IN THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS PRETORIA

CASE NUMBER: FAIS 03315/14-15/ EC 2

In the case between:

MAFA MKHOHLWA **Complainant**

and

WORKERS LIFE ASSURANCE COMPANY LIMITED **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 successfully applied for funeral cover from respondent wherein he required cover for himself and certain extended members of his family, including a cousin. The cousin had a history of tuberculosis and after the cousin passed away, complainant made a claim against the policy. Respondent rejected the claim relying on an applicable exclusionary clause.

[2] Complainant referred the matter to the Ombud for Long Term Insurance (OLTI). The latter did not resolve the dispute and referred the case to this Office.

[3] This Office attempted to facilitate a possible resolution of the dispute; but this was unsuccessful. The parties then requested that the matter be investigated and a final determination be made.

B. THE PARTIES

[4] Complainant is Mafa Mkhohlwa an adult male, employed by the South African Police Services, who resides at 28 Bukani Crescent, Gompo Town, Duncan Village, East London.

[5] Respondent is Workers Life Assurance Company Limited, a life assurance company that trades under the name and style of “Workerslife”. Respondent is a public company duly registered according to the company laws of South Africa and having its principal place of business at 273 Paul Kruger Street, Pretoria. Respondent is an authorised financial services provider as provided for in the FAIS Act.

C. FACTUAL BACKGROUND

[6] A representative of respondent, Olwethu Konya (Konya) met with complainant who wanted to apply for funeral cover for himself, his mother and cousin. This cousin is Sinethemba Mkohlwa who, at the inception of the policy was known to suffer from tuberculosis. Complainant’s mother and cousin were to be covered under the “extended family” provision of the funeral policy.

[7] Konya informed complainant that his mother was too old to qualify for cover as she was over 80 years old (although it appears from the application form that the mother was born in 1937, making her 76 years old at the time, which means that she would have qualified for cover under the “extended family from 65 to 80” section). Nevertheless, complainant’s mother was not covered.

[8] Complainant's 25-year-old cousin however, was covered. Through the services of Konya, a contract of insurance was entered into, under application number SL 186115 (the policy). The inception date of the policy was the 6th May 2013.

[9] On the 24th March 2014, complainant's cousin passed away. Complainant then proceeded to file a claim against the policy. Respondent required a claim form to be filled in and gave complainant a medical questionnaire to be filled out by the doctor or hospital. From the hospital records,the questionnaire was completed by a doctor at the Nkqubela Hospital, where the cousin received treatment for tuberculosis.

[10] The medical questionnaire revealed the following information:

a) Question 3 required the hospital to state if the patient had "Respiratory or lung disorders, e.g. tuberculosis, asthma, bronchitis, persistent cough." To this question the hospital answered "yes".

b) The hospital recorded that symptoms started in May 2012 and the patient last received treatment on the 26th June 2012;

c) The hospital further expanded on this by stating the following; "patient absconded from Nkqubela Hospital whilst on TB treatment; on 26/06/2012 and never readmitted again."

d) The patient also sought medical advice, or treatment in respect of AIDS or HIV infections. The patient received treatment for retroviral disease, but it was unknown when this happened.

e) The patient died as a result of "*disseminated tuberculosis*".

[11] The significance of the medical information is that:

a) The cousin, at the date of inception of the policy had a pre-existing, relevant, medical condition; and

b) Had received medical treatment for tuberculosis during 24 months prior to the commencement date of the policy.

[12] As a result of this medical information, respondent rejected the claim on the 16th April 2014. The basis being the two exclusionary clauses, one on the application form and another under permanent exclusions in the Popcru Funeral Family Benefit Scheme. The clauses are as follows:

a) *"Should death occur due to <u>any pre-existing medical condition</u> within the first 24 months prior to inception date, claims will be declined."* (the first exclusion) (own underlining)

b) *"A medical condition from any illness which arises from or is caused by a condition or defect for which medical treatment has been recommended, advised, sought out or received during the 24 months prior to the commencement date."* (the second exclusion)

[13] After rejection, complainant wrote to the respondent requesting them to pay the claim. Respondent stood by its decision and refused to make any payment.

[14] Complainant states that at the point of sale the representative of respondent did not explain the exclusionary clauses to him. The nature of the complaint then brought the matter within the jurisdiction of this Office.

[15] Respondent disputed complainant's version on the basis that the representative did explain the exclusionary clause to complainant who, by his signature on the application form, acknowledged same.

D. THE ISSUES

[16] On the facts of this case the following are the issues for determination:

a) Was complainant appropriately advised? In particular, were the exclusionary clauses in the policy disclosed and explained to complainant prior to him concluding the contract?

b) In the event the respondent is found to have been in breach of the Code, whether its conduct caused complainant the loss now complained of; and

c) Quantum.

E. COMPLAINANT'S VERSION

[17] According to complainant, Konya represented respondent at the time. Konya filled in the application form from information given by him. After she filled in the form, complainant signed it. During this process, Konya explained the following:

a) The waiting time in respect of a claim for his cousin, who was sick, will be three months; and

b) It was not possible to add his mother to the policy as she was too old.

[18] According to complainant, he told Konya that his cousin was “in and out of hospital with tuberculosis”. Konya responded by saying that it was fine as long as she finishes the waiting period of 3 months. Konya was filling in the form and thus complainant was unable to read the exclusion clause. The document was then merely presented to complainant for signature.

[19] At no time did Konya draw his attention to the exclusion contained in the application form, in its correct form; nor was his attention drawn to the permanent exclusion in the policy document. Incidentally, the policy document was received after he signed the application form and the terms and conditions in the policy were not in front of him when he signed. Complainant is adamant that these conditions were not explained to him by Konya or any other representative of respondent.

[20] As a result of the rejection, complainant suffered hardship as he experienced difficulty in making funeral arrangements for his cousin. He was forced to obtain an expensive loan and is still struggling to repay it. Complainant states that he was treated unfairly by respondent and believes that he was let down by the latter.

F. RESPONDENT’S VERSION

[21] Respondent simply relied on the medical report and the exclusions in the policy to reject the claim. Respondent relayed what had happened at point of sale but failed to furnish the Office with its records in terms of sections 3 (2) and 9 of the General Code of Conduct, (the Code). I return to these duties later in this determination. According to respondent, the following happened:

a) Konya was the representative who dealt with complainant; but at the time another representative was also present, her name is Busisiwe Makapela (Makapela);

b) Konya explained the medical exclusion that appears next to “Member Details” on the form; and

c) By signing the form, complainant acknowledged that he received the original policy document which contains the terms and conditions of the policy; and

d) Konya left her contact details with complainant who could have called her if he did not understand the terms and conditions.

[22] In a formal response to this Office, respondent made the following representations as to why they should not be held liable:

a) The exclusion clause was placed “prominently” on the form in the section “Member Details” and complainant ought to have been aware of it;

b) The exclusion clauses were also well placed in the main policy for complainant to have read it or be aware of it;

c) There was a duty on the complainant to read and understand the policy further, that he had a 30 day period to do so and if he was dissatisfied he could have cancelled with no penalty;

d) The exclusion clauses were explained by Konya and the dispute of fact in this regard must, on a balance of probabilities, be resolved in favour of respondent;

e) The pre-existing medical clause only applies to extended family members and not to main members and spouses. The representative is not expected

to ask confidential and intrusive medical questions when selling these products. Besides, complainant may not know that there was any illness present regarding extended family members;

f) This matter was referred to the OLTI who was satisfied that the exclusion was prominent enough on the policy. This Office should give some weight to the views expressed by the OLTI;

g) Konya was an RE5 qualified representative and Makapela was a representative under supervision; both corroborate one another in statements where they say that the exclusion clause was explained to complainant and his attention was drawn to the policy where the clause in question is found. Incidentally, Konya had not yet passed her exams at the time; she passed only on the 1st November 2013 (seven months after the inception date of this policy);

h) Respondent complied with Section 8 (1) (a) to (c) of the Code as the representative did explain the exclusions. As for the deceased's medical history, respondent submits that complainant did not say he was aware of any medical history and respondent is of the view that the cousin was not likely to disclose her history to anyone;

i) Respondent complied with Section 7 (1) (c) (vii) of the Code as the representatives explained the exclusion and complainant received the application form and terms and conditions. Respondent submits that there is no law, not in the Act nor the Code, that requires providers to record disclosures of exclusions made to clients in the record of advice; and

j) The dispute here is not about the main member, it is about the cousin. The main member “may not have full information on the medical condition of extended family members”.

I will deal with each of the above submissions later in this determination.

G. LEGAL FRAMEWORK

[23] Bearing in mind the peculiar facts of this case the following, legislative and policy framework, is applicable:

a) The provisions of the Act, in particular section 16;

b) Section 3 (2) of the Code;

c) Section 8 (1) (a) to (c) and section 8 (2)

d) Section 9;

e) Section 7 (1) (a) and 7 (1) (c) (vii);

f) section 2 of the General Code; and

g) The Treating Customers Fairly policy.

[24] I start with section 16 of the FAIS Act, the provenance of the Codes of Conduct. Section 16 (1) provides:

‘ *A code of conduct must be drafted in such a manner as to ensure that the 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 authorized 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 the 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 clients appropriate and available information regard their financial situation, financial product experience and objectives in connection with the financial service required;*

d) *act with circumspection and treat clients fairly in a situation with conflicting interests…….*' (own underlining)

[25] Section 3 (2) of the General Code, provides that a provider must have appropriate procedures and systems in place to:

(i) record such verbal and written communication relating to a financial service rendered to a client as are contemplated in the Act, this Code or any other Code drafted in terms of section 15 of the Act.

[26] Section 8 (1) (a) to (c) provides:

"A provider must, prior to providing a client with advice-

(a) take reasonable steps to seek from the client appropriate and available information regarding the client's financial situation, financial product experience and objectives to enable the provider to provide the client with appropriate advice;

(b) conduct an analysis, for purposes of the advice, based on the information obtained;

(c) identify the financial product or products that will be appropriate to the client's risk profile and financial needs, subject to the limitations imposed on the provider under the Act or any contractual arrangement;"

[27] Section 8 (2) states:

"The provider must take reasonable steps to ensure that the client understands the advice and that the client is in a position to make an informed decision."

[28] Section 2 of the Code provides:

"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."

[29] It must be mentioned that as a licensed FSP, respondent is bound by the "Treating Customer Fairly" (TCF) policy which has now been accepted within the entire industry. I will elaborate on this further on.

It is within this framework that this determination will be adjudicated.

H. THE DUTY TO GATHER NECESSARY AND AVAIALBLE INFORMATION AND RECORD THE ADVICE PROVIDED

[30] The Code, in section 8 (1) (a), places a duty on providers to obtain appropriate and available information for purposes of advice. In this case, information about the complainant's medical history and that of his extended family members was crucial as it has a direct impact on whether the policy benefits will be paid by the insurer.

[31] The provider is required to further analyze the information and recommend a product or products that will be suitable to the client's circumstances.

[32] The Code in section 9 requires the provider to record the advice, in particular, the product/s considered and the basis for concluding that the product recommended is likely to address the client's identified needs.

[33] I hasten to point out that the Code envisages a provider taking time to understand the client's circumstances prior to recommending the product. This understanding must be evidenced by the detail appearing in the record of advice. To be fair to the client, the provider is expected to make basic inquiries about the client's medical history and inform client that a condition, or indeed any condition, will result in a claim being declined. On respondent's own version, this was not done. The following is the justification:

"The representative is not expected to ask confidential and intrusive medical questions when selling these products. Besides, complainant may not know that there was any illness present regarding extended family members".

[34] This is entirely disingenuous. There is no basis for respondent to assume that complainant was unaware of the medical history of the cousin. If complainant did

not know, he could easily find out. Besides, it is well known and normal for the life assurance industry to ask “intrusive medical questions”. Life assurers routinely probe a prospective client’s medical history, including sending them for full medical examinations. This is so because life assurers need to satisfy themselves of the risk to which they are exposing themselves and properly underwrite it. I reject this explanation as nothing more than a feeble excuse for failing to comply with mandatory provisions of the Code.

I. RECORD OF ADVICE

[35] The high watermark of respondent’s case is that neither the Act nor the Code prescribes a format for recording advice; that there is no legislation which requires providers to maintain a record of exclusionary clauses explained to clients. This argument is nothing but a futile project calculated by respondents to deny investors the very protection that is afforded to them by the FAIS Act. In order to bring this futile project of theirs into fruition, respondent tenders the application form, signed by complainant, as its record of advice and urges for a finding that it complied with the Code.

[36] While it is true that section 9 of the General Code prescribes no set format and manner as to how advice dispensed to clients must be recorded, respondent’s claims about there being no requirement to record disclosures made to clients about exclusions is a complete misdirection.

[37] Section 3 (2) of the General Code, which requires providers to record all verbal and oral exchanges made during the course of rendering financial services, speaks exactly to this issue.

[38] The Purpose behind section 3 (2) was to ensure that providers who have duly complied with the law and afforded their clients material information [so that they are able to make informed decisions] are able to demonstrate their compliance. In an event such as this one, the record in terms of section 3 (2) will set the record straight. Thus, a client who unduly accuses a provider that has complied with the law, will have no leg to stand on. Such is the dual protection afforded by the provisions of the Code.

[39] Bear in mind that the so called record of advice is the same application form that is used for any and all of respondent's clients. The question that then arises is against what pertinent information was the advice provided. What respondent does not appreciate in this regard is that advice cannot be abstract. Advice is based on the client's circumstances. Thus it would serve no purpose to place a duty on providers to gather appropriate and available information from their clients prior to advising them, and then accept standard generic proposal forms as advice records. Besides, advice by its very nature, is aimed at placing clients in a position where they are able to make informed decisions. To put it simply, by the time a client agrees to a particular proposal, it should be with the benefit of advice provided by the provider. If respondent's arguments were to be accepted it would simply render the provisions of the code nugatory. In any event, respondent's

proposal form fails to meet the requirements of section 9 and cannot by any stretch of the imagination be a record of advice. To the extent that respondent's argument is aimed at undermining the protection afforded to consumers by legislation, it must be condemned as unlawful and inimical to the interests of clients and an affront to the integrity of the financial services industry.

[40] The following provisions are pertinent to this case. Up to this point, respondent has provided no evidence of compliance:

Section 7 (1) (a) provides as follows:

"Subject to the provisions of this Code, a provider other than a direct marketer, must-

provide a reasonable and appropriate general explanation of the nature and material terms of the relevant contract or transaction to a client, and generally make full and frank disclosure of any information that would reasonably be expected, to enable the client to make an informed decision.

Section 7 (1) (c) (vii) requires providers other than direct marketers to: "……..a*t the earliest reasonable opportunity, provide, where applicable, full and appropriate information of the following:*

(vii) concise details of any special terms or conditions, exclusions of liability, waiting periods, loadings, penalties, excesses, restrictions or circumstances in which benefits will not be provided;"

[41] I point out that there is no record as to why respondent's product, with its far reaching exclusions, was recommended as suitable for complainant's needs, which is a requirement of section 9.

[42] This Office is not persuaded by *ex post facto* statements made by respondent's representatives that they made full and proper disclosure. Section 3 (2), 7 (1) (c) (vii), 8 and 9 are peremptory. It is not clear why, after the legislature has gone to such great lengths to protect the consumer and bolster the integrity of the financial services industry, the likes of respondent would choose to operate their business in the manner suggested by respondent. These provisions were aimed at avoiding exactly the challenge respondents are facing. Thus, respondent's deliberate engineering of a dispute of fact, when it deliberately flouted the law must be rejected.

[43] Respondent made the choice not to comply with the law to its own detriment and that of its clients. It must accept the consequences.

[44] There is a further duty that respondent flouted while rendering financial services to complainant and that is section 2 of the Code. Section 2 calls upon providers to render financial services with due skill, care and diligence, in the interests of their clients and the integrity of the financial services industry. Given the far reaching nature of the two exclusion clauses, it can be said that very few people would successfully claim in respect of extended family members, making it even more compelling for respondents to ensure that they assist their clients by, firstly

ensuring that they gather pertinent information regarding extended family members; secondly, advising their clients and taking steps to ensure that they understand the exclusions; and finally, recording the advice provided. In providing the financial service in the manner it did, respondent must have foreseen that the product is highly unlikely to respond positively to a claim, thus placing its conduct in direct conflict with the duty to act in its client's interests.

[45] In its response, respondent further made the startling claim that complainant had a duty to read and understand the clause. Where respondent comes from with this duty, has not been explained. Incidentally, this is a duty placed on providers by the Code, namely, to take steps to ensure that the client understands the advice and that they are in a positon to make an informed decision[1]. Respondent further stated that Mkhohlwa had left her number with complainant and that the latter could have easily called and queried the clause or cancelled the policy within 30 days. These statements are all aimed at supporting respondent's decision to ignore the Code and not employ appropriate technology in its operations to fulfil the requirements of the Code when it renders financial services to clients.

[46] These assertions, made by respondent, are scary considering the scale of its operations, the ready-made or captive market in which it operates, and the potential harm that could visit most of its POPCRU members, who may be unaware of these far reaching exclusionary clauses in their policies. Respondent's conduct undermined the Treating the Customer Fairly principle. In this regard, the TCF

[1] See in this regard section 8 (2) of the General Code.

principle aims 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.

[47] Specifically TCF aims to:

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

b) minimize the sale of unsuitable products by encouraging best practice before, during and after a sale.

[48] Respondent recognizes that it is bound by the TCF policy and this is reflected in their website which states, inter alia, as follows:

i) "Each policy we sell takes us closer to ensuring all South Africans enjoy cover that is fair and good, regardless of their economic situation. When people know that they are adequately protected against life's hardships they are able to continue smiling, even in the face of adversity."

ii) "Although Workerslife continues to grow, we remain committed to the values that kick-started our success – respect, integrity, trust, hard work, innovation, credibility and always acting ethically." (Emphasis added)

[51] Respondent cannot now claim to have acted fairly towards complainant after violating the very law that is meant to protect the consumer.

J. THE APPLICATION FORM

[49] For purposes of this determination it is important to consider the main document viz, the “Popcru Family Benefit Scheme” new application form (the form).

[50] This document serves three purposes. Firstly, it is an application form to be filled in by the client as they make an offer for this type of assurance cover and to include extended family members. Once filled in and signed by client and the representative, it serves its second purpose of becoming a policy document containing binding terms and conditions. It then serves a third purpose as an application form for Popcru membership. The following are notable features of the form:

a) The form comprises a number of columns and rows; the columns contain member, spouse, beneficiary and extended family details whilst the rows contain the benefit details and premiums.

b) At the top of the page is a column with a bold heading “Member Details”. This column calls for the personal details of the main member and requires full names, gender, marital status, age, telephone numbers at work and home, employment details, postal address and identity number. This is a lot of information which is fitted into a very small space on the form. In this small space at the top of the column, right next to the bold words “Member Details”, appears the following:

“*Claims must be fully submitted within 365 days of death.*

Should death occur due to <u>any pre-existing</u> medical condition within the first 24 months prior to the inception date, claims will be declined." (own underlining)

[51] These words are written in very small font in an already cramped column. I make the following findings in this regard:

i) This material term of the contract is, contrary to what respondent submits, not "prominently" set out. The font is extremely small, making it difficult to read;

iii) The words are hidden within the column to the point that unless the clause is pointed out, a client could easily miss it or treat it as of no consequence;

iv) The manner in which the words are written calls for a representative to physically point it out to the client and to explain what it means; and

v) The wording appears in a column for "Member Details", yet it has nothing to do with member details; it is, on respondent's version, a binding exclusion. It can thus be confusing to a client filling in the form. Alternatively, a client filling in personal details in a very small space, which requires concentration, could easily miss these words or fail to appreciate its import during the process of filling the form.

[52] What is significant here is that, and it is not in dispute, complainant did not fill in this form. It was Konya who filled it and wrote in all the details. This being the case it is even less likely that Complainant would have seen and read the exclusion under "Member Details". I also consider that after the form is filled, complainant

has to sign it, in no less than eleven places. This alone will distract him from reading any of the small print.

[53] As for the policy, under the heading, "**Is there any permanent exclusion clauses?"** appears five different exclusions, one being the second exclusion quoted above. There is nothing unusual about where this condition is placed within the policy. However, this clause is so important that it requires the representative, not only to point it out, but also to explain in plain language[2] exactly what the clause means and how and under what circumstances the insurer will apply it and deny the insured the benefits.

K. THE EXCLUSION CLAUSE

[54] I have dealt with the exclusion clause appearing on the proposal form and pointed out that due to the significance of this clause, it should not be hidden in the document, in small print and in a place where one would not expect to find it.

[55] In terms of section 7 (1) (c) (vii), there was a duty on the representative to draw client's attention to the fact that this policy calls for 24 months. The purpose of this disclosure is to ensure that client makes an informed decision. The fact that this policy is sold as a benefit to Popcru members makes it even more necessary that this be explained to client. Lest client is left believing that as a member of Popcru, he is getting the best product the industry can offer. If this is not done, it simply amounts to an abuse of a captive customer.

[2] Section 3 of the General Code

[56] I now turn to the second exclusion which reads as follows:

"A medical condition from any illness which arises from or is caused by a condition or defect for which medical treatment has been recommended, advised, sought out or received during the 24 months prior to the commencement date." (Emphasis added)

[57] This exclusion is nothing more than a more onerous extension of the first exclusion. Now the exclusion is not for a "*pre-existing medical condition*" but for a medical condition *"from any illness*".

[58] The clause is drafted in very broad terms which clearly favours the insurer. It is so wide as to disproportionately favour the insurer, giving it virtually an unfettered discretion to reject claims and leaves the insured with uncertainty as to the cover. Even a casual consultation with a doctor can result in rejection.

[59] One has to read both exclusionary clauses with the medical questionnaire that a claimant has to refer for completion by a doctor. This questionnaire calls for a most comprehensive medical history, no possible condition has been left out. A simple yes answer to any question can result in rejection. To illustrate the point, I quote the first two questions in this questionnaire:

"Has the patient, or has the patient ever had any of the following?

1. *Disorder of the heart, e.g. rheumatic fever, heart murmur, raised cholesterol, shortness of breath, palpitations, chest pain or discomfort, angina pectoris or coronary thrombosis (heart attacks)?*
2. *High blood pressure, disease of the blood vessels or circulatory disorder e.g. cramps in the calves with exercise or walking, stroke, etc.?"*

There are 14 such questions. There is hardly any likelihood that a claimant's doctor will respond "no" to all fourteen questions, the claimant will have to have lived like a super-human.

[60] A policy holder who lived with high blood pressure for many years simply has no chance of making a claim on this policy. It is known that one in three South Africans has high blood pressure. A claimant could have consulted a doctor for cramps after walking a distance or after sporting activity such as running, a fairly routine and casual consultation such as this could result in rejection of the claim.

[61] If one considers the combined effect of both these exclusions, it is hard to imagine that any policy holder will be filing a successful claim against this policy. The whole purpose of this type of insurance is defeated as this particular policy will not provide the insured with the desired financial safety net. As in this case, even if the cousin died more than 24 months after the inception date, respondent would still have rejected in terms of the second exclusion. In terms of the Code, complainant had to be advised about this and respondents had a duty to explain this in plain language; in which event it was unlikely that complainant would have gone ahead with the proposal, in respect of the cousin, knowing that there was little or no prospect of successfully making a claim.

[62] Exclusion clauses may be void if in interpreting their ordinary and natural meaning, their literal construction creates an absurd result or defeats the whole purpose of the contract. For purposes of this determination, I do not have to make a finding as to whether or not theses clauses are void in law. I merely point it out as a risk to respondents if they persist with these exclusions as they stand.

L. DUTY TO DISCLOSE

[63] Being of such an onerous nature, there can be no dispute that the insurer's representatives were under a duty to disclose and explain these exclusionary clauses to a prospective client. This is a requirement of the Code. This much is not disputed by respondent who claims that such disclosure was made. Since no contemporaneous record was kept, respondent relies on *post facto* statements made by its representatives. Konya and Makapela gave statements that are vague, inadequate and contradictory, as I shall show here below.

[64] Due to the extraordinary breath of the exclusions, it must be necessary, not only to disclose and explain the exclusions, it is also necessary to disclose the medical questionnaire that will have to be completed in the event of a claim. In fairness to client, the exclusions must be read with the medical questionnaire. There is no dispute that the questionnaire was not disclosed to complainant, who saw it for the first time after the claim was made.

[65] This product is marketed to Popcru members and is called the "Popcru Family Benefit Scheme". The clear impression being made is that this very special and

advantageous policy is a privilege afforded only to Popcru members. A further impression is created that the policy was especially crafted to benefit only Popcru members. The net result of this is that innocent Popcru members will not suspect that this policy is mined with explosive exclusionary clauses which will render it unlikely that a successful claim can be made. On this basis alone, it is imperative that full disclosure of the exclusionary clauses must be made. It is not enough to merely point them out, there has to be an accompanying explanation, followed by a record that this was done.

[66] A further concern is that the representatives who went out and sold this policy were employees of respondent and were mandated to sell only this funeral policy. They did not market any other similar product. Nor is it likely that the representatives drew their member's attention to other products available on the market for the purposes of comparison and recommending the product that would be most suitable to the client's needs and circumstances.

[67] Members would naturally believe that this is a product provided by their own union and will not question its efficacy. They are not likely, then, to ask for or look for other products. Respondent was certainly aware of this and clearly exploited the situation.

[68] Failure to make full and open disclosure of the exclusions, coupled with the fact that only this product was offered by the representatives will have the following effect:

a) The client will not be in a position to make an informed decision;

b) The client will be deprived of the opportunity to make a free choice; and

c) The client will suffer abuse as a captive customer in the hands of the insurer.

[69] Accordingly, respondent cannot, in these circumstances, rely on any onus on complainant to read the policy and complain if he did not understand anything.

M. CONFLICT OF INTEREST

[70] Respondent is part of a group of companies in which Popcru has a significant interest. In effect Popcru, through respondent, is selling insurance to its own members. There is clearly a conflict of interest or at least a potential for conflict of interest as defined in section 1 of the Code.

[71] The Act in section 16 (1) (d) and Section 3A (2) (a) to (f) of the Code provides for the management of conflicts of interest. The respondent was expected to have adopted and published a conflict of interest policy and to have trained their representatives in terms of such policy. We saw no evidence of this in this matter.

[72] Indeed if respondent's representatives were trained in managing the conflict of interest, they would have informed complainant that the Popcru policy was not necessarily the best and that complainant should consult other FSPs to consider other products. It is not disputed that this was not done.

N. OMBUD FOR LONG-TERM ISURANCE

[73] Respondent submits that the Ombud for Long-Term Insurance (OLTI) considered the matter and found that the exclusionary clause was “prominent enough” on the form. The submission is that this Office should weigh what the OLTI found. There is no merit in this as the issue before this Office is a different one. Complainant told OLTI that the exclusions were not explained to him. This was OLTI’s response:

“I advised him that we will not be able to assist him with such issue as we don’t have jurisdiction against financial intermediaries. I told him that we will refer this issue to the FAIS Ombud.”

This sets the matter straight, OLTI’s comments about the application form are entirely irrelevant to this determination.

O. PRINT AND FORMAT

[74] I have already pointed out that the first exclusion is presented on the form in a manner that is confusing and in font that is too small. Section 3 (1) (a) (iv) of the Code provides as follows; representations made and information given:

“must, where provided in writing or by means of standard forms or format, be in a clear and readable print size, spacing and format”

[75] I find that respondent’s form contains important information, including the first exclusion, in small font and in a manner that is confusing to the reader. This is a contravention of section 3 of the Code.

P. OTHER CLAUSES

[76] Having read the policy document, I noticed a clause that deals with termination. Under the heading *"When will your cover cease*"; the following appears:

"main member – last day of the month when he turns 70".

[77] I make no finding in this regard; save to question the fairness of this clause. A main member could contribute premiums through his whole working life and just when he needs cover the most, membership is automatically terminated at 70. At which point it will be almost impossible to find alternative cover. The only relevance is that, at point of sale, this provision should have been disclosed and explained to all potential purchasers of this policy. There is no record that this was explained to complainant so he could look at alternative products.

[78] A further concern is the wording of two other permanent exclusions; the first reads as follows"

"Active participation in war, riot, civil commotion and terrorism"

[79] The concern is that Popcru members are police officers and wardens who, as part of their duties, may become involved in dealing with riots and civil commotion. Perhaps this clause is too widely crafted and does not specifically exclude being involved in the prohibited activity as police or wardens. Should this clause remain unchanged, it must be disclosed and explained to prospective purchasers of the policy.

[80] Of similar concern is the wording of the second permanent exclusion that drew my attention. This exclusion provides that if the insured is "*exposed to deliberate danger"* no cover is provided. Again, by the nature of a police officer's job there is bound to be such exposure as part of his or her duties. Should this clause remain as it is, full disclosure and an explanation must be given by the representative.

[81] In this case there is no record that any of these exclusions were disclosed and explained to complainant. Both Konya and Makapela are silent about this in their respective statements.

Q. CONCLUSION

[82] In the premises I make the following conclusions:

a) Respondent, in recommending this product to complainant, through their representatives, was in breach of Sections 16 of the Act, sections 2, 3, 7, 8 and 9 of the Code;

b) Respondent and their representative's conduct towards the complainant fell far short of TCF; and there was an equal failure to apply their own stated policy and outcomes for their members and indeed, all South Africans.

c) As a consequence of the aforesaid breach, complainant was induced into purchasing a policy he would otherwise not have purchased and did not consider alternative products. As a direct result he found himself in financial difficulty, having to borrow money when he was expecting a payment of R10 000 from respondent.

d) But for respondent's conduct, complainant would have purchased other funeral cover which would have paid him an amount of at least R10 000.

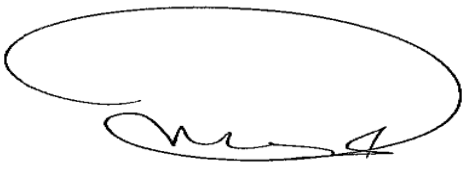
e) In the premises respondent must be held liable for payment of the cover amount of R10 000 to complainant.

R. THE ORDER

[83] For reasons stated above, I make the following order:

1. The complaint is upheld;
2. Respondent is ordered to pay complainant the amount of R10 000; and
3. Respondent is ordered to pay interest on this amount at the rate on 10, 25% per annum from the 24th March 2014 to date of payment.

DATED AT PRETORIA ON THIS THE 12th DAY OF SEPTEMBER 2016



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NOLUNTU N BAM

OMBUD FOR FINANCIAL SERVICES PROVIDERS