FAISOmbud
Office of the Ombud for Financial Services Providers

under the baobab tree
Issue 11 2016

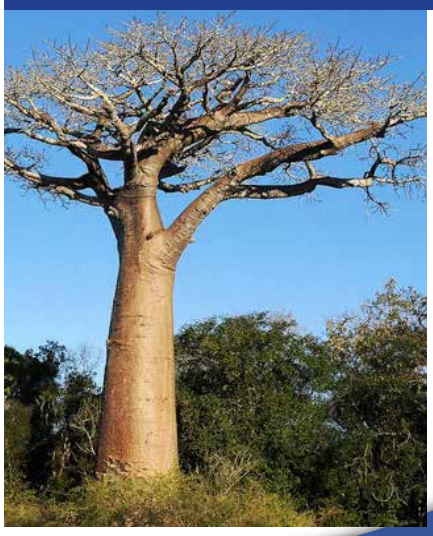
INTRODUCTION

Having reached the milestone of 10 issues in our previous publication, the second decade as it were of Under the Baobab Tree, the newsletter for the Office of the FAIS Ombud, gets underway with the 11th issue that has already seen us come to the end of the first quarter of 2016. In this edition we have chosen to focus on those complaints that involve short term insurance, a product category that continues to generate the highest number of complaints received by this Office.

Short term insurance remains very much a grudge purchase, and it is no surprise that the majority of short term insurance policies continue to be motor vehicle insurance policies, with current estimates showing that as much as 40% of consumers are uninsured against major losses. The National Treasury however is of the view that even households with some sort of financial security may become poverty stricken without cover against unexpected losses. This is one of the reasons behind the Insurance Bill which was presented to the National Assembly during January of this year, which will see the Insurance Act 2016 coming into effect.The Bill gives effect to the National Treasury's Micro-insurance Policy by supporting the development of the micro insurance industry, which National Treasury believes is vital to the South African market as it allows low-income households to gain access to insurance that is appropriate to their needs and also financially affordable. It is believed that enhancing access to insurance in this manner will positively affect economic growth and reduce income inequality.

Therefore the importance of insurance, in this instance short term insurance, cannot be denied, and so financial services providers need to ensure that when providing advice in relation to short term insurance that they obtain all relevant and available information to ensure that any recommendation made is appropriate to the needs of the client. All too often short term insurance is sold on the basis of premium, when in fact one size does not fit all, and there are so many aspects that if not adequately considered could have a detrimental effect should any future claim be unsuccessful.

Whilst the industry and specifically those that market and advice on short term insurance products need to embrace what is required in terms of the FAIS Act and its corresponding General Code of Conduct, it is hoped that the work done by the Office of the FAIS Ombud and publications such as this can highlight a few of those important aspects that may empower prospective clients to ask the relevant questions of their financial services provider and to hold them accountable for the advice provided.



CASE STUDY 1

UNDERSTANDING HOMEOWNERS INSURANCE

Homeowner's insurance provides cover for everything that is permanent and immovable within the boundary of your property, including the perimeter wall, the garage and gate and the motors that power them, outbuildings, swimming pool and/or borehole and associated pumps, and all the fixtures and fittings in the house itself. As with any form of insurance the insured value is vital to a successful claim and the insured value of your building must reflect the cost of replacing your home and not the market value. Failure to do so will leave one underinsured and result in the insurer applying average to any potential claim, which is the reduction of the amount paid in terms of a claim to reflect the extent to which one is underinsured. A vast majority of homeowner's policies are as a result of consumers having applied for a home loan where in some instances the home loan is conditional on approved buildings insurance. Whilst many clients may value the convenience of the transaction that may see the premium included in the monthly mortgage bond repayment, it is vital that prospective clients ensure that they understand the contents of the policy as well as the terms and conditions of the cover provided. This will ensure that one is not surprised by exclusionary clauses such as issues surrounding maintenance, and the importance of ensuring that any potential losses cannot be attributed to wear and tear or that could have been avoided.

THE CASE OF "MR M"

Facts

The Complainant had applied for a home owner's insurance policy with the respondent and when the building had sustained damages as a result of a fire during June 2015, he had duly lodged a claim against the policy. The damage caused by the fire was then assessed to be to the value R261 000.00.

The insurer subsequently offered to settle the claim to the value of R141 000.00 stating that the complainant had been underinsured and that as a result it had applied the rule of average in determining the quantum of the claim. The complainant outraged by what he believed was the insurers failure to adequately address his matter, claimed that he had not been informed of the requirement to have the building insured for its replacement value, or the additional requirement of ensuring that the property be periodically evaluated to ensure that the insured value remained up to date.

Aggrieved by the fact that the respondent had failed to honour his claim in full, the complainant had lodged a complaint with this Office.

Our Intervention

The complaint was accordingly addressed to the respondent in accordance with Rule 6(b) of the Rules on Proceedings of this Office. The respondent was requested to show its compliance with the provisions of the General Code of Conduct for Authorised Financial Services Providers and Representatives ('Code') and more specifically whether or not the respondent's representative had obtained all relevant and available information to ensure that the product recommended was appropriate to the complainants needs.

In his instance it would have required the respondent's representative to have ensured that the complainant was adequately covered from the inception of the policy, by having informed the complainant of the importance of insuring the property for its replacement value and therefore allowing the complainant to have provided him with the correct valuation. The representative, during this time would then also have been expected to advise the complainant as to the importance of ensuring that this value is updated on a regular basis.

In its response, the respondent was unable to provide any documentation showing compliance with the Code, and could only point to having sent the complainant the policy schedules on an annual basis. The respondent further maintained that it was the complainant's responsibility to ensure that he was adequately provided for, and that it had assisted the complainant by automatically adjusting the value of the property with CPI on an annual basis. The respondent was therefore of the view that the complainant should have noted this annual change and thus been aware of the requirement to ensure the value be regularly reviewed.

After this Office had confirmed its stance with regards to the respondent's failure to adequately provide for the needs of the complainant, and that as a result the respondent had failed to make the relevant disclosures, the respondent reconsidered its decision and made an offer to settle the claim to the value of the assessed quantum.

Lessons learnt

1. When applying for a home owner's insurance policy always ensure that you obtain and are aware of the replacement value of the property and not the market or retail value of the property.
2. Ensure that on a regular basis you revalue the property and ensure that the insured value is amended to reflect the effects of inflation and or any improvements or additions made.

CASE STUDY 2

HOW COMPREHENSIVE IS YOUR VEHICLE INSURANCE POLICY

For most people, a vehicle will be one of the biggest assets they will own, and it is likely that when purchasing the vehicle, one will enter into a finance agreement. Once all the applicable interest charges etc. have been factored in, one will owe significantly more on the vehicle than what it was purchased for. Comprehensive vehicle insurance policies typically insure your vehicle at the prevailing retail value, which reduces on a regular basis. Therefore in the event of your vehicle being stolen or written off you may just find that the settlement value offered by your insurer is insufficient to cover what you still owe to the finance house. One way of remedying this is through a product usually referred to as Credit Shortfall Insurance or Top Up Insurance, which pays the difference between what your vehicle is insured for, and the amount you still owe to the bank or finance house. In this way you prevent yourself from either having to buy a cheaper replacement vehicle or to keep paying for a vehicle you no longer have. There is therefore a duty on the financial services provider to ensure that the recommended policy provides for your needs, and that you understand not only the limitations of the proposed short term insurance policy, but how this may be remedied.

THE CASE OF "MRS G"

Facts

The complainant had an existing short

term insurance policy, and when she purchased a second hand vehicle, she requested the respondent to replace the existing vehicle on the policy with the 'new' vehicle. The complainant's instruction had been actioned by the respondent's representative, however when the complainant subsequently lodged a claim, the settlement value was lower than the outstanding amount owed by the complainant. The complainant also noticed that the settlement value provided had also included a deduction in respect of excesses that she claims had not been discussed with her.

Dissatisfied by the outcome of her claim, and the fact that she still owed the finance house a significant amount of money, the complainant submitted her complaint to this Office for assistance.

Our Intervention

Upon receiving the complaint, correspondence was directed to the respondent to which the respondent had replied that the credit shortfall cover had not been recommended as the specific product house it dealt with did not provide such an option. The respondent was also of the view that there was no need to have offered this product to the complainant as it should already have been offered by the dealership. The fact that the excesses applicable had been noted in the record of advice signed by the complainant in acceptance thereof, was also provided as proof that its representative had complied with the General Code of conduct in this regard. The respondent also pointed to the fact that the complainant had been sent a policy schedule clearly detailing the above mentioned aspects of the policy, which it believed was sufficient in discharging its duty in terms of the Code.

The matter was subsequently officially accepted for investigation by this Office, and it was recommended to the respondent that it reconsider its stance with regards to the resolution of the complaint. In making this recommendation this Office informed the respondent that it had a duty in terms of the Code to act with the required due skill care and diligence, in the interest of the complainant and that this duty could not be transferred to another party, in this case the dealership. The General Code of conduct also requires that an FSP obtain all relevant and available information to ensure that any recommendation made by the respective FSP was appropriate to the complainants needs. The relevance of the vehicle having been financed with a value that may have exceeded the prevailing retail value could not be overstated, and was material to determining the suitability of the product recommended.

It was also noted that the document put forth by the respondent as a record of the advice provided and disclosures made, did indeed record the excesses applicable. The concern however that was the extent of the excesses was not made known, and neither was the fact that an additional excess would apply in the event that the vehicle was stolen. It was therefore impossible for the complainant to have made an informed decision, a requirement that is not only provided for in terms of the General Code of Conduct, but one that can only be made prior to the conclusion of the transaction. This therefore negated the respondent's reliance on the complainant having received a policy schedule as sufficient compliance with the Code.

The respondent subsequently offered to resolve the matter with the complainant, with an offer in the amount of R80 337, an offer that was accepted by the complainant.

Lessons learnt

3. Always ensure that the prevailing retail value of your vehicle is sufficient, nett of any applicable excesses, to cover any outstanding amounts owed.
4. Ensure that your advisor provides details of the various credit shortfall options available. The product details and the extent to which cover is provided differ vastly between product providers.
5. Excesses are the first amount payable by you in the event of a claim, always ensure that your advisor discloses not only the standard excesses and the potential impact of these excesses, but that additional excesses applicable.

CASE STUDY 3

MINIMUM SECURITY REQUIREMENTS CAN HAVE MAXIMUM EFFECT.

One of the main reasons for the rejection of house content claims is when policyholders do not comply with the policy conditions as they relate to the minimum security requirements. The minimum security requirements may differ slightly between insurers, however more often than not may include the need for a burglar alarm (in some instances one linked to an armed response unit) and that the alarm be active and in working order, burglar bars across all opening windows and security gates in front of all doors leading outside, which includes sliding doors. When you apply for cover in respect of household contents the Financial Services Provider must disclose to you what the minimum security requirements are based on, amongst other things, the area in which you reside. In instances where one has employed additional security measures in excess of the minimum required, you may qualify for a cheaper premium. It must however be born in mind that the minimum security requirements are still applicable, and that any concessions made on your premium as a result of additional security measures require that those additional requirements need to be functional at the time of a claimed event in order for one to have a successful claim, regardless of whether or not the policy wording provides for such.

THE CASE OF "MR V"

Facts

The complainant, a 77 year old pensioner had a short term insurance policy facilitated by the respondent that provided cover for his household contents. On 14 June 2014 at around 16:30 pm there was a burglary at his

29 June 2014. Following the submission of the claim the complainant received correspondence from the insurer that the claim had been rejected on the basis that the minimum security measures, specifically those related to the requirement that security gates need to be fitted to all doors leading outside, had not been complied with.

The complainant confirmed that the perpetrators had in fact gained access through a sliding door which did not have security gate, however he claimed that this requirement had never been brought to his attention. The complainant, adamant that the loss incurred was as a result of the actions of the respondent submitted a complaint to this Office.

Our Intervention

In response to correspondence received from this Office, the respondent claimed that even though its representative had visited the complainant's residence on an annual basis, she was not a security expert and could not have been expected to comment on the complainant's failure to adhere to the minimum security requirements. The respondent further advised that a policy schedule was sent to the complainant subsequent to the inception of the policy and that the complainant ought to have been aware of the minimum requirements, yet the complainant had not raised any concerns in this regard.

This Office informed the respondent that providing a client with policy documents after the conclusion of the transaction could not be seen as having complied with the requirements of the Code, and that it could not transfer its responsibility in terms of the Code to the complainant. The respondent's representative had a duty to obtain all relevant and available information from the complainant, which in this instance would have included details with regards to the security measures at the residence. This would have allowed the representative to have determined whether or not the complainant complied with the minimum security requirements, and then have advised accordingly.

As the respondent had not provided any documentation showing compliance with the relevant provisions of the Code, this Office requested that the respondent look to resolve the matter with the complainant. The respondent thereafter made an offer to settle the matter as though the required security measures had been in place.

Lessons learnt

6. Minimum security requirements are a feature of every short term insurance policy, and prospective clients need to ensure that they comply in this regard as they form the basis upon which the insurer is prepared to underwrite the risk posed by the application.
7. Regardless of any additional security measures employed or whether one lives in a security complex there remains the requirement that one complies with the minimum security requirements as detailed in the policy wording.

CASE STUDY 4

THE IMPORTANCE OF MAKING FULL DISCLOSURE

Insurance premiums are individually calculated based on various risk factors, some of which will be unique to the individual applying for insurance. When assessing a potential client's risk profile, insurance companies rely on one to make full disclosure of all material facts. A material fact is one which would influence the decision making process of the insurance company when determining whether or not to accept the risk posed by a prospective client, and the premium charged in relation to the risk. An example of a material fact would include any previous claims or losses sustained. When a material fact is not disclosed and the insurer has based its assessment and acceptance of the risk on the facts presented, the insurer may, void the policy, which means that it can treat the policy as though it never existed and return the premiums to the policyholder and refuse to entertain the claim. It is therefore vital that prospective clients ensure that all information with regards to any and all previous claims or losses are disclosed when applying for an insurance policy. Reference made to the word loss is important, as disclosure is still required regardless of whether one had previously submitted a claim for a particular loss. Financial Services Providers however also have a duty to not only ensure that all relevant and available information with regards to previous claims and or losses are obtained, but that prospective clients are informed as to the importance of ensuring that full disclosure is made of any and all previous claims made or losses sustained.

THE CASE OF "MR T"

Facts

The complainant was involved in a motor vehicle accident. When the complainant had subsequently lodged a claim with the insurer the claim was rejected on the basis that he had, during the application stage, failed to disclose that he had been in two motor vehicle accidents in the previous 5 years. The complainant however claimed that he had never lodged a claim in respect of either of the two accidents and that during the application stage he had only been asked as to the number of claims submitted in the past 5 years.

The complainant was adamant that he had never been asked how many accidents he had, had and that if asked he would have disclosed this information, as he had no reason not to. The complainant was therefore of the view that he had been financially prejudiced as a result of the respondents actions, and submitted a complaint to this Office.

Our Intervention

Upon receiving the complaint it was referred to the respondent in accordance with the rules on proceedings of this Office. The respondent was requested to show compliance with the General Code of Conduct and specifically that all relevant and available information with regards to any and all claims or loses had been was obtained to have ensured that a correct assessment of the complainants risk profile could have been undertaken. The respondent was also asked to provide a copy of the recorded conversation to determine whether or not the complainant had

been informed as to the importance of disclosing not only any and all claims submitted, but any and all losses sustained as well.

In response to correspondence received from this Office, the respondent made an offer to the complainant to settle the claim in full. The offer was accepted by the complainant in full and final settlement of the complaint.

Lessons learnt

8. When applying for insurance always disclose any information that would be considered material to the determination of the risk posed.
9. Material information includes precise details of any and all claims submitted with previous insurers.
10. Previous losses, regardless of whether or not a claim was submitted, are vital in determining the risk posed by a prospective client.

CASE STUDY 5

EXCESSES CAN BECOME EXCESSIVE

An excess is the first amount payable in the event of a claim, and is the portion for which you are self-insured. The excess is payable regardless of whether or not the loss is your fault, and is an attempt by the insurer to reduce the number of minor claims as well as fraudulent claims submitted, by making you a co-insurer on the policy. The most common excess is the basic excess which is normally expressed as a percentage of the claimed amount subject to certain minimums such as 5% of the claim with a minimum of R2500. Most insurers also charge additional excess for instances where drivers are under the age of 25, where a vehicle has been stolen or hijacked, where one has had a licence for less than a year. There are even time of accident excesses where you may pay an additional excess if you are involved in an accident between say midnight and 5am. All these excesses are cumulative in addition to the basic excess which means for example, that that if you are under 25 with a licence of less than a year and you have an accident at 2am in the morning you could be liable for a significant portion of the claim. An excess waiver can be purchased at an additional premium, however this will only apply to the basic excess, the additional excesses will therefore still apply. Itthere is a relationship between the excesses on a policy and the premium payable, and insurance companies do offer different excess structures, so it is important that prospective clients are aware of the excesses applicable to the policy, and that the financial services provider ensure that the applicable excess structure is suitable to the clients specific needs.

THE CASE OF 'MRS M'

Facts

Subsequent to the purchase of a new motor vehicle during 2014 the complainant had approached the respondent for the purposes of obtaining cover for the vehicle. The complainant did have an existing insurance policy, and the new vehicle was to have replaced the existing vehicle noted on the policy. However, rather than adjusting the existing policy the respondent had recommended that the complainant apply for a new policy with another insurer. No reason is provided for the issuing of a new policy, and the complainant had been under the impression that this was a simple case of replacing one vehicle on the policy with another.

When the complainant then submitted a claim as a result of losses sustained to the new vehicle, which had her 25 year old son as the nominated driver, she was shocked to be informed that she would be paying double the excess as a result of additional excesses. The additional excesses were for the driver of the vehicle being under the age of 30 and that the loss had occurred with 6 months of the policy having incepted.

The policy that had been replaced only provided for additional excesses to drivers under the age of 25, and the additional excess for the claim within 6 months was only applicable as a result of the respondent having provided the complainant with a new policy. The complainant was therefore of the view that she would not have been liable for the additional excess charges had it not been for the actions of the respondent, and so approached this Office for assistance.

Our Intervention

The matter was directed to the respondent in accordance with the Rules on the Proceedings of this Office, and the respondent was asked to show compliance with the provisions of the General Code of Conduct and that its representative had clearly disclosed the implications and consequences of the proposed replacement transaction.

The respondent was also requested to provide documentation in support of why the replacement policy were deemed to have been appropriate to the complainant's need especially when the nominated driver was clearly noted as her 25 year old son, an age that attracted an additional excess that was not applicable on the replaced policy. The respondent was also asked as to the rationale behind the new policy that would see an additional excess applied for any claim with a 6 month

period, and whether the complainant had been informed of this so as to have placed her in a position to have made an informed decision.

On the basis of the correspondence from this Office, the respondent approached the complainant and offered to compensate her for the additional excesses charged, which was accepted by the complainant.

Lessons learnt

11. Always ensure that you understand the excesses that are applicable to your policy and that you understand what you are liable for in the event of a claim.
12. In the event that your financial advisor recommends a replacement of your existing policy it is important to ascertain whether the new policy provides the same excess structure as the policy to be replaced.
13. There is a correlation between the premium payable and the extent to which one is 'self-insured' at claim stage, a cheaper premium may translate into a larger excess payable in the event of a claim.

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