THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS
PRETORIA

CASE NUMBER: FAIS 04862/15-16/ GP 2

In the matter between:

BABALWA MOLATE **Complainant**

and

DISCOVERY LIFE LIMITED **Respondent**

DETERMINATION IN TERMS OF SECTION 28 (1) OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICES ACT, (ACT 37 OF 2002), (the Act)

A. INTRODUCTION

[1] This is a complaint arising out of a failure by Discovery Life Limited to suitably advise complainant - as required by the Code - in order to afford her the opportunity to make an informed decision.

[2] It is alleged by complainant that respondent, despite having been provided with necessary and available information[1], failed to appropriately advise her.

[3] As a result of respondent's ill advice, complainant claims she unknowingly accepted a later date as the date of inception of a life assurance contract covering her and her husband. Complainant concluded the contract on 23 March 2015 with the date of inception of the contract noted as 1 May 2015. But before the life cover

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[1] regard being had to her risk profile, financial needs, and circumstances

incepted, complainant's husband was killed in a motor vehicle accident on 18 April 2015, just 26 days from the date of concluding the life assurance with respondent. Complainant claims she and her two minor children are now left with no financial means to support them, a situation complainant alleges would not have arisen had respondent done its work in terms of the law and appropriately advised her.

[4] Complainant obtained information that she could have had an earlier inception date only when she was lodging the claim following the death of her husband, by which time it was already too late.

[5] For its part, respondent denies that it violated the law. Respondent claims that complainant had the choice to object to the date during the conversation with its agent and even after. Respondent says it was always up to complainant to select an earlier date, but complainant failed to exercise that choice. In all, respondent submits that it did everything to put complainant in a position where she could make an informed choice: in so doing, respondent upheld the duty to act in complainant's interests.

[6] After the death of her husband, complainant lodged a claim with respondent, which was rejected outright.

[7] Following a protracted exchange of correspondence between the parties, respondent finally conceded to pay what it calls an Immediate Cover and offered complainant the amount of R400 000. It is common cause between the parties that complainant and her husband had each applied for R2 000 000 life cover. The amount was based on advice provided by respondent during the telephonic conversation between complainant and respondent.

B. THE PARTIES

[8] Complainant, Mrs Babalwa Mclate is a 33-year-old widow, who was both a stay-at-home mother and a student at the times material to the advice. Her full details are on file with this Office.

[9] Respondent is Discovery Life Limited, a public company duly incorporated in terms of South African Laws with registration number 1966/003901/06. Its principal place of business is 155 West Street, Sandton. Respondent is an authorised financial services provider in terms of the FAIS Act, with licence number 18147. The licence is active.

[10] At all material times, respondent rendered financial services to complainant, through its Discovery Connect Distribution Channel. In this determination respondent and respondents should be read as one and the same.

C. FACTUAL BACKGROUND

[11] It appears from respondent's records[2] that complainant had made an enquiry regarding life cover at one of the Virgin Active Health Clubs. This enquiry led to the call made by respondent's direct marketing division, known as the Discovery Connect Distribution Channel to complainant, on 23 March 2015. Through the telephonic interaction, complainant concluded a life cover contract for herself and her late husband. Complainant was thus the contract owner and first life assured while her late husband, to whom she was married in community of property, was the second life assured. She was informed during the call that the commencement date would be 1 May 2015. Respondent's agent advised complainant during the

[2] The record referred to is that of a telephonic conversation between complainant and respondent's call centre agent.

call that it was a *'little too late'* in the month to begin the policy in April, a statement complainant accepted as a fact. Tragically, complainant's husband was killed in a car accident on 18 April 2015.

[12] Sometime after the death of her husband, complainant called respondent's offices to lodge a claim[3]. She was told by one Lizelle Badat, a claims administrator, that her husband had no life cover; he had died before the policy incepted. During the telephonic exchange, Ms Badat apparently advised complainant that respondent does offer immediate life cover for the full amount chosen, suggesting that complainant could have had the life cover commence immediately. Complainant was advised that respondent's legal team would listen to the recording and make an evaluation of the claim.

[13] On 8 June 2015, complainant received respondent's first letter of rejection which was penned by one of respondent's claims assessors, Ms Kadijang.

[14] The relevant aspects read:

"Dear Mrs Molate

We have assessed the claim after the death of Lehlogonolo Abner Molate who passed away on 18 April 2015.

The late Lehlogonolo Abner Molate applied for the above-mentioned Discovery Life Policy on 30 March 2015 and on the application form he selected a future start date [of] 1 May 2015 as the date of commencement for cover.

Section Terms and conditions for immediate cover of the application form [state]:

When immediate cover pays out:

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[3] The date is not mentioned in the record

We consider claims for immediate cover only if you meet all of the following conditions:

- *You intended to enter into a policy and pay premiums for full life, severe illness, and disability cover;*
- *You have not had any applications for life, severe illness or capital disability insurance with us, or any other assurers declined or only accepted on special terms. This includes application for increases in cover.*
- *You are younger than 65 years old;*
- *You have not asked for the full cover to start at a future date.....*

Unfortunately, we have declined the claim under the immediate Life Cover Benefit. The reason for the decline is because the life assured passed away before the selected future date when cover would have started. Immediate Life Cover does not pay out when a future date is requested." (My emphasis).

[15] In a later letter, Ms Kadijang wrote:

"We are currently assessing your claim for the late Lehlogonolo Abner Molate. It has come to my attention that the Discovery policy was sold to you telephonically on 23/03/2015 and your application commencement of the contract was 01/05/2015 (a date which was not selected by yourself but rather communicated..., Thompson.'). Based on the information we received from new Business we are now re-assessing your claim" (my emphasis).

[16] Complainant was advised to expect feedback by no later than 11 June 2015 from a Ms Leoni de Beer (de Beer). On 29 June 2015 Ms de Beer, a Claims and Admin Support Manager wrote to complainant and reiterated that the date of

commencement selected by complainant's husband was 1 May 2015. Ms de Beer however, went further and stated: ***"We hereby confirm that your claim does not qualify for life cover due to the unmet premium receipted on 2015/05/13".***

[17] It is accepted by both parties that complainant's husband did not apply for life cover. Complainant applied for life cover for both of them and was the contract owner. Her husband was the second life assured.

D. THE COMPLAINT

[18] In her letter dated 21 September 2015 complainant wrote:

"I believe I was denied the choice to have full immediate cover due to incorrect information at the point of sale. I was ill-advised by the Discovery Life's Sales Consultant – as a result, I did not get the full pay out I would have if I had been given the correct information. In my conversations with the Sales Consultant, Claims Administrator and Assessor, it can be observed that I was in fact disadvantaged by the information given by the Sales Consultant" (own underlining and italics).

E. RELIEF SOUGHT

[19] Complainant seeks payment of R1 600 000, being the balance remaining from the amount of R2 000 000 life cover, after deducting the payment made by respondent of R400 000.

To bring the claim within the jurisdictional limits of this Office, complainant agreed to forego the amount in excess of R800 000, which brings the claim to R800 000.

F. RESPONDENT'S RESPONSE

[20] On 22 October 2015, the complaint was referred to respondent in terms of rule 6 (b) of the Rules, so it could resolve the complaint with its client. Respondent replied refuting all claims of liability. A summary of respondent's response of 4 December 2015 is set out immediately here below:

20.1 Respondent confirmed having rendered financial services to complainant. To assist its call centre agents to meet the requirements of the FAIS Act, respondent has created a script to guide them during the course of rendering advice.

20.2 Respondent provided the abstract below as demonstration: -

'N.B. PLEASE ARRANGE DATES OF COMMENCEMENT ACCORDING TO THESE CUT OFF DATES'

- *If you sell a policy between 01st and 10th of the month, please arrange Date of Commencement for the first of the coming month (sale made between 01-10 June, DOC will be 01 July)*
- *If you sell a policy between the 11th and the 30th / 31st of the month, you must arrange Date of Commencement for the first of the month after next (sales made between 11-30 June, DOC will be 01 August)*

If clients [want] the DOC to be immediate please inform clients that he / she may be double debited if their application cannot be processed in time'.

20.3 The guidelines according to respondent have been put in place to minimise prejudice to clients. Such prejudice could come from delays relating to medical underwriting and possible double debit for premiums. In accordance

with the script, respondent's agent commenced complainant's policy on 1 May 2015, states respondent.

20.4 A further point raised by respondent was that complainant had neither objected to the date nor requested an earlier date even though the date was repeatedly confirmed during the course of the call.

20.5 Respondent also submitted that its agent had informed complainant of the Immediate Cover Benefit and the payment of R400 000 in the event death were to occur while respondent processed complainant's application.

20.6 On 30 March 2015, respondent sent complainant the policy schedule, with a welcome letter. Complainant was advised in the welcome letter to contact respondent in the event she wished to make any changes to the policy. Even after receiving these documents, complainant elected not to make changes to the policy.

20.7 Based on the foregoing submissions, respondent claims that complainant had ample opportunity to change the date of commencement of the policy during and after the sales call, but complainant chose not to do so.

20.8 In summation, respondent submitted that complainant was provided with all the material and relevant information to make an informed decision. Respondent advised that it had offered complainant the amount of R400 000 in accordance with the Immediate Cover Benefit upon submission of her complaint, which complainant accepted.

[21] The complaint was not resolved and on 18 March 2016, a notice in terms of section 27 (4) was issued to respondent requesting it to provide the Office with its full case and supporting documents.

[22] Respondent provided its response to the section 27 (4) notice on 8 April 2016. In brief, respondent conceded they did *'not explicitly give the complainant an option as to the date on which the policy would commence'.* However, respondent submitted that *'it is not necessarily standard practice for an advisor to provide a client with such an option in the first instance. It will all depend on the response from the client as to whether or not the advisor goes into further detail regarding the selecting of a particular commencement date'* (own underlining and italics).

22.1 Respondent repeated its earlier statements about the script and highlighted that the script contains reference and guidance information and suggested that the information in respect of commencement dates is meant to guide the adviser (call centre agent). Respondent argued that the fact that complainant was not given the option to choose an alternative date did not preclude her from objecting to the proposed commencement date or enquiring about an alternative date.

22.2 The onus, according to respondent, rests with complainant to object to the proposed commencement date and request an alternative date, at which time the adviser would have been obliged to discuss the implications of such commencement date with her. When complainant was informed about the date, she merely agreed to it.

22.3 Respondent again highlighted the administrative burden that comes with refunding premiums deducted in error and the attendant frustration to clients.

22.4 Respondent reiterated that the "Immediate Cover Benefit"[4] was always at complainant's disposal.

22.5 In conclusion, respondent maintained that complainant was fully advised regarding the cover available to her. Respondent's staff complied with the processes and ensured that a reasonable and an appropriate general explanation of the nature and material terms of the relevant contract were provided to complainant. On that basis, respondent's view is that it upheld its duty to act in the interest of the client.

G. DETERMINATION

[23] When rendering financial services to a client, respondent must comply with the provisions of the FAIS Act; the General Code of Conduct for Authorised Financial Services Providers and Representatives, (the Code); and the Treating Customers Fairly Regulatory Framework.

[24] The Code itself is drafted in terms of section 16 of the FAIS Act, the genesis of all the codes. Before canvassing the relevant sections of the Code, it is necessary to first look at section 16 to understand the mischief that was aimed at by the legislature. The section reads:

Principles of Code of Conduct

(1) A code of conduct must be drafted in such a manner as to ensure that the

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[4] This benefit seemingly, is offered to client as "interim cover" whilst underwriting takes place and provides cover up to the maximum amount of R400 000 for a period of maximum 30 days, until such time as the actual policy is in place.

clients being rendered financial services will be able to make informed decisions, that their reasonable financial needs regarding financial products will be appropriately and suitably satisfied and that for those purposes authorised financial services providers, and their representatives, are obliged by the provisions of such code to -

(a) Act honestly and fairly, and with due skill, care and diligence, in the interests of clients and the integrity of the financial services industry;

(b) Have and employ effectively the resources, procedures and appropriate technological systems for the proper performance of professional activities;

(c) Seek from client's appropriate and available information regarding their financial situations, financial product experience and objectives in connection with the financial service required;

(d) Act with circumspection and treat clients fairly in a situation of conflicting interests; and

(e) comply with all applicable statutory or common law requirements applicable to the conduct of business' (emphasis supplied).

[25] In so far as the "Treating Customer Fairly" (TCF) principles are concerned, which have now been accepted within the entire financial services industry, respondent, as a Financial Services Provider (FSP) is required to deliver the following six outcomes of TCF to its customers or clients:

25.1 Customers can be confident they are dealing with firms where TCF is central to the corporate culture.

25.2 Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.

25.3 Customers are provided with clear information and kept appropriately informed before, during and after point of sale.

25.4 Where advice is given, it is suitable and takes account of customer circumstances.

25.5 Products perform as firms have led customers to expect, and service is of an acceptable standard and as they have been led to expect.

25.6 Customers do not face unreasonable post-sale barriers imposed by firms to change product, switch providers, submit a claim or make a complaint.

[26] The TCF principles aim to raise standards in the way firms carry on their business by introducing changes that will benefit consumers and increase their confidence in the financial services industry. TCF aims to, amongst others:

26.1 help customers fully understand the features, benefits, risks and costs of the financial products they buy; and

26.2 minimise the sale of unsuitable products by encouraging best practice before, during and after a sale.

[27] Ultimately, the final question that must also be considered is whether or not respondent breached its statutory duty to appropriately and suitably advise complainant so that she was able to make an informed decision about the

proposals made by respondent's agents on that day. A further relevant question to ask is whether respondent discharged its duties with due skill, care and diligence, in the interests of its clients and the integrity of the financial services industry. In the event respondent were to be found to have failed to discharge its duty with due skill care and diligence, it would imply respondent was negligent[5] in advising complainant.

Issues for determination

[28] The issues that arise for determination are:

28.1 Whether respondent in rendering financial services to complainant upheld the Code.

28.2 If it is found that respondent failed to abide by the Code, whether respondent's conduct caused the loss complained of.

28.3 Quantum

Whether respondents appropriately and suitably advised complainant

[29] The relevant sections of the Code are:

29.1 Section 15 (2) (a) - in terms of this section, respondent must, *inter alia,* make *'enquiries to establish whether the financial product or products concerned will be appropriate, regard being had to the client's risk profile and financial needs, and circumstances.'*

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[5] Kruger v Coetzee 1966 (2) SA 428 A: [32]The classic test was formulated by Holmes JA in Kruger v Coetzee as:
'For the purposes of liability culpa arises if –
(a) a *diligens paterfamilias* in the position of the defendant-
(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
(ii) would take reasonable steps to guard against such occurrence; and
(b) the defendant failed to take such steps.'

29.2 Section 3 (1) (a) - a provider must ensure that the representations made and information provided to a client are:

(a) Representations made and information provided to a client by the provider must be–

(i) Factually correct;

(ii) provided in plain language, avoid uncertainty or confusion and not be misleading;

(iii) Must be adequate and appropriate in the circumstances of the particular financial service, taking into account the factually established or reasonably assumed level of knowledge of the client;

(iv) must be provided timeously so as to afford the client reasonably sufficient time to make an informed decision about the proposed transaction;'

29.3 Section 15 (3) (j) - a provider prior to the conclusion of any transaction must provide the client with the following information:

'Concise details of any special terms and conditions, exclusions, waiting periods, loadings, penalties, excesses, restrictions or circumstances in which benefits will not be provided;'

29.4 Section 2 - a provider must, '*at all times render financial services honestly, fairly, with due skill, care and diligence, and in the interests of clients and the integrity of the financial services industry'.*

[30] Section 15 (2) (a) is peremptory and leaves no room for discretion on the part of the provider. A related section for providers other than direct marketers is section

8 (1) of the code.

[31] In its first letter to this Office, respondent referred to a script that it had designed for its call centre agents and highlighted certain information. The information included:

31.1 Respondent's business processes;

31.2 The nature of information featured in their script. In this regard, guidelines were distinguished from reference information;

31.3 Respondent's concern for the possibility of double debiting its clients' accounts and possible delays arising from underwriting. It was stressed that these may upset certain clients;

[32] It was emphasised in the letter that complainant, notwithstanding the advisor's repetition of the commencement date during the sales call, had neither objected nor proposed a different date of commencement. Complainant also failed to propose an alternative date following receipt of the policy schedule; and

[33] Respondent also advised that it had paid complainant the immediate cover amount of R400 00.

[34] The challenge for respondents in all of this is that they have provided to this Office a record that shows objectively, that complainant was not advised that she had the right to choose the date of inception, nor the right to object to the date given to her. Apart from making this claim respondent makes no case whatsoever as to how complainant would have known of these rights. Having said this, I noted from the

response that respondents simply narrowed the problem to the question of dates. In my view the late date of inception was borne out of a bigger problem, which was respondent's failure to take complainant's circumstances into account when providing advice. These circumstances include complainant's risk profile, financial circumstances and needs.

[35] Beginning with the question of risk, one must consider that complainant and her late husband had no life cover whatsoever at the time and had never been covered before. It is clear from the respondent's record that complainant had no experience in financial products nor did her late husband. Respondent's record confirms that complainant's husband had taken the step of enquiring from another insurer about the possibility of obtaining life cover. For reasons that are unclear and not germane to this complaint, complainant decided to assume the responsibility of sourcing life cover for both of them.

[36] As persons who had never had life cover, they may not have been aware of the full implications of the risk they were facing. True, they had the sensibility to seek the services of professionals (respondents) to assist them and it was respondent's duty to take into consideration that in the event anything were to happen to the husband, complainant and her two minor children would have no financial means to carry on. This risk was glaring and respondent had a duty to take that into account in selecting the date.

[37] As I understand it from respondent's version, the dates from the script are guidelines and referencing material and as such there was nothing that could have prevented respondent's agent from advising complainant about covering her and

her husband immediately[6]. The problem here arose because respondent's representative never applied his mind to circumstances presented by their client and paid no attention whatsoever to the risk factors. I note respondent's repeated statements about the inconvenience that is caused to clients when their accounts are doubly debited. The inconvenience of a double debit pales when one considers the perilous position in which families find themselves when a bread winner dies without suitable life cover. Complainant and her husband may have seen the need to have life cover but they were not alerted to the risk confronting them. Respondent on the other hand, as the expert, was alive to the urgency of the situation; knew how the product worked; and knew that until 1 May, complainant and her husband had no life cover.

[38] A further demonstration of respondent's failure in advising complainant can be seen from the fact that complainant was given the inception date of 1 May (a future date in other words). This means that respondent, by its own conduct, had closed the opportunity for complainant to qualify for a claim under the Immediate Cover of R400 000. (See in this regard the conditions for Immediate Cover as set out in the letter of 8 June 2015 from respondent's claims assessor, Ms Kadijang.) (I will return to this factor.)

[39] The point about complainant having failed to change the start date, or select her own during the call and upon receipt of the welcome letter, is unfair. Respondent can produce no information to support the claim about complainant's knowledge. On the contrary, the circumstances of this case when viewed objectively show that

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[6] See respondent's response of 4 December 2016: *"If client wants the (DOC)[6] to be immediate please inform clients that he / she may be double debited if their application cannot be processed in time…"*

complainant would not have such knowledge, unless she was appropriately advised. Respondent is capitalising on its client's ignorance. Respondent's conduct in this regard undermines the spirit of the FAIS Act, the Code and the principles behind TCF.

[40] Further evidence that respondent failed to advise complainant can be found on respondent's record. The agent can be heard rushing through the script and at certain intervals reading through chunks of paragraphs, without explaining them to complainant. This, notwithstanding that most of these paragraphs were material to the contract. (Refer to the record and hear how respondent dealt with the issue of claims under the Immediate Cover Benefit. None of the conditions outlined in respondent's letter of 8 June 2016 were dealt with in the conversation.) It is no wonder that respondent conceded to pay the amount of R400 000. They must have realised that they had failed complainant.

[41] Complainant was repeatedly informed during the conversation that a financial needs analysis had not been carried out and that the life cover may not be adequate. She was told she would need to see a financial advisor for a needs analysis. In actual fact, the product sold to complainant fell short of her needs and this is evident upon listening to the conversation. How complainant was supposed to know what a "needs analysis" is, or the importance thereof, is not explained.

[42] Respondent cannot deny that the following information was always available to it:

42.1 Complainant and her late husband were a relatively young couple, with two young children, (toddlers) at the time.

42.2 Neither had ever had life cover.

42.3 From his business, complainant's husband generated income between R40 000 and R50 000. (The record shows that respondent worked on the average of R45 000). From the amount of R45 000 complainant received about R32 000 to run the household.

42.4 Complainant had no income of her own as a student; the husband was the sole provider.

40.5 In the event of death of the husband without a reasonable amount of life cover, complainant and her two children would have no financial means to carry on. In violation of the Code, none of these factors were considered by respondent.

[43] Respondent paid no regard to complainant's financial circumstances nor the risk that was confronting her, in contravention of section 15 (2) (a) of the Code. To put it more charitably, the evidence objectively evaluated shows no indication that respondent's representative considered complainant's circumstances.

Whether respondent's conduct met the requirements of section 3 (1) (a) (iii)

[44] The section requires that: *'representations made and information provided to a client by the provider,* ***must be adequate and appropriate in the circumstances of the particular financial service, taking into account the factually established or reasonably assumed level of knowledge of the client;'*** (my emphasis).

[43] I refer in this regard to respondent's response of 8 April 2016.

'….After having investigated the matter in full, we would like to take this opportunity to respond as follows:

'While we do concede that the adviser did not explicitly give the complainant an option as to the date on which the policy would commence, we respectfully submit that it is not necessarily standard practice for an advisor to provide a client with such an option in the first instance. It will all depend on the response from the client as to whether or not the advisor goes into further detail regarding the selecting of a particular commencement date'.

[44] Respondent's reference to its standard practice is prejudicial to clients who are first-time buyers of life cover. One does not have to be a genius to conclude, after listening to respondent's record, that complainant depended solely on the information supplied by respondent. That is the reason she sought the services of professionals in the first place. She knew nothing about life cover and had no idea she had an option to select the date for commencement of cover, nor was she even aware of the implications of beginning the life cover on 1 May 2015 while the financial service was rendered to her. Respondent on the other hand knew the implications.

[45] Apart from the respondent's representative posing questions to which for the most part, complainant had to give very brief answers, there is little effort made to invite complainant into a discussion. While respondent was definitely in control of the conversation, all that can be heard is the representative's rush to complete the script and close the transaction. Yet it was evident from complainant's answers that

she could not fully comprehend the full risk that she was facing. She relied solely on the guidance provided by respondent.

Whether respondent's conduct met the requirements of section 15 (3) (j)

[46] Section 15 (3) (j) provides that prior to the conclusion of any transaction the direct marketer must provide the client with the following information:

'Concise details of any special terms and conditions, exclusions, waiting periods, loadings, penalties, excesses, restrictions or circumstances in which benefits will not be provided;'

[47] In simple terms, complainant should have been advised that, given the commencement date of 1 May 2015, she and her husband had no life cover until the policy incepted. Respondent was further obliged to advise complainant that because of the inception date of 1 May 2015, complainant and her husband would not be eligible for a claim under the Immediate Cover option and no benefit would be paid in the event of either individual's loss of life[7]. None of this was communicated. Yet again, it would not have availed respondent to have simply left the matter at the hands of complainant. A provider discharging its duties with care and diligence and acting in the client's interests would have secured cover at the earliest date.

[48] I find that the standard practice and administrative processes[8] that respondent has in place are solely for its own convenience and are not a means of protecting or assisting its clients. Certainly, the possible frustrations mentioned by respondent

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7 Refer in this regard to the letter dated 8 June 2015

8 See paragraphs 20 and 43 regarding respondent's processes and standard practice.

and the administrative burden of refunding clients are far outweighed by the need to be protected from the harsh consequences that visit families when a breadwinner dies without life cover. Respondent's failure to disclose all the material facts prejudiced complainant.

[49] Complainant, after lengthy exchanges and frustration, was eventually paid the amount of R400 000 in terms of the Immediate Cover Benefit. The payment is small consolation given that complainant's family lost a breadwinner. Had respondent acted with the care and diligence required by the Code[9], he would have recognised that complainant's circumstances, and this includes the risk that complainant was facing, were more suited to life cover at the earliest date and would have advised complainant accordingly. Nothing in this approach would prejudice respondent. After all, it was for clients with circumstances such as complainant's that respondent saw fit to have early dates of commencement, subject to a double debit.

[50] Much was made of complainant's failure to object to the date of inception of 1 May or to propose a new date for inception, especially after she received her acceptance letter of 30 March 2015 confirming the inception date as 1 May 2015. What respondent does not explain is how complainant would have known about this option, given the outright statement made during the sales call that it was too late in the month to have the policy incept on 1 April 2015.

[51] It is disappointing that respondent places the duty on complainant to solicit information about an alternative commencement date; an option complainant could not have known about after having been told that it was a "little too late" for cover

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[9] Section 2 of the General Code

to start on 1 April 2015 which implied that there were no other options available to her.

Treating Customers Fairly

[52] Much of what I have already pointed out about respondent's conduct offends the TCF principles. However, I consider it necessary to refer to respondent's letters of 8 and 29 June 2015, in which respondent communicates its decision to reject complainant's claim. While I do not have the reasons for respondent's failure to first study its records prior to communicating with its client, it was disturbing to note that respondent had simply rushed to communicate its decision to reject the claim without taking the time to verify the facts. Having received input from complainant, after its letter of 8 June, respondent does not appear to have concerned itself with correcting the details, instead, respondent rushed back to complainant on 29 June, only this time with an added point about an unpaid premium, to bolster its case for rejection. All of this presents respondent as someone who was more concerned with covering all bases to avoid liability, even if this may not have been the case. Respondent had all the time from the date this claim was first lodged with its offices to consult its records to ensure that it communicates the correct details to its client. Such an approach is consistent with the duty to treat customers fairly.

[53] It further appears from respondent's letters to this office that notwithstanding the obvious violations of the Code, there was simply no willingness to do the right thing. It is one thing to escape liability for one claim and totally another to expose yourself to conduct that could be construed as avoiding a claim at all costs. Such conduct undermines the spirit of the FAIS Act, the General Code and the Principles behind TCF regulations.

[54] It might be that respondent handles these types of claims so frequently that they have stopped recognising the human face behind the claim. This in my view does little to foster the integrity of the financial services industry. It also runs counter to the inclusive approach adopted by the policy makers to ensure that South Africans are encouraged to participate in the financial services industry.

Whether respondent's conduct caused complainant's loss

[55] I have taken into account respondent's submissions to this Office and noted that respondent at no point made a case that complainant would not have qualified for cover at the earliest possible date. Accordingly, it was respondent's failure to appropriately advise complainant that led to complainant being left with no life cover upon the death of her husband. This makes respondent's advice the primary cause of complainant's loss.

[56] The next enquiry deals with legal causation. The question is whether, as a matter of public and legal policy, it is reasonable to hold respondent liable for the loss complainant suffered. In other words, can it be said that the inappropriate advice rendered resulted in the loss complainant suffered?

[57] I refer in this regard to the matter of *International Shipping Co (Pty) Ltd v Bentley*[10] where Corbett J noted the following:

"As has previously been pointed out by this Court, the law of delict causation involves two distinct enquiries. The first is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as "factual causation". The enquiry as to factual causation is

[10] 1990 1 SA 680 (A) [700 E-G].

generally conducted by applying the so-called "but-for" test, which is designed to determine whether a postulated cause can be identified as a causa sine qua non of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such a hypothesis, plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; .....If the wrongful act is shown in this way not to be a causa sine qua non of the loss suffered, then no legal liability can arise. On the other hand, demonstration that the wrongful act was a causa sine qua non of the loss does not necessarily result in legal liability. The second enquiry then arises, viz whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote".

[58] I concluded earlier that had it not been for the inappropriate advice rendered by respondent, complainant's attention would have been drawn to the need to secure life cover at the earliest date, after which complainant would have enjoyed cover for the full amount of R2 million. After respondent had spoken to both complainant and her late husband, who had both informed respondent that they had no life cover, the risk faced by complainant must have been foreseeable. Instead, respondent failed to appropriately apply its mind to the circumstances and recommended a date that suits its administrative processes, resulting in complainant accepting the later date communicated by respondent. This is the reason complainant's husband died without life cover.

H. QUANTUM

[59] Complainant's claim is for the amount of R1 600 000. As elaborated on in paragraph [19] above, the amount claimed is limited to R800 000. An order will be made that respondent pay to complainant an amount of R800 000, minus the premium applicable for the months of March and April 2015 when cover should have incepted.

I. ORDER

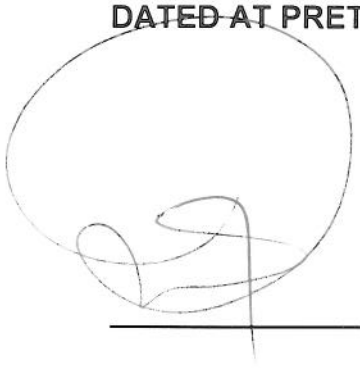
[60] In the premises, I make the following order:

1. The complaint is upheld.

2. Respondent is ordered to pay complainant the amount of R800 000 less premiums of the months of March and April 2015.

3. Interest on the amount of R800 000 shall be calculated at the rate of 10.25% from seven days from date of this order to date of final payment.

DATED AT PRETORIA ON THIS THE 05TH OF MAY 2017



NOLUNTU N BAM

OMBUD FOR FINANCIAL SERVICES PROVIDERS