IN THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS

HELD AT PRETORIA

CASE NO: FOC 1434/05 NP 2

In the matter between:

SUSANNA ALETTA GROBLER **Complainant**

and

DIRECT AXIS (PTY) LTD **Respondent**

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

The Parties

[1] Complainant is Susanna Aletta Grobler, an unemployed widow, who was married in community of property to Douw Gerbrandt Grobler ('the deceased') of 6 Leipoldt Street, Phalaborwa, Limpopo Province.

[2] Respondent is Direct Axis (Pty) Ltd an authorised financial services provider in terms of the FAIS Act and a company duly incorporated in terms of the laws of the Republic, with its principal place of business at 6th floor, Sanclaire Building, Claremont, Western Cape.

Background

[3] This complaint, received on 24 August 2005, concerns the rejection of a death claim made by the Complainant in terms of a Wesdirect Customer Protection Plan ('policy') over the life of the deceased. The policy, underwritten by Hollard Life Insurance Company Ltd., was effected through the intermediation of the Respondent. The policy is typically referred to as 'credit life' in the industry and is a form of risk cover put in place to secure debts issued by financial institutions. It affects millions of consumers who obtain goods or services on credit or where such consumers borrow monies through short term loans. Typically, the policy would, in the event of death or disability or in some cases retrenchment of the debtor, pay off the outstanding indebtedness. There is a simple process of putting the policy in place without adhering to stringent underwriting processes.

[4] In this case, the deceased had borrowed the sum of R25 000,00 from WesBank. The policy covering the outstanding liability due to WesBank in the event of death and certain other eventualities was put in place through direct marketing over the telephone.

[5] The deceased passed away barely two months after the policy was incepted. The cause of death is described as 'HEART FAILURE'.

[6] The claim was rejected by the insurers as a result of an alleged non-disclosure by the deceased of a pre-existing medical condition which contributed to the cause of death. This determination turns on whether there was proper explanation of the terms and conditions of the policy by the Respondent during the rendering of the financial service, so that the deceased could have made an informed decision about the proposed transaction and/or disclosed conditions which would have materially affected the risk that was underwritten.

[7] My determination and reasons therefore appear below.

The Complaint

[8] The Complainant in a three page letter detailed all the steps she had taken subsequent to the death of the deceased on 10 January 2005 to claim the proceeds of the policy. After the lapse of a period of some 6 months, she was finally informed by way of a letter from the underwriting agents dated 5 August 2005 that the claim was rejected.

[9] WesBank in a letter dated 5 August 2005, informed Complainant that she was now liable for payment of the outstanding indebtedness due by the deceased to WesBank. The balance outstanding according to the letter is the sum of R31 562.79. Thus the complaint is that as a result of the negligent rendering of the financial service and/or non-compliance with the FAIS Act by the Respondent, the

Complainant will potentially suffer loss in the sense that there would be a reduction in the net value of the joint community estate or, as is being claimed by WesBank she would have to pay the outstanding balance of the loan taken by the deceased.

The Response

[10] In its response to the complaint, Respondent maintains that in the telephonic conversation during which the policy was sold, the deceased was advised that no claim would be paid out as a result of illness or injuries that existed prior to the contract. The Respondent maintains that the deceased understood the exclusionary terms when the product was sold over the telephone.

[11] The Respondent further states that the terms and conditions 'flyer' was enclosed with a letter detailing all the loan details and that a copy of the credit life insurance policy document was also enclosed under cover of this letter.

[12] The Respondent further states that the deceased could have cancelled the policy within 30 days after entering into the contract and that the policy document includes general exclusions which states that 'no claim will be paid out as a result of illness or injuries that existed prior to the contract'.

[13] The Respondent relies on a medical report by a Dr W G Boshoff confirming the cause of death and the pre-existing condition contributing thereto. The Respondent

also places reliance on the fact that the deceased had taken out a previous loan from WesBank on the 30 April 2004 and this was also subject to a similar credit life policy. Therefore, so the argument goes, the deceased ought to have understood the terms and conditions of the policy sold to him during the loan transaction.

[14] A critical portion of Respondent's reply is that during the telephonic direct marketing exercise, the deceased accepted the exclusionary clauses of the policy on the basis of which the claim was rejected. The Respondent maintains that 'the client was advised that no claim will be paid out as a result of illness or injuries that existed prior to the contract.' According to Respondent the deceased responded by stating that he understood this.

[15] In the course of investigating this matter this Office obtained a copy of the 'flyer' referred to by the Respondent as well as a transcript of the conversation and the actual voice recording captured on a compact disc. This Office also had sight of the policy document issued to the deceased.

Determination and reasons therefore

[16] A critical aspect of this case which, in my view, would indicate whether the complaint will be upheld or not is the conversation that took place on 24 November 2004. It is during the course of this conversation that the financial service was rendered and terms and conditions of the loan were explained by Respondent and

apparently understood by the deceased. It is a conversation, which according to our estimate lasted approximately 9 minutes. The conversation is between the Respondent's call centre agent, one Clint Cupido ('Clint') and the deceased.

[17] Having listened to the recorded conversation and having read the transcript thereof it is clear that of the approximately 51 exchanges (contained in blocks on the transcript) between Clint and the deceased, 8 relate to the sale of the policy. I deem it appropriate to deal with these exchanges in order to set the tone for exactly what the actual disclosures were that were made to the deceased and on which the insurer relies in rejecting the death claim. The 8 exchanges are as follows:

[17.1] The first exchange relates to confirmation of the acceptance of the loan and a statement to the effect that 'en soos ons onafhanklike makelaars is het ons daarmee ingesluit n optionele beskermingsplan wat deur Hollard Versekering gedek is'. The deceased replies that he knew about it;

[17.2] The second, third and fourth exchanges relate to disclosure of the costs involved in respect of this policy and the commission paid. This according to the transcript is a total premium of R108,25 of which R22,22 is commission and R9,50 administration fees and the balance of R76,53 is the risk premium. The deceased responds by saying 'OK'. Clint also gives the deceased the assurance that this R108,25 premium is already included in

the R1002,30 being the monthly instalment on the loan. The deceased replies to the effect that 'dis alles ingesluit in daardie R1002,30 ne?' Clint then assures the deceased that it is so and further that the instalment remains constant over the term of the loan. The deceased responds by saying 'O nee dis in die haak';

[17.3] The fifth exchange contains a further assurance by Clint that if the deceased falls into arrears on the loan, WesBank will continue to pay the premiums, 'so dat u al die volle dekking van u versekering kan geniet'. Deceased responds by saying 'Dis reg ja';

[17.4] The sixth exchange informs the deceased that the policy would cover him if he was permanently or temporarily disabled or if he died or had any critical illness. Deceased is also assured by Clint that three months of premium will be paid in terms of the policy should he be retrenched. Deceased responds by saying 'Doodreg';

[17.5] The seventh and critical exchange goes as follows:

Clint: 'En ook geen eis word ook uitbetaal gevolg van siektes of beserings wat nou voor hierdie kontrak datum bestaan het nie.

Deceased: O ja-ek verstaan dit ja.'

[17.6] The eighth and final exchange with regard to the rendering of the financial

service relates to a statement by Clint to the effect that the policy summary and statutory notice will be sent to the deceased within fourteen days. The deceased is also informed that he is welcome to read the document and call back should he have any queries.

[18] It is also relevant to mention what one can consider the all-encompassing final word on the subject, contained in the 48th exchange between the parties. This is a question posed to the deceased as to whether he had any further questions related to the loan. The deceased's response is that he understands and that everything was explained to him clearly and that he had no further questions. The conversation ends on this note.

[19] Before I examine the critical exchange contained in paragraph [17.5] above, I deem it appropriate that I comment on the material aspects of the exchange detailed above and examine whether it complies with the General Code of Conduct for Authorised Financial Services Providers and Representatives, as contained in Board Notice Number 80 published in Government Gazette Number 25299 of 8 August 2003 ('the General Code').

[20] Section 3 (1) (a) of the General Code provides that:

'(1) When a provider renders a financial service –

(a) representations made and information provided to a client by the provider –

(i) …

(ii) must be 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;'

[21] Bearing in mind the responsibility of the provider as detailed in paragraph [20] above, the question which arises is; can it be said that the disclosure with regard to the exclusionary clauses found in the policy on which the insurer relies in rejecting the claim was made clear to the deceased and provided in plain language; that it avoided any uncertainty or confusion or that it was not misleading. An examination of the critical exchange referred to in paragraph [17.5] reveals the following:

[21.1] Clint makes a statement which, if translated literally, simply means that the deceased is being informed that no claim will be paid as a

result of illnesses or injuries that existed prior to this contract. The question which arises is; what did the deceased understand this to mean? Did it mean that the deceased cannot claim in respect of any illness or injury which existed prior to the contract or does it mean, as the policy wording indicates, that should there be any claim on the policy which is as a result of a pre-existing condition, then and in such event, the policy will not pay? Furthermore, and more importantly, did the deceased understand this as a question which called upon him to disclose any pre-existing conditions which could invoke the application of the exclusions set out in the policy? Regrettably, the deceased cannot provide us with an answer to this question. However, an examination of the probabilities might lead one to a conclusion in this regard.

[21.2] There is nothing on the evidence to indicate what 'the factually established or reasonably assumed level of knowledge' of the deceased was at the time that the financial service was rendered to him. Our investigation revealed the following:

[21.2.1] The highest standard of education passed by the deceased was Standard 6;

[21.2.2] The deceased was employed as a hoist driver in the

mines at the time of his death;

[21.2.3] The deceased and Complainant lived with their son on whom they relied for some support;

[21.2.4] The Complainant, whose highest standard of education is Standard 8 is a housewife;

[21.2.5] Complainant and deceased were constantly in debt and relied heavily on loans of the nature provided by institutions like WesBank to supplement the income the deceased earned from his employment.

[22] Taking into consideration that to the average South African consumer, financial services and financial products are, by their very nature, complex, it can be assumed that someone in the position of the deceased would be what one can consider a consumer in need of care. Without detracting from the responsibility to make proper disclosures in all instances, my view is that with this type of consumer, I believe that more than cursory attention should be paid to explaining terms, conditions, exclusions, limitations and other restrictions on financial products sold, in order that such a consumer can make an informed decision.

[23] If one were to assess what the reasonably assumed level of knowledge of the

deceased was at the time the policy was sold to him, one would say that he was the type of consumer who was unable to protect his own interest due to his inability to understand the character, nature or language of the transaction in question. This type of consumer is certainly one who can be subject to abuse, which one sees being perpetrated daily in this country.

[24] From the record of the exchanges between the Respondent and the deceased, it is quite clear that no exercise to establish the level of knowledge of the deceased was ever undertaken. Even if it is assumed that the Respondent knew the level of knowledge of the deceased, there is nothing in this exchange that reveals that anything was done to ensure that the representations made and information provided was adequate and appropriate or that it was provided in plain language, avoided uncertainty or confusion and was not misleading. In fact, my sense is that the statement in that critical exchange was confusing and misleading and certainly not adequate or appropriate, in the circumstances.

[25] The communication between Respondent and the deceased reveals that even if the deceased was a more sophisticated consumer he would not have understood the critical communication relating to exclusions as meaning exactly what was excluded in terms of the policy or as an invitation to make disclosures of pre-existing conditions which would invoke the application of the exclusions set out in the policy. It would appear from the record that an exercise was embarked upon by the Respondent which had as its natural consequence the purchase of this financial

product, whether it was appropriate or not.

[26] The record of the conversation reveals that a policy had already been put in place by the Respondent, even before this discussion. This is evident from the statement to the effect that '… en soos ons ook onafhanklike makelaars is het ons daarmee ingesluit n optionele beskermings plan wat deur Hollard Versekering gedek is,..' This is reinforced by the pre-calculated instalment, which includes the premium and other charges for the policy. It is important to mention that at the time the deceased concluded his transaction for the loan agreement at WesBank, it already included these premiums. Thus, if one were to comment on the state of mind of the deceased, it would not be unfair to conclude that he already had an indication of what his repayments would be and was therefore 'prepped' into accepting it.

[27] In the circumstances, whatever argument the Respondent may raise that the exclusionary clause was properly explained to the deceased flies in the face of Section 3 (1) (a) (iv) of the General Code which requires that such disclosures as are necessary 'must be provided timeously so as to afford the client reasonably sufficient time to make an informed decision about the proposed transaction.' In this case, the impression created is that the transaction relating to the sale of the policy was already in place. Simply informing an unsophisticated consumer, as the deceased was, that an optional protection plan is in place is not seeking his participation in a transaction that is contemplated. Rather, it is simply telling him that one is in place. This, in my view, is not what is intended by the FAIS Act, in its

various codes for authorised financial services providers.

[28] At the very least, in all the circumstances, the statement on which the Respondent relies created uncertainty and was confusing and misleading.

[29] I turn now to an examination of what the policy document says in respect of exclusions. I do so, in order to establish whether the statement made by Clint in paragraph [17.5] above adequately covers what the policy document provides as exclusions in terms of the policy. The policy document in Section C, paragraph 1 provides for:

'UITSLUITINGS VAN TOEPASSING OP AFSTERWE, ONGESKIKTHEID EN GEVREESDE SIEKTE' and says

'Geen bedrag sal betaalbaar wees indien Ons van Mening is:-

a) dat U siekte, ligaamlike besering, fisiese defek, swak gesondheid of enige ander insident of toestand wat wesenlik bygedra het tot die sterfte-, ongeskiktheid-of gevreesde siekte-eis voor the Aanvangsdatum van die Versekering bestaan het;'

[30] My first observation with regard to the exclusion referred to above is that it goes beyond what was spelled out by Clint in his one-liner referred to in paragraph [17.5] above. The exclusion spells out that if the insurer is of the view that a pre-existing condition contributed to death, disability or serious illness, then no amount will be payable. This is not the same as saying that no claim will be paid as a result of

previous illnesses or injuries that existed prior to the contract date.

[31] The second important consideration is what exactly those illnesses or injuries must be. If one were to simply go by what Clint said as referred to in paragraph [17.5] above, those illnesses could range between anything from a common cold to terminal cancer. It is clear to me that the disclosure should have been far more explicit as to what exactly those illnesses should be. Guidance in respect of what should have been spelled out to the deceased is contained in what the policy sets out as the defined events covered by the policy. The policy spells out by definition, *inter alia* what a heart attack, stroke, heart surgery etc. is. Now had Clint perhaps been more specific with regard to what those pre-existing conditions were that would invoke the application of the policy exclusions, perhaps one could say that there was proper explanation of the exclusions contained in the policy. It is clear that no such explanation was given to warrant that proper disclosure was indeed made at the time the financial service was rendered. Again, this would have been material in establishing whether the deceased made an informed decision when he accepted the policy with all its conditions, exclusions, limitations and exceptions.

[32] The third critical consideration is what exactly the deceased understood by ‘pre-existing condition’. There is nothing on the record that reveals that this was ever explained to the deceased. Simply saying injuries or illnesses that existed prior to the contract coming into existence is not good enough. Logic would demand that the nature of those illnesses or injuries should have been spelled out, bearing in

mind what the policy exclusions say. This is especially so, when one is dealing with the sale of this type of policy, where no stringent underwriting takes place.

[33] It is clear from an examination of the exchange between the Respondent and the deceased that the focus of Respondent's attention was more on explaining the terms and conditions of the loan and that nothing more than cursory attention was paid to the rendering of the financial service. The exchanges relating to the entire transaction took about 9 minutes and 2 seconds. The exchanges relating to the actual rendering of the financial service, including explaining the terms thereof took no more than 2 minutes and 2 seconds. How one can reasonably explain the terms, conditions, exclusions, waiting periods and other implications of a financial product in such a space of time is difficult to imagine.

[34] I turn now to examine the 'flyer' to which the Respondent also refers. This document is a two page document detailing the terms and conditions of the loan agreement. Although there is reference to the policy in this document, such reference is not material to the issue as it relates to the cession of the policy and not to the material terms thereof. I therefore do not deem it necessary to make further comment thereon, other than to say that this document does not assist the Respondent, nor does it take the case any further.

[35] Respondent has also relied on the fact that the deceased had the right to cancel the policy, should he have desired, within 30 days of having taken out the cover. Now, I

do not believe that people buy financial products with a view to cancelling them. I believe that the average consumer, and this would have been true of the deceased as well, intend to have cover in place to protect them against the eventualities that they believe they are covered for. In any event I do not believe that reliance on the 30 day cooling off period, in any way releases the Respondent from its obligation to disclose material terms when rendering the financial service.

[36] What is important to mention in relation to this aspect of the response is that nowhere in the conversation is it ever explained to the deceased that he is entitled to cancel the policy within the 30 day 'cooling off' period. As I have stated, I do not believe the deceased intended to cancel the policy, as he would have wanted the same to be in place. This is evident by the fact that in his previous transaction, to which the Respondent refers, deceased had a policy in place which ran for a substantial period, until its cancellation when the previous loan was cancelled and this new loan put in place with a new policy to cover the indebtedness due to WesBank.

[37] I think it appropriate that I comment on the relationship between WesBank and Respondent. Clint introduced himself as 'Clint van WesBank'. Throughout its dealings with the deceased no mention is made of Direct Axis, which our investigation revealed is the Respondent in this case. It is fair to assume that the deceased laboured under the mistaken belief that he was dealing with WesBank. It is public knowledge that WesBank is controlled by First Rand Limited, which we

have established owns a 51 percent controlling interest in Respondent. Respondent who has its FAIS licence number and is operating as a direct marketer is misrepresenting this fact to the public by introducing itself as WesBank and hiding behind this corporate veil. This surely is not what the legislature intended when it enacted Section 3 (1) (a) (i) and (ii) of the General Code to the effect that statements made must be factually correct, avoid uncertainty or confusion and not be misleading.

[38] A final aspect of this case that warrants comment is that the provider in this case, failed to follow the provisions of Section 44 (1) of the Long Term Insurance Act, 52 of 1998 ('LTI') regarding 'free choice'. This section requires a party to a contract in terms of which money is loaned or credit is granted to make available a long-term policy or its policy benefits for the purpose of protecting the interests of the creditor. It further states that the party required to make that policy or its policy benefits available shall be entitled and be given written notification to a free choice. Section 44 (1) (a) of the LTI states that this free choice entitles a party to enter into a new policy, to make available an existing policy or to utilise a combination of both. In the circumstances of this case, Respondent failed to comply with the provisions of this section and further failed to inform the deceased of his rights pertaining to free choice. It is clear that the 'optionele beskermingsplan' is not compliance but simply paying lip-service to compliance with Section 44 (1) (a) of the LTI. In reality, the deceased had no option than to take the policy presented by the Respondent.

Conclusion

[39] Research has shown that there is growing acceptance of electronic business transactions in the modern paperless environment to enable consumers to readily access and effect insurance cover. It is also argued that technology is making insurance feasible, requiring minimal advice.(Business Times Article accessed on www.btimes.co.za on 19.01.2006) The problem that faces the financial services industry, and direct marketers in particular, is the aspect of minimal advice as is evident in the present matter. In order to render an effective financial service and provide appropriate advice, direct marketers will have no option but to adhere to the provisions as detailed in the FAIS Act.

[40] It has been found that the actual rendering of the financial service in this matter took no more than 2 minutes and 2 seconds. It is an indication that direct marketers endeavour to maintain quick turnaround times to meet commission targets. It is evident that in an effort to maintain these turnaround times the unsuspecting consumer will be the victim, as is apparent in this case.

[41] The fact that the deceased was told by Respondent that no claim will be paid as a result of sickness or injuries that existed prior to the contract was simply not adequate or sufficient disclosure as envisaged by the FAIS Act. Respondent should have elicited more information regarding ‘pre-existing conditions’ in view of the materiality of this exclusionary clause.

[42] Clearly there was non-compliance in the rendering of the financial service as detailed above. This non-compliance is likely to lead to the Complainant suffering potential financial loss, which in this case would mean either her having to pay the outstanding indebtedness to WesBank or the joint estate subsisting between her and late husband having to pay the debt. It is evident that WesBank is pursuing this debt against the Complainant.

[43] In my view, a case has been made for non-compliance by the Respondent of the provisions of the FAIS Act when rendering this financial service. It is just and equitable in all the circumstances that Respondent makes good whatever loss the Complainant will potentially suffer as a result of its conduct. The order I therefore make is as follows:

Order

i. Respondent is ordered to pay the outstanding indebtedness due by the deceased to WesBank in terms of the loan granted with account number WDC21849A, including interest and penalties added thereon;

ii. Respondent is ordered to pay the case fees of this Office in the amount of R1 000.00 plus Value Added Tax thereon.

DATED AT PRETORIA ON THIS 19th OF JANUARY 2006

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CHARLES PILLAI
OMBUD FOR FINANCIAL SERVICES PROVIDERS