In the matter between:

COMPLAINANT

and

INSURANCE COMPANY **RESPONDENT**

STATEMENT OF DETERMINATION OF COMPLAINT GIVEN IN TERMS OF SECTIONS 74 AND 75 OF THE FINANCIAL SERVICES REGULATORY AUTHORITY ACT, 2010 (the Act)

1 BACKGROUND

1.1 Statutory provision for the resolution of disputes or complaints arising within the financial services industry in a manner alternative to the conventional court system began during the era of the Retirement Funds Adjudicator (the Adjudicator), provision for which was made in terms of the now repealed Part VIII of the Retirement Funds Act, 2005.

1.2 The repeal of this legislative provision came through section 83 (4) of the Act. Together with this repeal was the ushering in of the era of the Ombudsman of Financial Services in terms of Part XII of the Act.

1.3 Of note between the two periods is that the Adjudicator's mandate was, in terms of the said repealed Part VIII of the Retirement Funds Act and the repealed Part XVI of the Fund Act, 2005, to determine complaints arising only under these two pieces of legislation and such was the scope of the Adjudicator. On the other hand, the scope of the Ombudsman is wider and covers all non-CD financial services complaints including those arising under the Retirement Funds and Fund Acts.

1.4 Of necessity, to prevent an instance of disservice to financial services consumers and to afford transition from the era of the Adjudicator to that of the Ombudsman all the complaints lodged and remaining pending before the Adjudicator now stand to be determined by the Ombudsman.

2 INTRODUCTION

2.1 The Complainant is a policy holder with the Respondent Insurance Company (the Insurer) since the 30 March 2012. He lodged a funeral claim with the insurer in respect of the death of his dependent covered under the policy. The insurer repudiated the claim citing premium default. This Complaint is against Insurer's decision.

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3 COMPLAINT

3.1 The complaint was lodged with the office of the adjudicator on the 3rd July 2013. The Complainant states that he had a funeral cover with the Insurer for his benefit as well as his dependents, effective from the 30th March 2012. The premiums were deducted from Complainant's Bank A account.

3.2 The Complainant states that premiums successfully went through his account for the months of March 2012, April 2012, but was unsuccessful in May 2012. A double premium was taken for June 2012 to cover the May premium. Premiums for July and August 2012 were deducted successfully. September 2012 premium was unsuccessful. Single premiums were deducted in October and November 2012, respectively. The December 2012 premium failed to go through. A single premium was debited from the account in January 2013. The Complainant states that in contrast to Insurer's actions in June, no double deductions were made by the Insurer to recoup two premiums that were not met that September and December 2013, respectively. February 2013 premium also failed to go through. The Complainant states that on the 19th March 2013 he paid all three outstanding premiums in respect of the stated months of September and December 2012 and February 2013, as his policy was still in force. He states that April 2013 premium was paid on the 3rd of April.

3.3 On the 20th March 2013 the Complainant lodged a claim with the Insurer in respect of the death of his brother who died on the 18th March 2013. By letter of 16 April 2013 the Insurer repudiated Complainant's claim on the ground that the *"Termination and Cancellation section of the policy states that the Insurer will cancel the policy if premiums are more than 30 days overdue."* The Complainant argues that the Insurer opted not to cancel the policy after the first missed premium for March 2012, and still continued to debit his account for premiums; that the missed premiums could have been recouped had the Insurer sent double debit orders, as it did before. Therefore, in the circumstances the Insurer waived its rights under the policy. The Complainant argues that the policy was in force at the time of lodging the claim and is still in force to date. The Complainant further argues that the Insurer cannot cancel the policy partially to repudiate or deny the claim.

3.4 The Complainant concedes that his Bank A statement proved that there were no funds in his account to meet the owing premiums, but that he honestly believed at the material time that the account was well-funded. He wonders why the Insurer did not subsequently send double debit notes to make up for the deficiencies. The Complainant also claims that there was no way he could have known that his premiums were not met as he had no access to Bank A statements; that the Insurer never advised him of arrear premiums until the time when he approached the Insurer [to lodge funeral claim]. He states on another note that his Bank A statement does not reflect any charges for failed debit orders which is evidence that the Insurer did not make an attempt to obtain payment from his account. He further argues that whether or not there were funds in his account for the debit order is immaterial.

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3.5 The Complainant states that had double debit orders been issued there would not have been any arrears at the time he lodged his claim. He also points out that the arrear premiums were not for three consecutive months but were spread out. He argues that the Insurer chose to lapse the policy simply to evade the claim he made.

3.6 The Complainant states that he appealed to the Insurer on the 24th April 2013 for a reconsideration of its decision and or an ex gratia settlement, but the Insurer upheld its decision as per its 29th April 2013 letter. The Complainant therefore lodged this complaint with the office of the Adjudicator for an order directing the Insurer to settle his claim.

4 RESPONSE/DEFENCE

4.1 The Insurer filed its response on the 16th July 2013 dated 12th July 2013. The Insurer admits it received a claim from the Complainant which it rejected because of non-payment of some of the premiums.

4.2 The Insurer states that it sent through to the Complainant's Bank A account, a debit order which was returned unpaid due to unavailability of funds in the account. The Insurer attached Complainant's Bank A statement which reflects that there were no funds or insufficient funds in Complainant's account on the occasions when deductions ought to have been made from the account. The result was that Insurer had no access to premiums due to it. The Insurer further attaches a copy of reports from Real Pay Debit order system to illustrate the lack of funds in Complainant's account. The Insurer states that if there was money in the account and the debit order was erroneously returned, then the Insurer would have entertained the Complainant's claim.

4.3 The Insurer asserts that the responsibility to ensure premiums are paid and are up to date lies with the Complainant as the insured. He therefore bears the responsibility to ensure that there are sufficient funds in his Bank A account for premiums on the specified dates.

4.4 In response to Complainant's assertion that the policy was not cancelled per the cancellation clause and therefore the insurer waived its right to cancel and therefore the claim was covered despite the late payment, the Insurer's General Manager has this to say:

> "*Not cancelling a policy internally does not in any way waiver* [sic] *the policy terms and conditions to provide cover in exchange for premiums having been paid." Insurer Y has not canceled the policy partially; the policy remains active and will continue to be so, as long as the insured pays premiums. Cover however will not be provided for a period that premiums were not paid by the insured.* "(Underlining added)

4.5 The Insurer disputes Complainant's argument that by not cancelling the policy following the late premiums, it effectively waived enforcement of the policy terms. By *internally* the Insurer could be understood to refer to there being no changes made on the policy in its systems in response to the late payments.

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5 REASONS FOR DETERMINATION

5.1 The task at hand is to determine the validity of the insurer's repudiation of Complainant's claim, and whether its decision was in accordance with the terms and conditions of the Funeral Insurance Policy signed by the parties. The ancillary question is whether there was any waiver by the insurer of rights under the policy.

Payment of premiums

5.2 The Insurer rejected Complainant's claim for the reason that a few premiums remained out-standing on the policy for some time. The Complainant made a lump sum payment for these and then lodged a claim shortly thereafter. A premium is the money or consideration required of the insured in return for which the insurer undertakes its obligations under the contract.[1]The insured is liable to pay the premium on the conclusion of the contract. Failure by the insured to pay a premium will not absolve the insurer from liability unless this constitutes a repudiation of the contract, and there is a provision in the policy document to that effect.[2] In *casu* Complainant failed to make timely premiums, and fell into arrears for periods of over 30 days. It is observed also that the Insurer failed to cancel the policy as per the provisions of the cancellation clause in the policy contract.

Cancellation clause

5.3 Insurer's policy provides for cancellation of the policy in two circumstances as follows:

> "*Either the Policyholder or Insurer Y <u>may cancel the policy</u> at any time upon <u>30 days written notice</u>.*
> *Insurer Y <u>will cancel</u> the policy <u>if premiums are more than 30 days overdue</u>.*"
> [Emphasis added]

5.4 The first part of the provision is not relevant in this complaint. The complaint hinges on the second part of the quoted provision, namely, that the insurer *will cancel the policy if premiums are more than 30 days overdue*. The inference is that there is a grace period of 30 days from due date of the premium. According to the policy, premiums are payable in advance. Payment of arrears made up to the 30th day from due date, accordingly, amounts to payment made in time. The insurer may not cancel the policy during this 30-day extension period.

5.5 Pertinent questions arise around the brief one-sentence default cancellation clause of the policy contract and the rest of policy document. For instance,

- What is the effect on the policy and benefits under it when premiums are 30 days overdue but the policy is not cancelled?
- How is cancellation supposed to be done or effected?
- Is cancellation automatic upon default per the stated 30-day grace period?

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[1] *Lewis Ltd v Norwich Union Fire Insurance Co Ltd* 1916 AD 509 at 519.
[2] Gordon & Getz *The South African Law of Insurance* 4th Ed, 195.

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- If the policy is cancelled for default what is the effect of such cancellation in relation to cover for the insured event? Does the policy lapse and the Insurer contract come to an end?

Neither the cancellation clause nor any part of the policy contract deal with these and other relevant issues. Interpretation of the cancellation clause and the rest of the policy terms are in this determination, based on contract law principles, particularly Insurer law as expounded by the courts, textbook writers and other legal sources.

5.6 The following is an illustration and brief analysis of Complainant's payment schedule and defaults on the policy:

Date	**Premium status**	**Effect on contract**
30/03/2012	Paid for April	Effective date of contract.
30/04/2012	Paid for May	No issue
30/05/2012	Non-payment for June	Complainant has, in terms of the policy terms and conditions, until 30 June failing which the Insurer can cancel policy.
30/06/2012	Double premiums paid for June & July	One premium settles for Jun arrears, another for Jul 2013.
30/07/2012	Paid for Aug	No issue
30/08/2012	Paid for Sep	No issue
30/09/2012	Non-payment for Oct	Complainant has until 30 October before Insurer can cancel in terms of policy.
30/10/2012	Paid single premium for Oct	In effect prevented the policy from being vulnerable to cancellation due to the unpaid Oct premium. However, Nov premium remains outstanding which entitles Insurer to cancel by 30 November if still unpaid.
30/11/2012	Paid for Nov	Due for the unpaid Nov premium, December's premium is outstanding and policy is open to cancellation after 30 Dec if remains unpaid.
30/12/2012	Non-payment for Jan 2013, Dec also owing	Failure to pay premium for Dec 2012 and Jan 2013 made the policy susceptible to cancellation as premiums remained unpaid beyond 30 days stipulated by policy terms. However the Insurer did not cancel.
30/01/2013	Single Payment for Feb but covers Dec arrear	Payment covers premium arrear for Dec 2012; Jan and Feb 2013 remain outstanding.
28/02/2013	unpaid	Policy in arrears for Jan, Feb and March 2013. Policy should have been cancelled in December 2012.
19/03/2013	Paid premiums for 3 months	The Complainant paid outstanding premiums for Jan, Feb and March 2013. April 2013 premium remains out-standing.

		The policy never cancelled.
20/03/2013	Complainant lodges claim for funeral cover	
23/04/2013	Claim repudiated by insurer	The Insurer repudiated Complainant's claim of the 20th March.
29/04/2013	Insurer confirmed its repudiation	

5.7 Usually a policy document stipulates a certain date or ascertainable date/period within which premiums must be paid, as well as the grace period, if any, failing compliance therewith the policy lapses.[3] The policy administered by the Insurer on the other hand imposes an obligation on the insurer to act and cancel the policy if premiums are not paid after 30 days. The provision is not consistent with automatic cancellation of the policy. There must be an overt act by the insurer to cancel the policy. Obviously cancellation of the policy must be communicated to the insured. It follows that a policy that has not been cancelled, remains in force and effective. The Insurer concedes that it never cancelled the policy despite the recorded premium defaults on the part of the Complainant. The Insurer further accepted premiums meant to cover owing premiums, which was after the death of Complainant's dependant.

Repudiation of claim

5.8 The Insurer repudiated Complainant's claim due to default in some of the premiums. However the remedy for such default according to the policy contract should be cancellation of the policy. The Insurer concedes that it did not cancel the policy despite default in payments beyond 30 day's grace period. In the absence of cancellation the inescapable conclusion is that the policy terms remained valid and binding on the parties.

Waiver of terms

5.9 The other related inquiry is whether Insurer's failure to cancel the policy and its continued acceptance of premiums despite breach of the terms and conditions by the Complainant amounted to a waiver of its rights. Waiver is defined as "*a juristic act whereby rights in general may be abandoned.*"[4] The insurer may waive the terms relating to the payment of the premium. Thus a course of dealing which leads the insured to believe that punctual payment is not required, or will be excused, may relieve him from the consequences of delay.[5]

5.10 In the few months after commencement of the policy, the Insurer deducted double premiums in the month following failure by Complainant to make payment. After that it failed to make similar double deductions. The Insurer argues that the Complainant did not have enough money in his account for Insurer to make the double deduction as

[3] Invamy *General Principles of Insurance Law* 5 ed (London, 1986) 272-3.
[4] Wessels *The Law of Contract in South Africa* 2nd Ed (Durban, 1951) para 2344A n 5.
[5] *Steyn's Estate v SA Mutual Life Assurance Society* 1948 (1) SA 359 (C) at 373.

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before. The Ombudsman rejects any suggestion that the insured could relinquish its responsibility to ensure payment of premiums per the agreed mode. However the Insurer had the option to cancel the policy per the policy terms, which option it did not exercise. The Respondent, with full knowledge of its rights chose not to exercise them.[6] The Insurer effectively abandoned its right to cancel the policy.

5.11 Enforcement and rescission being inconsistent remedies, the election to continue with the contract necessarily implies abandonment of the right to rescind (and vice versa). Innes CJ stated that "*Where there are two courses open to a party, quite inconsistent with each other, and he elects to take the one, it follows that he must abandon the other*"[7]. The Insurer opted not to cancel the policy (in the face of what constituted a breach entitling it to cancellation), thus the policy remained valid. By so doing the Insurer cannot be heard to say that the Complainant committed a breach and therefore he is not entitled to claim under the policy. In other words, the Insurer cannot both *"approbate and reprobate."*[8] In *Wing v Harvey*,[9] the court upheld the view that acceptance of premiums on the footing that the policy is valid, with actual knowledge of a breach entitling avoidance is a waiver of the right to avoid the policy.

5.12 Complainant's claim that he was not aware that premiums were not being deducted is weak, doubtful and does not hold water. As earlier pointed out he bears the responsibility to ensure timely payments of premiums, and that includes following up. Nevertheless the decisive factor in this matter is the finding that in the absence of cancellation by the insurer, the policy was in force at the material time of the claim.
5.13 It is advisable for the Insurer to amend and strengthen the terms of its funeral policy plan to provide certainty to clients on specific consequences of a default in premiums. The policy should, for instance, address some of the questions raised in paragraph 4.5 above. The existing policy document is very scanty yet the Insurer seeks to read a whole lot of terms into it that are not apparent on the face of it. This is unacceptable and contrary to transparent and fair dealing with consumers of the service.

FINDING

1) The Complainant bears the responsibility for timely payment of premiums.
2) It is the term of the policy that failure to make premiums within the stipulated time entitles the Insurer to cancel the policy.
3) However, the policy terms do not provide for automatic cancellation, the insurer must take the initiative and cancel the policy.
4) The Insurer's failure to cancel the policy meant that the policy remained in force, thus entitling the insured to the benefits the insurer promised.

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[6] Steyn CJ in *Hepner v Roodepoort-Maraisburg Town Council* 1962 (4) SA 772 (A) stated that "*In the ordinary case of waiver, the facta probanda would be full knowledge of the rights in question and express waiver or waiver by plainly inconsistent conduct, ie knowledge of a particular kind and surrender of the right in a particular manner…*"
[7] Per Innes CJ in *Van der Merwe v African Agricultural & Finance Corporation Ltd* (*in liquidation*) 1905 TS 610 613.
[8] *Xenopoulos v Standard CD of SA Ltd* 2000 2 All SA 494 (W).
[9] (1854) 5 De GM & G 265.

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5) The policy terms make no provision on the consequences of late payment of premiums other than cancellation, making it possible for sustenance of the policy and validity of claims when there is no cancellation and late payments have been accepted.

From the totality of the foregoing the Insurer could not validly repudiate the claim.

ORDER

Insurer's repudiation of the claim is unfair and unreasonable; it is thus set aside. The Insurer is ordered to honour the claim lodged by the Complainant and to pay out in terms of the policy.

THUS DONE AT MBABANE ON THIS 08TH DAY OF AUGUST 2016 AND CERTIFIED A TRUE AND CORRECT DETERMINATION OF THE OMBUDSMAN OF FINANCIAL SERVICES IN TERMS OF SECTION 75 (5) OF THE FINANCIAL SERVICES REGULATORY AUTHORITY ACT NO. 2 OF 2010.

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