



annual report 2019



key figures

as at 31 December 2019



10 367
FORMAL
COMPLAINTS
RECEIVED



9 167
FORMAL
COMPLAINTS
CLOSED



13 787
COMPLAINTS
CAPTURED



117
DAYS AVERAGE
TURNAROUND
TIME



R94,934,891
AMOUNT
RECOVERED



85 483
CALLS RECEIVED
BY CALL
CENTRE



mission

To resolve short-term insurance complaints fairly, efficiently and impartially.

about us

We resolve disputes between consumers and short-term insurers:

- in a cooperative, efficient and fair manner;
- with minimum formality and technicality;
- as transparently as possible, taking into account our obligations for confidentiality and privacy.

This involves understanding all aspects of a dispute without taking sides, and making decisions based on the specific facts and circumstances of each dispute.







contents

- 06** Report by the Chairman
- 08** Report by the Ombudsman
- 10** Message from the CEO
- 14** Finance Matters
- 16** Office Statistics
- 18** A Statistical Analysis of Matters Closed by OSTI in 2019
- 22** Explanatory Notes and Insurer Statistics
- 26** The Uninsured and the “Not-So-Insured”
- 28** Misrepresentation After the Inception of the Policy
- 31** Same-same, but Different (in the context of cell phone claims)
- 32** The Fast Track Process
- 33** OSTI’s Interns on OSTI’s Role in Resolving Disputes
- 34** Board of Directors
- 35** Staff of the Ombudsman
- 36** Terms of Reference
- 42** Members of the Ombudsman Scheme
- 43** Useful Information about Other Offices

report by the chairman

Haroon Y Laher
Chairman of the Board

This is my third report – and who would have imagined it being written, on my balcony, in the midst of a pandemic that is a human tragedy. COVID-19 is indeed a human tragedy of enormous depth and proportions.

OSTI remains an independent organisation. It continues to deliver fair and just outcomes. The organisation remains strong in all its areas, and this is a tribute to the administrative and professional skills, the continued teamwork, and the energy of all involved. The organisation has not lost its focus, and is in good shape.

The “soft” amalgamation has gone off seamlessly. The single Insurance Ombudsman is now very much a part of us. Judge Ron McLaren is responsible, ethical and professional. He is liked and respected by the OSTI team. He has forged strong relationships, in a short time, with people in the OSTI family.

Edite continues to demonstrate real and true leadership (more about her leadership during the COVID-19 pandemic later). She has ensured that OSTI's role remains to resolve complaints in the quickest time period. Justice and fairness remains paramount, even

if the resolution does not always seem fair from the outside.

The office remains stable in the midst of all the changes around the amalgamation and increase in the number of complaints lodged during the year, and into 2020. Various initiatives introduced over the years, like going paperless, have and continue to bear fruit. The paperless world has particularly served OSTI well under the lockdown caused by the COVID-19 pandemic.

I thank my board for all their contributions made during this period. The success of OSTI is also very much due to the open debate policy adopted during board meetings. The board will remain unaffected until the “soft” amalgamation is settled through required legislative enactments.

I cannot end without referencing the COVID-19 pandemic and its impact on OSTI. Management, led by Edite and Miriam, was ahead of the curve. I commend them for thinking ahead – it ensured that staff were enabled to work from home. The board established an OSTI COVID-19 Crisis Committee (OCCC), chaired by me and consisting of Edite, Miriam, Gail Walters, Collin

Molepe and Gerhard Genis. The OCCC focused on the well-being and health of the OSTI, and communicated with them regularly to check on their well-being and health. Staff settled into their new reality and are working well together to achieve OSTI's goals. They are in contact with colleagues. As part of its mandated terms of reference, the OCCC also looked at the financial and operational impact of COVID-19. OSTI remains financially sound, and there was no material impact in April 2020 on the targets for the month. The situation will be monitored closely by the OCC. I thank the members of the OCCC for their contributions on the issues that impact on OSTI in a post-COVID-19 world. Together, we have lived the words of our President, Cyril Ramaphosa: *"The action we take now must .. be measured and incremental .. We cannot take action today that we will deeply regret tomorrow."*

I wish you health and safety.

Haroon Y Laher
Chairperson



report by the ombudsman

Deanne Wood
Ombudsman

During 2019 OSTI handled a record number of disputes. Despite the major challenge of this increase in dispute numbers, from 9779 received in 2018 to 10 367 in 2019, we managed to maintain our timeframes without compromising the quality of our recommendations. This despite the introduction of a new complaints handling process. We also continued developing a better understanding of our relationship with our customers – both insurers and complainants – to make our service more open and accessible.

One of the key tenets of OSTI's role is to ensure that the complaints it receives are resolved as expeditiously as possible. However, as is so often the case with efficiency enhancements, rapid resolution can come at the cost of quality decision-making. Over the past few years OSTI has focused on improving the quality of its decision-making processes. Regrettably, but perhaps inevitably, this has meant that its rate of resolution has decreased.

During 2019 OSTI gave considerable focus to streamlining its operational processes, re-examining how it uses its contractors and reviewing many of its suppliers.

With the changes to the resolution process now firmly embedded within the organization's infrastructure, it is my firm belief that OSTI will, in the ensuing years, find the appropriate balance between efficiency and quality.

As OSTI works to improve its own service, it will continue to engage with stakeholders and complainants through mediation and conciliation to help them resolve issues themselves without resorting to decision-based dispute resolution.

Single entry portal

In addition to the significant operational changes that OSTI embarked on in 2019, OSTI spent much of 2019 engaged in discussions with the Ombudsman for Long-Term Insurance in the hope that it would be able to register in 2019 a single insurance ombudsman scheme for the resolution of all insurance related complaints. The aspiration to create a single scheme arose in response to National Treasury's call to all financial ombudsman schemes to self-determine a rationalisation process. Due to delays in the commencement of chapter 14 of the Financial Services Regulation Act, the registration of a single scheme was not possible. Instead the two schemes resolved to enter into a shared services agreement and appoint one Ombudsman for the adjudication of both short-term and long-term insurance complaints.

This decision means that my time as OSTI's Ombudsman came to an end with effect from 31 December 2019. Retired Judge McLaren, the current Ombudsman for Long-term Insurance, in addition to his current role, took over the adjudicative role of OSTI's ombudsman

functions with effect from 1 January 2020. I wish him every success in his new role. I am confident that the insurance industry will benefit enormously from the cohesiveness and consistency that his appointment will bring to insurance complaints lodged with either of the two schemes.

As a second leg to the plan to create a single scheme, the operational elements of my role as the Chief Executive Officer of OSTI were taken over by my able deputy, Edite Teixeira-Mckinon, from 1 October 2019. In the few months of my remaining term I was able to observe her settle into her new role with confidence and ease. I have no doubt that OSTI will flourish under her measured and thoughtful leadership.

A note of thanks

I would like to thank the OSTI Board, under its Chair Haroon Laher, for giving me the opportunities to implement radical changes to OSTI and for its support for the improvements that I believe we have made to our service offering. It has been both a privilege and responsibility to be the custodian of such an important organisation. I am proud of all that OSTI's staff have achieved over the past three and a half years and am particularly proud of the way in which they have overcome the significant challenges that accompany any major overhaul. I would like to thank my executive and management team for their persistent support, wise council and invaluable input. I thank everyone at OSTI for their commitment and willingness to embrace new challenges, and for working together to deliver a fair and efficient dispute resolution service for the benefit of the South African insurance community.

Deanne Wood

Ombudsman for Short Term Insurance

March 2020

COVID-19 and OSTI's response

Edite Teixeira-McKinon
Chief Executive Officer

I started writing my report for the 2019 Annual Report whilst still working at the office. Its contents have since then changed many times as I was struggling to relate to a time pre-COVID-19. My mind could not relate to a life before the World Health Organisation declared the coronavirus a pandemic and before our President proclaimed COVID-19 a national disaster on 15 March 2020 and implemented a total lockdown on 27 March 2020.

What an incredibly turbulent time it has been and what a "baptism of fire" for me having only been in office for a few months.

It is amazing how we have been able to implement major changes at the speed of lightning. Literally overnight, working from home was no longer a privilege for a few staff members but was the way all of us were going to work. Usually such changes would have taken time to be implemented due to planning sessions, debates, revision of policies and so on.

At its first meeting in March this year, which was shortly after the pandemic was declared a national disaster in South Africa, our Board of Directors established a sub-committee, named the COVID-19 Crisis Committee. This committee was mandated to prioritise and regularly monitor the health and well-being of OSTI's staff; the financial and liquidity positions of OSTI and the impact of the lockdown on OSTI's operations and to identify local and global trends affecting OSTI post COVID-19.

In this crisis, the health and safety of our staff was and continues to be a top priority. After all, staff cannot be expected to focus on their work responsibilities when

their own well-being and that of their families are in peril. Our leadership team immediately focused on doing whatever was necessary to ensure the health and safety of staff and getting every staff member set up to work remotely. All staff who were already able to, were asked to stay at home and work from home. The rest were then configured to work remotely.

Because working from home was for most of our staff a new way of working, leadership needed to provide them with support and guidance. A protocol and tips on working from home were sent to everyone before the lockdown became effective.

With the rapid move to working from home, came a greater need for trust. The leadership team was required to trust the staff, every staff member to trust every other staff member and the staff to trust leadership. Trust is even more important during exceptional times like these. Leadership took the approach that, if you give staff your trust, they will, in return, be trustworthy.

Within a few days of being in lockdown, leadership communicated to the staff the two essential concepts that encapsulate trust, namely freedom and responsibility. We explained that freedom, which is also referred to as empowerment, is the opportunity to exercise personal choice and to have ownership of the work that one does and the decisions that one makes. Responsibility is ensuring that personal choice is exercised with care and concern for other people and the requirements of OSTI. Together, these concepts are ordinarily fundamental to driving fulfilment in any organisation and even more so during a crisis.

Effective communication during any crisis is crucial to maintaining trust with all stakeholders, our staff being one of them, and to restoring morale and confidence. We adopted a robust communication approach, especially as this crisis, like any other crisis, added another layer of complexity to communication with the circulation of false/fake news. Our approach has been to over-communicate; educating and informing our staff.

Even if we, as the leadership team, do not have all the answers to the challenges we are facing, if staff know what we are thinking and how we are thinking about the situation, it helps them feel a sense of control.

We immediately, on hearing the lockdown announcement, set up WhatsApp groups for quicker communication between teams and between members within a team. This was invaluable, especially in the initial stages when setting up staff at home and when some staff experienced connectivity issues. This phase required patience and support from everyone whilst we, together with our IT consultants, worked through the challenges of transitioning everyone to work remotely.

Once we had been in lockdown for a few weeks and the novelty started to wear off, our responsibility as leadership expanded to taking whatever steps we could to safeguard the psychological and emotional well-being of our staff. This was particularly necessary when the lockdown was further extended. We were very mindful of the vulnerability of those staff living on their own and we first reached out to and connected with them, before doing the same with each and every other staff member.

We sent regular communications on taking care of one's mental health and later we arranged for counselling sessions for the entire staff complement.

Our second priority was and still is to ensure the continued delivery of our services as an alternative dispute resolution forum and serving our members and their consumers, who also become our customers. In doing this, we are also working towards securing our relevance, post COVID-19.

Having over a year ago moved our IT and case management systems into the cloud, we were equipped to continue registering and resolving complaints from home. Our telephone system is also securely saved in the cloud and our call centre functionality is fully operational with the ability to receive and route calls. The majority of complaints are lodged via email and on our website. Complaints are primarily resolved via correspondence and all our staff have remote access to our case management system, which is totally paperless.

We have been on all social media platforms for a few years and we quickly developed a social media campaign in response to COVID-19 and the lockdown, highlighting our services and providing consumers with tips.

The total lockdown, which forced all our staff to work from home, resulted in heavier than normal traffic on the remote connectivity networks causing capacity and access constraints but the resourcefulness of our staff has meant that, until the time that I was completing my report, productivity had not been impacted. It has been, until now, "business as usual" in not so usual times.



We have provided virtual group coaching and counselling sessions to all our staff to ensure their ongoing development and to support them in these anxiety provoking times.

A new normal and the theme of our annual report

When we come out on the other side of the pandemic and the lockdown there is no doubt that there will be no going back to the norms of the past - instead a new normal will emerge. More than ever, we will be required to be less wasteful, cut costs and operate more cost effectively.

A new norm is already emerging with meetings becoming quick, often impromptu and flexible. We have noticed that, without asking, staff have tended to put more hours into work simply because they have more hours available as a result of, for instance, not having to spend time, hours in some cases, travelling to and from work.

Team work has improved; there is a greater spirit of co-operation and helpfulness. The staff have adopted a mantle of maturity and responsibility in respect of their work.

There is already a heightened awareness of the environment and its protection, and how fragile life

is. There is an increased appreciation of what we have and a gratefulness for freedom.

Although we cannot yet fully see the new norm and although we are all going through incredible change bought on by the impact of the coronavirus, we still operate in patterns of daily habits, behaviours and consistent actions that define how people, places and things interact.

Patterns enable us to make sense of our world, which brings me to the theme of the images used in our annual report; human beings and nature coming together to create beautiful patterns, geometry and shapes. A pattern is defined as “a noticeable regularity in the natural and man-made world that repeats itself in a predictable manner”.¹

Despite all the change and chaos that has taken place throughout the world over the last few months and despite the fact that we need change and sometimes chaos to evolve, we still look for patterns in our everyday lives. Change and routine, in whatever form, can and do co-exist and both are needed for progress to take place. Awareness of the basic patterns that exist in our world will help us see what is happening around us.

We have had to create a new routine/pattern to cope with our new reality and a more isolated existence.

Together with the COVID-19 Crisis Committee, we will

¹ Using Patterns to Make Sense of Your World – Scott Jancy

continue to monitor developments both locally and internationally in respect of the responses to COVID-19. We will develop OSTI's response and implement scenario planning. We will continue to advise our staff and other stakeholders as to the steps that we are taking to address the position as it develops so as to provide for a response that is measured and appropriate.

Being a leader during COVID-19

It is during times like these that we, as leaders, need to demonstrate concern for the real fears and anxieties that staff are experiencing, not only professionally and economically, but socially and personally. Even though we do not have all the answers to their questions, we should listen to and empathise with their fears and not hesitate to share our own concerns with them. As a leader one needs to be even more unguarded than usual in circumstances like these.

Simultaneously, leadership needs to take a rational line and vigilantly focus on protecting the financial performance from the "softness" that accompanies such a disruptive crisis. This sometimes requires taking decisive action on incomplete information.

As Bob Chapman, the CEO of Barry-Wehmiller, said "you can create economic value and human value in harmony".²

Ultimately, a leader during these times needs to be transparent about the harsh realities and must inspire others to persevere.

A word of thanks

I and the leadership team at OSTI are grateful to all our customers, the insurer members and insureds, and all our other stakeholders for their on-going support.

We are especially grateful to our staff who have demonstrated incredible resilience and adaptability in trying and uncertain times.

Our sincere appreciation goes to our board for establishing the COVID-19 Crisis Committee. This committee is headed by our Chair of the Board, Mr Haroon Laher, and three other members of our board. They have selflessly given of their time, freely shared their expertise, and have been instrumental in guiding and supporting me and my leadership team.

Thank you all for your dedication and passion in ensuring that OSTI continues to protect its staff, serve its stakeholders and operate effectively.

Edite Teixeira-Mckinon

Chief Executive Officer

April 2020

² Truly Human Leadership in Uncertain Times – Bob Chapman – CEO, Barry-Wehmiller

finance matters

Miriam Matabane

General Manager

2019 Annual Financial Statements

PricewaterhouseCoopers Inc. audited the annual financial statements for the year ended 31 December 2019. The financial statements were prepared in accordance with the International Financial Reporting Standards and the requirements of the Companies Act of South Africa.

With effect from 01 January 2019, and for the 2019 financial year, OSTI adopted IFRS 16 - Leases. IFRS 16 replaces IAS 17 - Leases and sets out the principles, measurement and disclosure of leases. IFRS 16 has introduced the amended requirements with respect to lease accounting. The right-of-use of assets and the lease liability are presented as separate items on the Statement of Financial Position. Interest charges on the lease liability are reflected as part of the finance costs, whilst the right-of-use of the asset is depreciated

over the term of the lease and this depreciation charge is presented in the Statement of Comprehensive Income.

OSTI recorded Revenue of R45.2 million for the year, an increase of 19% compared to 2018 (R38.1 million). The variance is mainly due to the annual fee per complaint increase from 2018 of R4 000 per complaint to R4 300 per complaint in 2019.

OSTI recorded operating costs of R42.8 million for the year, an increase of 8% compared to 2018 (R39.7 million). The favourable variance is as a result of cost containment measures implemented by management.

The Board of Directors is of the opinion, based on the information and explanations given by management and the external auditors, that the system of internal



control provides reasonable assurance that the financial records and controls may be relied on for the preparation of the Financial Statements.

The approved and audited Financial Statements are available on our website: www.osti.co.za

A copy of our 2019 Annual Financial Statements will be emailed to all our members.

Financial Position

OSTI remains financially sound with all member insurers having settled their outstanding debts in full for the financial year ended 31 December 2019.

The OSTI recorded a total of 10 367 registered complaints for 2019, representing an increase of 6% compared to 2018 (9 779). This increase is primary attributable to the launch of the new complaints handling process in January 2019 with one of its objectives being the improvement of efficiencies and the strengthening of internal controls.

OSTI continues to closely manage its cash balances to ensure availability of sufficient cash to meet financial obligations when they fall due.

We would like to extend our gratitude to all our members for their support and contributions.

Board, Audit and Risk Committee

The Board and Audit and Risk Committees approve the financial reports and review strategic, operational and compliance risks quarterly. The focus of risk management at OSTI is on identifying, assessing, managing and monitoring risks to ensure that mitigating measures are effectively implemented. OSTI endeavours to minimise operating risks by ensuring that an appropriate infrastructure, controls and ICT systems are in place, and are managed within predetermined procedures and constraints. OSTI's finance department thanks the members of the committees for their invaluable support and guidance.

New Membership

Yardrisk Insurance Limited's application for membership was approved during 2019 and Mutual and Federal Risk Financing's application was approved in March 2020.

The list of member companies is enclosed in this report.

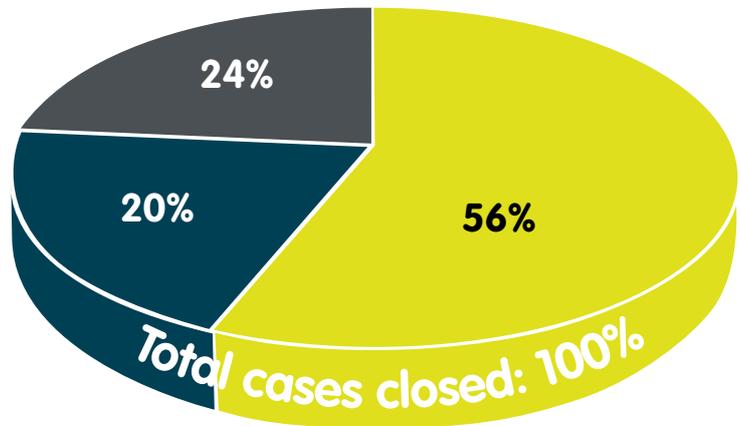
Miriam Matabane
General Manager



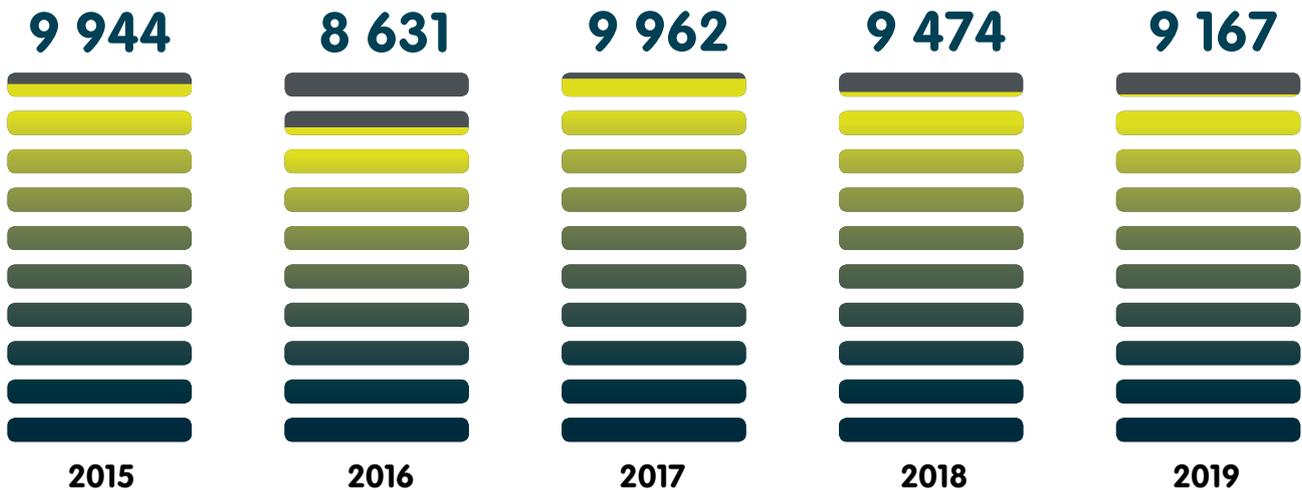
office statistics

Finalisation per period

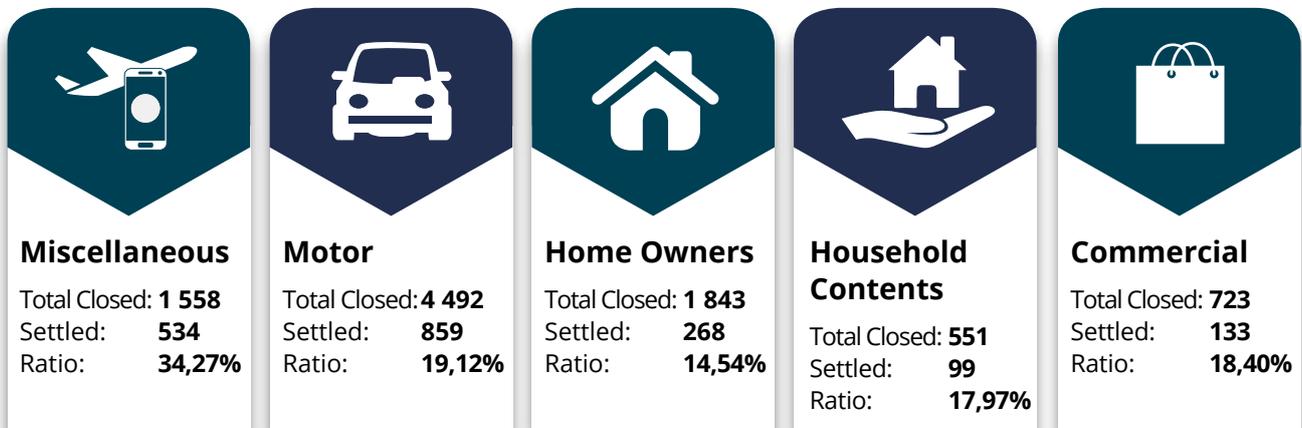
- ◆ Finalised within 4 months
- ◆ Finalised between 4 and 6 months
- ◆ Finalised in over 6 months



Formal complaints closed



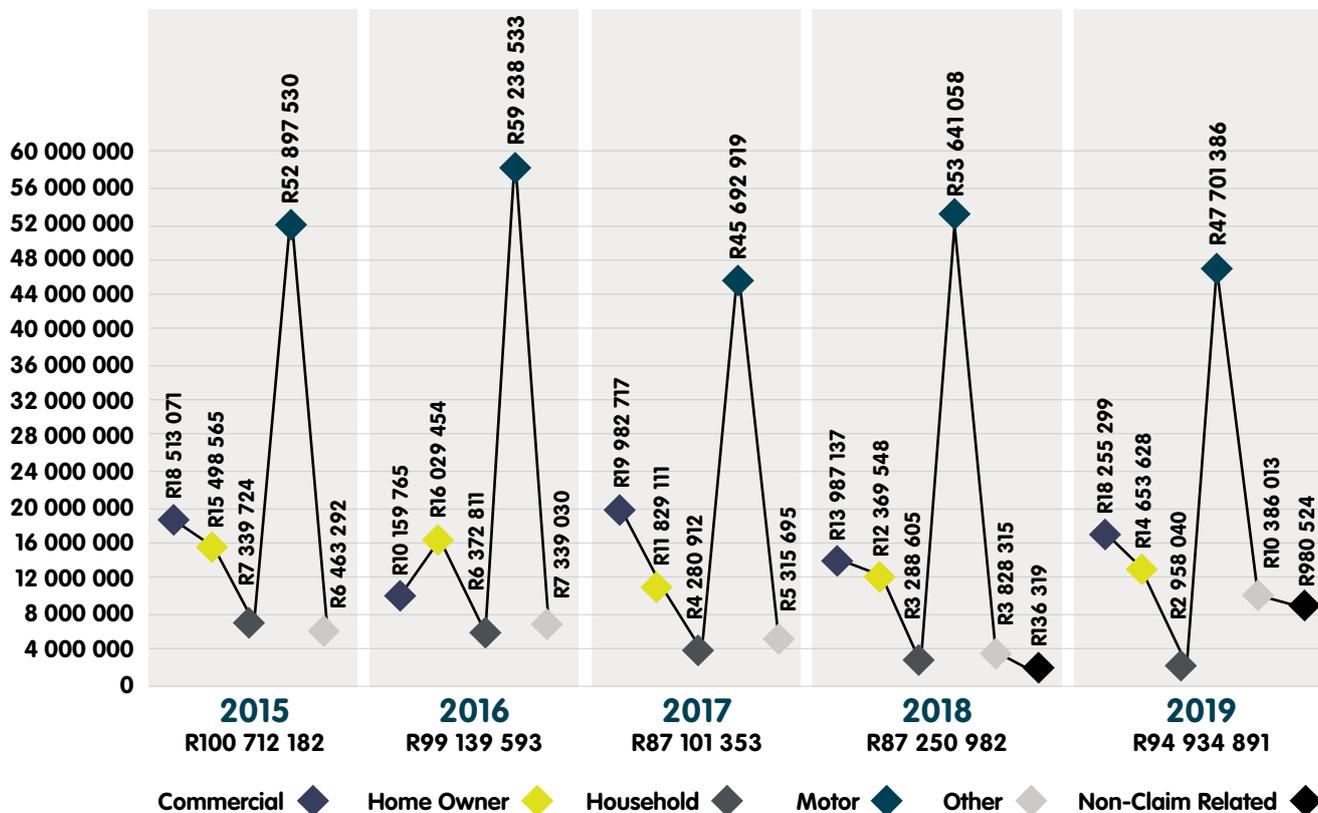
Claim types resolved ratio - 2019



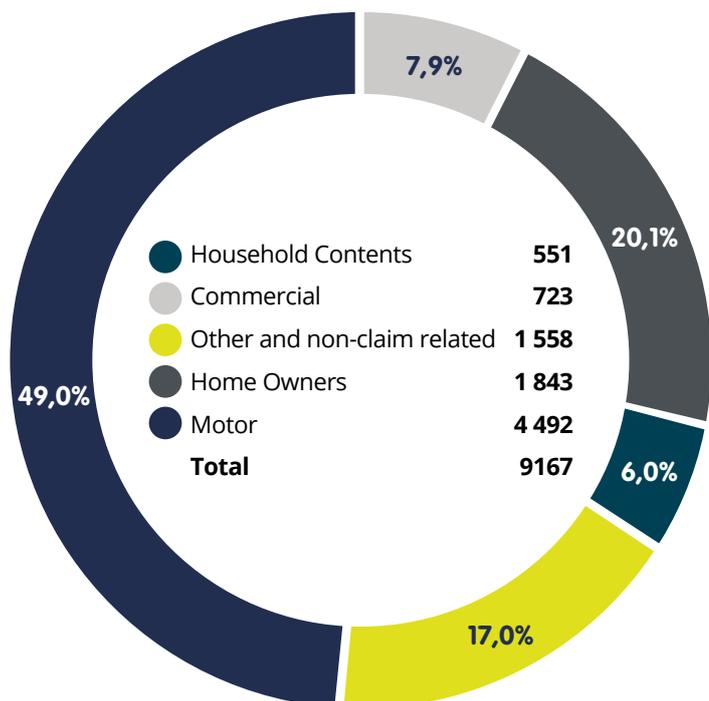
Formal rulings against insurers - 2019

CP TimberTransport/ New National Assurance Company Limited (C456/18)

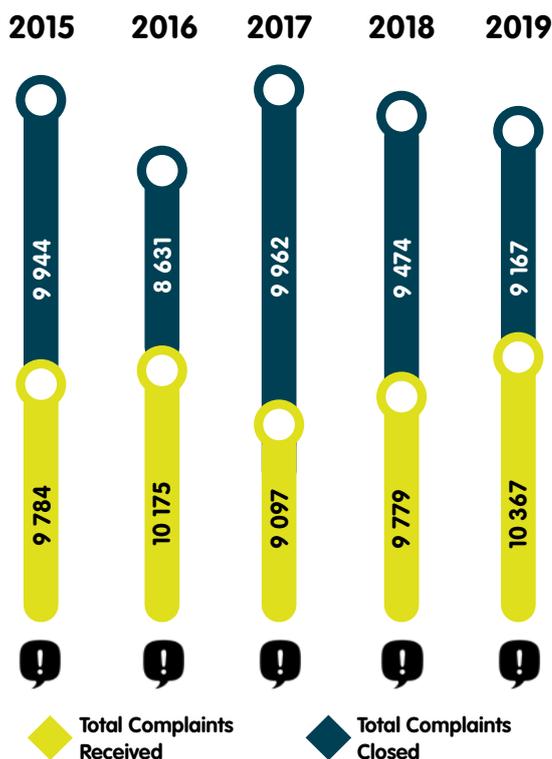
Rand value of complaints resolved in favour of insured - Claim type



Types of complaints by cases (on matters received for 2019)



Total Complaints Received and Total Complaints Closed



a statistical analysis of matters closed by OSTI in 2019

Ayanda Mazwi

Senior Assistant Ombudsman

During 2019, OSTI finalized a total of



9 167 formal complaints.

The majority were in respect of **motor vehicle** claims at **49%** followed by **homeowners/building** claims at **20%**, **commercial** claims at **8%** and **household content** claims at **6%**, with the balance of **17%** of complaints being **non-claim related** or related to other types of cover.

The majority were in respect of :



Motor vehicle claims at **49%**.



Followed by **homeowners/building claims** at **20%**.



Commercial claims at **8%**.



Household content claims at **6%**.



With the balance at **17%** of complaints being **non-claim related** or related to other types of cover.

“So what concerning these categories did people complain about the most?”

Motor vehicle claims

The **majority** of these **complaints**, at **73%**, were for **accidental damage**. Warranty and mechanical breakdown claims comprised 8%. Theft and hijack claims also comprised 8%. This trend remains consistent with previous years.

OSTI considered **4492** motor vehicle claim disputes in 2019. The **primary cause** for complaints related to **claims settlement calculations**. The type of disputes falling under this category vary. Our office wishes however to highlight that the predominance of these disputes related to vehicle credit short-fall and uninsured accessories. Standard comprehensive motor vehicle insurance will not necessarily cover the total amount owed to the bank in respect of a financed vehicle. Vehicle credit shortfall is the gap between the vehicle's insured value (covered under comprehensive motor vehicle insurance) and the amount owing to the finance house. Should a vehicle be stolen or written off in an accident, the vehicle's credit shortfall can be crippling as the consumer is left owing money on a motor vehicle that he/she no longer has. Consumers must, therefore, ensure that their policies include cover for the credit short-fall and any financed accessories which have been added to the insured motor vehicle.



These cover options are in most cases offered at an additional premium and administered under their own terms, conditions and exclusions.

The **secondary cause** for complaints was rejections based on the insured's alleged **non-disclosure or misrepresentation of underwriting details at the sales stage**. In 2018, OSTI saw a **22% decrease** in the number of these complaints when compared to the previous year. In 2019, there was a further **20% decrease**. OSTI always highlights in its engagements with consumers and the public at large, the importance of providing truthful and accurate information to the insurer during the underwriting of the policy, as well as the insurer's obligation to conduct the sales process by agreed industry codes of practice and the Policyholder Protection Rules.

238 complaints relating to rejections on the ground that the insured was **driving under the influence of alcohol** (DUI) were considered by OSTI in 2019. In 2018, we recorded a **15% decrease** when compared to the previous year. The statistics in 2019 indicate a further **13% decrease**. This is encouraging as it displays an improvement in consumer responsible conduct, such as using e-hailing services, and the positive influence of measures taken by insurers in this area, such as providing their customers with chauffeured services. OSTI has always cautioned consumers that a DUI rejection may be justified on circumstantial evidence alone, despite the driver not having been tested for alcohol by way of a breathalyzer or blood test, or having been convicted of a criminal offense concerning the incident. In previous years, some insurers relied

on insufficient circumstantial evidence to justify these rejections, in which case OSTI would overturn the insurers' decisions. Perhaps these statistics also indicate that insurers are validating DUI claims in a fairer manner.

In 2019, **19%** of motor vehicle claim disputes were resolved in favor of the insured's claim, and OSTI put **R47 701 385,68** back into the pockets of the insured.

Homeowners insurance claims

54% of complaints considered by OSTI under homeowner's insurance related to claims for damage caused by **acts of nature**, largely storm-related. This figure dropped from **58%** recorded in **2018**.

OSTI considered **1843** homeowners' insurance claim disputes. The primary cause for complaints, at **30%**, was the rejection of claims on **wear and tear, gradual deterioration and lack of building maintenance** being the proximate cause of the damage. While this cause for complaint declined by **18%** when compared to **2018**, this rejection reason continues to be the main basis for consumer dissatisfaction in homeowner's insurance coverage. If the damage claimed is attributed to the poor condition of the property, the policy may not respond - even if an insured event did occur. In general, OSTI bases its assessment of these matters on the information contained in expert reports and photographs submitted by the parties. The evidentiary burden of proof lies with the insurer if it rejects the claim on an exclusion and the insurer must establish a causal connection between the condition of the property and the damage.



The **secondary cause** for complaints related to rejections based on **no insured event having operated**. The insurer is only liable if the claim made falls within the scope of cover provided, in other words, if an insured event as stated in the policy terms and conditions is proven by the insured as being the cause of the damage. Here, the burden of proof is on the insured, who must provide evidence and demonstrate that the effective cause of the loss is an insured event.

15% of homeowner's insurance disputes were resolved in favor of the insureds' complaint, with a **recovery of R14 653 628,32**.

Household content insurance claims

Theft and burglary claims comprised **67%** of complaints considered by OSTI under this category, a **4%** decline compared to last year's figure.

Claims settlement calculations remain the **primary cause** for complaints, as in the previous year. The disputes mainly related to issues of underinsurance, replacement values and proof of ownership in respect of the claimed items.

The **secondary cause** for complaints was rejections where the insurer's **underwriting criteria for the insured event were not met**. Examples include minimum security requirements, such as a

burglar alarm with armed response, burglar bars, and burglar gates not being complied with by the insured. Consumers are advised to review their policy documents and ensure compliance with their insurers' conditions of cover.

Complaints relating to damage caused by **power surge** increased from **3%** in 2018 to **6%** in 2019. This may be attributed to load-shedding and power failures experienced in the year. Damage caused by power surge is excluded in some household content insurance policies. Consumers must read through their policy terms and conditions and consult with their insurers or brokers to ensure that there is cover in place to repair or replace their valuables in this event.

18% of household content insurance disputes were resolved in favor of the insureds' complaint, with a **recovery of R2 958 039.99**.

Commercial insurance claims

The **majority** of commercial complaints considered by OSTI related to **motor vehicle (32%)** and **building (23%)** claims. OSTI considered **723** commercial complaints in 2019. Overall, the **primary cause** for the complaints was rejections based on **gradual deterioration, wear, and tear and lack of maintenance**. The secondary



cause for complaints was the **claims settlement calculations** followed by rejections on the ground that the insurer's specific **conditions of cover were not met**, such as a valid professional driver's license, a vehicle's roadworthiness, alarm warranties and fire safety measures.

18% of commercial insurance disputes were resolved in favor of the insureds' complaint, and OSTI **recovered R18 255 299.01**.

'Other' & non-claim related policy complaints

The remaining complaints relate to various insurance products - including personal accident, water loss, travel insurance, all risks, mobile device cover, legal expenses, hospital, and medical gap cover. General policy-related disputes include policy amendments/endorsements, policy cancellations/lapses, premium increases/rebates, and service-related complaints. We often find that the **primary cause** for complaints under this category is **the quality of the communications** that take place between the insurer and the insured during underwriting and over the operation of the policy.

This category, overall, comprised **17%** of the formal complaints considered by OSTI in 2019. **34%** of these

disputes were resolved in favour of the insureds' complaint. Overall, OSTI recovered **R11 366 537.68** for insureds in this category of complaints.

OSTI's Customer Experience

In 2018, OSTI reported that 60% of complainants who completed our customer experience surveys indicated that they were satisfied with our service, processes, and communications.

In January 2019, OSTI adopted, as part of its commitment to developing a better understanding of its relationship with customers, a stronger customer-centric approach. We introduced insurer surveys in the evaluation of OSTI's overall delivery of service and quality outcomes.

In relation to the number of complaints finalized in 2019, 22% of complainants and 25% of insurers completed surveys. Out of these, **75% were satisfied with our service, processes, and communications**.

Customer experience, in the content of OSTI, entails, at its core, delivering high quality and efficient complaint resolutions and customer experience therefore remains an integral part of our business strategy.

Ayanda Mazwi
Senior Assistant Ombudsman

explanatory notes and insurer statistics

Explanatory notes

1. The data must be understood in the correct context and it is therefore necessary to record some words of explanation in relation to these statistics.
2. The office of the Ombudsman has limited jurisdiction over commercial lines policies and, in any event, has jurisdiction for personal lines business only up to R3.5 million, save for home owner claims where the jurisdictional limit is R6.5 million. The statistics therefore focus only on personal lines claims (statistics provided by the Financial Sector Conduct Authority ("FSCA")) and personal lines complaints received by this office. Commercial lines complaints, which are not reflected in the statistics, represent about 8.0% of the total complaints to the office of the Ombudsman.
3. Also excluded from the insurer statistics are those complaints resolved "on transfer". In terms of the complaints handling process that came into effect on 1 January 2019, an insurer is given an opportunity to resolve a complaint directly with the insured where the insured lodged a complaint with OSTI before first approaching his/her insurer to resolve the complaint. This process is referred to as the "on transfer" process. If the insurer resolves the complaint to the satisfaction of the insured, then the decision of the insurer is not recorded as an overturn against the insurer in these statistics but is included in the overall office statistics. Further comments on the overturn rate appear below.
4. No adverse conclusions should be drawn against any insurer based purely on the number of complaints against them received by this office. Larger insurers issue proportionately more policies which cannot form the basis of a complaint to this office due to our jurisdictional limits. Thus, for example, when considering the percentage of complaints received by this office against a large insurer, the large insurer, upon a superficial analysis, therefore appears to attract a relatively low number of complaints. What is the more important statistic is the proportion of personal lines complaints relative to an insurer's share of the total personal lines claims reported to the FSCA. The clearest indicator of this is column 5, being the number of complaints to this office per thousand claims received by an insurer. Where an insurer receives a high number



of complaints to this office per thousand claims, this may be an indicator that claims are dealt with unfairly by the insurer. However, this statistic should be considered in conjunction with columns 8 and 9, being the share of matters resolved through conciliation by the parties/enforcement by OSTI. The overturn rate is an indicator that the decision of the insurer with respect to a complaint was changed in some respect by this office with some additional benefit to the insured. Further comments on the overturn rate appear below.

5. Please note that a claim can be received by an insurer in year one and a complaint in respect of that claim may be received by OSTI only in year two – hence the number in column 1 may be greater than the number in column 3. The statistics record the numbers received by insurers and the OSTI respectively during 2019.
6. Also note that under column 1, certain insurers may be shown by the FSCA statistics as having received no claims during 2019. This may be explained on the basis of either the company issuing only commercial lines policies or that the company is dormant. We repeat that only personal lines statistics are included in the table as this is what has been received from

the FSCA. (columns 1 and 2)

7. The overturn rate per insurer as shown in the table is for personal lines claims only. It excludes commercial lines claims and complaints resolved on transfer (see point 3 above). If a high overturn rate is registered, this may, but not necessarily, indicate that the insurer is not treating its customers as fairly as it should. However, the overturn rate should be treated with considerable caution as a high overturn rate can also be indicative of a high degree of co-operation being received by the Ombudsman's office from a particular insurer in resolving a complaint to the satisfaction of the customer. The Ombudsman takes into account the following two circumstances in determining the Overturn Rate:
 - a) The decision of the insurer is overturned by the Ombudsman by way of a recommendation which is accepted or by way of a Final Ruling.
 - b) A resolution of the dispute has been mediated by the Ombudsman with the insured receiving a benefit which he/she would not have received without the involvement of the Ombudsman.
8. Any media queries in relation to the insurer statistics should be directed to the particular insurer.



insurer statistics

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|--------------------------------------|---|--|-----------------------------|--|---|------------------------------|---|---|---|
| Name of Insurer* | Claims received by Insurers (FSCA statistics) | Share of claims received by the particular insurer (FSCA statistics) | Complaints received by OSTI | Share of the total number of complaints received by OSTI | Number of Complaints received by OSTI per thousand Claims received by Insurer | Complaints finalised by OSTI | Complaints finalised with some benefit to the insured | Share of matters resolved through conciliation by parties | Share of matters resolved through enforcement by OSTI |
| Abacus | 4 972 | 0,13% | 10 | 0,11% | 2,011/1000 | 8 | 5 | 50,00% | 12,50% |
| Absa | 133 805 | 3,55% | 604 | 6,46% | 4,514 /1000 | 609 | 112 | 16,91% | 1,48% |
| AIG Insurance | 9 805 | 0,26% | 32 | 0,34% | 3,264 /1000 | 28 | 8 | 25,00% | 3,57% |
| Alexander Forbes | 55 790 | 1,48% | 166 | 1,78% | 2,975 /1000 | 158 | 23 | 13,92% | 0,63% |
| Allianz | 857 | 0,02% | 4 | 0,04% | 0/1000 | 3 | 0 | 0,00% | 0,00% |
| Auto & General | 240 254 | 6,38% | 400 | 4,28% | 1,665/1000 | 319 | 42 | 11,29% | 1,88% |
| Bidvest | 24 410 | 0,65% | 80 | 0,86% | 3,277 /1000 | 68 | 8 | 8,82% | 2,94% |
| Bryte | 153 062 | 4,07% | 163 | 1,74% | 1,065/1000 | 134 | 48 | 33,58% | 2,24% |
| Budget | 78 687 | 2,09% | 374 | 4,00% | 4,753/1000 | 330 | 35 | 9,09% | 1,52% |
| Centriq | 37 567 | 1,00% | 147 | 1,57% | 3,913/1000 | 148 | 53 | 31,76% | 4,05% |
| Chubb | 1 432 | 0,04% | 5 | 0,05% | 3,492/1000 | 4 | 0 | 0,00% | 0,00% |
| Compass | 10 501 | 0,28% | 57 | 0,61% | 5,428/1000 | 128 | 6 | 4,69% | 0,00% |
| Constantia | 55 441 | 1,47% | 271 | 2,90% | 4,888/1000 | 203 | 59 | 27,09% | 1,97% |
| Dial Direct | 34 277 | 0,91% | 192 | 2,05% | 5,601/1000 | 142 | 18 | 10,56% | 2,11% |
| Discovery | 198 979 | 5,29% | 312 | 3,34% | 1,568/1000 | 297 | 48 | 14,48% | 1,68% |
| First for Women | 45 405 | 1,21% | 174 | 1,86% | 3,832/1000 | 142 | 13 | 7,04% | 2,11% |
| FirstRand Short-term | 14 437 | 0,38% | 2 | 0,02% | 0,139/1000 | 1 | 1 | 0,00% | 100,00% |
| Genric | 53 526 | 1,42% | 45 | 0,48% | 0,841/1000 | 59 | 11 | 15,25% | 3,39% |
| Guardrisk | 270 230 | 7,18% | 544 | 5,82% | 2,013/1000 | 509 | 128 | 22,59% | 2,55% |
| Hollard | 313 522 | 8,33% | 497 | 5,32% | 1,585/1000 | 534 | 125 | 22,10% | 1,31% |
| Hollard Specialist Insurance Limited | 32 859 | 0,87% | 76 | 0,81% | 2,313/1000 | 86 | 26 | 29,07% | 1,16% |
| Indequity | 2 619 | 0,07% | 4 | 0,04% | 1,527/1000 | 6 | 2 | 16,67% | 16,67% |
| Infiniti | 30 216 | 0,80% | 57 | 0,61% | 1,886 /1000 | 53 | 4 | 7,55% | 0,00% |
| King Price | 112 182 | 2,98% | 501 | 5,36% | 4,466/1000 | 405 | 48 | 10,12% | 1,73% |
| Legal Expenses | 24 443 | 0,65% | 109 | 1,17% | 4,459/1000 | 70 | 12 | 17,14% | 0,00% |
| Lion of Africa \$ | 898 | 0,02% | 90 | 0,96% | 0/1000 | 138 | 54 | 38,41% | 0,72% |
| Lloyd's | 199 | 0,01% | 2 | 0,02% | 0/1000 | 6 | 1 | 16,67% | 0,00% |
| Lombard | 17 855 | 0,47% | 69 | 0,74% | 3,864/1000 | 59 | 11 | 16,95% | 1,69% |
| MiWay | 118 948 | 3,16% | 432 | 4,62% | 3,632/1000 | 437 | 32 | 5,72% | 1,60% |

| Name of Insurer* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|--|-----------------------------|--|---|------------------------------|---|---|---|
| | Claims received by Insurers (FSCA statistics) | Share of claims received by the particular insurer (FSCA statistics) | Complaints received by OSTI | Share of the total number of complaints received by OSTI | Number of Complaints received by OSTI per thousand Claims received by Insurer | Complaints finalised by OSTI | Complaints finalised with some benefit to the insured | Share of matters resolved through conciliation by parties | Share of matters resolved through enforcement by OSTI |
| Momentum ST | 43 549 | 1,16% | 94 | 1,01% | 2,158/1000 | 81 | 7 | 8,64% | 0,00% |
| Monarch | 17 438 | 0,46% | 8 | 0,09% | 0,459/1000 | 5 | 3 | 60,00% | 0,00% |
| Nedgroup | 70 666 | 1,88% | 312 | 3,34% | 4,415/1000 | 265 | 61 | 21,13% | 1,89% |
| New National | 17 595 | 0,47% | 181 | 1,94% | 10,287/1000 | 191 | 43 | 20,42% | 2,09% |
| NMS | 111 668 | 2,97% | 2 | 0,02% | 0,018 /1000 | 3 | 3 | 100,00% | 0,00% |
| Oakhurst | 64 898 | 1,72% | 332 | 3,55% | 5,116/1000 | 324 | 54 | 14,51% | 2,16% |
| Old Mutual | 244 370 | 6,49% | 792 | 8,47% | 3,241 /1000 | 724 | 129 | 16,71% | 1,10% |
| OUTsurance | 291 901 | 7,75% | 298 | 3,19% | 1,021/1000 | 275 | 22 | 8,00% | 0,00% |
| PPS | 6 184 | 0,16% | 12 | 0,13% | 1,940 /1000 | 3 | 2 | 66,67% | 0,00% |
| Renasa | 92 397 | 2,45% | 182 | 1,95% | 1,970 /1000 | 155 | 43 | 27,74% | 0,00% |
| SAFIRE | 7 163 | 0,19% | 6 | 0,06% | 0,838/1000 | 7 | 0 | 0,00% | 0,00% |
| SAHL | 24 344 | 0,65% | 86 | 0,92% | 3,533/1000 | 74 | 6 | 5,41% | 2,70% |
| Santam Ltd | 383 938 | 10,20% | 557 | 5,96% | 1,451/1000 | 473 | 73 | 14,16% | 1,27% |
| Santam Structured | 33 982 | 0,90% | 210 | 2,25% | 6,180/1000 | 183 | 22 | 12,02% | 0,00% |
| SASRIA | 1 142 | 0,03% | 2 | 0,02% | 1,751/1000 | 3 | 3 | 100,00% | 0,00% |
| Shoprite | 17 915 | 0,48% | 3 | 0,03% | 0,167/1000 | 5 | 3 | 60,00% | 0,00% |
| Standard | 128 935 | 3,42% | 637 | 6,81% | 4,940/1000 | 544 | 76 | 12,13% | 1,84% |
| Unitrans | 4 677 | 0,12% | 5 | 0,05% | 1,069/1000 | 6 | 3 | 50,00% | 0,00% |
| Vodacom | 107 177 | 2,85% | 150 | 1,60% | 1,400 /1000 | 110 | 67 | 57,27% | 3,64% |
| Western National | 17 646 | 0,47% | 38 | 0,41% | 2,153 /1000 | 41 | 12 | 24,39% | 4,88% |
| Workerslife | 15 | 0,00% | 23 | 0,25% | 0/1000 | 22 | 8 | 31,82% | 4,55% |
| Yardrisk Insurance Limited [@] | 0 | 0,00% | 0 | 0,00% | 0/1000 | 0 | 0 | 0,00% | 0,00% |
| TOTAL | 3 764 778 | 100,00% | 9349 | 100% | 2,48/1000 | 8 578 | 1573 | 16,72% | 1,62% |

Please Note:

The Statistics for ABSA Insurance Co Ltd include statistics for ABSA Idirect and ABSA Insurance Risk Management Services Limited.

The Statistics for Old Mutual Insure include statistics for Iwyze and Mutual & Federal Risk Financing.

FSCA Legend

@ New license

\$ Run-off of business

the uninsured and the “not-so-insured”

Peter Nkhuna

Senior Assistant Ombudsman

The generally accepted statistic is that only 30 to 35 % of motor vehicles on South African roads are insured.

This statistic is simply based on recorded data. It is my contention, however, that in reality a greater proportion of vehicles considered insured may not in fact be insured. My submission is admittedly based on what some may call “anecdotal evidence” from complaints received by our office. The ratio of complaints received by OSTI to the total claims submitted to insurers is only 0.24% for 2019, so perhaps it is indeed only anecdotal.

Part of the reason for this view is that some consumers of insurance products do not comply with the terms and conditions of their policies. This may be either as a result of them not being aware of their responsibilities, or, alternatively, simply ignoring such responsibilities. We often find that insureds are of the mistaken belief that, by simply paying premiums, they are entitled to have all their claims settled by their insurers. On the contrary, the ombudsman’s finding in the matter discussed below demonstrates how important it is that insureds honour their own obligations.

Most motor policies impose the following responsibilities which are sometimes ignored or not met:

1. The duty to make accurate disclosures at all times;
2. The duty to allow only licensed drivers to drive the insured vehicle;
3. The duty not to drive the insured vehicle whilst the

driver is under the influence of alcohol;

4. The duty not to drive the insured vehicle recklessly;
5. The duty not to use an un-roadworthy vehicle on public roads; and
6. The duty to maintain the insured vehicle and keep it in a good state of repair;

The effect of ignoring or not meeting any of the above responsibilities is that, when an insured claims, the insurer may be entitled to decline liability.

In other words, while the vehicle would at face value be insured, in reality, and as a result of the insured not complying with the obligations set out in the policy terms and conditions, the vehicle is not covered. The insured would be operating on the premise that the vehicle is insured while his/her own conduct would lead him/her to being exposed to, at least, some of the risks that may materialise.

In one of the cases OSTI recently dealt with, the policy required that the insured keep his vehicle in a good state of repair. However, for whatever reason, the insured did not do this.

On a particular day, while the insured was driving his vehicle, he noticed that the vehicle was on fire. He, together with members of the community in the area, tried to douse the fire. There appeared to the insured to be no specific reason why the fire ignited. The insured subsequently registered a claim with the insurer.



During the assessment of the claim, the insurer found that the vehicle had been poorly maintained. It further found that the fire incident was as a result of the vehicle not having been properly maintained.

The assessor appointed by the insurer to determine the cause of the fire made the following findings:

- i. There were no signs of fire damage to the vehicle except for fire damage in the engine compartment;
- ii. The fire damage appeared to emanate from inside the engine;
- iii. There was evidence that the engine had overheated as a result of a cracked and broken plastic breather pipe of the positive crankcase ventilation system;
- iv. There was also evidence of one of the coolant hoses having been fitted by tying it with a piece of wire instead of a circlip/clamp normally used for such fittings, and the seal on the end of the rubber pipe was damaged;
- v. In addition, there was further evidence of advanced wear and tear, including oil leaking through the turbocharger's oil seals; and
- vi. It was the assessor's view that the fire was the direct result of the poor condition of the vehicle and that, if the vehicle had been properly maintained, the fire would not have occurred.

On the basis of the assessor's findings, the insurer declined liability for the claim and relied on the policy wording which stated that the insurer was not liable for "failure, breakage or rust, wear and tear, depreciation, perishing, fading, mechanical or electrical breakdown".

Being unhappy with the outcome of the claim, the insured lodged a complaint with our office.

It was the ombudsman's finding that the insurer's stance on the claim could not be faulted.

It is clear from the above example that, while this vehicle and the insured would have formed part of the statistics of the insured population, based on the condition of the vehicle, it was not, in fact, as comprehensively insured. In terms of the policy, there was no cover for any losses relating to accidents, fire or the other related perils where the condition of the vehicle was material to the loss.

In the case discussed above the insured had failed to keep his end of the bargain, whilst, at the same time, expecting his insurer to honour the claim. In this case, had the insured maintained his vehicle, as required in terms of the policy, there would have been no loss or damage and therefore no claim.

It is conceivable that the insured's conduct could result in all of the benefits under an insurance policy becoming nullified, and not only some of them.

Insurance consumers are therefore encouraged to familiarise themselves with their policy terms and conditions and to conduct themselves accordingly, otherwise, they may find themselves unable to enjoy the benefits of their policies.

Peter Nkhuna
Senior Assistant Ombudsman

misrepresentation after the inception of the policy

Thasnim Dawood

Senior Assistant Ombudsman

Mr. V lodged a claim with his insurer for damage to his motor vehicle arising out of a motor vehicle accident. The vehicle was being driven by the insured's daughter-in-law, Mrs. M. The insurer rejected the claim on the grounds of material misrepresentation/ non-disclosure, on the basis that there was a material change in risk, of which it had not been informed.

The insurer advised that the regular driver of the vehicle on the policy was the insured's son, Mr. M. In the insurer's rejection letter the insurer stated that, when the cover for the insured vehicle was accepted, it was accepted based on the information and disclosures provided by Mr. V's broker when adding the vehicle to the already existing policy. Mr. V signed a form which noted all the relevant and necessary details. The insurer advised that Mr. V was asked for the details of the regular driver of the vehicle and the risk address as this had a direct impact on the insurer's decision to accept the risk. The insurer referred to the document where Mr. V stated and signed that Mr. M would be the regular driver of the vehicle. The vehicle had been bought for Mr. M.

During the investigation of the claim, the insurer found that Mr. and Mrs. M were separated from their marriage for approximately six to eight months prior to the accident and they were not living together. Mrs. M was living at a different address to the address noted on the policy. When they separated, Mr. M told Mrs. M that she could make use of the vehicle for herself and their children. Mrs. M had been using the vehicle ever since.

The insurer advised that both Mr. M and Mr. V were aware that Mrs. M did not have a driver's license and only had a learner's license and they were aware that Mrs. M would be using the vehicle as the regular driver.

The insurer advised that it was not informed that the regular driver and risk address had changed. The insurer submitted that the failure by both Mr. V and Mr. M to disclose the changes in the risk resulted in a non-disclosure of material facts. The insurer submitted that, if it had been made aware that Mrs. M would be the regular driver of the vehicle, it would not have accepted the risk as the regular driver, in terms of the policy, is required to have a valid driver's license.

The insurer referred to the following policy wording:

"information that affects and changes the risk: there is an obligation on you to advise us immediately on the happening of any event that may affect our decision to accept the risk or the terms on which we accept the risk or our continued acceptance of the risk. Should you not adhere to these obligations, we may void the whole or any part of this policy and the section as from inception or date of change" and for this general condition, the term "you" includes any person acting on your behalf. "

According to Mr. V, he did declare that Mr. M would be the regular driver, that Mrs. M would drive the vehicle and that she did not have a valid driver's license.

Mr. V submitted that he informed his broker that Mrs. M had a learner's license. He advised that he repeatedly

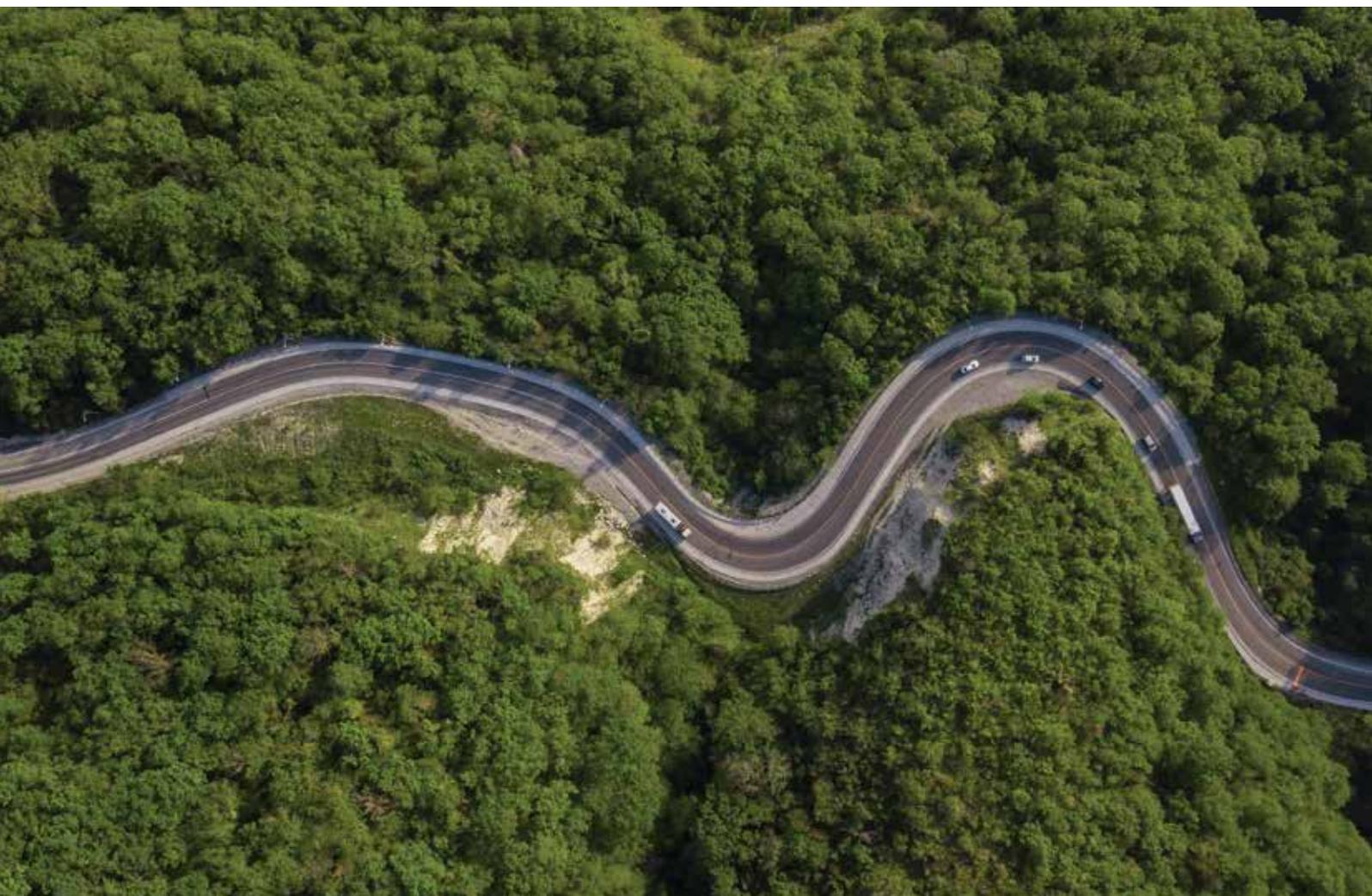
asked his broker to confirm that Mrs. M was covered by the policy even though she only had a learner's license. According to Mr. V, the broker confirmed that Mrs. M was covered. The insured argued that Mrs. M complied with the legal requirements of a holder of a learner's license, especially with the condition that such person may drive a vehicle if another person, who has a valid driver's license, accompanies him or her. Mr. V submitted that the policy contract did not define or describe the term "driver's license" and that it did not make any mention of a learner's license. He argued that, as a result, while the policy does not make reference to a learner's license, there is no restriction on the term "driver's license". According to Mr. V, he informed his broker that Mrs. M only had a learner's license and his broker assured him that she was covered under the policy.

Mr. V then referred to the policy wording and stated that it did not define a "regular driver". Mr. V said that

his broker's explanation was that "as long as his son was declared the regular driver, then his wife was automatically included and covered by the insurer."

Mr. V submitted further that the change in risk address was only material to the risk of theft and hijacking and that it was not material to the risk of accident. He argued that he had disclosed all the necessary information to his broker.

The insurer submitted that "license" means a valid driver's license and that the reference to a learner driver is there to ensure that there is no confusion that a learner driver needs to comply with the legislation concerning learner drivers. The insurer submitted that the issue was not whether Mrs. M could lawfully drive a vehicle in the circumstances permitted by the relevant legislation. The issue was that Mrs. M had become the regular driver of the vehicle which was a risk that the insurer would not have accepted. ▶



The insurer advised that the risk it underwrote changed fundamentally and that the insurer did not cover regular drivers who held only learner drivers' licenses. The insurer submitted that Mr. V did not meet his disclosure obligations in terms of the policy in that the insurer was not made aware, at any time prior to the accident, that the regular driver of the vehicle and the risk address had changed.

The insurer did not view Mr. M and Mrs. M as being "one as the other". The insurer submitted that factors such as age, driving experience and the number of years of holding a valid driver's license, have a direct impact on the acceptance of a risk and, if the risk is accepted, the conditions and rates that are applied to the premium. The insurer referred to the regular driver clause in the policy which reads as follows:

"2 REGULAR DRIVER CLAUSE

We use pertinent information about the stated regular driver to determine the premium we charge to insure each vehicle. This information includes the person's age, driving history, driving ability and financial status. You have to advise Us immediately of a change in the following:

2.1 The regular driver of a vehicle;

2.2 The occupation of the regular driver;

2.3 Change of use of the vehicle;

2.4 The financial status of the regular driver (including information relating to any judgments, convictions or if the regular driver has been declared insolvent or placed under administration);

2.5 Change of address where vehicle is kept overnight. We may decline to indemnify or compensate You for Your loss, damage or any liability under this section if the risk is materially changed without Our written consent."

The insurer stated that, when considering a change in the risk address, the insurer assesses not only the new address but also the security of the premises and where the vehicle is parked at night.

The insurer advised that in this matter it had not been given an opportunity to assess the changes in the risk. The insurer submitted that Mr. V's failure to disclose the change in the regular driver resulted in a material non-disclosure which entitled it to void the policy.

The issues that OSTI had to decide were whether there was a material change in risk and whether the insurer was entitled to reject the claim based on material non-disclosure.

When the policy was underwritten, the insurer was advised that the regular driver of the vehicle would be Mr. M and he was noted as such. It is common cause that Mr. M was in possession of a valid drivers license. It is also common cause that Mrs. M only had a learner's license. In order for Mrs. M to have driven the insured vehicle, she would have needed to comply with the requirements of the relevant legislature, in particular, to drive the vehicle while accompanied by a person who had a valid driver's license. At the time of the accident, Mrs. M had become the regular driver of the vehicle. This meant that there was a material change in the risk and the fact that Mrs. M only had a learner's license was clearly material to the risk, if not to the loss. The insurer would not have accepted the risk had it know that Mrs. M was the regular driver. The insurer did not accept regular drivers who only had learner's licenses.

Under the circumstances, our office found that there had been a material change in the risk in respect of the regular driver and that the insurer was entitled to reject the claim on this basis. Mr. V did not inform the insurer of this change and, had the insurer been informed, it would not have continued to accept the risk.

As a result the insurer's rejection of the claim was upheld and Mr. V's complaint was dismissed.

Thasnim Dawood

Senior Assistant Ombudsman

same-same, but different ... (in the context of cell phone claims)

Darpana Harkison

Senior Assistant Ombudsman

The insured submitted a claim for the theft of his cellphone, a Samsung S7 Edge, which took place during a burglary at his risk address on 20 October 2018. The insured referred the matter to the Ombudsman's office due to his dissatisfaction with the insurer's offer of settlement.

On 5 January 2018, the insured contacted the insurer to amend the policy as he and his wife had separated. When the insured asked the insurer's sales consultant what he would be paid by the insurer should anything happen to his cellphone, the insured was advised that he would be paid the insured amount, being R15 000.00, minus his excess of R500.00.

At the time that the insured submitted the claim, the Samsung S7 Edge could not be replaced and the insurer offered to settle the insured's claim by replacing the Samsung S7 Edge with a Samsung Galaxy S8. However, based on his conversation with the insurer on 05 January 2018, the insured was adamant that the claim must be settled on a cash-in-lieu basis in the sum of R14 500.00.

The issue to be determined by OSTI was whether the insurer's offer of settlement amounted to indemnification on the part of the insurer.

Short-term insurance contracts are contracts of indemnity which means that the insurer's obligation is to place the insured back in the same financial position that he was in immediately prior to the loss or damage. Indemnity also means that the insured should not profit from the insurer's settlement of the claim. Therefore, if the insurer were to settle the claim on a cash-in-lieu basis in the sum of R14 500.00, this would have amounted to the insured making a profit from the loss and the offer would fall outside of the scope of a short-term insurance contract.

The policy wording which the insurer relied on to substantiate its offer of settlement provided that:

"Need to claim

We have the choice to settle your claim in any of the following ways:

- *Paying out cash to you.*
- *Repairing the damage at a repairer of our choice.*
- *Replacing the item at a supplier of our choice.*
- *Any combination of the above.*

What's it worth

The insured value that's noted on your policy schedule is the maximum amount that we'll pay for any claim, less the excess amounts payable by you, and less any dual insurance and under-insurance."

It was pointed out to the insured that, when dealing with contents items, which depreciate in value due to use and rapidly changing technology, it becomes difficult for an insurer to place the insured back in the same financial position. Consequently, an extension of the indemnity principle is that where the risk item is insured for its replacement value, the insurer is then permitted to replace the lost used item with a new item which is similar to the item which was on cover.

It was not in dispute that the replacement phone, which the insurer sought to provide to the insured, was a newer and more modern phone than the one that was on cover. Therefore, the insured was advised that the insurer's offer to replace the Samsung S7 Edge with a Samsung S8 Galaxy did amount to indemnification on the part of the insurer.

The insurer then offered to settle the claim on a cash-in-lieu basis in accordance with the policy wording, which granted the insurer the right to decide the manner in which the insured was to be indemnified in the event of a loss.

In conclusion, OSTI held that the insurer had successfully proven that, on a balance of probabilities, its offer of settlement was fair and reasonable and in accordance with its obligations to indemnify the insured as set out in the policy wording. A recommendation was accordingly made to the insured to accept the insurer's offer.

Darpana Harkison

Senior Assistant Ombudsman

the fast track process

Hannes Bester

Assistant Ombudsman and Team Leader of the Fast Track Department

In October 2018, OSTI embarked on a new project in the office's case resolution department. This project came about after much internal deliberation as well as research of international ombud schemes that work on a similar model to the office's model. Having analysed all the pros and cons, it became clear that there was a need to try this new way of resolving complaints, especially since both the insurer members and complainants would benefit from it.

The Fast Track Department, colloquially and within the office called "the Trackies", was established and the fast track process was implemented. The department, consisting of assistant ombudsmen and case administrators, is tasked with effectively and efficiently profiling every personal lines complaint that is registered by the office. A complaint is profiled to determine whether or not it is capable of being resolved early in the dispute resolution process.

Once a complaint is identified as easily resolvable, a decision is made and the complaint is resolved. The party against whom the decision has been made is, however, given an opportunity to disagree with the decision and to provide additional information in substantiation of its disagreement. If the arguments raised by this party require further investigation, then the case is transferred to the Standard Complaints Handling Department.

An important and essential element that is required, to enable the Trackies to profile a complaint as easily resolvable, is the quality of the insurers' first responses to the complaints. The quality and comprehensiveness of an insurer's first answer is crucial to this process. Without quality and comprehensive responses, together with all the evidence relied on by the insurers,

complaints cannot be resolved early in the dispute resolution process.

Due to the volume of new complaints and the strict time frames set for the Trackies team, there is no time to request further information from the insurer, if it is not included in the first response. The result of the insurer not providing all the information upfront is that a complaint, which could have been resolved at this stage, cannot be resolved and must be referred to the Standard Complaints Handling Department for resolution.

The statistics show that the decision to implement a fast track process was justified. The fast track department contributed to resolving 36% of the total complaints resolved by OSTI in 2019. The average time taken to resolve these disputes was 50 calendar days.

Earlier this year, all of the senior adjudicators acquired accreditation as mediators. Mediation is an alternative way of resolving disputes and, going forward, the fast track team will focus more on implementing a mediation process that is suitable to OSTI's environment.

Mediation early in the dispute resolution process tends to be more effective than later in the process, when the parties' stances have become more entrenched and the parties become less likely to agree to a negotiated outcome.

The Fast Track Department is also well-positioned through its profiling capabilities to identify those matters suited to resolution by mediation.

Hannes Bester

Assistant Ombudsman and Team Leader of the Fast Track Department

OSTI's interns on OSTI's role in resolving disputes

OSTI is an independent and impartial, non-profit industry ombud-scheme. The office does not represent either party in a complaint. Instead, the office acts independently and impartially. OSTI cannot investigate or gather evidence on behalf of complainants. It will therefore not contact service providers or obtain expert reports.

The general expectation of almost every complainant in our office is that, because they are paying their premiums, their claims, which are true and honest, should be honoured by the insurers.

As a starting point, in order for an insured to have a valid complaint against the insurer, the insured is required to demonstrate that she/he has a valid claim in terms of the insurance policy. This means that the insured carries the primary burden of proving that the loss or damage claimed for falls within the scope of cover provided by the policy. In other words, the insured is required not only to allege but also to prove the claim which involves the presentation of substantive evidence.

The onus is on complainants to provide OSTI with the evidence on which they rely to support their matters.

The outcome of a complaint is determined by weighing the version of events on a balancing scale of fairness and reasonableness to establish what is more likely or probable. This exercise is called deciding a case on a "balance of probabilities" and refers to the standard test used when deciding civil disputes.

As an ombud scheme our aim is to provide an informal and easily approachable forum for the resolution of disputes whilst using alternative dispute resolution methods. This encompasses the use of a range of different and flexible techniques that promote access to free, effective and efficient dispute resolution mechanisms. The idea of alternative dispute resolution, or "ADR", is to provide a bridge between no redress at all, and costly and complicated court procedures.

OSTI's approach is to apply flexible standards and principles such as equity, fairness and reasonableness to the particular circumstances of every individual complaint. This enables us to consider each matter on its own merits rather than by simply and strictly

applying the law. OSTI is mandated in its terms of reference to resolve complaints using the criteria of law, and where appropriate, equity and fairness.

Our office cannot give legal advice to the parties about a specific complaint as this would compromise its ability to act independently in resolving the dispute. OSTI is not a court of law and therefore does not conduct formal hearings in the same way a court does.

Complainants are not bound by our decisions and our decisions are only binding on the insurers. If either the complainant or insurer is unhappy with a decision by OSTI, the complainant or insurer has the option of escalating the matter in terms of our escalation process, which can be found on our website under the heading "Complaints Handling Process".

As OSTI is an alternative to the court system, it is easily approachable, has a more flexible process and is inexpensive for complainants. More often than not we are able to resolve matters to the satisfaction of both parties. The forum gives both parties a chance to present their case and tell their story which mitigates against the escalation of the conflict.

When policyholders submit claims to insurers they expect insurers to finalise their claims as soon as possible. Complainants have the same expectation of our office when they lodge their complaints.

Whilst OSTI has an effective complaints handling process, this can be impacted by the quality of and speed at which information and documentation is provided by a complainant. Complainants therefore have a significant role to play in the processing and finalisation of their complaints.

The cooperation of the insurer also has a bearing on the time it takes to resolve a complaint against it. Insurers, like complainants, are required to provide evidence to support their stances and defences on each matter.

In circumstances where the insurer avoids liability because of an exclusion or exception in the policy, the duty to prove the exclusion or exception lies with the insurer. All three parties to a complaint, namely OSTI, the insured and the insurer, play a role in how efficiently complaints are resolved.

board of directors

Haroon Laher
Richard Steyn
Viviene Pearson
Makgompi Raphasha
Collin Molepe
Gail Walters

Gerhard Genis
Magauta Mphahlele
Paul Crankshaw
Leigh Bennie
Thuli Zungu

staff of the ombudsman

Ombudsman

Retired Judge Ron McLaren

Chief Executive Officer

Edite Teixeira-Mckinon

General Manager

Miriam Matabane

Senior Assistant

Ombudsman

Ayanda Mazwi

Darpana Harkison

Peter Nkhuna

Thasnim Dawood

Office Manager

Azeht Du Plessis

Assistant Ombudsman

Abri Venter

Hannes Bester

Johan Janse van Rensburg

John Theunissen

Kgomotso Molepo

Nadia Gamielien

Regina Chindomu

Sangeetha Sewpersad

Valerie Mngadi

Zuleckha Cara

Junior Assistant

Ombudsman

Latoya Masango

Assistant to the Ombudsman and Chief Executive Officer

Janine Jacobs

Project Coordinator

Marilize Blignaut

Complaints Registration Manager

Karinien Kok

Complaints Registration Administrators

Gadija Fisher

Maureen Nel

Refilwe Mokoena

Complaints Transfer Manager

Jo-Anne Goqo

Complaints Transfer Administrator

Mary Tshabalala

Melissa van Zyl

Case Administrators

Aadielah Soliman

Claudia Kampmann

Joanne Sergel

Louisa Godspower

Selinah Zwane

Vantera Freemantle

Receptionist

Lebohang Morokolo

Clerical

Mavis Mabaso

Clerical Assistant/ Cleaner

Mariam Khampepe

terms of reference

1. Preamble

- 1.1 The Ombudsman is appointed to serve the interest of the insuring public and all short-term Insurers registered under the Short-term Insurance Act and including Lloyds. The Ombudsman provides, free of charge, an accessible, informal and speedy dispute resolution process to Policy Holders who have disputes with their Insurers where those disputes fall within the Ombudsman's jurisdiction.
- 1.2 The Ombudsman acts independently and objectively in resolving disputes and is not under instructions from anybody when exercising his or her authority. The Ombudsman resolves disputes using the criteria of law, equity and fairness. These Terms of Reference define the powers and duties of the Ombudsman.
- 1.3 The services rendered by the Ombudsman are not the same as those rendered by a professional legal advisor and are confined purely to resolution in terms of clause 3.1 below or mediation or conciliation in an attempt to settle complaints.

2. Definitions

In these terms of reference the following expressions have the following meanings:

- 2.1 "the Board" means the Board of Directors of the Ombudsman for Short-term Insurance NPC;
- 2.2 "Commercial Lines Policy" means a policy (a) issued to a person who is not a natural person, or (b) if issued to a natural person is intended to indemnify such a natural person in respect of a commercial enterprise conducted by the natural person for his or her own benefit.
- 2.3 "the Complainant" means any Policy Holder who makes a complaint to the Ombudsman in respect of any insurance services provided by their Insurer;
- 2.4 "Ruling" means, with respect to a complaint, a written directive issued by the Ombudsman which is binding on the Insurer and which is based either in law or equity;
- 2.5 "the Ombudsman" means the Ombudsman for Short-term Insurance appointed from time to time by the Board of the Ombudsman for Short-term Insurance NPC;
- 2.6 "Ombudsman's office" means the office of the Ombudsman established to perform the functions set out in these terms of reference;
- 2.7 "Policy" means a short term insurance Policy issued by an Insurer to a Policy Holder;
- 2.8 "Policy Holder" means the person entitled to be provided with the Policy benefits under a Policy;
- 2.9 "Insurer" means a short-term insurer registered as such in terms of the Short-term Insurance Act of 1998;

3. The Ombudsman's Powers and Duties

- 3.1 The Ombudsman shall:
 - 3.1.1 act within these terms of reference;
 - 3.1.2 receive complaints relating to the provision within the Republic of South Africa of insurance services by an Insurer to a Policy Holder;
 - 3.1.3 resolve such complaints, relating to the provision of insurance services, by agreement or by the making of a ruling or by such other means as may seem expedient, subject to these terms of reference.
- 3.2 The Ombudsman should advise the public on the procedure for making a complaint to the Ombudsman's office and should take such steps as are reasonably possible conducive to client and industry education and training. The Ombudsman shall in his annual report referred to in clause 3.9 below provide details of steps taken in this regard.
- 3.3 On receipt of a complaint in the prescribed format, the Ombudsman will notify the Insurer of the complaint by providing the details of the complaint to the Insurer, and the Insurer shall then be obliged to give all relevant information and assistance required (including documentation requested by the Ombudsman) to enable the Ombudsman to assess fully the merits of the complaint.
- 3.4 During any period in which the Ombudsman is unable to exercise his duties owing to absence, incapacity or death or in a situation where a conflict of interest may arise, the Board may appoint a deputy or acting Ombudsman to act in place of the Ombudsman.
- 3.5 The Ombudsman shall have the overall responsibility for the conduct of the day to day administration and business of the Ombudsman's office. The Ombudsman may appoint an Administrator to be responsible to him for day to day matters of administration of the Ombudsman's office.
- 3.6 The Ombudsman shall have the power on behalf of the Ombudsman's office to appoint and dismiss employees, consultants, legal experts, independent contractors and agents and to determine their salaries, fees, terms of employment or engagement.
- 3.7 The Ombudsman shall have the power to incur expenditure on behalf of the Ombudsman's office in accordance with the current financial budget approved by the Board.
- 3.8 The Ombudsman shall give the Board any information and assistance which it reasonably requires, including the making of recommendations to the Board on any issues which the Ombudsman believes requires the Board's attention.

- 3.9 The Ombudsman shall publish an annual report on the activities of the office, which shall be published by 30 May of each year. Such report will be available to the public.

4. The Jurisdiction of the Ombudsman

- 4.1 The Ombudsman shall only consider a complaint made to him if he is satisfied that:

4.1.1 the complaint is not the subject of existing litigation;

4.1.2 the complaint is not the subject of an instruction to an attorney in contemplation of litigation against the relevant Insurer except where the attorney has simply assisted the Policy Holder in bringing the application to the Ombudsman;

4.1.3 the complaint does not involve a monetary claim in excess of the amount determined by the Board from time to time and that in respect of Commercial Lines Policies the annual turnover of the Complainant does not exceed the amount determined by the Board from time to time. *

**The limits are currently as follows namely, (a) R4 million for house owner's claims; (b) R2 million for all other claims provided that (c) in respect of Commercial lines policies, the turnover of the insured entity must not exceed R25 million per annum*

4.1.4 the complaint is made by a Policy Holder or a duly authorised representative of the Policy Holder to whom or for whom the insurance services in question were provided;

4.1.5 the complaint relates to any dispute in regard to a Policy and/or any Claim or Claims thereunder or any dispute in regard to insurance premiums, or any dispute on the legal construction of the Policy wording relating to a particular complaint complying with the requirements of this clause 4.1;

4.1.6 the complaint is being pursued reasonably by the Complainant and not in a frivolous, vexatious, offensive, threatening or abusive manner, as the Ombudsman may decide in his or her sole discretion;

4.1.7 the complaint has not become prescribed in terms of the Prescription Act, 1969 or any enforceable time bar provisions contained in the Policy, provided that in relation to any enforceable time-bar provisions in the policy

4.1.7.1 the Ombudsman shall have the power to condone non-compliance therewith upon good cause shown, and

4.1.7.2 the provisions of any enactment which provides for the extension of any period contained in such time-bar provision shall be given effect to.

- 4.2 Should a complaint be lodged with the Ombudsman's office and thereafter the Complainant refers such dispute to an attorney for the further conduct of the dispute and/or direct correspondence with the Insurer, or for litigation, then the Ombudsman will immediately withdraw from the matter.

- 4.3 With the written consent of an Insurer and at his discretion the Ombudsman may investigate a complaint which exceeds his jurisdiction and make a recommendation or a Ruling in relation thereto.

- 4.4 A Complainant may at any time terminate the Ombudsman's adjudication of the complaint and resort to litigation.

5. Limits on the Jurisdiction of the Ombudsman

Subject to these terms of reference, the Ombudsman shall have the power to consider a complaint made to him and make a recommendation or Ruling in regard thereto except:

- 5.1 Where the Ombudsman determines that it is more appropriate that the complaint be dealt with by a court of law or through any other dispute resolution process;
- 5.2 Where the matter is already under the consideration by the person appointed to adjudicate disputes in terms of the Financial Advisory and Intermediary Services Act.

6. Time Barring Provisions

- 6.1 Any enforceable time bar clauses in terms of a Policy shall not run against a Complainant and shall be interrupted during the period that the complaint is under consideration before the Ombudsman. In particular, the Insurer waives and abandons all or any rights to rely in subsequent litigation on any time barring provisions in the Policy applying to the commencement of litigation after rejection of a claim, or after the happening forming the subject of the claim or after notification of the claim. In the event of the complaint being finalised in the office of the Ombudsman the Complainant shall have 30 (thirty) days or the remaining period of the time bar provision of the relevant policy, whichever is the longer, within which to institute proceedings against the relevant Insurer, provided however, that the Claim had not already become time barred in terms of the Policy when the complaint was received by the Ombudsman and the Ombudsman has not condoned the late receipt of the complaint as is envisaged in clause 4.1.7

- 6.2 For the purposes of clause 6.1, the time during which a matter is before the Ombudsman shall (provided that the complaint is accepted for adjudication) commence on the day that it is lodged with the Ombudsman's office to the time that the Ombudsman dismisses the complaint or makes a Ruling.

- 6.3 Save as may be otherwise provided in the Financial Services Ombud Schemes Act 37 of 2004 as amended or in any other legislation relating to or governing the Ombudsman, the lodging of any complaint with the Ombudsman shall in no way affect the running of prescription in terms of the Prescription Act, 1969 in respect of such complaint.

7. Rulings

- 7.1 When all the material facts are agreed or the facts have been established to the Ombudsman's satisfaction on a balance of probabilities, the Ombudsman may make a Ruling.

- 7.2 Rulings shall be based on the law and equity.
- 7.3 Where a material fact cannot be established or cannot be resolved on a clear balance of probabilities the Ombudsman may not make a Ruling. In such cases the Ombudsman shall advise the Complainant that the complaint is not one on which he or she can assist and that alternative recourse may be sought through the courts.
- 7.4 Any Ruling made by the Ombudsman shall be binding on the Insurer concerned save where an appeal against such Ruling is noted as is provided in Clause 8 below.

8. Right of Appeal against Rulings or Findings of the Ombudsman

- 8.1 Any party affected by any formal ruling or finding on the part of the Ombudsman may appeal against the ruling or finding of the Ombudsman, either in part or in whole. In this context a "Ruling" shall mean, in relation to a complaint received, "a written directive issued by the Ombudsman which is binding on the insurer and which is based either in law or equity and fairness or a combination of law and equity". "Finding" shall mean, with respect to a complaint, "a written directive issued by the Ombudsman in relation to the complaint received in terms of which the Ombudsman has dismissed the complaint or declined to intervene in a dispute between the complainant and insurer".
- 8.2 No appeal against the ruling or finding of the Ombudsman shall be considered by any Appeal Tribunal, unless the Ombudsman shall have granted the applicant leave to appeal against such ruling or finding.
- 8.3 The Ombudsman shall only grant leave to appeal to any appellant where he is of the opinion that:
 - 8.3.1 There is a reasonable prospect that the appeal, either in whole or in part, if prosecuted, will succeed; and
 - 8.3.2 The matter is one of complexity or difficulty; or
 - 8.3.3 The ruling or finding in question involves issues or considerations which are of substantial public or industry interest or importance or It is in the interest of justice or public policy that the ruling or decision be considered by an Appeal Tribunal; or
 - 8.3.4 The ruling or decision involves principles of law where the law may be considered to be uncertain or unsettled; or
 - 8.3.5 The matter in dispute involves the jurisdiction of the Ombudsman to entertain the dispute; or
 - 8.3.6 The issues are of such a nature that the judgment or order sought by the appellant will not be of academic relevance only and will have a practical effect or result.
- 8.4 The power to grant leave to appeal as contemplated in this section shall not be limited by reason only of the value of the matter in dispute, or the amount claimed or awarded by the Ombudsman, or by reason only of the fact that the matter in dispute is incapable of being valued in money.
- 8.5 Notice of any intention to appeal against any ruling or finding of the Ombudsman shall be filed with the Ombudsman within a period of 30 calendar days of the handing down of any ruling or finding and shall state whether the appellant appeals against the whole or part of the ruling or finding of the Ombudsman, the findings of fact and/or ruling of law appealed against and the grounds upon which the appeal is founded. The notice of intention to appeal shall be accompanied by an application for leave to appeal.
- 8.6 A Notice of Cross-Appeal shall be delivered within 15 calendar days after delivery of the Notice of Appeal, or within such other period of time as may, upon good cause shown, be permitted by the Ombudsman. The provisions of these rules with regard to appeals shall equally apply to cross-appeals. A "cross-appeal" shall mean a process by which the respondent in any appeal proceedings, having been advised by the Ombudsman of receipt of a notice of intention to appeal, wishes in turn to appeal against the terms of the ruling or finding made by the Ombudsman in relation to the complaint submitted to the Ombudsman.
- 8.7 Where an appeal has been noted, or an application for leave to appeal has been made, the operation and execution of the ruling or finding of the Ombudsman shall be suspended, pending the decision of the Appeal Tribunal on the matter, unless the Ombudsman, on the application of a party and on good cause shown, otherwise directs.
- 8.8 Upon receipt of a Notice of Appeal the Ombudsman shall within a period of 5 business days thereafter notify every other party to the dispute that a Notice of Appeal has been received.
- 8.9 All documentation in connection with any appeal proceedings including the notice of intention to appeal and the application for leave to appeal, shall be served upon the office of the Ombudsman by hand or alternatively by way of registered post or by e-mail save where the Ombudsman shall have expressly consented to any other method of service. Documentation served upon the Ombudsman shall be in A4 format and shall be clearly legible and capable of being photocopied. Wherever possible, original documents should form the subject of any appeal proceedings but copies of documents shall be acceptable subject to the provisions of these terms of reference.

Applications for Leave to Appeal

- 8.10 Any party who desires to appeal against any ruling or finding of the Ombudsman shall, within 30 calendar days of the handing down by the Ombudsman of any final ruling or finding, serve upon the Ombudsman as provided for herein, a Notice of intention to Appeal, together with an Application for Leave to Appeal which shall set out the basis for the proposed appeal as contemplated in Clause 8.5 above, together with reasons why Leave to Appeal against such ruling or finding should be granted by the Ombudsman. The granting of leave to appeal shall be a prerequisite for the prosecution of any appeal.
- 8.11 Failing receipt by the Ombudsman of any Notice

of Appeal within the time period referred to in paragraph 8 above, the final ruling or finding by the Ombudsman shall become final and binding upon the parties and shall be carried into effect without further delay.

- 8.12 Any late filing of a Notice of Appeal or an Application for Leave to Appeal shall be null and void save where accompanied by an application for condonation for the late filing of the appeal. Any application for condonation must set out in full the reasons why condonation should be granted, the reasons for any non-compliance and that the matter is one worthy of consideration.
- 8.13 The Ombudsman, after considering any application for condonation, may grant or refuse such application in his discretion.
- 8.14 Where leave to appeal against any ruling or finding of the Ombudsman is refused by the Ombudsman, the unsuccessful party may, within 15 business days of notification of such refusal, petition the Chairman of the Appeal Tribunal, to review the decision of the Ombudsman not to grant leave for appeal. The same provision shall apply mutatis mutandis to any application for condonation for the late filing of an appeal.
- 8.15 Any such request shall be addressed to the Chairman of the Appeal Tribunal via the Ombudsman who shall convey such request to the Chairman of the Appeal Tribunal. The Chairman of the Appeal Tribunal shall within a reasonable period of time but in any event not later than a period of 15 calendar days of the receipt of any such petition, either confirm or amend the decision of the Ombudsman not to grant leave to appeal or refusal to condone any application for the late filing of an appeal. The Ombudsman shall thereafter within a period of 5 business days, inform the parties accordingly.

Appeals

- 8.16 An appeal against the ruling or finding of the Ombudsman shall be heard by an Appeal Tribunal who shall consider the matter as if it were the Ombudsman and shall include the consideration of procedural as well as substantive matters pertaining to the objection raised by such party to the decision of the Ombudsman.
- 8.17 The Appeal Tribunal may, where it considers it necessary or in the interests of justice, permit the leading of evidence or new evidence on any matter, even if the Ombudsman himself did not hold a hearing, or receive evidence on any matter prior to making a finding on any complaint referred to him.
- 8.18 Where the Appeal Tribunal decides to permit, or calls for the leading of evidence, or evidence is led on material that was never considered by the Ombudsman, the tribunal may decide, in its sole discretion to invite the Ombudsman to consider the matter in the light of such evidence and to canvass the views of the Ombudsman on the matter. The Ombudsman should be invited to comment on the new material in the manner and on such terms as it may regard to be fair to both parties.

- 8.19 Save where the Appeal Tribunal permits or calls for the leading of evidence, no evidence shall be led and the matter shall be decided by the Appeal Tribunal on the basis of the record of appeal furnished to it by the Ombudsman, including the documentation filed by the parties in connection with the appeal.
- 8.20 The record of appeal shall, save where in the opinion of the Ombudsman additional documentation is required, consist of the following:-
- 8.20.1 The complainant's Application for Assistance form and supporting documentation;
- 8.20.2 The insurer's response to the complaint;
- 8.20.3 The complainant's reply to the insurer's response to the complaint;
- 8.20.4 The Ombudsman's finding in relation to the complaint and any reasons furnished by the Ombudsman for any ruling or finding; and
- 8.20.5 The submissions or representations made by the parties to the Appeal Tribunal in connection with the appeal.
- 8.21 The Ombudsman may, in his discretion, when submitting the documentation to the Appeal Tribunal in connection with any appeal, make representations to the Appeal Tribunal by way of explanation or elaboration of his earlier determination and shall be entitled in such representations to deal with such matters as policy, industry practices and the approach followed by him in regard to equity. In addition the Ombudsman may furnish the Appeal Tribunal with such other information as he may consider to be of assistance or guidance to the Appeal Tribunal, save that the parties shall be afforded an opportunity to respond to any such additional material thus placed before the Appeal Tribunal.
- 8.22 Save as aforesaid, the Ombudsman shall not participate in the appeal process save where he should be asked to do so by the Appeal Tribunal itself on such terms and in such manner as may be determined by the Tribunal.

Composition of the Appeal Tribunal

- 8.23 The Chairman of the Board, in consultation with the Vice-Chairman, must appoint the members of the Appeal Tribunal from the persons nominated by the Ombudsman.
- 8.24 The Appeal Tribunal must consist of a Chairperson and at least two members appointed for a minimum period of two years.
- 8.25 The Chairman of the Board must appoint the Chairperson of the Appeal Tribunal and such Chairperson must either be a retired Judge or a practicing Attorney or Advocate, or a person who formally practiced as an Attorney or Advocate, with at least ten years' experience and with appropriate experience in Insurance Law.
- 8.26 The Chairperson of the Appeal Tribunal is responsible for assigning matters for adjudication, taking into consideration the nature and complexity of the dispute or any special circumstance, to a panel of two or more members of the Appeal

Tribunal who are suitably qualified to decide on a particular matter.

- 8.27 The Chairman of the panel must be the Chairperson of the Appeal Tribunal.
- 8.28 The person's nominated by the Ombudsman must be:
- 8.28.1 Practicing Attorneys or Advocates or persons who formerly practiced as an Attorney or Advocate, with at least ten years' experience and with appropriate experience in Insurance Law, and may include retired Judges; or
- 8.28.2 Persons with extensive experience in relation to the insurance industry and who by virtue of their knowledge, training and experience are able to perform the functions of a member of the Appeal Tribunal; or
- 8.28.3 Academics with the particular knowledge of specific areas of the law or persons of specific knowledge, skill or training whose expertise as an expert in any particular field may be appropriate.
- 8.29 The Chairman of the Appeal Tribunal may, in consultation with the Chairman of the Board and the Ombudsman, appoint a person who is not a member of the Appeal Tribunal to serve on the panel if in the opinion of the Chairperson of the Appeal Tribunal such appointment is merited or deemed desirable.

The Hearing of Appeals

- 8.30 The Ombudsman shall be in charge of all practical or administrative matters preceding and relating to the hearing of an appeal and shall be responsible for the preparation of the record, the giving of notices and the making of arrangements for the hearing of an appeal, the recording of evidence, if any, and all such other matters incidental to the hearing or disposal of the appeal.
- 8.31 The Appeal Tribunal shall determine its own procedure both prior to and during the course of the hearing, including the hearing of oral evidence.
- 8.32 Appeals shall be heard at such place and time and in such manner as the Appeal Tribunal shall determine from time to time.
- 8.33 Not later than 10 business days before the hearing of an appeal, the appellant shall deliver to the Ombudsman a concise and succinct statement of the main points which he intends to argue on appeal, as well as the list of legal authorities (if any) to be tendered in support of each point to be raised. Not later than 5 business days before the hearing of an appeal, the respondent shall deliver a similar statement.
- 8.34 The Chairman of the Appeal Tribunal may, after consultation with the Ombudsman, direct that a contemplated appeal be dealt with as an urgent

matter and that the appeal be prosecuted at such time and in such manner as the Chairman of the Appeal Tribunal deems appropriate.

- 8.35 The Appeal Tribunal should approach the matter on appeal put forward as if it were the Ombudsman determining the complaint. The Appeal Tribunal shall take into account the balance of probabilities and its finding shall be based on the criteria of law, equity and fairness.
- 8.36 The Appeal Tribunal shall deliver its judgment on the matter in writing to the Ombudsman within one calendar month of the conclusion of the hearing. The Ombudsman shall in turn deliver a copy thereof to the parties within a period of 10 business days.

Representation

- 8.37 Any party to any appeal shall have the right to be represented at the hearing but, wherever possible, the parties should confine their submissions in regard to matters before the Appeal Tribunal to written submissions contained in a statement of case including, where appropriate, heads of argument.
- 8.38 Any party who employs a representative to represent their interest before the Appeal Tribunal shall be personally responsible for any fees and expenses associated with such representation.

The Effect of the Decision and Order of the Appeal Tribunal

- 8.39 Where a complainant appeals against the ruling or finding of the Ombudsman, such person shall abide by the decision of the Appeal Tribunal and the order of the Appeal Tribunal shall be final and binding in relation to the proceedings before the office of the Ombudsman. The complainant shall however be entitled, if so desired, to thereafter pursue the matter further in any court of law.
- 8.40 An unsuccessful appellant insurer shall have no further right of recourse or action and shall be bound by the terms of the order of the Appeal Tribunal save that nothing contained herein shall in any way affect the right of an insurer to review any ruling made by the Ombudsman or the Appeal Tribunal in a court of law.

Precedent

- 8.41 In recognition of the requirement that rulings made by the Ombudsman shall not establish any precedent in the Ombudsman's office, the decisions of the Appeal Tribunal shall not be accorded any formal status or regarded as creating binding precedents, but may serve as guidelines for future cases. Such findings or orders may however, serve as strong persuasive value for the Ombudsman and any other Appeal Tribunal in which the same dispute may be raised so as to ensure consistency in the decisions of the office of the Ombudsman.

Cost to the Parties to Appeals

- 8.42 Where an insurer notes an appeal against any final ruling of the Ombudsman and is not, in the opinion of the Chairman of the Appeal Tribunal, successful with such appeal, it shall defray the cost of such appeal incurred by the Ombudsman in connection with the appeal proceedings.
- 8.43 Where the insurer is the appellant in any proceedings, save where the Chairman of the Appeal Tribunal may direct otherwise, the cost to be paid by the insurer in relation to any appeal proceedings may be determined by the Board of the Ombudsman for Short-term Insurance, from time to time.
- 8.44 Where the complainant is the appellant in any appeal proceedings the Ombudsman may, in his discretion and taking into account, inter alia, the amount of the claim, the complexity of the issues and the complainant's personal circumstances, call upon such party to pay a deposit in an amount determined by the Ombudsman which deposit shall be refunded to the appellant should the appellant be successful in the appeal. In the event that the appeal fails, the deposit shall be forfeited to the office of the Ombudsman and shall constitute the only liability on the part of the complainant for the costs of the appeal proceedings. If the appeal is, in the view of the Appeal Tribunal, successful, the amount paid by the appellant shall be refunded to the appellant.
- 8.45 In no case shall the Appeal Tribunal award costs in favour of a successful party and in no case shall a losing party to an appeal be ordered by the Appeal Tribunal to pay costs to the other party, save where the Chairman of the Appeal Tribunal considers that, having regard to the presence of exceptional circumstances, a punitive order as to costs against any party is merited.

9. Policyholder/Complainant's Rights

The Policy Holder/Complainant's rights to institute proceedings in any competent court of law against the Insurer shall not be affected by any of the provisions of these terms of reference provided that, if the Policy Holder/Complainant institutes proceedings while the complaint is under investigation by the Ombudsman, the provisions of clause 4.2 shall apply.

10. Precedents

Rulings shall not establish any precedent in the Ombudsman's office.

11. Confidentiality

(As approved at the Annual General Meeting held on 28th June 2011)

- 11.1 The Ombudsman shall as far as possible, maintain confidentiality unless the parties concerned expressly exempt him or her from that duty and

the duty shall continue after the termination of his or her services. The duty of confidentiality shall however, not prevent the Ombudsman from:

- 11.1.1 Publishing details of rulings made by him or her.
- 11.1.2 Reporting on details of rulings or furnishing statistical information in connection with the workings of the office to the South African Insurance Association (SAIA), the Financial Services Board (FSB), the National Treasury or any other body or organisation which may be entitled to receive such information from the Ombudsman in connection with his/her activities and/or which may have a legitimate interest in such information, having regard to its statutory mandate, role as an industry association or otherwise.
- 11.1.3 Publishing statistics and related information in the Annual Report of the Association concerning complaints received by the Ombudsman against members of the Association as approved by the Board of the Ombudsman for Short-term Insurance from time to time.
- 11.1.4 Filing, either on behalf of the Company, or any complainant from whom a complaint is received, a complaint with SAIA in connection with any Code of Conduct applicable to or adopted by that organisation and which may be applicable to any member of the Company.
- 11.2 The Insurer and the Complainant shall not be entitled to make use of any information which comes to their knowledge as a result of the intervention of the Ombudsman during the course of any investigation by him or her.
- 11.3 A complaint will be regarded as confidential as between the Policy Holder, the Insurer and the Ombudsman and it is for the Ombudsman to decide what should be disclosed to the Insurer and/or the Policy Holder.
- 11.4 Documents brought into being as a result of any approach to the Ombudsman shall not be liable to disclosure or be the subject of a discovery order or subpoena in the event of any legal proceedings between the Complainant and the Insurer.
- 11.5 The Ombudsman or any member of his staff will not be liable to be subpoenaed to give evidence on the subject of a complaint in any proceedings.

12. Complaints not settled in defined period

The Ombudsman shall report to the Board all complaints, which have not been completed in one or way or another within a time, laid down by the Board. This time period shall initially be set at 6 (six) months calculated from the date that a complaint became an accepted complaint.

members of the ombudsman scheme

| | |
|---|---|
| Abacus Insurance Limited | Lombard Insurance Limited |
| Absa Insurance Company Limited | MiWay Insurance Limited |
| AIG Insurance Company | Momentum ST Insurance Company Limited |
| Alexander Forbes Insurance Company | Monarch Insurance Company Limited |
| Allianz Global Corporate | Mutual and Federal Risk Financing |
| Auto & General Insurance Company | Nedgroup Insurance Company Limited |
| Bidvest Insurance Limited | New National Assurance Company Limited |
| Bryte Insurance Company Limited | NMS Insurance Services (SA) Limited |
| Budget Insurance Company Limited | Oakhurst Insurance Company Limited |
| Centriq Insurance | Old Mutual Insure Limited |
| Chubb Insurance South Africa Limited | OUTsurance Insurance Company Limited |
| Compass Insurance Company Limited | Professional Provident Society Short-term Insurance Company Limited |
| Constantia Insurance Company Limited | Renasa Insurance Company Limited |
| Dial Direct Insurance Limited | SAFIRE Insurance Company Limited |
| Discovery Insure | SAHL Insurance Company Limited |
| First for Women Insurance Company Limited | Santam Limited |
| FirstRand Short-term | Santam Structured Insurance Limited |
| GENRIC Insurance Company Limited | SASRIA SOC LIMITED |
| Guardrisk Insurance Company Limited | Shoprite Insurance Company Limited |
| Hollard Insurance Company | Standard Insurance Limited |
| Hollard Specialist Insurance Limited | Sunderland Marine (Africa) Limited |
| Indequity Specialised Insurance Limited | Unitrans Insurance Limited |
| Infiniti Insurance Limited | Vodacom Insurance Company Limited |
| King Price Insurance Company Limited | Western National Insurance Limited |
| Legal Expenses Southern Africa Limited | Workerslife Insurance Limited |
| Lion of Africa Insurance Company Limited | Yarkrisk Insurance Limited |
| Lloyd's South Africa (Pty) Limited | |

useful information about other offices

1. Ombudsman for Long-Term Insurance

Private Bag X45, Claremont 7735
Telephone: 021 657 5000
Sharecall: 086 010 3236
Fax: 021 674 0951
E-mail: info@ombud.co.za
Website: www.ombud.co.za

2. Financial Advisory and Intermediary Services Ombud

546 Jochemus Street, Erasmus Kloof,
Kasteel Park 2nd Floor
Sharecall: 0860 324 766
Telephone: 012 470 908/
012 762 5000
Fax: 012 348 3447
E-mail: info@faisombud.co.za
Website: www.faisombud.co.za

3. The Ombudsman for Banking Services

34 - 36 Fricker Road, Ground Floor,
Illovo, Johannesburg
Sharecall: 0860 800 900
Telephone: 011 712 1800
Fax: 011 483 3212
E-mail: info@obssa.co.za
Website: www.obssa.co.za

4. Credit Ombud

P O Box 805, Pinegowrie, 2123
Call Centre: 0861 662 837
Tel: 011 781 6431
Fax: 086 674 7414
E-mail: ombud@creditombud.org.za
Website: www.creditombud.org.za

5. Motor Industry Ombudsman of South Africa

Suite 156, Private Bag X025,
Lynnwood Ridge, 0040
Telephone: 010 590 8378
Call Centre: 086 116 4672
Fax: 086 630 6141
E-mail: info@miosa.co.za
Website: www.miosa.co.za

6. Consumer Goods and Services Ombud

292 Surrey Avenue Ferndale
Randburg, 2194
Telephone: 011 781 2607
Call Centre: 0860 000 272
Fax: 086 206 1999
E-mail: info@cgso.org.za
Website: www.cgso.org.za

7. Ombudsman Central Helpline

Share call: 0860OMBUDS/0860 662837

8. Pension Funds Adjudicator

P O Box 580, Menlyn, 0063
Telephone: 012 346 1738 /
012 748 4000
Fax: 086 693 7472
E-mail: enquiries@pfa.org.za
Website: www.pfa.org.za

9. National Credit Regulator

127, 15th Road, Randjespark, Midrand
Call Centre: 0860 627 627
E-mail: complaints@ncr.org.za
Telephone: 011 554 2600 /
011 554 2700
Fax: 087 234 7822
Website: www.ncr.org.za

10. Public Protector

Private Bag X677, Pretoria, 0001
Telephone: 012 366 7000 /
012 336 7112
Fax: 012 362 3473
Toll free number: 0800 11 20 40
E-mail: registration2@pprotect.org
Website: www.publicprotect.org

11. Financial Sector Conduct Authority

P O Box 35655, Menlo Park, 0102
Toll-free: 0800 20 37 72
Telephone: 012 428 8000
Fax: 012 346 6941
E-mail: info@fsca.co.za
Website: www.fsca.co.za

12. National Consumer Commission

Private Bag X84, Pretoria, 0001
Tel: 012 428 7000
Fax: 086 758 4990
E-mail: complaints@thencc.org.za
Website: www.nccsa.org.za

13. City of Johannesburg Ombudsman

48 Ameshhoff Street, Braamfontein
Sappi Building
Call Centre: 010 288 2800
Website: info@joburgombudsman.org

14. National Consumer Tribunal

Telephone: 012 683 8140 /
012 742 9900
Fax: 012 663 5693
E-mail: Registry@thenct.org.za
Postal address: Private Bag X110,
Centurion, 0046

15. Office of the Tax Ombud

Menlyn Corner, 2nd Floor,
87 Frikkie De Beer Street,
Menlyn, Pretoria, 0181
Telephone: 012 431 9105
Call Centre: 0800 662 837
Fax: 012 452 5013
E-mail: complaints@taxombud.gov.za

16. S.A. Military Ombudsman

Private Bag X163, Pretoria 0046
Telephone: 012 676 3800
Toll free: 080 726 6283
Fax : 012 661 2091
E-mail: intake@miliombud.org



One Sturdee - 1 Sturdee Avenue, First Floor, Block A,
Rosebank, Johannesburg, 2196

Postal Address: P O Box 32334, Braamfontein, 2017

Tel: +27 11 726 8900 | **Fax:** +27 11 726 5501 | **Sharecall:** 0860 726 890

Website: www.osti.co.za | **E-mail:** info@osti.co.za

Website: www.insuranceombudsmanportal.co.za