pandemic or nationwide lockdown. Where the insureds enjoyed the extended business interruption cover for infectious/contagious diseases, the issue was mainly whether the direct cause of the business interruption was the government-imposed lockdown or COVID-19.

Legal certainty on the question of causation was sought and received widespread media attention during 2020. This issue was ultimately decided on by our courts. The outcome of COVID-19-related business interruption claims submitted in 2020 is now being considered by insurers based on the court decisions.

16% of commercial insurance disputes were resolved in favour of the insureds' complaint and OSTI recovered **R38 909 691.15**. These figures do not reflect the outcome of the business interruption complaints as the relevant court judgment was only handed down in December 2020. Most of these claims are only being processed in 2021.

"Other" and non-claim-related policy disputes

The remaining complaints relate to various types of insurance cover and products including personal accident, water loss, travel, all risks, mobile devices, legal expenses, hospital and medical gap cover. This category, overall, comprised **25%** of the formal complaints considered by OSTI in 2020. Disputes relating to **mobile device theft and accidental damage** were the highest in this category, at **30%. COVID-19-related travel insurance** disputes comprised **7% of all these disputes**.

29% of the total complaints in this category were resolved in favour of the insureds' complaint and OSTI recovered **R12 245 301.72**.

OSTI's customer experience

Customer experience, in the context of OSTI, entails delivering efficient and effective resolutions to both the complainants and the insurance industry. Customer experience surveys are completed by complainants (the insureds) and insurers at the conclusion of each stage in the complaints handling process.

In relation to the number of complaints finalised in 2020, **76% were satisfied with our service, process and communications.**

Ayanda Mazwi
Senior Assistant Ombudsman and Head of Department for Customer Experience & Public Relations

EXPLANATORY NOTES AND INSURER STATISTICS

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.

2. OSTI has limited jurisdiction over commercial lines policies and, in any event, has jurisdiction for personal lines business only up to R3.5 million, save for homeowners' claims where the jurisdictional limit is R6.5 million. The statistics therefore focus only on personal lines claims (statistics provided by the Financial Sector Conduct Authority ("FSCA")) and personal lines complaints received by this office. Commercial lines complaints, which are not reflected in the statistics, represent about 14% of the total complaints.

3. Excluded from the overturn rate per insurer, as shown in the table, are those complaints resolved "on transfer". In terms of the complaints handling process that came into effect on 1 January 2019, an insurer is given an opportunity to resolve a complaint directly with the insured where the insured lodged a complaint with OSTI before first approaching his/her insurer to resolve the complaint. This process is referred to as the "on transfer" process. If the insurer resolves the complaint to the satisfaction of the insured, then the decision of the insurer is not recorded as an overturn against the insurer in these statistics but is included in the overall office statistics. Further comments on the overturn rate appear below.

4. 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 FSCA. 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 columns 8 and 9, being the share of matters resolved through conciliation by the parties/enforcement by OSTI.

   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.

5. 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 1 may be greater than the number in column 3. The statistics record the numbers received by insurers and the OSTI respectively during 2020.

6. Also note that under column 1, certain insurers may be shown by the FSCA statistics as having received no claims during 2020. This may be explained based on 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 FSCA (columns 1 and 2).

7. The overturn rate per insurer as shown in the table is for personal lines claims only. It excludes commercial lines claims and complaints resolved on transfer (see point 3 above). 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 OSTI from a particular insurer in resolving a complaint to the satisfaction of the customer. OSTI takes into account the following two circumstances in determining the overturn rate:

   (a) The decision of the insurer is overturned by OSTI 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 OSTI with the insured receiving a benefit which he/she would not have received without the involvement of OSTI.

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

INSURER STATISTICS

"A complaint finalised on transfer" refers to a complaint where the complainant did not first approach the insurer to resolve the complaint. In such a case, the insurer is given an opportunity to resolve the complaint directly with the complainant and, if the complaint is resolved at this stage without OSTI's intervention, the complaint is closed "on transfer" and is excluded from columns 6 to 9 in the below statistics.

	1	2	3	4	5	6	7	8	9
Name of Insurer	Claims received by Insurers (FSCA statistics)	Share of Claims received by the particular Insurer (FSCA 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	Share of matters resolved through conciliation by parties	Share of matters resolved through enforcement by OSTI
Abacus Insurance Limited	4 035	0.11%	17	0.18%	4.213/1 000	8	5	62.50%	0.00%
Absa Insurance Company Limited	181 214	4.76%	567	5.90%	3.129/1 000	473	63	13.32%	0.00%
AIG South Africa Limited	15 650	0.41%	39	0.41%	2.492/1 000	34	11	29.41%	2.94%
Allianz Global Corporate & Speciality SA Limited	382	0.01%	5	0.05%	0.013/1 000	3	1	33.33%	0.00%
Auto & General Insurance Company Limited	194 857	5.11%	365	3.80%	1.873/1 000	384	34	8.33%	0.52%
Bidvest Insurance Limited	20 493	0.54%	76	0.79%	3.709/1 000	70	7	10.00%	0.00%
Bryte Insurance Company Limited	153 310	4.02%	260	2.71%	1.696/1 000	190	48	25.26%	0.00%
Budget Insurance Company Limited	62 877	1.65%	263	2.74%	4.183/1 000	270	28	9.63%	0.74%
Centriq Insurance Company Limited	322 390	8.46%	267	2.78%	0.828/1 000	127	39	30.71%	0.00%
CFAO Motors Insurance Limited[%] (previously Unitrans Insurance Limited)	3 164	0.08%	2	0.02%	0.632/1 000	2	1	50.00%	0.00%
Chubb Insurance South Africa Limited	941	0.02%	7	0.07%	0.007/1 000	6	0	0.00%	0.00%
Compass Insurance Company Limited	23 469	0.62%	37	0.39%	1.577/1 000	50	4	8.00%	0.00%
Constantia Insurance Company Limited	80 606	2.12%	796	8.29%	9.875/1 000	808	189	23.02%	0.37%
Corporate Guarantee (South Africa) Limited	2	0.00%	0	0.00%	0.000/1 000	0	0	0.00%	0.00%
Dial Direct Insurance Company Limited	29 939	0.79%	140	1.46%	4.676/1 000	159	18	10.69%	0.63%
Discovery Insure	187 171	4.91%	362	3.77%	1.934/1 000	295	42	13.90%	0.34%
Dotsure Limited[%] (previously Oakhurst Insurance Company Limited)	73 191	1.92%	258	2.69%	3.525/1 000	280	30	10.71%	0.00%
First for Women Insurance Company Limited	37 763	0.99%	123	1.28%	3.257/1 000	138	20	14.49%	0.00%
First Rand Short-Term Insurance Limited	35 104	0.92%	19	0.20%	0.541/1 000	10	3	0.00%	0.00%
GENRIC Insurance Company Limited	39 362	1.03%	53	0.55%	1.346/1 000	56	7	5.36%	0.00%
Guardrisk Insurance Company Limited	276 279	7.25%	570	5.94%	2.063/1 000	481	168	33.89%	1.04%
Hollard Insurance Company Limited	198 565	5.21%	390	4.06%	1.964/1 000	352	78	22.44%	0.57%
Hollard Specialist Insurance Limited	14 046	0.37%	49	0.51%	3.489/1 000	43	20	46.51%	0.00%
Indequity Specialised Insurance Limited	2 732	0.07%	1	0.01%	0.366/1 000	1	0	0.00%	0.00%
Infiniti Specialised Insurance Limited	24 918	0.65%	51	0.53%	2.047 /1 000	52	12	23.08%	0.00%
King Price Insurance Company Limited	109 232	2.87%	428	4.46%	3.918/1 000	501	51	9.78%	0.40%
Land Bank Insurance Company (SOC) Limited	683	0.02%	1	0.01%	0.001/1 000	0	0	0.00%	0.00%
Legal Expenses South African Limited	25 740	0.68%	78	0.81%	3.030 /1 000	105	17	17.14%	0.00%
Lion of Africa Insurance Company Limited[$]	17	0.00%	4	0.04%	0.235/1 000	23	16	65.22%	4.35%
Lloyd's South Africa (Pty) Limited	134	0.00%	5	0.05%	0.037/1 000	4	1	25.00%	0.00%

ombudsman for short-term insurance

Name of Insurer	1 Claims received by Insurers (FSCA statistics)	2 Share of Claims received by the particular Insurer (FSCA statistics)	3 Complaints received by OSTI	4 Share of the total number of Complaints received by OSTI	5 Number of Complaints received by OSTI per thousand Claims received by Insurer	6 Complaints finalised by OSTI	7 Complaints finalised with some benefit to the insured	8 Share of matters resolved through conciliation by parties	9 Share of matters resolved through enforcement by OSTI
Lombard Insurance Group	18 386	0.48%	67	0.70%	3.644/1 000	73	5	6.85%	0.00%
MiWay Insurance Limited	105 194	2.76%	412	4.29%	3.917/1 000	379	24	5.80%	0.53%
Momentum Insurance Company Limited% (previously Alexander Forbes)	49 022	1.29%	161	1.68%	3.284/1 000	159	18	10.06%	1.26%
Momentum Short-Term Insurance Company Limited	43 510	1.14%	108	1.12%	2.482/1 000	95	8	8.42%	0.00%
Monarch Insurance Company Limited	30 919	0.81%	5	0.05%	0.162/1 000	2	1	50.00%	0.00%
Mutual and Federal Risk Financing	53 080	1.39%	143	1.49%	2.694/1 000	54	37	68.52%	0.00%
Nedgroup Insurance Company Limited	65 963	1.73%	335	3.49%	5.079/1 000	306	55	17.65%	0.98%
New National Assurance Company Limited	14 594	0.38%	139	1.45%	9.524/1 000	120	26	17.50%	0.83%
NMS Insurance Services (SA) Limited	112 042	2.94%	2	0.02%	0.018/1 000	1	1	0.00%	0.00%
Old Mutual Insure Limited	165 683	4.35%	788	8.20%	4.756/1 000	740	146	19.46%	0.27%
OUTsurance Insurance Company Limited	281 543	7.39%	248	2.58%	0.881/1 000	235	13	5.53%	0.00%
Professional Provident Society Short-Term Insurance Company Limited	5 184	0.14%	13	0.14%	2.508/1 000	18	5	27.78%	0.00%
Renasa Insurance Company Limited	94 041	2.47%	148	1.54%	1.574/1 000	170	55	31.76%	0.59%
SAFIRE Insurance Company Limited	6 037	0.16%	5	0.05%	0.828/1 000	5	2	0.00%	0.00%
SA Home Loans Insurance Company Limited	26 704	0.70%	108	1.12%	4.044/1 000	84	3	3.57%	0.00%
Santam Insurance Limited	353 743	9.28%	546	5.69%	1.543/1 000	502	42	8.37%	0.00%
Santam Structured Insurance Limited	15 713	0.41%	243	2.53%	15.465/1 000	246	33	13.01%	0.41%
SASRIA (SOC) Limited	593	0.02%	3	0.03%	0.005/1 000	2	1	50.00%	0.00%
Shoprite Insurance Company Limited	10 418	0.27%	3	0.03%	0.288/1 000	2	1	50.00%	0.00%
Standard Insurance Limited	124 625	3.27%	685	7.13%	5.496/1 000	688	77	11.05%	0.00%
Vodacom Insurance Company Limited	96 717	2.54%	149	1.55%	1.541/1 000	115	44	37.39%	0.87%
Western National Insurance Limited	15 120	0.40%	47	0.49%	3.108/1 000	48	6	12.50%	0.00%
Workerslife Insurance Limited	2 757	0.07%	13	0.14%	0.005/1 000	16	9	56.25%	0.00%
Yardrisk Insurance Limited@	155	0.00%	0	0.00%	0.000/1 000	0	0	0.00%	0.00%
TOTAL	3 810 009	100.00%	9 604	100%	2.521/1 000	8 985	1 525	16.57%	0.37%

Legend:
@ *New licence*
% *Change of name*
$ *Run-off of business*

Please Note:
The Statistics for Absa Insurance Company Limited include statistics for Absa Idirect and Absa Insurance Risk Management Services Limited.

The Statistics for Old Mutual Insure include statistics for Iwyze.

PERCEPTION VS REALITY

The insured submitted a claim for accident damage to his vehicle, a silver Opel Astra ("the incident vehicle"). The accident took place when a third party collided with the rear of his vehicle on 16 April 2019.

The insurer rejected the claim on the ground that the insured misrepresented the details of the regular driver when the policy was sold. The insured referred the matter to the Ombudsman's office due to his dissatisfaction with the rejection.

The insured's policy incepted on 6 February 2019. He placed the following two vehicles on cover:

1. a white 2013 FORD ECOSPORT 1.5 TDCI TREND; and
2. a silver 2017 OPEL ASTRA 1.4T ENJOY 5DR.

During the sales conversation, the insured nominated his father as the regular driver of both vehicles. He was advised of the consequences of not nominating the correct regular driver.

During the validation of the claim the insurer established that the insured was, in fact, the regular driver of the incident vehicle since the commencement of the policy. The insurer relied on the following evidence in substantiation of its rejection of the claim:

- The incident vehicle was previously insured with another insurer where the insured was noted as the regular driver.
- The third party stated that she had only seen the insured driving the Opel Astra and that his father drove the white Ford EcoSport.
- The insured's father said that the insured would use the incident vehicle more, but he also uses both vehicles.
- The insured's neighbour confirmed that the insured owned the white Ford EcoSport and had recently purchased a silver Opel Astra.

The insurer advised that had it been notified of the correct identity of the regular driver, it would have charged a higher premium. Therefore, the insured's misrepresentation with regard to the regular driver was material to its underwriting of the risk.

The issue to be determined by OSTI was whether the insurer correctly rejected the claim.

As the insurer was relying on an exclusion to reject the claim, the insurer bore the onus of demonstrating that the insured was the regular driver of the incident vehicle since the commencement of the policy. In terms

of the decision in **Visser v 1Life Direct Insurance Ltd** 2015 (3) SA 69 (SCA) 74F – G, an insurer can only prove that a statement is false, i.e. a misrepresentation, if it proves the truth.

During the sales conversation the question posed was, "*Who will drive this vehicle most often and more frequently than any other person?*" For the insurer to prove who that person is, it needs to undertake a quantitative assessment of the times and instances when the vehicle was driven since it was placed on cover, which was for approximately only two months when the loss took place.

In the validation conversation with the assessor, the insured's father confirmed that the insured's employer provided the insured with transport to and from work. However, whilst the insured's father did state that the insured "normally" drove the incident vehicle, it was pointed out to the insurer that this statement must be considered in light of the insured's allegation that he was off from work once a week and then every fourth weekend. The insurer was advised that, in terms of its own definition of a "regular" driver, the "normal" driver would not necessarily be the regular driver considering how few opportunities the insured had to drive the vehicle from the commencement of the policy to the time of the loss.

On the other hand, contrary to the insurer's summary of the evidence of the insured's neighbour, the insured's neighbour in fact confirmed that the insured "drives the two Astras". When probed further regarding "*Which one does he drive the most?*", she confirmed "*the white one. The silver one just stands there….*"

As regards the evidence of the third party, she indicated that she lives in another area. Therefore, her evidence that she normally sees the insured driving the silver Opel Astra could not be a confirmation that the insured was the regular driver of the vehicle.

It was also pointed out to the insurer that the fact that the insured was noted as the regular driver on previous policies was not sufficient evidence for the insurer to discharge its onus of proving that the insured was in fact the regular driver since the commencement of the policy.

OSTI therefore overturned the insurer's rejection of the claim and recommended that the claim be settled in full. The insurer agreed to abide by OSTI's recommendation.

Darpana Harkison
Senior Assistant Ombudsman

FAILURE TO PROVE DUE CARE AND PRECAUTION, BASED ON SPEEDING

On 13 December 2018 Mr P was involved in an accident while driving Mr M's vehicle. Mr P said that he saw a dog running across the road and swerved to avoid it. In doing so, he lost control of the vehicle and collided with a tree on the side of the road and then a school fence.

The vehicle was taken for assessment and declared uneconomical to repair. The insurer also commenced with its validation of the claim and appointed an expert to determine the speed at which the vehicle was driven at the time of the collision. The insurer appointed three forensic experts to reconstruct the accident.

The reports obtained concluded the following:

- The vehicle's tracking report showed that the ignition of the vehicle was switched on at 06:29:57 on the day of the accident and the vehicle was on a "highway road". At 06:33:15 (some four minutes later) the tracking device recorded a speed of 15 km/h and detected harsh braking. The insurer rejected the report and stated that the data on tracking reports is not reliable, because there is a delay in downloading the data from the satellite.
- The first expert analysed the digital data from the vehicle and established that the vehicle was travelling at 138 km/h when it collided with the tree. This expert also established that the vehicle was travelling at 43 km/h when it collided with the fence.
- The second expert measured the radius of the curve in the road before the driver lost control of the vehicle. This expert concluded that, based on the length of the radius, the critical speed of the bend is 68 km/h. Critical speed refers to the speed above which a bend cannot be negotiated by a motor vehicle. This meant that Mr P did not exceed the critical speed because he did not lose control of the vehicle while manoeuvring the bend.
- The third expert calculated the speed that the vehicle was travelling when the driver lost control of the vehicle by using the basic motion equation. The variables considered by this expert include distance, friction value and constant acceleration. According to this expert the vehicle was travelling at a speed of between 75 – 85 km/h when Mr P lost control. The third expert opined that if the incident driver had travelled at a speed less than or within the regulated speed limit of 60 km/h, the collision would not have occurred.

During the validation of the claim Mr P told the insurer's investigator that the vehicle was driven at a speed of between 100 – 120 km/h.

The insurer rejected the claim on the ground that Mr P did not take due care and precaution to prevent the accident. The insurer based its decision on the digital data from the vehicle and on Mr P's submission that he travelled at a speed of between 100 – 120 km/h in a 60 km/h zone.

The terms and conditions of the policy state as follows:

> *"Your responsibilities*
>
> *To have cover, you need to do the following:*
>
> - *Take all reasonable steps and precautions to prevent any accidents or losses that occur."*

Mr M argued that the insurer had no grounds on which to reject the claim since all three experts arrived at different conclusions. The insured specifically objected to the insurer's use of the first expert's report on the basis that this expert never inspected the scene of the accident. Mr M stated that the expert made a mistake regarding the direction of travel of the vehicle, a fact which the insurer conceded and rectified. Mr M argued that the first expert's mistake cast doubt on the correctness of the entire report.

Mr M also disagreed that the vehicle had travelled at a speed of 138 km/h. He argued that the vehicle could not reach this speed within the short distance travelled. In support of this argument Mr M supplied video footage of himself driving around the bend before the accident. The purpose of this was to demonstrate that the vehicle could not have negotiated the bend at 138 km/h or accelerated enough to reach this speed. Mr M also argued that the speed recorded on the tracking report is accurate and should be considered as it demonstrates that the vehicle was not travelling at a high speed.

The insurer conceded that the findings of the three experts were different and contradictory. The insurer, nevertheless, maintained its reliance on the first expert's report. The insurer stated that the extensive damage sustained by the vehicle in the accident suggested that the vehicle was travelling at a far higher speed than reported by Mr P. The insurer said that it was not plausible that the vehicle had travelled at the speeds determined by the second and third experts.

The insurer also pointed out that the first expert's conclusion was based on digital data retrieved from the vehicle and was, therefore, more accurate and objective.

The insurer argued that the three experts' findings created a clear dispute of fact which meant that the complaint fell outside of OSTI's jurisdiction.

The insurer argued further that the tracking report did not reflect the true speed of the vehicle and requested that Mr M obtain a buffer report. The buffer report revealed that a maximum speed of 85 km/h was reached by the vehicle before it collided with the tree.

After reviewing all the evidence OSTI recommended that the insurer reconsider its rejection of the claim on the grounds that the speeds reported by the experts were too far apart, as they ranged between 85 km/h and 138 km/h. OSTI pointed out that there was no dispute of fact between the parties since two of the insurer's expert reports were consistent with the tracking report and that the insurer cannot declare a dispute of fact in respect of its own evidence.

OSTI advised that the speed at which the vehicle was driven was not sufficient to justify a rejection of the claim on the grounds that Mr P failed to exercise due care or take reasonable precautions to prevent the loss.

OSTI noted that the standard for recklessness had not been proven by the insurer. Mr P was faced with a sudden emergency when a dog ran across the road. Mr P lost control of the vehicle when he attempted to avoid a collision with the dog. This version had not been disproved by the insurer.

OSTI found that the insurer had not discharged the onus of proving, on a balance of probabilities, that Mr P had failed to exercise due care or take reasonable precautions to avoid the accident.

Accordingly, OSTI recommended that Mr M's claim be settled.

The insurer agreed to indemnify Mr M for the accident. It also agreed to refund the towing and storage costs. As a gesture of goodwill, the insurer also refunded the service fees and interest charged on the finance agreement from the date of loss.

Johan Janse van Rensburg
Assistant Ombudsman

BUSINESS INTERRUPTION INSURANCE IN A WORLDWIDE PANDEMIC (COVID-19)

There is no doubt that the current COVID-19 pandemic has had a huge impact on the insurance industry worldwide. In South Africa businesses have been hit hard by the measures implemented by the government in order to curtail the spread of this very infectious disease. Many businesses were forced to close their doors permanently as they could not weather this storm. This resulted in huge losses of revenue. The tourism and leisure industries were particularly hard hit. This caused many businesses to turn to their insurers for relief which, in turn, led to various cases of litigation regarding business interruption claims and the interpretation of clauses contained in certain commercial insurance policies.

The big question was whether COVID-19 was the cause of businesses being interrupted or, in fact, the government intervention to curtail the spread of the disease. It is against this backdrop that the complaint under discussion was received.

The insured's claim related to loss of income as a result of lockdown restrictions published on 18 March 2020 by the Minister of Cooperative Governance and Traditional Affairs in terms of section 27(2) of the Disaster Management Act, 57 of 2002. Needless to say the insured could not carry on business as a result of the restrictions and incurred financial losses due to the business being interrupted.

The insured had business interruption cover. The policy contained an extension under the business interruption cover for *Murder, Suicide, Food Poisoning*, etc. Under this extension the insured is covered for loss resulting from an interruption of or interference with the business in consequence of a contagious or infectious disease at its premises or within a 50 km radius of its premises. The insurer accepted that COVID-19 is an infectious disease for purposes of the extension. However, it asserted that the insured peril, in terms of the policy, is the outbreak of COVID-19 at or within a 50 km radius of the insured's premises. It argued that a general pandemic and the national government action in response to the pandemic, including the nationwide lockdown, were not considered insured perils.

Even though the insured could prove that cases of COVID-19 had occurred within the 50 km radius and at the premises, with staff being infected, the insurer declined liability. The insurer argued that the cause of the business being interrupted was not the cases of COVID-19 at the insured's premises and within a 50 km radius, but due to government action and the nationwide lockdown imposed in response to the imminent threat of a pandemic. Therefore, the cause of the business being interrupted was disputed by the insurer.

In a letter to the insurer this office indicated that, in its view, the insured's business was interrupted due to the lockdown which was imposed by the government in reaction to COVID-19. Using a simple test for factual causation, it advised that *"but for"* COVID-19 the lockdown would not have been imposed and the business would not have been interrupted. Therefore, there is a factual causal link between the local cases of COVID-19, the lockdown and the business being interrupted. In determining legal causation the question is whether, having regard to directness, the absence/presence of a **novus actus interveniens**, legal policy, reasonableness, fairness and justice, the harm is too remote from the conduct or whether it is fair, reasonable and just that the insurer is burdened with liability. In OSTI's view, it was. This view is based on the judgment in the Café Chameleon v Guardrisk Insurance matter, which was later confirmed by the Supreme Court of Appeal in **Guardrisk Insurance Co Ltd v Café Chameleon CC** 2021 (2) SA 323 (SCA).

At that time, in a UK High Court decision of a test case brought by the UK Financial Sector Conduct Authority, it was decided that the COVID-19 pandemic and the government and public response to it were a single cause of loss satisfying the requirement for cover under these types of policies.

It was therefore the recommendation of this office that the claim be settled. The insurer accepted the recommendation and the claim was duly settled.

John Theunissen
Assistant Ombudsman

SHOULD COMPANIES BE DOING MORE TO VERIFY AN EMPLOYEE'S DRIVER'S LICENCE?

The insured suffered a loss on 14 February 2019 when one of its employees was involved in a motor vehicle collision whilst driving the company's vehicle.

The insured claimed for the damage to the motor vehicle from its insurer. The claim was rejected by the insurer on the basis that the driver did not have a valid driver's licence.

In support of its stance, the insurer relied on the following exclusion in the policy:

> *"SPECIFIC EXCEPTIONS APPLICABLE TO ALL SUB-SECTIONS*
>
> *1. The Company shall not be liable for any accident, injury, loss, damage or liability:*
>
> *(c) incurred while any vehicle is being driven by:*
>
> *(ii) any other person with the general consent of the Insured, who is not licensed to drive such vehicle, but this shall not apply if the Insured was unaware that the driver was unlicensed and the Insured can prove to the satisfaction of the Company that, in the normal course of his business, procedures are in operation to ensure that only licensed drivers are permitted to drive insured vehicles."*

The insured approached OSTI for assistance stating that it objected to the rejection of the claim but had not received a response from the insurer. In its complaint the insured stated that it proved beyond a reasonable doubt that it did not know that the employee's licence was invalid. The insured accused the insurer of having malicious intent by not settling the claim and by not responding to its objection. The insured sought compensation for loss of income and damage to the business as a result of the insurer's failure to settle the claim.

The office stated that, based on the way the evidence was presented by the parties, it could safely be inferred that the driver drove the insured vehicle *"with the general consent"* of the insured and that he was *"not licensed to drive such vehicle"*. Once these facts have been established, then the exception in clause 1(c)(ii) above came into operation.

The exception, however, was not an absolute bar to a claim because it has a further provision which, for convenience, is referred to as "the proviso". The proviso itself has two components which can be summarised as follows:

1. Absence of knowledge.
2. Proof to the insurer's satisfaction. The insured must prove that ***"in the normal course of his business, procedures are in operation to ensure that only licensed drivers are permitted to drive the insured vehicles".***

The office found that the evidence established on a balance of probabilities that the insured ***"was unaware that the driver was unlicensed"***.

The insured set out the following facts on which it relied for submitting that *"in the normal course of its business,*

procedures are in operation to ensure that only licensed drivers are permitted to drive insured vehicles".

The insured advised that, before employing a driver, the driver's licence was physically checked, and the driver's driving ability was tested. In this case, the driver proved his ability to drive well. The insured submitted that its vehicles are monitored for speeding, harsh driving and harsh braking. This employee's driving behaviour was impeccable and there was no reason to believe that he was unlicensed.

The insured submitted that the driver passed through numerous routine roadblocks conducted by road traffic authorities and the validity of his licence had never been questioned. When the accident was reported to the police by the driver, the validity of his licence was not questioned.

The driver stated that he obtained his licence through normal procedures. A representative of the insured attended The High Commission of Malawi in Johannesburg where it was confirmed verbally that the driver had a valid licence until 2016 and he had renewed his licence which was valid until 2022.

The insured submitted that it had exercised proper and reasonable control over the driver to ensure compliance with the National Road Traffic Act, 93 of 1996.

The insurer produced a document from a business known as "Check Your Driver" which incorporated a document that appears to emanate from the office of the Malawi Consulate General. The document stated, ***"it is concluded that the information presented to this office by your officer is not genuine … and should not be regarded as an International driving licence (SADC Licences)"***. A note explained that ***"SADC"*** stands for ***"Southern African Development Community"***.

The office found that the fact that a licence looks valid establishes little more than that it is not obviously or patently false. Likewise, the fact that the employee performed well in the "drive test" conveys no more than his ability to drive. Furthermore, licence inspections at "routine roadblocks" can hardly be said to form part of the insured's ***"normal course of business"***, as envisaged in and for the purpose of the exception.

The office stated that it was clear that the employee's driver's licence was invalid and the submissions made by the insured were of no assistance.

The office noted that, when deciding the issue about whether the insured ***"can prove to the satisfaction of the company"***, the insurer's decision must be objective and reasonable.

After a review of all the information, the office found that the insurer had made an objectively reasonable decision when it concluded that the insured did not prove ***"that, in the ordinary course of (its) business, procedures (were) in place to ensure that only licensed drivers are permitted to drive insured vehicles"***.

The office concluded that the insurer was entitled to invoke the exception to repudiate liability for the insured's claim.

Nadia Gamieldien
Assistant Ombudsman

REMOTE JAMMING – COMMON SENSE, FAIRNESS AND EQUITY

The insured reported a claim for a bag that was stolen from his car boot. The bag contained travel documents and some personal electronic items. The insurer declined the claim on grounds that there was no violent and forcible entry into the vehicle. According to the insured he locked the vehicle by remote control while walking away from the vehicle.

The insurer relied on the following policy provision:

> *4.3 Specific exclusions applicable on this extension*
>
> *We will not be liable for loss or damage:*
>
> *4.3.13 to insured property lost from an unattended motor unless the insured property was concealed in a locked boot or compartment forming part of a locked vehicle and there is violent and forcible entry to the vehicle.*

The facts and circumstances of the loss were not in dispute. However, it was the insured's submission that even though there was no violent and forcible entry into the vehicle, as there was video footage of the loss, the insurer should indemnify him.

The insured submitted that, *"The intention of insurance policy wording is to prevent insurers from being taken advantage of by unscrupulous individuals making fraudulent claims. The intention surely is not to provide the insurer with a means for refusing assistance when theft has been proven to have occurred. It is my contention that as their stated Group values as well as their mission statement claims that their purpose is to become 'customer obsessed' by 'going beyond expectations', that they cannot be justified if applying decision-making that goes against this."*

The insured further argued,

> *"It is therefore reasonable to conclude that a company with such a values-driven approach would use policy wording to protect themselves from both false claims and gross negligence and not as a tool or loophole by which they can get out of paying a proven, credible claim by a client in good standing. I believe that the CCTV evidence both shows that there was not gross negligence and also proves that a theft did indeed occur from a concealed compartment, in a locked boot."*

The office viewed the video footage in question and it was clear that the insured suffered what appeared to be a genuine loss in a targeted theft incident.

The office has previously dealt with disputes involving similar facts and the office's approach in these matters is well documented: where there are alternative methods of establishing that the loss was authentic, the insurer will be required to settle the claim. Video footage is one such method.

Apart from establishing that the insured suffered a genuine loss, the reason why insurers provide no cover in the absence of signs of forcible or violent entry is to ensure that insureds are diligent in safeguarding insured items and that they are not reckless in this regard. In other words, the policy requires an insured to lock the insured vehicle and not just leave it unlocked when unattended.

From the available evidence it appeared that the thieves were operating some sophisticated scheme through which the theft was effected. There was otherwise no explanation why the vehicle, from which the thief disembarked to commit the theft, happened to arrive shortly after the insured had left his vehicle and somehow targeted his vehicle.

When considering the matter the office suggested to the insurer that, on a balance of probabilities, the thieves had used a sophisticated method to keep the insured vehicle under surveillance and to gain access into it. This then meant that the insured could not have negligently left the vehicle unlocked, but rather that the cause of the loss must have been the use of this sophisticated method to gain access into the vehicle.

It would therefore be unfair for the insurer to decline the claim for what seemed to be a genuine loss, albeit the insurer is entitled to do so in terms of its policy wording.

As the office is entitled to not only evaluate the merits of a dispute on the relevant contractual and legal provisions, but also on considerations of fairness and equity, it was the office's view that the circumstances of the loss justified an approach to the insurer that it considers settling the insured's claim.

The office accordingly recommended that the insurer settle the insured's claim.

In its response, the insurer insisted that the policy did not provide cover under the current circumstances.

It further emphasised that the video footage did not show that the insured had locked the vehicle when leaving it and the insured could not be given the benefit of doubt. The locking of the vehicle, the insurer submitted, would have prevented the loss and there was no basis on which to conclude that the insured had locked the vehicle or that any sophisticated device had been used to effect the loss.

In the light of the insurer's further representations the office found that there was no basis on which to compel the insurer to settle the claim.

The above outcome demonstrates that, even in the face of a well-documented and consistent approach, the specific set of facts and circumstances of each matter will always determine the outcome of a dispute.

Peter Nkhuna
Senior Assistant Ombudsman

NON-DISCLOSURE OF CRIMINAL CHARGES AT SALES STAGE

Mrs E approached our office for assistance as she was unhappy with the insurer's decision to reject her late husband's motor vehicle accident claim. According to the letter of rejection the insurer declined liability on the ground that Mr E had failed to disclose material facts when the policy was incepted.

According to the insurer Mr E had failed to disclose that he had previously been charged with driving under the influence of alcohol in 2011 and 2014. The insurer submitted that, during the sales conversation in October 2015, Mr E was asked to disclose any convictions against him in relation to driving under the influence. He responded that he had never been convicted of driving while under the influence. The insurer advised that it was prejudiced by Mr E's non-disclosure in that it would not have accepted the risk on cover had it been aware of his previous charges and convictions.

The office considered the information and evidence presented in the dispute in light of section 53 of the Short-Term Insurance Act, and we did not agree with the insurer's decision.

For the insurer to succeed in its rejection of a claim on the grounds of non-disclosure during the sales stage the insurer must demonstrate that it created a proper duty of disclosure by asking a clear and concise question. It must further demonstrate that the insured's response amounted to a misrepresentation or non-disclosure in that the insured provided false or misleading information. Therefore, in determining whether the insurer created a duty of disclosure and whether there was a non-disclosure on the insured's part, regard must be had to the specific question(s) asked.

Our office listened to the recording of the sales conversation. The question put to the insured was:

> *"Is there any other person besides yourself, who normally drives the vehicle that has been convicted of any driving offence or had their licence endorsed or taken away?"*

Mr E responded ***"No"***. The insurer asked no other question relating to charges or convictions for driving offences.

The wording of the insurer's question limited its application to persons other than the insured. In our view, had the insurer sought to determine whether Mr E himself had previous driving offences, it should have asked so. As the insurer is aware of the importance of its underwriting criteria it, therefore, had the duty to concisely and unambiguously ask Mr E the relevant question regarding his own charge and conviction history. The insurer failed to do so.

In the case of **Mahadeo v. Dial Direct Insurance Co Ltd** 2008 (4) SA 80 (W) it was stated that policyholders could not be faulted for the way in which they understood the questions posed nor should they be held responsible for the interpretations placed by them on the nature of the questions put. The judgment further referred to comments made by Stratford JA in **British America Assurance Co v Cash Wholesale** 1932 AD 70 at 74 where he stated that: *"Now the questions are framed by the insurance company and it is its duty to make them clear and unambiguous especially when it attaches so much importance to the truth, and such dire consequences to the untruth, of the answers. If then, the question is capable of two reasonable meanings, that which is the more favourable to the insured will be accepted by a court of law when the truth of this answer is assailed."*

As the insurer did not create a duty of disclosure regarding Mr E's own history and limited the question to other drivers besides Mr E, it was held that the insurer was not entitled to raise the defence of non-disclosure and/or misrepresentation.

It was accordingly the recommendation of this office that the insurer settle the claim. The insurer accepted our recommendation and settled the claim in full.

Regina Chindomu
Assistant Ombudsman

NO PROSPECTS OF SUCCESS – LEGAL EXPENSES

ombudsman for short-term insurance

Mr A complained that his insurer, in respect of a legal expenses policy, had allowed his burglary claim against his other insurer, namely XYZ Insurer, to prescribe. According to Mr A the legal expenses insurer had failed to monitor the issue of prescription, resulting in him not being able to sue XYZ Insurer.

The insured lodged a claim under his legal expenses policy for a burglary claim that had been rejected by XYZ Insurer on the basis that there was no cover at the time of the loss because the policy had been cancelled at the request of Mr A.

The legal expenses insurer rejected Mr A's claim against XYZ Insurer on the basis that Mr A did not have reasonable prospects of success. The policy excludes claims where there are no reasonable prospects of success.

The legal expenses insurer sought the opinion of various legal professionals on the insured's prospects of success against XYZ Insurer. The opinions generally provided were that Mr A did not have any prospects of success. The evidence is that Mr A instructed his broker to cancel the policy with XYZ Insurer. Thereafter Mr A was informed of the cancellation. At the time of the burglary there was no policy in place. Based on this it was found that Mr A would not have any prospects of success in his claim against XYZ Insurer.

While Mr A continued to contest the opinions of the legal professionals appointed by the insurer he submitted that, during this period, the insurer allowed his claim against XYZ Insurer to prescribe. Mr A submitted that, while he is aware that he is unable to proceed against XYZ Insurer, the relief that he sought from OSTI was ***"to sue the RESPECTIVE ROLEPLAYERS during the course of my matter and failures of procedure under their watch"***.

Ombudsman's Findings

The issue that OSTI had to decide was whether Mr A would be successful in pursuing any relief sought against the legal expenses insurer. The relief that Mr A was seeking from this insurer and/or the legal professionals that were appointed by this insurer, is a recovery in respect of his claim against XYZ Insurer. It is compelling that, at the time of the burglary, the policy with XYZ Insurer was cancelled and therefore Mr A had no cover for the claim. Based on the evidence, the legal expenses insurer found that Mr A did not have any prospects of success against XYZ Insurer.

In terms of the legal expenses policy the insurer is entitled to reject a claim where there are no reasonable prospects of success. On that basis OSTI was unable to fault the insurer.

Even if it were to be found that the claim against XYZ Insurer had prescribed due to the negligence of the insurer and/or the legal professionals, no claim against XYZ Insurer could succeed. The test would then be whether, but for the negligence of the insurer and/or the legal professionals, Mr A would have had a claim against XYZ Insurer. The onus lay with Mr A to prove this and we found that Mr A had not discharged this onus.

Even if it were found that the claim was "allowed to prescribe", it does not take the matter any further as, ultimately, Mr A could not succeed with his claim against XYZ Insurer and therefore can have no damages claim against the insurer nor the legal professionals, in their own capacities, jointly and/or severally.

Considering all the above, OSTI found that there was no basis on which to make a finding in favour of Mr A and the complaint was dismissed.

Thasnim Dawood
Senior Assistant Ombudsman

DO NOT LET ANYONE DRIVE YOUR CAR WITHOUT A LICENCE!

Miss N habitually allowed her unlicensed partner, Mr X, to drive her vehicle. On this occasion Mr X became the victim of an attempted hijacking. Although the perpetrators failed to get away with the vehicle, the vehicle was left with some damage. Miss N reported the incident to the insurer and registered a claim for stolen items and damage to the insured vehicle.

The insurer rejected the claim when it discovered that Mr X did not have a valid driver's licence when the hijacking happened. The insurer relied on the following provision of the policy:

> ***7.11 What is not covered?***
>
> *You will not have cover:*
>
> *If you or any person with your permission is driving or towing your vehicle and is not fully licensed to drive.*

The insurer argued that this claim fell squarely within the ambit of the above exclusion.

Miss N was unhappy that her claim was rejected. Miss N felt that the clause on which the insurer relied to reject her claim was not applicable as Mr X's driving ability did not come into play in the given circumstances. According to Miss N the hijacking would have happened even if Mr X had a valid licence. In essence, Miss N argued that the licence requirement was not material to the loss.

In the alternative, Miss N argued that she permitted Mr X to drive the insured vehicle because she had had a medical emergency. In an interview with the insurer's investigator, during the claim's validation process, Mr X confirmed that he went to a pharmacy to purchase over-the-counter medication for Miss N. Mr X also confirmed that, before going to the pharmacy, he first attended a business meeting.

The insurer maintained its rejection of the claim and refuted Miss N's explanation that she had had a medical emergency and pointed out that the incident driver would not have first attended a personal business meeting before going to the pharmacy if there had indeed been a medical emergency.

It was the office's view that the role played by the unlicensed driver in the loss is irrelevant for purposes of the exclusion clause because the prohibition applies to the policyholder. The agreement between the insurer and the policyholder is such that the risk of loss or damage will not pass to the insurer if the policyholder permits an unlicensed person to drive or tow the insured vehicle. The moment the policyholder hands the keys over to an unlicensed person, there is no cover. Whatever happens after that, whether a hijacking or an accident, would not be covered.

Like any other contract, an insurance contract normally contains prohibitive clauses which bar the policyholder from engaging in certain conduct. An insurer includes prohibitive clauses to avoid exposure to unacceptable risks. However, there may be instances where the policyholder engages in prohibited conduct out of necessity. This will be the case when the policyholder finds himself/herself having no choice but to engage in the prohibited conduct to prevent a greater harm from occurring.

Policyholders may invoke necessity as a ground for holding the insurer liable to indemnify them. Considerations of fairness and equity may result in our office compelling the insurer to reconsider its stance in circumstances where prohibited conduct occurred out of necessity. Our office therefore needed to satisfy itself that this was, in fact, the case in this matter.

In Miss N's case, the office held that the insurer was contractually entitled to reject the claim. The exclusion clause prohibits Miss N from giving unlicensed persons permission to drive or tow her insured vehicle. As Miss N did this habitually, the office agreed with the insurer that the claim fell squarely within the ambit of the exclusion.

The office also agreed with the insurer that there had been no medical emergency because, if a medical emergency had existed, Mr X would not have first attended a business meeting before going to the pharmacy. In the circumstances the office upheld the insurer's decision to reject the claim.

Policyholders must beware that non-compliance with the policy terms and conditions could leave them exposed to a declined claim with dire financial implications.

Relebogile Mashego
Junior Assistant Ombudsman

APPENDICES

SUBSCRIBING MEMBERS

OMBUDSMAN
FOR LONG-TERM INSURANCE

1Life Insurance Limited

3Sixty Life Insurance Limited
Union Life

Abacus Insurance Limited
JDG Micro Life Limited

Absa Insurance and Financial Advisers (Pty) Limited

Absa Life Limited
Allied Insurance
UBS Insurance

Acsis Limited

AIG Life South Africa Limited
Chartis Life

Alexander Forbes Investments Limited
Investment Solutions Limited

Alexander Forbes Life Limited

Allan Gray Life Limited

Assupol Life Limited
Prosperity Life

AVBOB Mutual Assurance Society

Bidvest Life Limited
Mclife

BrightRock Life Insurance Limited
Lombard Life Limited
Pinnafrica Life

Centriq Life Insurance Company Limited

Channel Life Limited
PSG Anchor Life

Clientèle Life Assurance Company Limited

Constantia Life and Health Assurance Company Limited

Constantia Life Limited

Discovery Life Limited

Dotsure Life Limited
Oakhurst Life Limited

Emerald Life (Pty) Limited

FedGroup Life Limited

First Rand Life Assurance Limited

Guardrisk Life Limited
Platinum Life

Hollard Life Assurance Company Limited
Crusader Life
Fedsure Credit Life

Hollard Specialist Life Assurance
Regent Life

Investec Life Limited

Just Retirement Life (S.A.) Limited

Liberty Group Limited
AA Life
ACA Insurers
Amalgamated General Assurance
Capital Alliance Life
Fedsure Life
Frank Life Limited
IGI Life
Liberty Active
Manufacturers Life
Norwich Life
Prudential
Rentmeester Assurance
Rondalia
Saambou Credit Life
Standard General
Sun Life of Canada
Traduna

Merritt Insurance Limited

Metropolitan Life Limited
Commercial Union
Homes Trust Life

MMI Group Limited
African Eagle Life
Allianz Life
Anglo American Life
FNB Life
Guarantee Life
Legal and General
Lifegro
Magnum Life
Metropolitan Odyssey
Protea Life
Rand Life
Sage Life
Shield Life
Southern Life
Yorkshire

Nedbank Limited

Nedgroup Life Assurance Company Limited
BOE Life
NBS Life

Nestlife Assurance Corporation Limited

New Era Life Insurance Company Limited

Ninety One Assurance Limited
Investec Assurance Limited

Old Mutual Alternative Solutions Limited
MS Life

Old Mutual Life Assurance Company (South Africa) Limited
Colonial Mutual

OUTsurance Life Insurance Company Limited

Professional Provident Society Insurance Company Limited

PSG Life Limited
M Cubed Capital
Time Life

Real People Assurance Company Limited

Safrican Insurance Company Limited

SA Home Loans Life Assurance Company Limited

Sanlam Developing Markets Limited
African Life
Permanent Life
Sentry Assurance

Sanlam Life Insurance Limited

Santam Structured Life Limited
RMB Structured Life Limited

Shield Life Limited

Smart Life Insurance Company Limited

Viva Life Insurance Limited
Resolution Life

Vodacom Life Assurance Company Limited

Workerslife Assurance Company Limited
Sekunjalo Investments

The names of the members are in bold font and the other names are of insurers which were taken over.

ombudsman for short-term insurance

Abacus Insurance Limited
Absa Insurance Company Limited
AIG South Africa Limited
Allianz Global Corporate & Speciality SA Limited
Auto & General Insurance Company Limited
Bidvest Insurance Limited
Bryte Insurance Company Limited
Budget Insurance Company Limited
Centriq Insurance Company Limited
CFAO Motor Insurance Limited
Chubb Insurance South Africa Limited
Compass Insurance Company Limited
Constantia Insurance Company Limited
Corporate Guarantee (South Africa) Limited
Dial Direct Insurance Company Limited
Discovery Insure
Dotsure Limited
First for Women Insurance Company Limited
First Rand Short-Term Insurance Limited
GENRIC Insurance Company Limited
Guardrisk Insurance Company Limited
Hollard Insurance Company
Hollard Specialist Insurance Limited
Indequity Specialised Insurance Limited
Infiniti Specialised Insurance Limited
King Price Insurance Company Limited
Land Bank Insurance Company (SOC) Limited
Legal Expenses Southern Africa Limited
Lion of Africa Insurance Company Limited
Lloyd's South Africa (Pty) Limited
Lombard Insurance Group
MiWay Insurance Limited
Momentum Insurance Company Limited
Momentum Short-Term Insurance Company Limited
Monarch Insurance Company Limited
Mutual and Federal Risk Financing
Nedgroup Insurance Company Limited
New National Assurance Company Limited
NMS Insurance Services (SA) Limited
Old Mutual Insure Limited
OUTsurance Insurance Company Limited
Professional Provident Society Short-Term
Insurance Company Limited
Renasa Insurance Company Limited
SAFIRE Insurance Company Limited
SA Home Loans Insurance Company Limited
Santam Insurance Limited
Santam Structured Insurance Limited
SASRIA (SOC) Limited
Shoprite Insurance Company Limited
Standard Insurance Limited
Vodacom Insurance Company Limited
Western National Insurance Limited
Workerslife Insurance Limited
Yardrisk Insurance Limited

APPENDICES

STAFF

OMBUDSMAN
FOR LONG-TERM INSURANCE

Management Team
Judge Ron McLaren
Jennifer Preiss
Clyde Hewitson
Tony Sterrenberg

Adjudicators/Assessors
Denise Gabriels
Heinrich Engelbrecht
Nceba Sihlali
Nuku van Coller
Lisa Shrosbree
Yvonne Barnard-Theron
Sonya Marais-de Jager
Ganine Bezuidenhoudt
Deon Whittaker
Prevanya Moodley
Abigail Machine
Vuyolwethu Skolo
Kathy Heath
Sithandwa Tolashe
Tamara Sonkqayi
Jenny Jenkins
Nosiphiwo Sifingo
Nikelwa Tolashe

Support Staff
Rosemary Galolo
Charmaine Bruce
Marshalene Williams
Lynn Fitzpatrick
Angelo Swartz
Sureena Gallie
Colline Alexander
Tania Thomas
Nicolette May
Yolanda Augustine
Colleen Louw
Melanie Trout
Phindiwe Fana
Puleka Ngalo
Tracy Clarke
Virginia Smith
Shanon Augustine
Brenda Wyman

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Ombudsman
Judge Ron McLaren

Chief Executive Officer
Edite Teixeira-Mckinon

General Manager
Miriam Matabane

Senior Assistant Ombudsmen
Ayanda Mazwi
Darpana Harkison
Peter Nkhuna
Thasnim Dawood

Office Manager
Azeht du Plessis

Assistant Ombudsmen
Hannes Bester
Abri Venter
Johan Janse van Rensburg
John Theunissen
Kgomotso Molepo
Nadia Gamieldien
Regina Chindomu
Sangeetha Sewpersad
Valerie Mngadi
Zuleckha Cara
Elizabeth Haworth

Junior Assistant Ombudsmen
Relebogile Mashego
Vuyisile Ramakoaba

Assistant to the Ombudsman and Chief Executive Officer
Janine Jacobs

Project Manager
Marilize Blignaut

Complaints Registration Manager
Karinien Kok

Complaints Registration Administrators
Gadija Fisher
Mbali Mdakane

Complaints Transfer Manager
Jo-Anne Goqo

Complaints Transfer Administrators
Melissa van Zyl
Tshireletso Tshabadira

Case Administrators
Aadielah Soliman
Claudia Kampmann
Joanne Sergel
Louisa Godspower
Thulisile Mgiba
Refilwe Mokoena
Maureen Nel
Selinah Zwane
Vantera Freemantle

Accounts Assistant
Comfort Sebalane

Receptionist
Lebohang Morokolo

Clerical Assistant/General Worker
Mariam Khampepe

Legal Interns
Sephetha Mpja
Kgothatso Maja
Eunine Dlamini
Luqmaan Chopdat
Tsholofelo Malatse

Administrative Interns
Lucky Jacobson
Mapule Ramoshaba

OTHER **OFFICES**

ASISA
Cape Town Office
PO Box 23525, Claremont 7735
Tel: 021 673 1620
E-mail: info@asisa.org.za
Johannesburg Office
3rd Floor, Sandton Close
2 Block A
Norwich Close 2196
Tel: 010 276 0970
E-mail: info@asisa.org.za

CONSUMER GOODS AND SERVICES OMBUD
292 Surrey Avenue Ferndale
Randburg 2194
Tel: 011 781 2607
Call Centre: 0860 000 272
Fax: 086 206 1999
E-mail: info@cgso.org.za

COUNCIL FOR MEDICAL SCHEMES
Private Bag X34, Hatfield 0028
Tel: 012 431 0500
Fax: 086 673 2466
E-mail: complaints@medicalschemes.com

CREDIT OMBUD
PO Box 805, Pinegowrie 2123
Tel: 011 781 6431
Call Centre: 0861 662 837
Fax: 086 674 7414/011 388 8250
E-mail: ombud@creditombud.org.za

FINANCIAL ADVISORY AND INTERMEDIARY SERVICES OMBUD
PO Box 74571, Lynnwood Ridge 0040
Tel: 012 470 9080/012 762 5000
Fax: 012 348 3447/086 546 5694
E-mail: info@faisombud.co.za

FINANCIAL SECTOR CONDUCT AUTHORITY
PO Box 35655, Menlo Park 0102
Tel: 012 428 8000
Toll free: 0800 203 772
Fax: 012 346 6941
E-mail: info@fsca.co.za

MOTOR INDUSTRY OMBUDSMAN OF SOUTH AFRICA
Suite 156, Private Bag X025,
Lynnwood Ridge 0040
Tel: 010 590 8378
Call Centre: 086 116 4672
Fax: 0866 306 141
E-mail: info@miosa.co.za

NATIONAL CONSUMER COMMISSION
PO Box 36628, Menlo Park 0102
Tel: 012 428 7000
Fax: 0861 515 259
E-mail: complaints@thencc.org.za

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

NATIONAL CREDIT REGULATOR
PO Box 209, Halfway House,
Midrand 1685
Tel: 011 554 2600/011 554 2700
Call Centre: 0860 627 627
E-mail: complaints@ncr.org.za

OMBUDSMAN FOR BANKING SERVICES
PO Box 87056, Houghton 2041
Tel: 011 712 1800
Sharecall: 0860 800 900
Fax: 011 483 3212/0866 766 320
E-mail: info@obssa.co.za

PENSION FUNDS ADJUDICATOR
PO Box 580, Menlyn 0063
Tel: 012 346 1738/012 748 4000
Fax: 086 693 7472
E-mail: enquiries@pfa.org.za

PUBLIC PROTECTOR
Private Bag X677, Pretoria 0001
Tel: 012 366 7000/012 336 7112
Toll free: 0800 112 040
Fax: 012 362 3473
E-mail: registration2@pprotect.org

SA MILITARY OMBUDSMAN
Private Bag X163, Pretoria 0046
Tel: 012 676 3800
Toll free: 080 726 6283
Fax : 012 661 2091
E-mail: intake@milombud.org

STATUTORY OMBUD
PO Box 74571, Lynnwoodridge 0040
Tel: 012 470 9080
Fax: 012 348 3447/086 546 5694
E-mail: info@faisombud.co.za

TAX OMBUD
PO Box 12314, Hatfield 0028
Tel: 012 431 9105
Call Centre: 0800 662 837
Fax: 012 452 5013
E-mail: complaints@taxombud.gov.za

OMBUDSMAN
FOR LONG-TERM INSURANCE

Sunclare Building, 3rd Floor
21 Dreyer Street, Claremont 7700
Private Bag X45, Claremont 7735
Telephone: 021 657 5000
Sharecall: 0860 103 236
Fax: 021 674 0951
E-mail: info@ombud.co.za
www.ombud.co.za
Registered non-profit organisation number 036-985-NPO

osti ombudsman for short-term insurance

1 Sturdee Avenue, First Floor, Block A
Rosebank, Johannesburg 2196
PO Box 32334, Braamfontein 2017
Tel: 011 726 8900
Sharecall 0860 726 890
Fax: 011 726 5501
E-mail: info@osti.co.za
www.osti.co.za

www.insuranceombudsman.co.za