INTRODUCTION

This, the 12th issue of Under the Baobab Tree, the newsletter for the Office of the FAIS Ombud, sees the end of the second quarter of 2016. In this edition we have chosen to focus on those complaints that involve funeral policies, which are the most prevalent form of insurance in South Africa with just less than 90% of all risk cover being attributed to this form of insurance.

Funeral policies are included in the definition of assistance business which means that the benefits provided cannot exceed R30000. Whilst funeral policies are an effective way of ensuring that the insured's family and those who depend on the insured do not have to take on an unreasonable financial burden in order to pay for a funeral ceremony, the reality is often a lot different for those left behind and who rely on the benefits provided. The reason being that unlike the more traditional forms of life cover that conduct medical underwriting at application stage to determine the risk posed by the prospective client, funeral policies do not conduct upfront medical underwriting to determine the risk posed by the prospective client. As a result these policies must therefore include limitations such as waiting periods and other exclusions to mitigate the risk posed by clients who are guaranteed acceptance despite any adverse medical conditions. These waiting periods and exclusions are not always either taken into consideration or disclosed to prospective clients during the application stage of the policy.

Many clients are left disappointed when claims are rejected as a result of the lives assured not complying with the provisions of the policy and therefore falling fowl of the exclusionary clauses. Clients however do have recourse in that the FAIS Act and its corresponding General Code of Conduct for Authorised Financial Services Providers and Representatives (the Code) do require that a financial services provider firstly obtain all relevant and available information to ensure that the product recommended is not only appropriate, but that the required disclosures can be made to ensure that the client is placed in the position to make an informed decision.

CASE STUDY 1

The main objective of insurance is to compensate the policy owner for losses, usually financial in nature, sustained as a result of an insured peril. To allow the policy owner to be compensated for a loss that does not affect that person financially would create a moral hazard, as there would be no reason or incentive for that person to prevent the loss. As a result insurable interest is a basic requirement for the issuance of an insurance policy, making it both legal and valid. A person has an insurable interest in something when loss or damage to it would cause that individual to suffer a financial loss or certain other kinds of losses. In terms of funeral insurance the principle of insurable interest is normally satisfied if the parties are closely related and the beneficiary of the cover would suffer financial loss from the insured person's death, such as spouses, who are able to insure each other's lives. Insurable interest must exist at the time of applying for the life cover and need not exist in the event of a claim being submitted.

THE CASE OF "MS M"

Facts

The complainant had successfully applied for a funeral policy and had included her husband as a life assured on the policy. It is important to note that the complainant and her husband had been married in terms of Customary Law. Subsequent to the inception of the policy, the complainant's husband had passed away after only two premiums having been paid towards the policy. The complainant after lodging a claim in respect of the insured amount of R 10 000.00, was distraught to learn that the claim had been rejected on the basis that according to the respondent, she did not have any insurable interest. Furthermore the respondent had also alleged that the complainant had not complied with the requisite waiting period of the payment of at least one premium.

Our Intervention

Upon receipt of the complaint by this Office, it was directed to the respondent in accordance with the rules on proceedings of this Office. The respondent was requested to provide this Office with documentation showing 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 had obtained all relevant and available information to ensure that the product ultimately recommended had been appropriate to the complainant's specific needs and circumstances.

In this instance, clarification was also sought from the respondent on the grounds for rejection as there was proof that the deceased had paid ilobolo for the complainant. In terms of the Recognition of Customary Marriages Act, a customary marriage is valid if the negotiations, rituals and celebrations are in accordance with customary law. The fact that the marriage is not registered at Home Affairs, does not invalidate the marriage in any way.

A response was received from the respondent, wherein it advised that it had reconsidered the original decision taken and had that it had conceded that the complainant did indeed have insurable interest as a result of the marriage having complied with the negotiations, rituals and celebrations in accordance with Customary Law.

Lessons learnt

1. 1. Insurable interest is a vital component of a valid insurance contract, and requires that anyone who applies for cover on the life of another, stands to lose financially in the event of that person's passing.
2. 2. Spouses are an example of a relationship that brings about insurable interest and includes those married in terms of customary law;
3. 3. Insurable interest need only exist at the time of applying for the insurance policy, and is not required at claim stage.

CASE STUDY 2

A pre-existing condition is a medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company. This broad definition is used by insurance companies, who provide products such as funeral policies, to deny claims where the deceased has passed away as a direct or indirect result of a medical condition that had existed prior to the inception of the policy. Insurance companies are entitled to deny these claims because unlike your more traditional forms of life cover, cover in respect of funeral policies is provided without the insurance company conducting any medical tests upfront, and without knowing the risk posed by the life which is to be covered. It is therefore paramount that a financial services provider ensure that it obtains all relevant and available information from a prospective client that will allow for a detailed disclosure of this exclusion and any other instance in which cover will not be provided. Disclosure of this information will allow the client to make an informed decision as to the appropriateness of the recommended policy to his/her specific needs and circumstances.

THE CASE OF "MR L"

Facts

The complainant had an existing funeral policy with the respondent which had incepted during May 2015, and was paying a monthly premium of R269.00. This policy had provided cover for the complainant's stepfather as well as other family members. During March 2016 the complainant had lodged a claim with the respondent after the passing of his stepfather, and the claim had been rejected on the basis that the deceased had suffered from a pre-existing condition.

The complainant argued that this had not been disclosed to him at the inception of the policy and that he had first been made aware of this exclusion upon the submission of his claim. Furthermore the complainant was of the view that as he had never missed a premium his claim should be honoured by the respondent, and he approached this Office for assistance.

Our Intervention

The complaint was sent to the respondent who was asked to provide documentation required in terms of the FAIS Act and its corresponding General Code of Conduct for Authorised Financial Services Providers and Representatives. This documentation, which would have included a record of the advice provided to the client, was required to show that the respondent had not only obtained all relevant and available information from the complainant to determine whether this product was suitable to the needs of the complainant, but also that all material terms of the policy had been disclosed. Disclosure of the material terms of the policy would have ensured that the complainant had been placed in a position to have made an informed decision.

The respondent was therefore informed that it had been required to establish information such as the medical history of the complainant and those he wished to insure on the policy. This information would have enabled it to have had a discussion around the fact that an individual such as the deceased may not have a valid claim in the event of death by natural causes. The respondent acknowledged its shortcomings in this regard and honoured the claim amount in the amount of R10 000 in full and final settlement of the complaint.

Lessons learnt

4. For insurance products such as funeral policies, where no underwriting is conducted at application stage, exclusionary clauses which exclude cover in respect of any pre-existing medical condition are included in the policy to limit the risk posed to the insurance company.
5. When looking to purchase a funeral policy always ensure that your financial services provider discloses all material information especially with regards to exclusions for pre-existing conditions and any other instances in which cover will not be provided. This will allow one to determine whether the product recommended is suitable to their needs and circumstances.

CASE STUDY 3

With regards to funeral policies, dependent children are more often than not only covered in terms of the policy until attaining the age of 21, or unless the policy owner is able to prove that the child is either a student or financially dependent upon the parent. In addition to this, children who are incapacitated by a physical or mental infirmity can usually be provided for in terms of the policy on an unlimited basis. The majority of complaints in this regard emanate from child dependents who were younger than 21 when the policy incepted, and it is evident that financial services providers fail to inform clients of this exclusion of cover when insuring a child dependent on a funeral policy.

THE CASE OF "MR S"

Facts

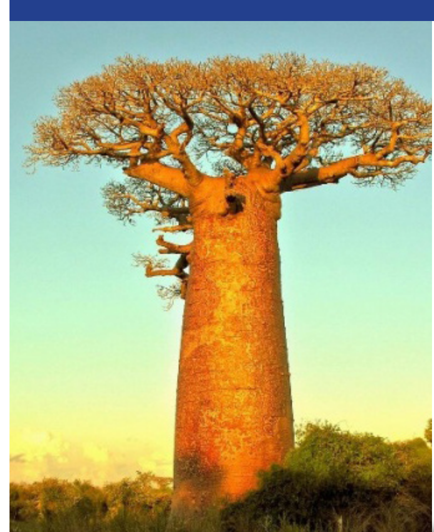
The complainant, who was the owner of a funeral policy recommended by the respondent, claimed that the respondent had failed to inform him that there was an age limit of 21 years for individuals covered as dependents on his funeral policy. The complainant had been paying a premium in respect of himself and his younger brother, who was covered as a dependent on the policy. At the inception of the policy the complainant's brother was 18 years of age, and at the time of his passing he was 24. The subsequent claim submitted by the complainant had been rejected on the basis that the deceased's cover had lapsed when he had turned 21. The complainant was adamant that this was never explained to him at point of sale or during any of the annual renewal letters he received, and had approached this Office for the respondent to pay the full benefit of R 10 000.

our Intervention

Upon receipt of the complaint, the respondent was requested to furnish this Office with a record of the advice provided with specific emphasis on the disclosures made with respect to the exclusions applicable to dependents covered on the policy. The respondent was unable to do so, and had instead merely referred to the policy documents which contained this clause, insisting all the while that this limitation was an industry standard which the client ought to have been aware of. The respondent was however prepared to make an ex gratia offer of R 5000 in lieu of its failure to maintain the relevant documentation. The complainant had initially rejected the offer, insisting that the full benefit be paid to him, however he had eventually accepted the offer in full and final settlement of the complaint.

Lessons learnt

6. It is important for one to be aware of any limitations on your funeral policy especially with respect to any extended family members for whom cover is provided.
7. Unless one is able to prove insurable interest, cover for dependants over the age of 21 shall not be provided.
8. Whilst this may be an industry standard, there is still a duty on the financial services provider to disclose such limitations of cover and allow you the client the opportunity to make an informed decision.



CASE STUDY 4

Waiting periods are unavoidable in funeral insurance as there is no upfront medical underwriting in respect of the risk posed by the client. As stated in the introduction above, funeral policies therefore include limitations such as waiting periods, which commence on the date that an insured person becomes entitled to the cover, usually upon receipt of the first premium, and no benefit is payable during this period if death occurs as a result of natural causes. Waiting periods are usually defined as a period wherein claims are excluded during the first 3, 6 or 9 months of inception of the policy. It is important that one appreciates that a waiting period is dependent on the term (time), and not the number of premiums paid. In other words the payment of, for example, six premiums does not guarantee a successful claim when the deceased person passes away during the 5th month of a six month waiting period.

THE CASE OF "MR F"

Facts

The complainant had successfully applied for funeral cover with the respondent, with his grandmother also named as a life assured. The policy incepted on 1 October 2012 and the complainant was required to make payment by no later than the 15th day of each month. The complainant's first premium was paid on 10 October 2012 at the offices of the respondent, with the arrangement that all subsequent payments would be made in this way. The complainant was as a result not provided with any alternative methods of payment.

The complainant subsequently found employment in another province and had asked a family member to make the payments on his behalf. The agreement was that the complainant would deposit the premium into the family member's account who would then pay this to the respondent on the complainant's behalf. During July 2015, the complainant's grandmother passed away before the premium was due. When the complainant lodged a claim, he was advised that the claim was rejected due to the non-payment of premiums. The respondent claimed that the complainant had missed three consecutive premiums before the payment received during June 2015 and claimed that the complainant's policy was therefore subject to a three month waiting period from June 2015. The respondent therefore said that the complainant's claim had been submitted during the three month waiting period and could, as a result, not be honoured. The complainant claimed to not have been advised that his policy was subject to a waiting period due to non-payment of premiums when he paid the premium during June 2015 and had been under the impression that his policy had remained active with no conditions of cover save for the obligation on him to continue to pay his premiums.

Our Intervention

Upon receipt of the complaint, we requested the respondent to provide us with proof that the complainant had been advised of the circumstances under which benefits would not be paid. Specifically, we asked the respondent to s prove that the complainant had been advised that in the event of non-payment of premiums, that his policy would lapse but that should he subsequently pay the outstanding premiums that his policy would be reinstated and be subject to a new three month waiting period. The respondent was unable to provide us with any of the documentary proof required and instead provided us with a copy of the policy document which only stated that the policy would be cancelled after non-payment of three consecutive premiums but was silent on the conditions surrounding the reinstatement of the policy. The respondent ultimately conceded to the fact that on acceptance of the premiums paid during June its representative had failed to advise the complainant that the payment was to reinstate a lapsed policy and of the consequences that this entailed. The respondent further conceded that the complainant had been given the impression that the policy was active and that the full benefits were available. As a result, the respondent offered to pay the complainant the full benefit of R20 0000.00.

Lessons learnt

9. A contract of insurance creates dual responsibilities for the contracting parties. So while the insurer accepts the risk posed by the client, the insurer does this in exchange for the premiums payable by the client.
10. In the event of the non-payment of premiums, the insurer has a right to cancel the contract of insurance. An insured party must therefore ensure that all premiums are paid on time to prevent the policy from being cancelled.
11. Should the client desire to reinstate the cancelled policy, the client needs to be aware that there may be a new waiting period applicable to the reinstated policy.

CASE STUDY 5

An underwriter is a long-term insurance company registered with the Financial Services Board that receives your premiums and is responsible for paying the benefits in the case of death. The most important feature of any funeral policy therefore is that the policy should be underwritten by a registered long-term insurance company. This is to ensure that the member is guaranteed of a legitimate claim in the event of the death of a life assured on the policy. Furthermore the policyholder must ensure that he or she receives a copy of the policy document, which must bear the name of the long-term insurance company which is underwriting the funeral policy. A prospective client must also be vigilant that the funeral policy they wish to purchase is underwritten by a registered financial services provider. Should one be unsure as to the legitimacy of an entity, the Financial Services Board provides details of all registered entities on its website.

THE CASE OF 'MS M'

Facts

In 2009, the complainant had successfully applied for a funeral policy with the burial society which operated its business within her residential area. During this time, the burial society had itself applied for a burial society support plan with an insurer who then acted as the burial society's underwriter. The burial society support plan was intended to cover the members of the burial

society for all burial costs for a main member and four adult dependents. Cover for the burial society support plan commenced during May 2010.

The complainant had diligently paid premiums for her funeral cover from the inception of the policy until the death of one of the life assureds covered in terms of the policy. The complainant duly lodged a claim with the burial society, which was subsequently rejected on the grounds that the complainant had updated her policy, and as a result, a new waiting period had been instituted. The complainant queried the burial society's decision to reject her claim with the underwriter and was advised by the burial society that their policy with the underwriter had lapsed because some members of the burial society had failed to pay their premiums. The complainant thereafter directed her query to the underwriter and was advised that the initial policy for the burial society had lapsed in September 2012 due to non-payment of premiums. The underwriter further advised that the burial society had in fact changed its name during 2012 and applied for another funeral policy under its new name. That policy also lapsed due to non-payment of premiums.

Complainant was in a position where both the underwriter and the burial society denied liability for the claim. Complainant alleged that she had not been notified of the name change, and that she had not been notified of the lapsed status of the burial society's policy. In essence, she had been paying premiums to the burial society consistently in vein. Complainant therefore requested our assistance to hold either the burial society or the underwriter liable to settle her claim.

Our Intervention

Upon receipt of the complaint, it was directed to the chairperson of the burial society who alleged that:

- The society had one bank account which all members were required to pay their premiums into. The underwriter would thereafter deduct the society's monthly premium from that account;
- The members of the society were advised to pay their premiums before the 1st day of each month to enable the underwriter to collect the full premium;
- The policies in question had lapsed because some of the members of the society had either failed to pay their monthly premium or had paid late, which meant that when the underwriter attempted to deduct the society's monthly premium, there were insufficient funds in the account;
- The chairperson alleged that this was the structure that the members had agreed upon during their meetings.

The complaint was thereafter referred to the underwriter as an authorised financial services provider.

The underwriter was requested to provide this Office with proof that the complainant had been notified of the cancellation of the burial society support plan due to the non-payment of premiums. The underwriter argued that it had sent an SMS to the chairperson of the society and that it was the chairperson's duty to notify each member of the society of the lapsed status of the policy. We advised the underwriter that such conduct was not in accordance with the spirit of the Code of Conduct and that it was required by the Policy Holder Protection Rules to notify each member of the society of the lapsed status of the policy. The underwriter was unable to furnish this Office with the requisite proof and had instead offered to pay the full benefit amount of R5000.00 to the complainant, in full and final settlement of the complaint.

Lessons learnt

12. When applying for a contract of insurance, confirm that the burial society has an underwriter who will carry the risk of compensating the burial society's members in the event of a loss or you may be exposed to non-payment of a claim where there aren't enough premiums that have been collected to meet the claims submitted to the burial society.
13. Before applying for a contract of insurance, always ensure that the burial society is registered with the Financial Services Board by obtaining the financial service's providers number and confirming their registration details with the Financial Services Board directly.

under the baobab tree

OFFICE OF THE OMBUD FOR FINANCIAL SERVICES PROVIDERS

TEL 012 470 9080 / 012 762 5000
EMAIL info@faisombud.co.za
WEBSITE www.faisombud.co.za
Sussex Office Park, c/o Lynnwood Road and Sussex Avenue, Lynnwood, 0081

Anyone who has a complaint about the service delivery of this office must kindly email their complaint to hestie@faisombud.co.za