In the matter between:

THE COMPLAINANT

and

THE INSURANCE COMPANY **RESPONDENT**

STATEMENT OF DETERMINATION OF COMPLAINT GIVEN IN TERMS OF SECTIONS 74 AND 75 OF THE FINANCIAL SERVICES REGULATORY AUTHORITY ACT NO. 2 OF 2010 ("THE FSRA ACT").

INTRODUCTION

1. This complaint relates to the conduct of insurance business. The Complainant is Ms. X, and the Respondent is The Insurance Company. The Respondent is a licensed financial services provider in terms of the FSRA Act, 2010. The Ombudsman has jurisdiction to hear this matter in terms of Section 74 & 75 of the FSRA Act No. 2/2010.

THE COMPLAINT

2. On 18 September 2020, the Complainant submitted a sworn statement of her complaint (the Complaint Form). The complaint form was supported by documents. The following are some of the documents:

Document	Dated
Letter from Respondent	23 July 2020
Schedule of Premiums Paid	Ending July 2020

THE RESPONSE / REPLIES

3. On 27 January 2021, the Respondent submitted a response to the complaint. The response had several supporting documents, including the following:

DOCUMENT	DATED
Policy Document	1 September 2018
Letter from Client Requesting Change in payment mode	29 Nov 2018
Breakdown of Client Policy Payment	Undated
Letter from Client requesting removal of life assured	15 June 2020
Letter to Client declining Claim	23 July 2020
Proof of payment of Refund	28 July 2020

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THE REPLIES

4. The Complainant replied to the Respondent's response by a letter dated 8 March 2021.

    4.1. There are no new issues raised in the reply and as such, the complaint form and the response become the principal documents outlining the facts between the parties to this compliant.

MAIN FACTS

5. The main facts to be gleaned from the complaint as articulated by the form are as follows.
    5.1. The Complainant was a premium payer for a funeral insurance product with the Respondent.
    5.2. The policy purchased concerned is the XXXX Funeral Insurance. The policy was held under policy number XY.
    5.3. The salient terms of the policy were as follows:
        5.3.1. The monthly premium payable is per the agreed schedule;
        5.3.2. The premium must be paid monthly and in advance. If the premium is not received within thirty (30) days following the due date, the policy shall be deemed to have been cancelled at midnight on the preceding monthly due date.
        5.3.3. Cover under the policy is provided for a 12-month term and automatically renews on the annual anniversary date unless cancelled.
        5.3.4. Either the policy holder or Insurance Company may cancel the policy at any time upon thirty (30) days written notice.
    5.4. Per the policy schedule, the commencement date for the cover was 1 September 2018.
    5.5. The sum assured is stipulated as E40 000. 00 (forty thousand Emalangeni)
    5.6. The policy holder is one Ms. XY, I.D. No. 60xxxxxxxxx
    5.7. The assured lives are those of Ms. XY (as immediately described) and Ms. XXY (I.D. No. 42xxxxxxxxx).
    5.8. From the documents, Complainant was the premium payer for the above policy.
    5.9. By letter dated 29 November 2018, Complainant changed its payment method under the policy from 6 months advance payments to 3 months advance payments.
    5.10. By letter dated 15 June 2020, Complainant removed one of the beneficiaries, namely Ms. XXY (as described).
    5.11. The remaining insured life (Ms. XY) passed away on the 11 July 2020, predicating a claim under the policy.
    5.12. The payments by the Complainant under the policy appears as follows:

Month	Premium Received	Comments (If any)
29 November 2018	E558	The initial payment period was payment once in 6 months. This was readjusted to once in 3 months.
22 March 2019	E558	
28 August 2019	E558	
25 October 2019	E558	
23 December 2019	E558	
10 July 2020	E558	

    5.13. Complainant initiated a claim on 14 July 2020, to which Respondent refused to pay in terms of letter dated 23 July 2020.

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DETERMINATION AND REASONS THEREOF

6. It is the role of the Ombudsman to determine whether the Complainant was treated fairly in the claims process against the policy. Further, the Ombudsman is to determine whether the Complainant is owed a refund by the respondent in the amounts particularized in the complaint form, particularly all premiums paid under the policy.

COMMON CAUSE & CONTENTIOUS FACTS

7. From a reading of the submissions, there are more common cause facts than there are contentious facts. Facts about the existence of the policy, the premium amounts paid, and the initial and readjusted premiums payment method, the removal of Ms. XXY, the death of Ms. XY are all not in contest. There are no contentious facts save for the legal principles involved in insurance.

THE APPLICABLE LAW

8. The relationship between the parties is one of insurance. The Complainant is a consumer, and the Respondent is a provider of insurance. This is a regulated activity in terms of the Insurance Act, 2005. It is settled law that insurance is a contract-based relationship. This means that the contract of insurance becomes the primary instrument of regulating the affairs of the parties. (Prof) MFB Reinecke (2016), Assistant Ombudsman, Office of the Ombudsman for Long Term Insurance in his article, "INSURABLE INTEREST IN THE CONTEXT OF LONG-TERM INSURANCE", states that:

> "The authorities simply emphasized that a contract of insurance is a contract to transfer a risk threatening the patrimony of the insured. This implied that the insured must prove an interest upon the insured event to prove that he has in fact suffered a loss…"

9. Based on the above quotation, the policy document (insurance agreement) will be of critical importance when it comes to the understanding of the relationship between the parties. The most important features of the relationship have been captured in paragraph 5 above. This was a funeral insurance contract. In terms of clause 4.2 of the policy document, this insurance relationship was a short-term contract, renewable automatically unless expressly terminated. Such termination will be on notice. This therefore distinguishes the relationship from a long-term insurance.

10. The law applicable, as well as the facts presented call for the Ombudsman to answer two (2) principal questions. In the first instance, had the policy in question lapsed and secondly, is the Complainant entitled to any of the premiums paid. To answer these questions, the provision of the Policy will be instrumental. Clause 1 "About the Policy", the following term is provided:

> "This document contains the terms and conditions that apply to your Funeral Insurance Policy. Together with your original application and the Policy Schedule, it forms the

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basis of the contract between you, the Policyholder and the insurer, …" [emphasis added]

11. The above provision goes on to enjoin the Policyholder to ensure the policy meets her requirements as well as invite any questions or further information. To this end, the Ombudsman finds that by reason of the execution of the contract on or about September 2018, all the contracting parties were satisfied that its terms were in line with their requirements. To strengthen the above, none of the supporting documents submitted by either party suggests that there was a misunderstanding as to the requirements, terms, and expectations under the policy.

12. The next consideration is clause 3.5. This clause provides;

"The premium must be paid monthly and is due in advance. If the premium is not received within thirty (30) days following the due date, the policy shall be deemed to have cancelled at midnight on the preceding monthly due date." [emphasis added]

13. This is an important term of the contract. It is accepted and trite law that the obligation to pay the premium lies with the insured. The prior payment of such premium is usually made a condition precedent (indispensable term of the contract), as was in terms of Clause 3.5. without the payment of premiums, there will be no contract. It is for this reason that Clause 3.5. expressly spelt out the consequences of non-receipt of premiums; namely, the cancellation of the policy.

14. It is not in dispute that before 10 July 2020, the last premium payment was made in December 2019. It is also not in dispute that the Complainant had revised the payment method from 6 months to 3 months. By necessary extension, the next due date for the premium was March 2020. By not paying the next premium, the provisions of 3.5. came into operation by law and the policy was deemed to have been cancelled. The language of the policy is imperative, as it created a legal status which does not require anyone to prove. This therefore removed the obligation on either party to notice the other of this status as not only was it agreed earlier, but it was also a condition precedent.

14.1. As a result of the non-payment of premiums in March 2020, the policy lapsed per Clause 3.5. and the parties were relieved of their obligations. This cancelation has to be distinguished from one at the instance of either the policyholder or insurer. This cancellation comes as a legal consequence of a legal fact (i.e., the non-payment / non-receipt of premiums). None of the parties triggered this cancellation.

15. The question that remains is, therefore, if the Respondent owes the premiums paid under the policy to the Complainant in light of the circumstances that transpired in July 2020. The first is the payment of the premiums on the 10 July 2020, and the second being the death of the remaining insured the following day; being the 11 July 2020. The law on repayment of premiums is well articulated. Davis (1993) in dealing with this subject provides;

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"The insured may recover the premium if the risk has not attached. The general rule applicable [to] the claims by the insured for the return of the premium is that if the insurers has never been at risk they have not earned a premium and ought to return it. As Lord Mansfield set in *Stevenson v Snow*, "The insurer shall not receive the running risqué if he runs none. If therefore, the contract is vitiated by fundamental mistake, or the insured has no insurable interest, the insurer must repay the premium received, for their risk which, in fact, it never ran." [emphasis added]

16. The above quotation puts into perspective the issue of repayment of premiums. The general principle is that as long as the premiums were paid towards a risk that not only existed, and also attached at the time of payment, then the premium shall not be refunded. In simple terms, as long as there was a risk, the premium cannot be returned. In terms of the facts before the Ombudsman, the insurable risk came to cease on or about March 2020. Therefore, any premiums paid before that date were towards risk that attached to the insurer (Respondent) and as such were earned. These premiums are not refundable as the life of insured was still intact and the policy was still active.

    16.1. As for the premiums paid in July 2020 after the policy was cancelled per Clause 3.5., there was no insurable interest, and the Respondent was not entitled to them. These, therefore, are the only premiums subject to refund and by a notification dated 28 July 2020, the Respondent refunded the Complainant. From the documents submitted and considered by the Ombudsman, there are no further premiums subject to this principle.

17. In concluding the applicable law, it is appropriate for the Ombudsman to deal with the nature of the business of insurance. One of the key principles of insurance is that of utmost good faith (uberrima fides). In stating the principle, the following is captured:

    "A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party." The phrase "utmost good faith" is also known by its Latin equivalent as uberrima fides." [*Mutual and Federal Insurance Company Ltd v Municipality of Oudtshoorn (240/82) [1984] ZASCA 129; [1985] 1 All SA 324 (A) (16 November 1984)*]

18. This is an obligation placed on both parties. For the insured, it manifests itself by disclosing everything known to him (or her) that can influence the rights and obligations under the insurance contract. In *Cater v Boehm* the court found:

    "Insurance is a contract of speculation. The special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the assured only; the underwriter trusts to his representation, and proceeds upon confidence that he does not keep back any circumstances in his knowledge to mislead that underwriter into a belief that the circumstance does not exist. The keeping back such circumstance is a fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention, yet still the underwriter is deceived,

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and the policy is void; because the risqué run is really different from the risqué understood and intended to be run at the time of the agreement… The policy would be equally void against the underwriter if he concealed… Good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from the ignorance of the fact and his believing the contrary."

19. The practical importance of the above excerpt is in the two (2) days in July 2020. To discharge this obligation, the Complainant should have disclosed the reason for resuming payment of the premiums. This is more so because the death of one of the insured persons a day later is strongly indicative of mala fides on the part of the Complainant. The Ombudsman will, however, not pronounce on the duty of good faith as there was no evidence supporting any such contentions. Suffice to amplify the importance of contracting parties in insurance contract to always deal with one another with the outmost of good faith.

FINDING

20. The Ombudsman finds that the Respondent acted in line with Clause 3.5 of the Funeral Insurance Policy, in declining to pay the claim;

21. The Ombudsman further finds Complainant is not owed any premiums paid before March 2020 when the policy was cancelled as the insurer was entitled to the premiums by virtue of the risk it held at the time.

THE ORDER

22. The complaint is not upheld;

23. There is no order made to the Respondent.

THUS, DONE AT MBABANE 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 OF 2010.

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THE OMBUDSMAN OF FINANCIAL SERVICES

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