IN THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS PRETORIA

CASE NO: FAIS 05402/09-10/ GP2

In the matter between:

PETER JOSEPH HARTEN **Complainant**

and

WALTER KRANZ INSURANCE BROKERS CC **First Respondent**

WALTER KRANZ **Second Respondent**

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

A. INTRODUCTION

[1] Complainant filed a complaint that the second respondent recommended changes to a policy providing cover for permanent disability and in doing so acted negligently in failing to provide appropriate cover. The insured risk event materialized and the payment in terms of the policy fell far short of what complainant was expecting.

[2] Second respondent admits to recommending changes to the policy but denies that he acted negligently. He states that he acted according to his mandate and there was a duty on complainant to check his policy and correct any errors or draw attention to changes he did not agree to.

B. THE PARTIES

[3] Complainant is Peter Joseph Harten an adult male who was a director of Harten and Associates (Pty) Ltd which carried on the business of financial planners.

[4] First respondent is Walter Kranz Insurance Brokers CC, a duly registered close corporation which carries on business as a financial services provider (FSP). First respondent is a registered FSP with registration number FSP 10155.

[5] Second respondent is Walter Kranz an adult male FSP who is the key individual of and member of first respondent. The financial services in question herein were rendered by second respondent and for purposes of this determination I will refer to both first and second respondents as “respondent”.

C. PROCEDURAL HISTORY

[6] For purposes of this determination I consider it important to briefly set out the history of this matter in my office. Complainant initially filed a complaint against respondent relating to how respondent had dealt with his disability cover in a policy with Mutual and Federal Insurance. The matter was not fully investigated and was not determined in terms of section 28 (1) of the Act.

[7] The complaint was summarily dismissed on the basis that there was no reasonable prospect of success and both parties were informed. Complainant was dissatisfied with this and made representations urging this office to investigate the complaint and make a determination. On the 14th December 2012 and after reconsidering the matter this office informed the parties that "the *Ombud is of the view that this matter does indeed warrant an investigation".*

[8] Complainant thereafter approached the Board of Appeal (the Board) and submitted that the matter be referred back to this office for determination. Complainant also applied for condonation for the late filing of his appeal to the Board. The Board, having considered complainant's written submissions, agreed that it would be appropriate for the complaint to be referred back to this office so that it may be reconsidered. The Board, in its ruling stated as follows:

a) There was no final determination in this matter;

b) This complaint had to be dealt with "*where both the complainant and respondent are entitled to submit their case, furnish facts, information and documents in respect of this matter. Thereafter, the Ombud will consider the merits and furnish a determination";* and

c) The Ombud's office should proceed with this matter in terms of section 27(4) and (5) of the Act.

[9] I make reference to this ruling to emphasize the fact that this office may deal with the complaint notwithstanding the early decision to dismiss. This office is not *functus officio* nor is it compromised in any other way in dealing with this matter in terms of section 27 of the Act.

[10] After the Board made known its ruling, notices in terms of section 27 of the Act were delivered to the parties. Both parties made comprehensive written representations. This time, respondent consulted an attorney who made full written representations supported by comprehensive documentation. The parties were given an opportunity to respond to each other's representations. This office, through its own investigations gathered further useful information and thereafter the matter became ready for determination. I must point out that all the information obtained by my office was referred to the parties who were given an opportunity to comment or respond.

D. THE COMPLAINT

[11] Complainant was covered for permanent disability in terms of a contract of insurance between Harten and Associates (Pty) Ltd and Mutual &Federal Insurance; the policy number being 7040032 (the policy). This is a short term contract which was subject to annual renewal.

[12] In September 2006 Harten and Associates, in writing, instructed Mutual & Federal to renew the policy. At that time the stated benefit cover for death and permanent

disability, for complainant, was three times the declared earnings of R200 000, making the policy benefit R600 000.

[13] In October 2006 Harten and Associates sold its book of short term insurance to respondents and at which point stopped doing business as a short term insurance broker. Included in this book was the policy in question.

[14] On the 25th September 2007, the parties met to discuss renewal of the policy. At that time the cover in question was provided in the policy under "*Stated Benefits"* (SB). Respondent pointed out, at this meeting, that there were disadvantages to this as this type of cover is subject to any payments made by Workman's Compensation, (Compensation commissioner) and accordingly payments, in the event of risk, may take a long time to process. Respondent recommended that the basis of the cover be changed to "*Group Personal Accident"* (GPA). Complainant accepted this advice and further instructed respondent to increase cover from R200 000 per annum to R300 000 as declared earnings. This meant that three times the declared earnings would result in cover of R900 000, representing an increase from R600 000 to R900 000.

[15] Respondent amended the policy to GPA but failed to adjust the benefit cover as instructed. In fact respondent caused the benefit to be reduced from R600 000 to R300 000. At the time, complainant was unaware that this reduction in benefit had taken place.

[16] On the 9th October 2007 respondent sent complainant an e-mail confirming that the changes to the policy had been made. However there was no indication that the sum insured was now reduced from R600 000 to R300 000. Nor was there any indication that the instruction to increase cover to R900 000 was not carried out.

[17] On the 3rd August 2008 complainant had a bicycle accident which rendered him a paraplegic. In May 2009 a neurologist certified that he was permanently disabled. Mutual & Federal accepted complainant's claim and paid an amount of R300 000. Complainant was expecting R900 000.

[18] On the 3rd July 2009 the parties met and complainant pointed out that there must have been an error as the payment benefit was very low and not what he expected from the policy. Respondent refused to take any responsibility and said that complainant must take whatever steps necessary to resolve this issue.

[19] It is complainant's case that the insurance benefit was significantly reduced due to the negligence of respondent. Accordingly he is looking to respondent to compensate him for the shortfall. Complainant seeks payment from respondent in the amount of R600 000; the difference between what he should have received (R900 000) and the reduced benefit paid in terms of the policy (R300 000).

E. SECTION 27 NOTICE

[20] In addition to referring the details of the complaint to respondent, this office sent a notice to respondent in terms of section 27 (4) of the Act where, *inter alia,* the latter was requested to respond to the following:

a) An explanation was requested as to why it was appropriate for respondent to recommend the change in the policy replacing “Stated Benefits” with “Group Personal Accident”. Respondent was referred to section 8 of the General Code of Conduct for Financial Services Providers and Representatives (the Code);

b) This office accepted, on respondents own version, that he was aware of the difference between the two sections of “Stated Benefits” and “Group Personal Accident” in the policy. Accordingly respondent was called upon to explain why he did not specifically draw complainant’s attention to the fact that the amendment to the policy resulted in a substantial reduction of the cover amount;

c) Respondent was called upon to produce his record of advice as contemplated in section 3 (2) (a) of the Code. It was pointed out here that there was an interaction between respondent and client and that respondent was obliged to comply with the Code and cannot merely rely on client’s own assumed level of knowledge; and

d) Respondent was asked to demonstrate how he complied with the provisions of section 7 (1) (a) of the Code in placing the complainant in a position to make an informed decision.

F. RESPONDENT'S RESPONSE

[21] I now set out the details of respondent's response to the complaint and the section 27 notice. Respondent, initially, acted in person but later engaged the services of an attorney.

[22] After the investigation of the complaint was referred back to this office by the Board, respondent submitted that this office no longer enjoyed jurisdiction to determine the complaint in that :

a) The matter was summarily dismissed and in terms of section 27(1) (a); this amounted to a final determination. Accordingly this office was *functus officio;* and

b) The matter became prescribed in terms of section 27(3) (a) (i) of the Act.

[23] Having stated this, respondents also made it plain that due to this lack of jurisdiction, they will not participate in any further investigation conducted by this office. Respondent also took the stance that any further decision by this office will be a nullity.

[24] However, in response, my office explained, for reasons set out above, that the matter had not been finally determined on the merits and that the Board referred the matter back to this office for investigation and determination. The Board ruling then made it competent for this office to investigate and determine the matter notwithstanding the previous summary dismissal. It was also pointed out, with reference to section 27(3) (a) (ii) that the complaint had not become prescribed. In addition respondent was referred to section 27 (2) of the Act which provides as follows:

"Official receipt of a complaint by the Ombud suspends the running of prescription in terms of the Prescription Act, 1969 (Act No. 68 of 1969), for the period after such receipt of the complaint until the complaint has either been withdrawn, or determined by the Ombud or the board of appeal, as the case may be."

This office was accordingly not time barred from dealing with the complaint.

[25] Ultimately, respondent and their attorney accepted that this office had jurisdiction to investigate and determine the complaint and provided comprehensive responses to notices in the investigation of the matter. The respondent denies that there was any misrepresentation or negligence in the advice given to complainant and denies any responsibility for the amount of the payment made by the insurance company in terms of the policy. Respondent's reasons appear below.

[26] According to respondent, complainant already had a Multilink II policy issued by Mutual and Federal with an inception date in 2003. The annual renewal was 1st September of each year. Respondent was not involved in advising complainant to purchase this policy. Respondent only became involved in giving advice after the latter took over the short-term insurance portfolio of Harten and Associates (Pty) Ltd in October 2006.

[27] The first occasion when advice was given as to the terms of this policy was at a meeting which took place on the 25th September 2007 when the terms of renewal was discussed between complainant and second respondent. It is at this meeting that respondent advised complainant to change the permanent disability cover from SB cover under the policy to GPA. The reason for this advice was that benefits under SB were subject to a reduction by any amount paid under workman's compensation. In the event of a claim this could cause substantial delays in receiving payment. This was not the case under GPA in the policy.

[28] It is not disputed that this advice was given by respondent and nor is it disputed that complainant accepted the advice and instructed respondent to make the changes. According to respondent, complainant was also advised to increase cover but he indicated that he did not "*wish to pay any additional premium on this policy".* Respondent explained the difference between cover under SB and GPA to complainant who understood it. Besides, according to respondent, complainant was an experienced FSP in his own right and did not require any explanation.

[29] Respondent then submits as follows:

"There is no basis to suggest that there was any misunderstanding that in the event of permanent disability or death that the benefit payable would be calculated on multiples of the annual salary of the individual concerned".

I chose to quote the respondent here as this goes to the very heart of the dispute before me.

[30] Respondent further points out that on the 9th October he sent a letter to complainant detailing the changes made to the policy. The summary of insurance made it clear precisely what cover was afforded under the GPA policy. The stated benefit in the case of death or permanent disability is R300 000. Having received this summary of insurance, complainant made no request to change cover back to SB rather than GPA.

[31] Respondent concludes their submission as follows:

"In the circumstances, we are satisfied that there is no basis to suggest that Mr Harten was under the impression that the death and personal disability benefits offered under the Group Personal Accident were calculated in multiples of his annual salary nor any basis to contend that Walter Kranz Insurance Brokers were in any way responsible for Mr Harten been (sic) under any misapprehension as to the level of benefits available".

[32] On the 10th December 2015, respondent's attorney responded to the section 27 notice and in particular addressed the questions put to the respondent. They

further expanded and explained respondent's defence to the complaint. Whilst still claiming that this office is no longer competent to adjudicate this matter, they nevertheless dealt with the merits of the complaint. I set out the main features of the defence below.

[33] Firstly respondent submitted that the advice given to make the changes in the policy from SB to GPA was appropriate in the circumstances and was in the interests of the complainant. Respondent acted according to section 8(1) (a) to (c) of the Code. Justification for the advice is repeated and I do not intend to state the details again. I must say that there is no dispute that the advice to change cover from the SB section to GPA was suitable for complainant's needs and was appropriate. The dispute relates to the reduction in cover.

[34] As for the reduction in cover, the following is submitted:

a) The reduction in cover was brought to the attention of complainant in an updated insurance summary dated 9th October 2007. Complainant was instructed to:

"Kindly read the attached documentation in order to satisfy yourself that all the particulars are correct and complete. Please let us know immediately if any amendments are required. Should we not hear from you within 14 days from date hereof, we will accept that the documents were issued correctly and no additions of cover are required."

The policy schedule under GPA clearly specified cover in the amount of

R300 000 in respect of permanent disability of complainant. A further opportunity to check the policy schedules was afforded to complainant when the originals of the documentation was delivered to him;

b) A period of ten months lapsed and complainant did not complain that the cover amount was incorrect;

c) At the meeting of the 25th September 2007 a copy of the existing schedule was available and respondent, in manuscript, made changes to the figures. The old figure was deleted and the figure “R300 000” was written. These changes are consistent with the policy schedules of the renewed policy delivered to complainant. Respondent then points out that if cover for R900 000 was required, then this is the figure that he would have inserted. There was no instruction to increase cover to R900 000;

d) The complainant agreed to the reduced cover provided by the replacement benefit because *“the premium for comparable levels of cover is approximately R900 per annum, more expensive for Group Personal Accident than for Stated Benefits.* Respondent submits that in order to maintain an affordable premium, the complainant was satisfied that R300 000 cover under the GPA was adequate. In expanding this submission, respondent states that:

"The increased cost is due to Total Temporary Disability being included in Stated Benefits cover, whereas it is additionally charged for under the Group Personal Accident policy at a rate of 13.21% of the weekly cover."

e) Complainant has about 25 years' experience in the short-term insurance industry and was well aware of the difference between the two benefits. It was not necessary to explain the difference to him. Further, he accepted the reduced pay out provided by the replacement benefit.

Respondent then concludes that there was no breach of section 2 of the Code.

[35] This office requested respondent to provide his record of advice in respect of this transaction. Respondent admits that he did not maintain a record of advice, in terms of section 3(2) (a) of the Code, but claims that the surrounding documentation shows that he acted in the interests of the complainant. He relies on the matter of Dianne Horsely Janssens and LifeforceFinancial Services.

[36] Finally respondent submits that he complied with section 7 (1) (a) of the Code in that he made full and frank disclosure of information required by complainant to make an informed decision.

G. THE ISSUES

[37] The issues before me are fairly narrow and can be briefly stated as follows:

a) Did respondent, in any way, commit breach of the Code when providing complainant with financial advice? In particular Sections 2, 3, 7 and 8;

b) This issue can only be properly determined after the principal dispute of fact between the parties is resolved;

c) That dispute of fact is simply whether or not complainant instructed respondent to reduce cover and whether respondent drew complainant's attention to the reduced benefit and that complainant indicated he accepts same. Bear in mind that respondent does not dispute that in amending the section of the policy he did reduce the cover value for permanent disability;

d) If the dispute of fact is resolved in favour of the respondent, that will end the matter;

e) If the dispute is resolved in favour of the complainant, then I will have to address the consequences with regard to breach of the Code and the consequences of such breach.

H. ANALYSIS AND FINDINGS

[38] At the outset it is important for me to set out the following undisputed facts:

a) Before respondent took over Harten and Associate's short-term portfolio, complainant enjoyed cover under an existing policy;

b) The policy was a Mutual &Federal Multilink II policy which had an inception date of 2003. The policy is a typical business all risk type insurance where complainant's business and certain movable assets were covered against risk. The policy also provided death and disability cover for complainant and his wife, who also worked in the business;

c) Until September 2007, disability cover for complainant was taken under the SB section of the policy. The cover benefit was calculated as three times the complainant's declared annual earning. The declared earning was stated as R200 000 and therefore the cover benefit was R600 000. The schedule to the policy stated as follows:

- *"Cover in respect of*

  PJ Harten
- *Estimated annual earnings : R200 000*
- *COVER*
- *On Permanent Total Disablement : R200 000"*

The cover was calculated as 3 times annual earnings, and was stated in the policy as follows:

"Death & Total Permanent Disability 3 times earnings"

d) When it was time to renew the policy in September 2007, respondent became the FSP in relation to this policy and gave complainant advice;

e) Complainant instructed respondent, for purposes of renewal, that the declared earnings amount must be adjusted from R200 000 to R300 000, thereby increasing the cover benefit for permanent disability from R600 000 to R900 000 (being R300 000 multiplied by 3);

f) Respondent agreed to and did adjust the declared earning amount to R300 000;

g) Complainant, at the time of consulting with respondent, was not aware of the impact of the benefit being subject to workman's compensation. In particular that there may be a delay and that whilst he will be paying a premium for R600 000 cover, there will be a reduction after the workman's compensation payment was deducted;

h) In order to address this disadvantage of being covered under the SB section of the policy, respondent advised that the cover be taken under the GPA section instead where workman's compensation will not have any effect. This advice was accepted by complainant;

i) Complainant suffered permanent total disablement as a result of a bicycle accident in August 2008;

j) At the time of this accident, the cover in terms of the policy had been reduced from R600 000 to R300 000. How the reduction happened represents the substance of the dispute in this matter;

k) Complainant made a claim against the policy and was paid R300 000.

I. COMPLAINANT'S CONDUCT

[39] On respondent's own version, complainant did not request a change from SB to GPA. This was respondent's advice. In the process of accepting this advice, complainant instructed respondent to increase his declared income from R200 000 per annum to R300 000 per annum. The importance of this lies in the fact that it is common cause that complainant increased his declared income for the sole purpose of increasing his disability and death cover in terms of the policy. The increase in declared income served absolutely no other purpose. Clearly then, the parties would not even have discussed increasing the declared income if the intention was to decrease cover benefits.

[40] This is what complainant states:

"*I agreed to the change from Stated Benefits to Group Personal Accident and we decided to increase my declared earnings from R200 000 to R300 000 per annum. This would increase the cover provided by the policy from R600 000 to R900 000 under the Death and Total Permanent Disability section and the Total Temporary Disability cover from R3850 per week to R6000 per week."*

[41] Respondent even noted this in manuscript on the old schedule (striking out R200 000 and writing in R300 000). Even in the updated insurance summary, the following appears:

"Estimated Annual Earnings: R300 000"

This is consistent with respondent having received instructions to increase the declared earnings. This much is not disputed by respondent.

[42] It is equally not in dispute that under the SB section of the policy, complainant had cover, for permanent disability, in the amount of R600 000 (being his declared income of R200 000 multiplied by 3). It is further not in dispute that for purposes of renewing the policy, complainant increased his declared income to R300 000. The only possible purpose of this increase was to provide for an increase in cover. It makes no sense at all for complainant to increase his declared income so that his disability cover can be reduced. There are no facts before me to support this probability.

[43] It makes even less sense that respondent should receive instructions to increase the declared or estimated income only for the purpose of reducing the cover from an existing R600 000 to R300 000. This is highly improbable and not supported by any fact.

[44] Accordingly complainant's version that he increased his declared income, from R200 000 to R300 000, for the purpose of increasing his cover from R600 000 (three times R200 000) to R900 000 (three times R300 000) must be accepted. It must then follow, on the probabilities, that complainant did not instruct respondent to reduce his benefit cover to R300 000 in the event of permanent disability. The whole purpose of amending the policy was to provide complainant with better

benefits and better cover for permanent disability. Why would he then agree to worse cover and worse benefits from what he already had?

[45] I cannot accept respondent's version that complainant reduced his cover to reduce his premiums. He was already paying premiums for R600 000 cover for permanent disability. There is no evidence that he changed from SB to GPA to reduce his premiums. The change was on respondent's advice and it had nothing to do with the cost of cover. If the premium was the reason to accept a reduced cover under GPA, then it made no sense to increase the declared income and to make any amendments at all. By all accounts, complainant would then have been better off making no amendments to the policy.

[46] The point must then be made that the increase in declared income to R300 000 was merely a means of calculating the increased cover complainant desired. This figure was never intended by complainant to be the cover amount itself for permanent disability. This figure was intended by complainant to be multiplied by three to provide him with the desired cover of R900 000. This much was in fact discussed with respondent, evidenced by the fact that he does not dispute that complainant instructed him to increase his declared annual income.

[47] By all accounts the switch from SB to GPA had nothing to do with the amount of the cover. It was merely to avoid the inconvenience of possible delays brought about by workman's compensation. Therefore it is highly improbable that at the

same time complainant will want reduced cover which is substantially worse than what he already had under the existing SB section of the policy.

J. RESPONDENT'S CONDUCT

[48] Respondent attempts to avoid liability by placing blame on complainant in respect of two grounds:

a) That complainant is a FSP in his own right and it was not necessary to explain the difference in cover/benefits in the two sections of the policy; and

b) The summary of insurance was delivered to complainant under cover of a letter calling on the latter to check and satisfy himself that particulars of the cover provide were correct. Respondent relies on the assumption that complainant read and understood the document and did not complain about the cover amount for permanent disability.

[49] I first deal with the fact that complainant was an FSP. This is irrelevant and does not relieve respondent of his own duties as a licensed FSP. Nor does this fact relieve respondent from his obligations to comply with the Act and Code when providing financial advice. Respondent cannot rely on an assumption that the client is familiar with the product and then proceed to sell the product without satisfying himself that client understands the product, that it is appropriate for his needs and is in a position to make an informed choice. Respondent was, at all material times, under a duty to comply with section 7 and 8 (1) (a) to (c) of the Code. I find as follows:

a) Even on respondent's own version, complainant did not have knowledge about the policy. Complainant was unaware of the impact of workman's compensation on the SB section of the policy. It was the respondent who drew his attention to this. On his own version, respondent cannot rely on the fact that his client was an FSP;

b) Respondent admits that he did not explain the difference in benefits, between SB and GPA, to complainant. On his own version, he was in breach of Section 8 (1) (d) of the Code;

c) On respondent's own version, the changes to the policy amounted to a partial replacement of an existing policy. He was then obliged to comply with Section 8 (1) (d) of the Code. Again, on respondent's own version, he failed to comply;

d) There was equally a duty on respondent to check the summary to ensure that he carried out his client's mandate correctly and according to instructions.

[50] I now turn to the letter that respondent relies on. It is not in dispute that this letter together with a summary of benefits was delivered to complainant. I will assume, in favour of respondent, that complainant read this letter and the attached summary. I make the following findings:

a) Delivery of the letter alone does not amount to compliance with the code. Respondent, as an FSP, had to follow up and explain the summary of insurance to complainant. It is not in dispute that this was not done;

b) Respondent relies on the fact that the summary states as follows:

"COVER

On Permanent Total Disablement R300 000"

The submission is then made that complainant was aware of the decrease in cover and did not complain it was too low. I cannot accept this; respondent merely quotes from the summary the one line that suits his version. Respondent fails to deal with this in context of the whole document. At the beginning of the page relied on by respondent the following appears:

"Cover in respect of:

PJ Harten

Estimated Annual Earnings: R300 000" (my emphasis)

[51] Thereafter the cover amount for disability is stated as R300 000. Respondent was entirely justified in reading this as disability cover being three times his declared annual income of R300 000, namely R900 000. If this was not the case why would the increased declared amount even appear in the schedule? This is the way cover was calculated in SB section of the policy. Naturally he interpreted this as R300 000 times three. It simply made no sense to interpret this as a benefit of only R300 000. There is no evidence that complainant instructed respondent to obtain cover the equivalent of his declared income. It therefore comes as no surprise that

complainant did not complain that the insured amount was incorrect. Besides, complainant had no reason to believe that his FSP will actually reduce his cover.

a) On respondent's version, the renewed policy contained two material changes;

b) Cover was moved from SB section to GPA section of the policy; and

c) Cover amount for permanent disability was reduced from R600 000 to R300 000.

[52] On respondent's own version, he was obliged to draw his client's attention to these changes and in particular to the drastically reduced cover amount. Respondent repeatedly points out that complainant understood the difference in the two sections of the policy and accepted the advice to change the section from SB to GPA. However, this is not the substance of the dispute herein. The dispute is over the cover amount and not the section of the policy. Respondent's version that complainant instructed him to reduce the cover and was satisfied with such reduction is not supported by any facts. Had respondent complied with Section 8 (1) (a) to (d) of the Code, this problem would not have come about and any misunderstanding between client and FSP would have been cleared up.

[53] Respondent admits that he did not keep a record of advice in terms of Sections 3 (2) (a) and 9 of the Code. However he states that the sum total of all the surrounding documents, which he provided, effectively amounts to a record of

advice and this office must take cognizance of it. This office does take cognizance of all the documents provided by the parties and if it appears from such documentation that there was compliance with the Code, no adverse finding will be made.

[54] I have carefully considered the documents provided by respondent and my findings are as follows:

a) There is absolutely no record of complainant's instruction for respondent to reduce his permanent disability cover from R600 000 to R300 000;

b) There is no record that the reduction in cover was motivated by a desire to reduce premiums;

c) There is no record that the disability cover under the GPA section of the policy is calculated differently from that in the SB section. That the cover under GPA is the equivalent of client's declared annual income;

d) There is no record that this calculation was explained to complainant, who then acknowledges that he understood same and agreed to it;

e) There is no record that respondent explained the consequences of reducing cover and why this was possibly not in the interests of client. On his own version, respondent submits that he advised complainant to increase cover;

f) It is not in dispute that the complete Mutual and Federal policy schedule was only delivered to complainant by respondent on the 29th March 2009; after the bicycle accident.

The inevitable conclusion is that respondents own documentation does not support his version of the disputed facts.

[55] It was not intended by the Act and the Code that keeping a record of advice be treated as a mere option by FSPs. Actual compliance is required and FSPs must keep a proper record of this on file. Failure to do so will expose FSPs to risk. As in this case, on the probabilities, respondent was negligent in failing to ensure that the cover was calculated as three times the declared income of client. He failed to read the summary of insurance that came from Mutual and Federal and his error went unnoticed by him. Had respondent complied with Sections 3 and 8 of the Code, this would not have happened.

[56] The Act and Code do not merely have a regulatory purpose, they are there to assist and protect both FSPs and consumers of financial products. When an FSP fails to comply, then he does so at his peril. Failure to comply compromises both client and FSP. There will be consequences and this case is in point.

K. MUTUAL AND FEDERAL

[57] This office contacted the insurer to seek clarity from them about the policy. Mutual and Federal then responded, in writing as follows:

a) In the event that cover for R900 000 was requested, this would have been within their limits in terms of the policy and such request would have been accepted;

b) In the event that cover was provided in this amount, the sum of R900 000 would have been paid in the event of a claim; and

c) The onus was on the broker to load the correct amount of the cover. In this case the broker loaded a flat R300 000 and not as three times the declared annual income or a flat R900 000.

L. CAUSATION

[58] But for respondents conduct, the insurer would have paid complainant R900 000 instead of R300 000.

[59] The cause of this loss was respondent's failure to comply with the Code. Further, respondent could reasonably have foreseen that his negligent conduct would cause loss to complainant. There was thus a duty of care on respondent to ensure that his conduct did not result in loss to complainant. In negligent breach of this duty, which negligence is set out above and which breach includes breach of the Code, respondent caused complainant to suffer loss in the amount of R600 000. In the premises respondent is liable to compensate complainant in the said amount.

M. CONCLUSION

[60] In the premises, for reasons set out above, I come to the following conclusions:

a) Complainant instructed respondent to increase cover for permanent disability in the GPA section of the policy from R600 000 to R900 000;

b) Respondent failed to carry out his instructions or he negligently loaded the incorrect amount when the policy was renewed;

c) Respondent failed to check the policy schedules and thereby failed to notice that the wrong amount was loaded;

d) Respondent breached Sections 2, 3,7 and 8 of the Code;

e) But for respondent's failure to insure for the correct amount, complainant would have been paid R900 000 and not R300 000; and

f) Respondent's conduct resulted in loss to complainant in the amount of R600 000;

g) Respondent is liable to pay to complainant the sum of R600 000.

N. THE ORDER

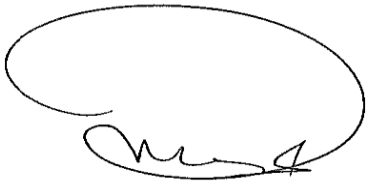
[61] In the result, I make the following order:

1. The complaint is upheld;

2. Respondents are ordered to pay to complainant the sum of R600 000, jointly and severally, the one paying the other to be absolved;

3. Respondents are ordered to pay interest on this amount at the rate of 10,25% per annum from the 30th July 2009 to date of payment.

DATED AT PRETORIA THIS THE 15th DAY OF JUNE 2016.



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