THE OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS

CASE NO: FAIS 5534/07–08/ GP 2

In the matter between:

KGABO POSCH MOLOKOMME	**COMPLAINANT**
and	
WAYNE DUVAL	**1ST RESPONDENT**
QUANWAY INSURANCE BROKERS CC	**2ND RESPONDENT**

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

A. PARTIES

[1] The complainant is Mr. Kgabo Posch Molokomme, an adult male residing at Alexandra, Gauteng Province.

[2] The first respondent is Mr. Wayne Duval, an adult male, a member and key individual of the second respondent. Respondent's address is Unit 3, King Phillip Estate, Suikerbekkie Street, Randburg, Gauteng Province.

[3] The second respondent is Quanway Insurance Brokers CC, (registration number 2005/074487/23), a close corporation duly registered in terms of the

applicable laws of the Republic of South Africa, with its registered address described as 366 Kent Road, Randburg, 2195, Gauteng[1]. Second respondent's principal place of business is Unit 3, King Phillip Estate, Suikerbekkie Street, Randburg, Gauteng Province. Second respondent is an authorised financial services provider with license number 14751. The license has been in force since 2004.

[4] Throughout, the dealings with complainant, 1st respondent represented second respondent.

[5] Reference to respondent means both respondents, where the need arises, it will be specified.

B. BACKGROUND

[6] The complaint arises out of respondent's alleged failure to render financial services with care and diligence as prescribed in Part II, Section 2 of the General Code of Conduct, (General Code).

[7] From the unopposed version of the complainant, it appears that during or about 2 March 2008, at about 05h00, as the complainant was driving towards Pretoria from Johannesburg, he was involved in a car accident. As a result of that accident substantial damage was caused to his vehicle. Complainant states that he hit a pavement following obstruction of his view by another vehicle.

[1] This is in terms of CIPRO records

[8] Upon lodging a claim with respondent he learnt that he was no longer insured with Constantia Insurance Company Limited, (Constantia), the insurer he had originally contracted with.

[9] Following a protracted period of telephone calls with the respondent, complainant had to finally deal with the reality that he had no insurance.

[10] With no cogent explanation from the respondent as to what happened to complainant's insurance arrangement, complainant's search for the truth uncovered that respondent had unilaterally and unlawfully cancelled his policy with Constantia sometime in November 2007.

[11] Through interaction with various bodies and individuals, complainant established that respondent's clients[2] were transferred to another insurer, Renasa Insurance Limited, (Renasa). No explanation however was provided by respondent as to why complainant's insurance arrangement was not transferred to Renasa.

[12] To date, complainant's claim for repairs to his vehicle, storage fees of R22 000, remain unpaid.

C. COMPLAINT'S VERSION

[13] On 24th November 2006, complainant purchased short term insurance cover for his vehicle, through the intermediation of the first respondent. The insurance

[2] This refers to the clients who were with Constantia.

was purchased on the same day of purchasing his vehicle, a 2 litre white Ford Focus with registration number, VCF 009 GP.

[14] According to the documents furnished by complainant to this Office, Constantia Insurance Company Limited ("Constantia") were the insurers and, Watermark Risk Management Services (Pty) Ltd ('Watermark"), the underwriting managers.

[15] The policy had a renewal date of 24 November 2007 with monthly premiums of R696.95.

[16] Following the accident on Saturday 2 March 2008, complainant called respondent's offices to notify them. Complainant followed up on Monday, 4 March with a further call and a facsimile to notify the respondent of the claim. A secretary from respondent's offices telephonically confirmed receipt of his facsimile, noting that respondent would make contact with complainant.

[17] On 5 March 2008, complainant received a call from respondent who promptly informed him that his insurance premiums had been outstanding since November 2007. Expressing shock and disbelief, complainant retorted he had always had sufficient cash in his bank account to cater for his insurance arrangements. Following a few exchanges over the phone, an agreement was reached that complainant would fax his bank statements to respondent, which complainant did. It would appear that respondent must have satisfied himself on complainant's assertions regarding provision on a monthly basis to pay for his premiums. On the same day, an agreement was reached that complainant

would pay the sum of R3000 into 2nd respondent's bank account, this to make up for unpaid premiums for four months. Complainant paid the R3000 as directed[3].

[18] Having not heard from respondent since the payment was made, complainant decided to make a call to Renasa for progress, only to be told by a Colin Scott that Renasa is not aware of such an arrangement. Complainant says, '*this is when I realised that Wayne had been lying to me all along*.'

[19] On the morning of 16th March 2008, complainant went to respondent's offices where he met first respondent at a coffee bar in a lower floor of the same building. It was there that complainant learnt that he had no insurance whatsoever and that the amount of R3000 he had paid to respondent would not restore the insurance arrangement. Alarmingly, respondent simply advised complainant that he was acting as the insurer and that from that point onwards he (respondent) would handle the claim himself but would follow what the insurer would have done.

[20] Respondent apparently went on to inform complainant that he would obtain quotes and repair complainant's vehicle, noting that he would not pay for storage. Complainant refused to accept respondent's offer and insisted that respondent pay for storage including the cost of hiring a vehicle, as had been provided for in the Constantia policy; to which respondent simply noted, he would pay. Having been assured that respondent would follow what was

[3] Proof of payment into respondent's bank account has been furnished to the Office.

provided for in the policy, complainant's concerns were assuaged, so it would appear.

[21] Respondent repeatedly reneged on his promises, leading complainant with no option but to lodge a complaint to this Office.

[22] From the unopposed version of the complainant, it appears that on the renewal date of the policy, respondent without informing the complainant, decided to cancel the complainant's policy with Constantia and move his clients' insurance arrangements to Renasa Insurance Company Limited ("Renasa"), a practice that is often referred to in the industry as '*moving the book*'.[4]

[23] Although the respondent has not furnished the reasons for cancelling his client's insurance arrangement with Constantia, from this Office's experience, there can be any number of reasons that could prompt a broker to '*move his book*' between various insurers, but the most frequent has to do with a high claims ratio. Under those circumstances the broker is forced to find alternative arrangement for his clients. Those alternative arrangements will very rarely be suitable to all the clients.

[24] Complainant's efforts to have his claim resolved were met with resistance by the part of respondent.

[4] See in this regard the determination of Jacob Johannes Grove 4564/07-08 GP 3

D. RELIEF SOUGHT

[25] Complainant seeks the amount he would have been indemnified with by the insurers, had it not been for the unlawful conduct of the respondent of unilaterally cancelling his policy with Constantia. Complainant has included in his claim, an amount of R22 000, being storage fees and the undisputed payment of R3000 into respondent's account.

E. INVESTIGATION

[26] Upon receipt the complaint was referred to the respondents in terms of the Rules, requesting respondents to resolve same with their client. Complainant had provided evidence that he had already lodged a complaint with the respondents and that a period of six weeks had expired since such complaint was lodged. It was for this reason that the respondent was provided a reduced period within which to resolve the complaint directly with this client.

[27] Despite this, the respondents failed to resolve the complaint and further refused to co-operate with the Office.

[28] On 7 July 2008, this Office sent the respondents a notice in terms of section 27(4) of the FAIS Act requesting them to file their response together with all documentation that would support their version.

[29] On the 13 August 2008, this Office wrote to the respondents, calling upon them to file their response or resolve the matter with the complainant. Respondent simply noted in his response that he had investigated the matter and satisfied

himself that he needs to sort it with his client. He further informed this Office that he had contacted his insurers with regard to a claim against his Professional Indemnity ("PI").

[30] On 29 January 2009, this Office wrote to the first respondent seeking an update on the PI claim. First respondent simply wrote back advising that he had been travelling abroad and promised to revert without delay, of which he failed to do. To date not further communication has been received from the respondent. Clearly, respondent has no intention to resolve or assist this Office in resolving the complaint.

F. ISSUES TO BE DETERMINED

[31] The issues to be determined are:

a. Whether respondents failed to act honestly, fairly, with due skill, care and diligence, and in the interests of his client and those of the financial services industry as demanded by section 2 of the General Code;
b. If it is found that the respondents conduct did in fact fall foul of the particular section of the Code, whether such failure occasioned the loss complained of;
c. Quantum.

[32] In reaching the findings, this Office has considered the undisputed version of the complainant and information obtained from complainant's erstwhile insurers.

[33] It should be reiterated that upon receipt of the complaint, this Office forwarded the complaint to the respondents, requesting them to resolve the matter with their client without reference to this Office. Respondents were further invited to file their response, especially in the light of the serious allegations made by complainant against them. To date, no response has ever been received. Such is the contempt with which respondent has treated this Office.

[34] When the respondents cancelled the policy, they had no mandate from the complainant nor did they attempt to seek such mandate. It can thus be concluded that the cancellation could not have been in the complainant's interests. This is clear from the fact that respondent was not even remotely aware that complainant's insurance arrangement was not successfully transferred to the new insurer. It was only when complainant lodged his claim that they became aware.

[35] Had respondent diligently followed the move with a reconciliation exercise, he would have noted that complainant's insurance was not with the "new insurer" and acted accordingly. Not only was respondent's conduct void of care and diligence, it undermined the General Code.

[36] It would be a waste of time to canvass the various sections of the Code that were violated by respondent's conduct. Respondent, clearly, was neither concerned with the Code nor his client's rights when he cancelled complainant's insurance.

[37] A further assault on the rights of the client is that of denying them the right to choose whether they want to deal with a particular insurer. Clients like

complainant learn after the fact they are now insured with a new insurer without them having had any say in the matter and are expected to continue with the payment of premiums and adhere to the terms and conditions of the new insurer violation as though they were party to the negotiation of such terms. Such conduct cannot be allowed. Brokers like respondent continue to feel emboldened to act in this fashion because, very often, there is no resistance from clients. They are simply not aware that they have been violated.

[38] As for the respondent's attempt to put the blame on complainant for not paying premiums, this is disingenuous. Complainant's assertions that he has always made sufficient provision for the payment of his premiums have not been disturbed and, had it not been for respondent's unlawful act of cancelling his policy, complainant in all likelihood, would have been insured at the time of the accident.

G. QUANTUM

[39] Complainant has provided proof of the following:-

i) Storage in the amount of R22 000; and

ii) Payment of the amount of R3000 to respondent's bank account.

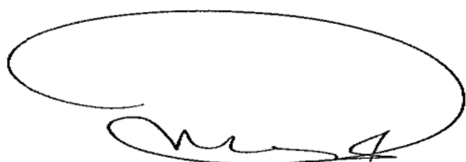
[40] As regards the damage caused to complainant's motor vehicle, this Office has obtained a reasonable estimation the quantum through the services of a loss adjuster. The loss adjustor indicates that complainant would have repaired the vehicle for R49 700. This Office is prepared to award complainant the aforesaid as a fair and reasonable amount of compensation for his damages.

H. ORDER

[41] The following order is made:-

1. The complaint is upheld.
2. The respondents are hereby ordered to pay, jointly and severally, the one paying the other to be absolved the sum of R52 700 to complainant.
3. The amount is made up as follows:
   - 3.1 R49 700 (reasonable amount representing damage to the vehicle) and
   - 3.2 R3000 (amount paid to the respondents after the claim was lodged) R52 700;
4. Interest on the aforesaid amount shall accrue at the rate of 9% per annum from a date, which is seven days from date of this order.

DATED AT PRETORIA ON THIS THE 11th DAY OF AUGUST 2014



NOLUNTU NELLISA BAM

OMBUD FOR FINANCIAL SERVICES PROVIDERS