Funeral Insurance: A Perception from the Office of the Ombudsman for Long-term Insurance[*]

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Introduction

1.1 Much of the funeral insurance business[1] in South Africa, many believe,[2] is blighted: fraud is rife; irregularities abound; some operators function both illegally and unscrupulously; and the public, especially the less affluent segment, is on occasion cynically exploited. But all is not unsavoury. Many registered insurers and licensed intermediaries active in this area are above-board and render an invaluable service to the community as a whole. Funeral insurance fulfils an unmistakable need and there are thousands of policies in South Africa operating regularly and without mishap. As it was

[*] This article should preferably be read in conjunction with the website of the Ombudsman for Long-term Insurance at <http://www.ombud.co.za>. There are copious references in the footnotes to cases on the website under their Case Report ('CR') numbers.

[1] Funeral business is a convenient term for life insurance policies marketed as providing death benefits to meet funeral costs.

[2] Both the Financial Services Board ('FSB') and the Life Offices Association ('LOA') are in the process of investigating funeral insurance. The LOA adopted a *Code on Assistance Business* with a view to countering abuses it has identified in the industry. In terms of the *Code*, all administrators shall be registered with the FSB by the assistance insurers they represent. An administrator is defined as any person or legal entity which provides intermediary services for any registered assistance insurer. FinMark Trust has commissioned a study into funeral insurance of the concerns expressed about abusive practices in this area of insurance. This study, under the title 'A Regulatory Review of Formal and Informal Insurance Markets in South Africa', version 4.5 of which is dated Apr 2005, will be referred to hereinafter as 'the *Finmark Study*'. During Aug 2003, Parliament's Portfolio Committee on Finance ('PCOF') heard evidence of, and expressed concern about, widespread abuses perpetrated by unscrupulous go-betweens and funeral insurers. This evidence received prominent publicity in the financial press. The headlines of Bruce Cameron's article in *Personal Finance* of 9 Aug 2003, for instance, read: 'Massive Fraud in Funeral Assurance Industry Exposed; Millions of South Africans contributing to funeral policies will be given a pauper's funeral because of widespread fraud'. The people who are mostly targeted by unscrupulous operators are exactly those in greatest need of this type of insurance protection, the less affluent members of society. During the course of the discussions before PCOF, also at its sitting of 7 Sept 2005, a number of abuses were identified, some of which will be mentioned below.

stated in our 2003 *Annual Report*:[3]

[3] The Ombudsman for Long-term Insurance *Annual Report 2003* in par 3.2 at 24. See too the *Annual Report 2004* at 42-8.

> 'But it must not be forgotten that funeral business is an important segment of the total insurance industry, all the more so because funeral insurance serves the basic needs of a large number of less affluent consumers. Moreover, since the proceeds of funeral insurance may be utilised for purposes other than funeral expenses, this type of policy is often a factor in the financial planning of many households.'[4]

1.2 The Office of the Ombudsman for Long-term Insurance does not enjoy the benefit of a wide-angled overview over the entire long-term insurance industry. By its terms of reference, it is concerned not with industry pathology but with individual dissatisfactions with registered insurers who are subscribing members to its scheme. As such the Office is not a microcosm of the entire industry. Roughly fifteen per cent of complaints received by the Office involves some or other aspect of funeral insurance. It is from that narrow and tapered perspective that this section of the industry is viewed by our Office and it is our exposure to those complaints that prompts this contribution.

1.3 This is not, as a contribution, intended as a comprehensive analysis or résumé of the law of funeral insurance;[5] its purpose is rather to share with those who may be interested some empirical intelligence within this specialised domain.

1.4 Although some problems are specific to funeral insurance, the ills and mischiefs encountered elsewhere in the industry are similarly evident within this area of insurance: misselling, mistakes and misunderstandings about policy terms, misleading marketing material, miscalculation and misappropriation of proceeds, mismanagement, misconduct by illegal operators – a miscellany of misdeeds.

1.5 As with insurers generally, some funeral insurers are more inclined than others to ferret out points to avoid or delay liability. But the fault lies not only on the one side. While most claimants and complainants are honest and genuine, they are not, as a class, all unstained innocence. Some are downright deceitful or avaricious, some suffer from self-induced memory lapses, and many are unrealistic and stubborn in their expectations. Insurers cannot be denounced for not being gullible: for their own protection they need to be vigilant.

What Is Funeral Insurance?

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[4] Funerals are costly affairs. A few years ago the average cost of a funeral was estimated to be in the region of about R5000. It may now well be closer to R10 000. Whites in the Johannesburg area, according to the *Finmark Study* op cit note 2 at 7, spend an average of R4000 per funeral, Blacks R8000, and Indians less than R3000. For many families money of that sort may not be readily available. Yet a funeral may be a social imperative. Unless you come to my funeral, the wag said, I won't come to yours. Funeral insurance in a sense amounts to savings in advance for an inevitable but unsought for end.

[5] See, eg, JP van Niekerk 'Funeral Insurance: A Rare Decision and Some General Observations' (2001) *SA Mer LJ* 638; MFB Reinecke, Schalk van der Merwe, JP van Niekerk & Peter Havenga *General Principles of Insurance Law* (2002) in par 589; CD Shone *Assistance Policies in Terms of the Long-term Insurance Act with Specific Regard to the Unregistered Insurer* (unpublished LLM thesis, University of South Africa (2003)).

2.1 Funeral insurance may broadly speaking be described as an undertaking by one party, the insurer, to another, the policyholder, to provide, in consideration of predetermined contributions usually payable at predetermined regular intervals, a funeral service or a cash benefit or a combination of both, on the death of the life assured, in respect of whom the policyholder has an insurable interest, regardless of the aggregate of contributions the insurer may have received in respect thereof at the time of the death of the life assured.[6]

2.2 In terms of the Long-term Insurance Act ('the Act'),[7] a so-called assistance policy is a life policy of R10 000 or less per life assured (or such other amount as the Minister of Finance may determine). Funeral business may be written under either a licence restricted solely to assistance business, that is, a policy not exceeding R10000 per life assured, or one permitting the sale of unrestricted life policies.[8] The main incentive for writing funeral policies as assistance business is the absence of a cap on commissions,[9] which accordingly allows for the marketing of products which have relatively high administration costs and extended distribution chains.[10] The benefit payable on the death of the life assured may be the provision of a service,[11] or a cash benefit, or both.[12] And when the undertaking is to perform a funeral service, either party to the assistance policy 'may request that a policy benefit which is expressed otherwise than in a sum of money shall be provided as a sum of money equal in value to the cost that would have been incurred by the long-term insurer had the non-monetary benefit been provided'.[13] The failure on the part of insurers to advise consumers of that option is one of several identifiable abuses encountered in practice.[14]

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6 Where there is no underwriting, the insurer's assessment of its risk is predicated not on its own risk with reference to the particular insured, but on the general risk pool: see the Finmark Study op cit note 2 at 92. See too pars 3.4 and 10 below.

7 52 of 1998, s 1(1)(*ii*); see too ss 74 and 75.

8 See the *Finmark Study* op cit note 2 at 38 and 63.

9 Part 3 of the Regulations under the Long-term Insurance Act, read with the relevant table.

10 Because values are low, commission may be high relative to the benefit but low relative to the effort required to earn the commission.

11 Shone op cit note 5 at 15 states: 'These usually include an undertaking by the insurer to provide a funeral, variously described to include the services generally regarded as being included in a funeral, with limitations on when the service will be provided. The service may be described to include the removal and preservation of the deceased, a hearse and family car, a defined type of coffin, wreaths and attendance to registration of death and related formalities. The cost of a grave is generally included but not always and may be limited to a public grave.'

12 See too the *Finmark Study* op cit note 2 at 7-8.

13 Section 53; the *Finmark Study* op cit note 2 at 64. See too the website under CR 138.

14 The *Finmark Study* op cit note 2 at 29.

2.3 When a cash benefit is paid in lieu of a funeral service, the amount so paid need not be utilised for its perceived purpose and insurance companies need not monitor whether the monies paid out on a funeral policy are employed to defray funeral costs. When an actual funeral service is performed and its costs do not exceed the sum stipulated in the policy, the balance so saved may be payable to the policyholder, the beneficiary or his estate, as the case may be, as if the insurance was of a non-indemnity nature.[15] [16]

Some Common Features of Funeral Insurance

3.1 A characteristic of this market is the large number of insurers. In 2005 there were some 40 registered insurers with assistance licences, the majority of which also carried on business under life licences.[17] Name changes seem to occur regularly. In the result it may sometimes be difficult for policyholders, anxious to claim, to locate their adversaries. By the same token, it is burdensome for the smaller insurers to muster the means to comply with the not inconsiderable regulatory requirements of the Act, including the Policyholder Protection Rules (Long-term Insurance), 2004, promulgated under it, the Financial Advisory and Intermediary Services Act,[18] and the *Code on Assistance Business* issued by the LOA.

3.2 Another feature of this market is that its patrons are often from the less affluent and perhaps less sophisticated sectors of society.[19] They are often found in rural areas and

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15 According to Van Niekerk op cit note 5 at 647, the insurance 'will be one of non-indemnity if the insurer undertakes to pay a fixed sum of money which may or may not in full or in part have to be expended on a funeral; it will be one of indemnity if the insurer undertakes either to provide a specified funeral or to pay no more than the cost of such a funeral' (see, too, Shone op cit note 5 at 16 and 41-3). Van Niekerk also states at 647 that if the insurance is one of indemnity, the doctrine of subrogation is applicable. A major disappointment for consumers, according to Shone at 6, 8, 17 and 23, occurs when they naively believe that their contract is one of indemnity and that, having made regular payments in advance, they had prepaid for a complete funeral service at their deaths, when, in fact, the sum insured ultimately paid out might fall significantly short of its contemplated purpose.

16 In a recent case the member subscribed for funeral cover of R5000 on the life of her mother-in-law. On the latter's death, she negotiated a fee of R5600 for the cremation with the funeral parlour. After the funeral and when she enquired to arrange for payment of the balance of R600, she discovered that the administrator had, on behalf of the insurer, negotiated a fee of R4400, which amount had been paid by the administrator and accepted by the funeral parlour in full and final settlement of the costs of the funeral. When the policyholder claimed the 'saving' of R600, the administrator sought to justify its retention of the amount on the basis that 'the discount' was negotiated not for the policyholder but for itself 'to finance the call centre'. There was nothing in the contract to that effect and the insurer, on reflection, decided to pay the R600 to the policyholder 'since the matter was not handled satisfactorily and the member was brought under the wrong impression'. The policyholder accepted the payment and the file was closed.

17 Cf the *Finmark Study* op cit note 2 at 38.

18 Act 37 of 2002.

19 The point is also made in the *Finmark Study* op cit note 2 at 3, 7, 17 and 41.

would be particularly vulnerable to sharp practices. It is common for the Office to receive complaints from complainants that they either could not read or properly understand the terms of the insurance policies and that they were completely dependent on what was explained to them by intermediaries. In many cases the funeral policy will be the only financial arrangement that a customer has ever made. Frequently policyholders would not have bank accounts. In those circumstances the opportunities for chicanery and exploitation are multiplied.

3.3 Funeral insurance is generally written as term insurance and comes to an end at the expiry of the agreed term. Such policies normally provide for periodic renewal. This, too, can lead to abuse.[20] As the policyholder grows older, frailer and closer to death and interment, the policyholder may thus face termination of his policy at the very time when his need for funeral insurance is most acute and no other insurer would be likely to offer him insurance. So, too, when premiums become unaffordable, particularly after the policyholder has retired. The problem is compounded when the policy contains a clause, as some policies do, escalating premiums by as much as fifteen per cent per year and the policyholder was not specifically made aware of it. In the result, the policy may lapse when it is most inopportune for it to do so.[21]

3.4 There is generally little[22] or no underwriting in respect of the risk. It is for that reason that such policies often contain limitations such as waiting periods and exclusion clauses, some of which are discussed in greater detail below.

The Structure of a Funeral Insurance Policy

Individual Policies

4.1 Benefits may be provided in terms of either individual policies or scheme policies. An individual policy may in the first instance be taken out by a policyholder with himself as 'the life assured' to defray the cost of his own funeral, thereby reducing the financial

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[20] Cf the *Finmark Study* op cit note 2 at 92-4. Funeral policies are sometimes written as a one-month contract renewable monthly.

[21] We encountered a recent instance where a scheme was set up for old age pensioners, on the face of it a somewhat risky business venture. The underwriters frequently changed because of the bad risk experienced and eventually the scheme was terminated by the funeral administrator because of the ever escalating premium rate. This left the remaining members without cover where alternative cover, because of their advanced age, might no longer be obtainable. After our intervention and at our suggestion, the insurer made an offer to the individual members to continue with the cover at more or less the same rate but without the luxury of the intermediary who previously assumed a dominant role in the proceedings. The amount so saved was to be utilised by the insurer for their benefit. Sadly, there was no meaningful response and our rescue attempt simply petered out. See too the website under CR 139.

[22] An applicant may be required to complete a health questionnaire or confirm that he or the proposed life assured is of sound health: see par 10 below.

burden otherwise falling on his relatives or his estate to bury him. In such a policy the policyholder will ordinarily nominate a beneficiary. Most policies provide for such a nomination. There is no restriction on the person or class of person who may be so nominated: it remains the policyholder's own preference who he would like to bury him or to benefit from his death. Failing any valid nomination, the benefits of the policy will devolve on his estate.[23]

[23] See par 5.2.4 below.

4.2 The policyholder may separately or in addition take out a policy with his spouse or children or close relatives as 'the lives assured' and himself as the policyholder, thereby reducing the financial burden with which he believes he would otherwise be lumbered to bury those who predecease him. However, the application form for insurance or the policy itself may limit the class of persons in respect of whom such insurance may be taken out. Where a 'child' is designated but the name of a step child or foster child is inserted as the life assured, the nomination may be invalid as falling outside the class of risk the insurer was prepared to assume.[24] The designation of a class circumscribes, as it were, the insurable interest.[25] Such a multiple policy should not otherwise occasion any particular problems. Depending on its terms, it may be construed either as a single policy for an entire family, or as several policies with overlapping terms but assembled in a single document.

Scheme Policies

4.3 In the case of a group or scheme policy, the policyholder would normally be a fund or scheme with individual members.[26] The latter situation may be construed as a contract between the insurer and the fund, evidenced by a master policy issued to the fund as the policyholder, and a separate contract between the fund and its members to ensure that, on the death of the lives assured, the members, their nominees or estates, as the case may be, would receive the benefits due to them in terms of the policy.[27] Then again, the insurance contract may provide that payment is to be made directly to the funeral parlour.[28]

A Plethora of Participants

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[24] See the *Annual Report 2004* op cit note 3 at 45.

[25] See idem at 43 and 44, the *Annual Report 2005* op cit note 3 at 47, and the website under 'Papers and Presentations: Reinecke "Insurable Interest" '.

[26] In the Policyholder Protection Rules (Long-term Insurance), 2004, 'assistance business group scheme' means

> 'the provision of policy benefits under an assistance policy to a group where –
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> (*a*) individual persons are the policyholders;
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> (*b*) no individual underwriting takes place;
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> (*c*) the individual person whose life is insured, is directly or indirectly paying premiums;
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> (*d*) the policy may be cancelled by either party to the policy; and
>
> (I) the policy has term cover only;
>
> and "scheme" has a corresponding meaning'.

[27] Cf *Beling v The Southern Life Association Ltd*, cited by Shone op cit note 5 at 11; *Sage Life v Van der Merwe* 2001 (2) SA 166 (W); and *Connoly v The Southern Life Association Ltd*, discussed in (2001) 4 *Juta's Insurance Law Bul* 9-14.

[28] See par 2.3 above.

There are, typically, several parties or instances who must or may be involved in funeral insurance.

5.1 On the side of the insurer:

(*i*) The *insurer* itself which assumes the risk for an agreed consideration.[29] It is of vital importance to the interests of the policyholder that the insurer should be duly registered as a long-term insurance company.[30]

(*ii*) The *administrator* which, in the case of schemes, usually manages the scheme on behalf of the insurer. If authorised to do so by the insurer it collects the premiums, makes the payments and administers the scheme.[31]

(*iii*) The *intermediary or agent*. The intermediary may be an independent broker or a mandatary of either party.[32] When he is authorised to enter into a contractual relationship on behalf of his principal, the intermediary would be an agent in the true sense. Even when lacking such authority, he may still be acting on the instructions and in the interest of either the insurer or the insured, perhaps even within the same transaction, and in that case the intermediary is sometimes somewhat loosely described as 'an agent' for the one or the other instead of as a mandatary. For example, it is usually said that he will be acting as the insurer's 'agent' in marketing the policy or in explaining its terms to the proposer and as the insured's 'agent' in completing the application form. Where the intermediary is a 'true agent', his knowledge may be deemed to be that of his principal.[33]

5.2 On the side of the policyholder:

(*i*) The *policyholder* is the party contracting with the insurer and as such is normally entitled to the rights and benefits of the policy.

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29 When the insurer is a subscriber to the Ombudsman's scheme, the Ombudsman would have jurisdiction to deal with any complaint lodged against it by either the individual policyholder, his successor in title, a life insured, a premium payer, or a beneficiary, or, in the case of a scheme, by a scheme in its capacity as policyholder or by any member of the scheme in his capacity as a beneficiary.

30 Much of the *Finmark Study* op cit note 2 is devoted to the unregulated sector of the industry and to the prominent role played in this regard by burial societies (see at 50, 74 and 78) and funeral parlours (see at 23, 26, 50 and 79). Burial societies normally register under the Friendly Societies Act 25 of 1956; benefits are not to exceed R5 000. However, not all burial societies are duly registered as such.

31 As the *Finmark Study* op cit note 2 points out (see at 1, 32 et seq, 48 and 80), administrators, owning or controlling the client base 'sometimes assume the role of product providers'. However, this form of stage-management cannot detract from the true nature of the relationship between administrator and insurer as being one between agent and principal, even if the principal may remain unrevealed or relegated to the background. It has been estimated that there are some 50 funeral administrators in South Africa at present.

32 Cf idem at 48-9.

33 See the Ombudsman website under 'Papers and Presentations: Reinecke "Imputation of Knowledge". See the website under CR 30 and CR 136.

(*ii*) In the case of a group or scheme policy, the policyholder may be a burial society, scheme, fund, union or stokvel.[34] These are parties actively promoting their particular schemes for the benefit of their members. For instance, a trade union may promote the scheme, the union members contributing to the scheme through their union memberships.[35]
(*iii*) The *policyowner* would normally be the policyholder but the policy may be 'sold' and the rights under it transferred to a third party as cessionary, either as an out-and-out transaction or as a form of security.[36] The policyholder will then no longer be the 'owner' of the policy; in the case of a security cession, his ownership would be attenuated until the secured debt has been redeemed.
(*iv*) The *life assured* is the person on whose death the policy pays out. The life assured may, but need not be, the policyholder. Additional 'lives assured' may be added to the policy for an additional contribution. The potential 'lives assured' may be listed in the policy documentation by category, for example the policyholder's close family members (which, depending on the terms of the policy, may include foster or adopted children). Where the categories are not listed, the 'lives assured' would be restricted to persons in whom the policyholder would have an insurable interest.[37] The life assured is not a party to the contract. His signature to the application form is not, therefore, required for the validity of the contract, unless the application form or the policy expressly so stipulates.[38] Contrary to a belief sometimes expressed, the death of the first (or principal) life assured followed by payment does not, in the absence of a provision to that effect, terminate the policy.[39]

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34 'Stokvel' is defined in the South African Oxford Dictionary as 'an informal group saving scheme that provides small scale rotating loans'. See, too, WG Schulze 'Origin and Legal Nature of the Stokvel' (1997) 9 *SA Merc LJ* 13 and 153 and the *Finmark Study* op cit note 2 at 13-8, 74, 78, 86-7 and 97. On friendly societies, see idem at 69 et seq and 103.

35 A difficulty sometimes experienced in practice occurs when the union, accepting the premiums, fails to pay over the amounts received to the administrator or the insurer, as a result of which the insurer is unable to meet claims on the policies. The Ombudsman Office has consistently taken the view that this is a matter as between the insurer and the administrator, on the one hand, and the insurer and the union, on the other hand. The member, being a third party beneficiary, has a self-standing claim against the underwriter. See too the website under CR 137.

36 See PM Nienaber 'Some Problems Involving Security Cessions of Life Insurance Policies' (2004) 16 *SA Merc LJ* 83; the Ombudsman website under 'Papers and Presentations: Nienaber "Security Cessions"'; and the *Annual Report 2003* op cit note 3 at 52-5.

37 See the website under 'Papers and Presentations: Reinecke "Insurable Interest" '; the *Annual Report 2004* op cit note 3 at 45.

38 A misdescription of the life insured would not be material except if it affects the premium rate. See pars 11.6 and 11.7 below and the website under CR 136.

39 See the Ombudsman website under 'Papers and Presentations: Reinecke "Insurable Interest"' and par 18.2 below. See too the website under CR 88 and par 18.2 below.

(*v*) The *premium payer* will usually, but again need not necessarily, be the policyholder. Any third party may assume the policyholder's obligation to pay the premiums to the insurer. The premium payer's signature is also not a requirement, in the absence of a stipulation to the contrary, for the conclusion of the contract. A premium payer who is neither policyholder nor nominated beneficiary, enjoys no rights under the policy, for example the right to payment of benefits on the death of the life assured or to negotiate changes to or the cancellation of the policy.[40]

(*vi*) The *nominated beneficiary*[41] is entitled, on acceptance, to payment of the benefits which falls due in terms of the policy on the death of the life assured. The nomination could be made in the proposal form at the time of the conclusion of the contract or, unless it is forbidden by the contract itself, afterwards. A beneficiary nomination is normally capable of unilateral revocation or change in accordance with the formalities prescribed in the contract.[42] The nomination of a beneficiary is construed in our law as a contract in favour of a third party.[43] This means that the benefit, having been accepted, inures to the benefit of the nominated third party and not to the benefit of the policyholder or his insolvent or deceased estate.[44]

The nomination may be either for proceeds or for ownership.

In the first situation the policy effectively comes to an end on the death of the last of the *lives assured* and payment of the policy benefit is made to, or in favour of,

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[40] See the *Annual Report 2004* op cit note 3 at 44. Miss A, describing herself as single, applied for a funeral policy with company X. The premium payer was Mr B, her fiancé, who consented to it on the same application form as the one signed by Miss A. The policy made no provision for a beneficiary nomination. When Miss A died, Mr B claimed. The matter was approached by the insurer on the basis that Mr B was the real policyholder who insured the life of Miss A and, consequently, that the issue was whether there was a sufficiently close identity of interest between Miss A and Mr B to give him a vested claim to the benefits under the policy. That, in our view, was the wrong approach. Miss A was the policyholder. Mr B had no claim on the policy as such since he was not the nominated beneficiary but merely the designated premium payer; he assumed an indebtedness without acquiring an entitlement. Payment should therefore have been made to Miss A's estate. See too the website under CR 24.

[41] See too par 12 below; Nienaber op cit note 36 in par 17.

[42] See *Moonsamy v Nedcor Bank Ltd* 2004 (3) SA 513 (D); Susan Scott 'Begunstigingsaanwysings en Sessie van Regte ingevolge Lewensversekeringspolisse – Wat Elke Testateur en Eksekuteur Moet Weet' (2005) 17 *SA Merc LJ* 110.

[43] See Reinecke, Van der Merwe, Van Niekerk & Havenga op cit note 5 in par 408; *Warricker v Liberty Life Association of Africa Ltd* 2003 (6) SA 272 (W); *Pieterse v Shrosbree* 2005 (1) SA 309 (SCA). For a divergent view, based on the wording of the policy concerned, see *Sage Life Ltd v Van der Merwe* 2001 (2) SA 166 (W). See too the website under CR 1 and CR 55.

[44] *Arthur E Abrahams & Gross v Cohen* 1991 (2) SA 301 (C) is authority for the proposition that there is a duty resting on both the insurer and the executor to inform the beneficiary of his potential entitlement, the breach of which duty could in principle give rise to delictual liability for economic loss. See too Reinecke, Van der Merwe, Van Niekerk & Havenga op cit note 5 in par 411.

the nominated beneficiary. If the *policyholder* dies, the policy vests in his estate and as such may be ceded to a third party.

In the second situation the policy caters for the eventuality of the policyholder pre-deceasing the life assured. The policy provides for the appointment of a new policyholder to succeed the policyholder if the latter should die before the life assured. There may be certain financial advantages in keeping the policy intact after the policyholder's death. This is achieved by providing for the substitution of a nominated third party as the new policyholder or 'owner of the policy'. Either the new owner or the beneficiary, if there is one, will then become entitled to payment on the policy on the death of the life assured.[45] However, acceptance of the benefit by the third party may go hand in hand with the assumption of an obligation, for instance, to continue paying future premiums under the policy. In that respect it would be a form of delegation.[46]

(*vii*) The *cessionary*. The cession may be an out-and-out one or a security cession. In the latter event the cedent retains a so-called 'reversionary interest' or an attenuated 'bare ownership' in the policy pending the redemption of the secured debt.[47] In the case of an out-and-out cession the right to revoke th existing beneficiary nomination or to appoint a new one passes to the cessionary.[48] Those rights should, however, only vest in the security cessionary once it is established that the secured debt will not be redeemed so that the security cessionary is permitted to take action on the cession.

(*viii*) The *borrower*. Many funeral policies do not have a cash, surrender or loan value but if a policy did accumulate a cash value and its terms so permit, the policyholder may borrow against the policy from the insurer.

5.3 The contractual interrelationship between the various participants may be demonstrated diagrammatically as follows:

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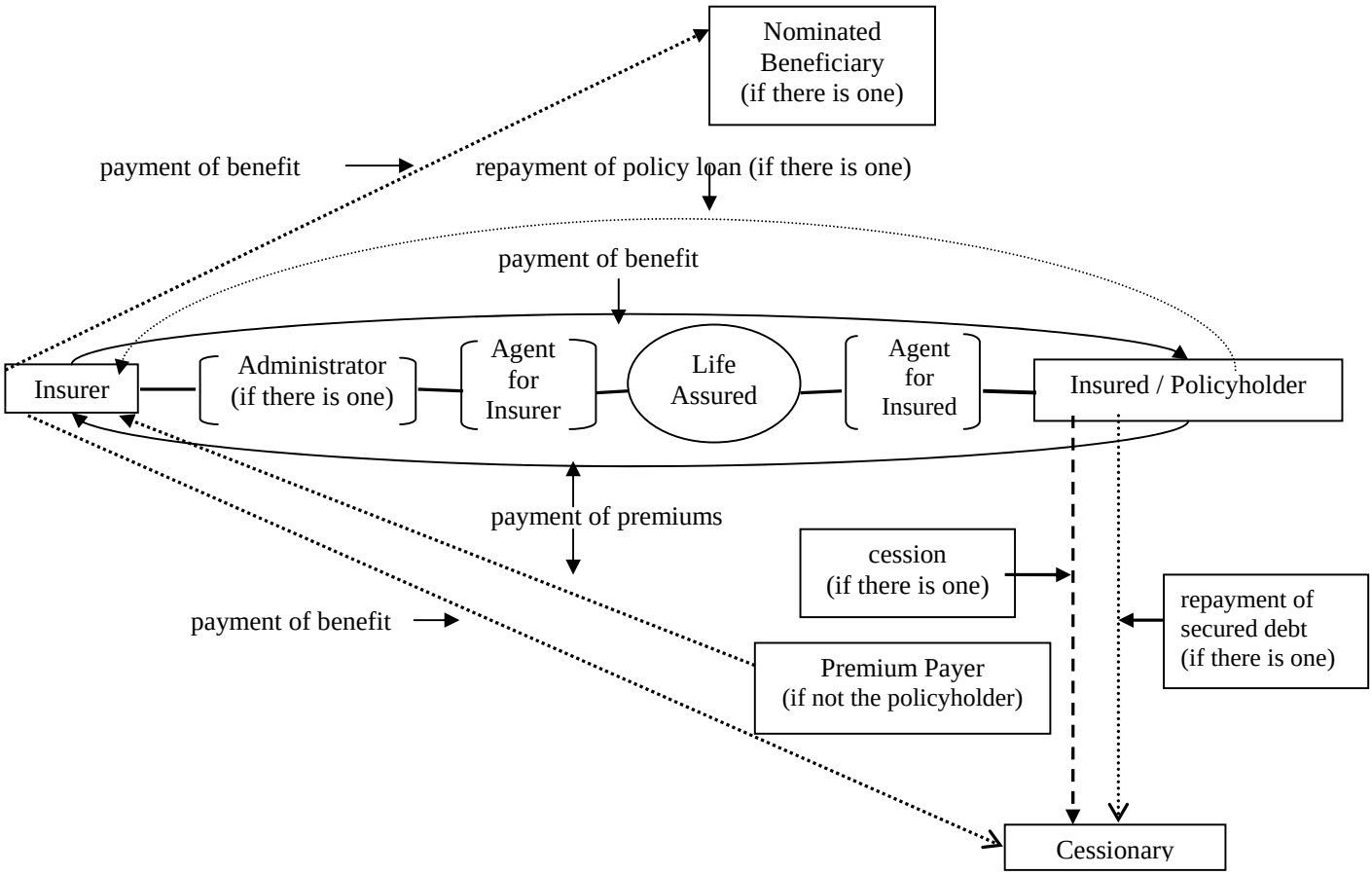
45 See too the website under CR 140.

46 Idem under CR 20.

47 See PM Nienaber 'Cession' in: WA Joubert (founding ed) *The Law of South Africa* Vol 2, Part 2, 2 Reissue (2003) in par 53.

48 The general rule is that rights are freely cedeable and special facts or circumstances have to be raised why this general rule should not be applicable to the right to revoke the beneficiary nomination. Any limitation to the right or power to revoke a beneficiary nomination must be sought in the agreement creating the right (that is, the policy) or in the obligationary agreement underpinning the cession.

Schematic Representation of Contractual Interrelationship between Parties



5.4 It follows from the above[49] that:

(*i*) when the policyholder and the life assured are one and the same person and dies, payment of the proceeds of the policy is to be made to

(*a*) the nominated beneficiary, if there is one;

(*b*) the policyholder's estate, if there is none.

(*ii*) when the policyholder and the life assured are not the same person and the policyholder dies:

(*a*) the policy devolves on his estate, if there is no nomination for ownership;

(*b*) if there is no nomination for ownership,[50] the nominee becomes the new policyholder.

(*iii*) when the policyholder and the life assured are not the same person and the life assured dies the proceeds of the policy are paid out:

(*a*) to the nominated beneficiary for proceeds,[51] if there is one;

(*b*) to the original policyholder or new policyholder, as the case may be, if there is no such nomination for proceeds.

5.5 This wide spread of participants does have a negative side. More go-betweens mean more parties to partake in the premium income. Policyholders sometimes ask how their premiums are apportioned. The response may be disconcerting. For instance, it was revealed in a recent case where the sum assured was only R5000, that of the monthly premium of R20, R10 was split as commission, R7,50 went towards the insurer, and R2,50 was an administration fee.

Some Occurring Problems

Old Policies, Small Benefits

6 Venerable policies, like venerable policyholders, diminish with age. Policies dating back to a period when premiums, measured in today's terms, were low and benefits were modest, are often overtaken by inflation. As soon as the sum assured was reached, such policies tended to be made paid-up; often the benefits were worth no more than £10. The value of such policies would not remotely be sufficient to provide a fitting funeral to the deceased. When that happens there is disappointment on the part of family members who realise that the policy to which the deceased had contributed so loyally and for so long is, for all practical purposes, worthless. As an Office we have engaged with the FSB in this respect but sadly there is not much we can do to assist. A contract, even if eroded by inflation, is still a contract. Fortunately this is a dwindling phenomenon

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49 And leaving aside the situation where payment is to be made directly to a funeral parlour.

50 See par 5.2(*vi*) above.

51 Ibid.

since modern contracts are no longer designed in this fashion.[52]

Policy Documents

7.1 The terms of the contract of insurance should be embodied in a policy,[53] but such a document does not always exist and if it does, it is not always issued to the policyholder. Sometimes only a certificate or a booklet is issued when a policyholder's application for funeral insurance is accepted. In terms of the Long-term Insurance Act,[54] the policyholder should within 60 days of taking out a policy receive a membership certificate summarising the core provisions of the contract and specifying how much of the premium is paid to the insurer and how much to an intermediary or administrator. In addition, the policyholder is entitled to insist on a copy of the actual policy containing the full terms of the contract to which he had committed himself. Judging by some of the complaints we receive, one would have to be naive to believe that everything happens by the book.

7.2 Policies are sometimes so densely worded as to be bewildering, particularly to the uneducated.[55] This enables some insurers to repudiate claims by reference to carefully crafted exclusion clauses or the failure on the part of the claimant either to provide requisite information or to comply strictly with prescribed claim procedures. This is an area where we sometimes have to invoke our equity jurisdiction.[56]

7.3 The identity of the policyholder is, of course, an integral part of the contract. Uncertainty about who the true policyholder is and the failure by the intended policyholder to actually agree to be a party to the contract, would obviously affect its validity. In a recent case[57] it was not apparent from the application form whether the complainant or the late Ms A was intended to be the true policyowner; if it was Ms A, she was not the one who apparently signed the form. That being so, the insurer took the view that the application form, as signed, did not bind it and it refunded to the complainant all the premiums received from him. We invited the complainant, if he disagreed with that view, to provide us with the answer to the insurer's approach. In the event he was unable to do so and the file was closed.

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52 Many insurers provided enhanced benefits over and above the contractual amounts, but even so the amounts paid out would fall short of the cost of a funeral.

53 A policy document, like any written agreement, is capable of rectification. See the *Annual Report 2004* op cit note 3 at 43-4.

54 See s 48.

55 A policy document not supported by consensus between the parties would have no legal standing. See our website under CR 85 and CR 94. The same is true for any amendment to its terms. See our website: under CR 89 and CR 91.

56 See pars 19 and 20 below.

57 See our website under CR 22.

7.4 We do sometimes receive complaints that insurers unilaterally increase the premiums payable in terms of the policy. In one such instance the insurer responded by pointing out that the contract permitted an increase 'to bring the rates in line with actual claims experienced'. We eventually concluded, after some debate with the insurer, that the clause in question was not invalid 'for want of certainty and/or because it permits of unilateral exploitation'.[58]

Marketing

8.1 Marketing of funeral insurance also takes place by telephone and through various channels such as banks, trade unions and retail outlets.[59] According to complaints received by the Office, customers purchasing goods on credit at retail outlets are sometimes unaware that by doing so they are unwittingly entering into contractual relationships, underwritten by insurers, which might or might not contain funeral insurance components. Part of the instalment payments on the debt might be allocated as premiums on the policy. Complainants would eventually notice a deduction from their accounts in respect of recurring premiums although they were unaware that they had entered into any contracts of insurance. In one such instance the complainant was told: 'When you make a purchase at one of our stores, if the cashier presses the "enter" button on the computer, you will automatically get a funeral policy.' Hence the customer may be paying for a policy on which he or his estate will never claim because he was unaware of its existence. Any such transaction, if uncovered, would of course be invalid, at the instance of the customer, for lack of consensus. Our Office would insist on a refund of premiums plus interest and, in an appropriate case, on the payment of additional compensation for the inconvenience and distress caused by such unauthorised premium deductions. Complainants who have been inconvenienced in this manner are often from the lower income groups. Unauthorised deductions of this nature could have a significant negative effect on their financial situations.

8.2 Some of the material furnished by or on behalf of insurers or administrators, be it media advertising or brochures, may be misleading in what they promise; or the information given may not be matched by the actual terms of policies which are eventually issued to clients or customers. In such instances the Office has in the past allowed policyholders either to avoid their policies or directed the insurers to honour the promises contained in their marketing material.[60]

Misselling

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58 See Schalk van der Merwe, LF van Huyssteen, MFB Reinecke & GF Lubbe *Contract: General Principles* 2 ed (200*) in pars 8.3 and 8.4.

59 See also the *Finmark Study* op cit note 3 at 49. See also the *Annual Report 2003* op cit note 3 at 25, the *Annual Report 2004* op cit note 3 at 43, and cf our website under CR 28.

60 See the *Annual Report 2003* op cit note 3 at 47.

9 In soliciting potential subscribers, insurers or their agents sometimes talk their customers into taking out insurance on terms which, viewed objectively and in retrospect, were not necessarily in their best interests. Inappropriate advice of that nature, also termed misselling, occurs with funeral insurance as with other forms of insurance although perhaps less so than in situations where the emphasis is on investment rather than risk. The approach of the Ombudsman Office in such cases has been the subject matter of public contributions by both the Ombudsman and Deputy Ombudsman.[61]

Non-disclosure by the Proposer

10 Applicants for this type of cover are not usually asked to complete a health questionnaire but when they are, the answers must of course be accurate: a wrong reply may be a material mis-disclosure and give rise to the repudiation of a claim.[62] When underwriting is thus required and a material fact, relevant to the risk undertaken by the underwriter, is either misstated or not disclosed, the insurer may rescind the agreement, in which case the question of a refund of premiums may arise.[63] By not insisting on underwriting, it is suggested, the insurer waives its common law defence of non-disclosure.[64]

Fraud, Misdescription and Other Related Matters

11.1 Fraud is protean, and is perpetrated by illegal operators, by agents of legal insurers, by independent intermediaries, but also by actual or would-be insured.

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61 See PM Nienaber 'Misselling – A Working Model' (2005) 2 Quarter *FSB Bulletin* at 5; our website under 'Papers and Presentations: Nienaber "Misselling – A Working Model" ' and 'Papers and Presentations: J Preiss "Misrepresentation and Misselling" '.

62 See par 3.4 above.

63 See the *Annual Report 2004* op cit note 3 at 21-29. See too our website under CR 90.

64 See too par 17.2 below. On non-disclosure generally, see our website under 'Papers and Presentations: Disability Workshop: Slabbert "Non-disclosure and Change of Occupation" '.

11.2 Commencing with illegal operators, the public, by and large, is trusting and fraudsters feed on trust. Funeral parlours, loan sharks and unscrupulous funeral insurers sometimes work in tandem to generate new business and to lure unsuspecting victims into a network of inappropriate policies. The problem lies mainly with operators and syndicates who solicit business and profess to provide funeral insurance cover when they are neither registered as insurers nor as funeral administrators. So, too, funeral administrators sometimes presume to act as self-insurers.[65] Only duly registered insurance companies may underwrite funeral insurance. Being unregistered and operating as they do outside the boundaries of legislative control, such operators are not in the business to profit but to profiteer. Registration under the Long-term Insurance Act[66] is not a legal prerequisite for the validity of a contract of insurance. Some administrators or insurers initially pay claims so as to lull their customers into a false sense of security. But once they have accumulated enough funds, they vanish or fold. Contractually they may be bound, factually they can't be found. Some of these illegal operators are prosecuted at the instance of the FSB, but prosecution and conviction offer scant satisfaction to defrauded policyholders.[67] What we experience in the Office in this regard is probably no more than a mere smattering of actual instances. It is a matter of regret that in such cases we are unable to be of greater assistance to disillusioned policyholders. The Office only has jurisdiction against insurers who are subscribing members, not against fraudsters who might pose as such.

11.3 There are several instances of fraud perpetrated by employees or agents of insurers, registered or not, who forage for commission, dupe gullible consumers into subscribing to insurance policies under false pretences, and contrive to have the premiums deducted from policyholders' salary accounts, for instance on the pretext that they were assisting the complainants with their income tax.

11.4 Our standard procedure when such instances of fraud are reported and uncovered, is to order the insurer, if a subscribing member, to repay all premiums received with interest and, in addition, to pay compensation for the trouble and expense it took to annul the transaction and to recover premiums paid.[68]

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65 See, generally the *Finmark Study* op cit note 2.

66 See s 60(1) of the Act. In terms of s 60(2) the other party may cancel the policy as if the policy had been breached.

67 One such recent example is that of two Christian burial societies in the Cape Town townships which had their Chief Executive Officer charged in court because he failed to pay members their funeral benefits after some R2,5m seemingly disappeared from the funeral society.

68 See the *Annual Report 2004* op cit note 3 at 10.

11.5 On the side of insured, the fraud may consist of false claims. Because the proceeds of a payment in terms of a policy do not in fact have to be applied to its professed purpose, that is, to meet the expense of a funeral,[69] this form of insurance lends itself to abuse and creates scope for sophisticated scams. We have had evidence of pretended deaths, or of impostors acting or being presented as 'lives assured' or as policyholders or beneficiaries. Year after year our *Annual Reports* recount instances of such swindles. One such instance[70] was that of a fraudster who, with the help of hospital staff, took out funeral policies on the lives of terminally ill people with whom he stood in no familial relationship. He duly paid the premiums during the waiting period and afterwards. Whenever one died, he collected and pocketed the proceeds as the nominated beneficiary. What was particularly galling was that he had the impertinence to complain to this Office when one of his claims against the insurer was repudiated. It is such instances of fraud that prompt funeral insurers to be justifiably suspicious of any claim that appears to be even vaguely irregular.[71]

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[69] See par 2.3 above.

[70] See the *Annual Report 2003* op cit note 3 at 25. See too our website under CR 23, CR 26 and CR 29.

[71] In two recent cases (one of which is discussed in the *Annual Report 2004* op cit note 3 at 27-8) the dates of birth of the lives assured were misstated in the application form for funeral insurance. The application forms contained the following clause:

> 'If any material information has been withheld or any material information supplied proves to be incorrect the contract will be invalid and all contributions paid will be forfeited.'

In both instances the dates of birth reflected in the identity documents submitted at the claim stage showed the lives assured to be much older than represented and neither qualified for cover in terms of the provision of the policy concerned. Claims were submitted on behalf of the claimants by a paralegal organisation.

The insurer declined (*I*) to meet the claims; or (*ii*) to consider a refund of any portion of the premiums paid.

The Office agreed with (*I*) but not with (*ii*).

As far as (*ii*) is concerned, the insurer relied on the clause quoted and stated that the claims were fraudulently advanced.

It was our view that the forfeiture clause constituted a penalty clause in terms of the Conventional Penalties Act 15 of 1962, which, as such, was subject to reduction in terms of its s 3. Moreover, we did not agree that it was established on a balance of probabilities that the claimant in each case 'acted with fraudulent intent'. From the documentation it would appear that the claimant acted in concert with an agent of the insurer. Furthermore, there was nothing in the documentation to indicate that the claimant was aware of the provisions of the policy relating to the maximum entering age under the policy concerned. As we stated in our letter to the insurer:

> 'To establish fraud it had to be shown that the proposer, knowing that the life assured was too old to qualify for cover, deliberately misstated his age so as to be able to claim on the policy in the event of his death. The complainant in this case, as proposer, expressly denied that he was aware of the eligibility requirement in the policy. According to him the application form was completed by your agent to whom he handed the life assured's identity document from which the correct age was apparent. There is no evidence from the agent to contradict this version.
>
> 'This is not, therefore, speculation, as you suggest; it is an express allegation made by the complainant which remains uncontradicted by the other party to the transaction. If one has to speculate it is whether the agent himself would have stood to gain (e.g. by way of commission) from inserting the wrong details on this and other similar application forms.

11.6 A misdescription of the relationship of the life assured to the policyholder may amount to a misrepresentation, entitling the insurer to repudiate liability if a claim should be made in respect of such a person. But if the misdescribed person nevertheless falls within the designated class of 'lives assured', it may well be held that the misrepresentation was not material.[72]

> 'The onus is on the insurer to establish fraud. You appear to assume that simply because the complainant was aware of the age of the life assured therefore "the only reasonable conclusion is that the deceased (sic) acted with fraudulent intent in trying to mislead the insurer regarding his age at inception". In the absence of proof of knowledge of the eligibility requirement in the policy, an inference of fraud cannot be made.'

The insurer was accordingly asked to estimate how much of the total of the premiums paid could fairly be allocated to costs and expenses incurred by the insurer in respect of the cover for the deceased and any other specified factors it would regard as relevant for that purpose.
The insurer made such a calculation and paid the balance to the claimant. The Office had no reason to query the calculation and accordingly accepted the result.

[72] The point is well illustrated by a recent case dealt with by this Office (and mentioned in the *Annual Report 2004* op cit note 3 at 45). The class in that case included both 'son' and 'foster child', but not grandchildren. The policyholder included her grandson in her application form for insurance in the extended list of 'lives assured', but she wrongly described him as her 'son'. She duly paid the premiums and when he died, she claimed on the policy. Her claim was repudiated on the ground that it was fraudulent. She explained that she in fact looked after the child after her daughter had abandoned him in her care. 'We black people take a grandchild as ours if the mother is not married', she explained. De facto he was a 'foster child'. He therefore qualified as a 'life assured'. The misrepresentation (that he was her son), even if deliberately made, was accordingly not material. The claim was upheld. See too *Strydom v Certain Underwriting Members* 2000 (2) SA 482 (W). This may be compared to a case where the life assured was wrongly described as the policyholder's biological mother. The insurer alleged that this description was untrue and that she was in fact someone who merely raised the policyholder and who, thus, did not fall within the category of permitted 'lives assured'. See, too, the website under CR 136.

11.7 A misdescription of the age of the life assured may, but will not necessarily, be fatal to a claim.[73]

Beneficiary Nominations

12.1 As stated earlier,[74] a nominated beneficiary, is the third party under a contract in favour of a third party, whose claim is separate from and superior to that of the policyholder or his insolvent or deceased estate.

12.2 Depending on the terms of the policy, a beneficiary nomination is normally revocable by the policyholder.[75] It becomes payable on the death of the life assured. It follows that:

(*i*) the policyholder may revoke it at any time prior to his death;[76]

(*ii*) an acceptance of the benefit by the nominated beneficiary will only become enforceable after the policyholder's death; and

(*iii*) any revocation by the policyholder of the nomination during his lifetime will either pre-empt or override the nominated beneficiary's acceptance of the nomination.

12.3 When it comes to beneficiary nominations for proceeds,[77] there is a distinction between the following situations:

(*i*) Where the nominated beneficiary in fact never existed. In that event the nomination fails and the benefit would devolve on the policyholder's estate.[78]

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73 See the *Annual Report 2004* op cit note 3 at 27-8. As to the effect of s 59 (2) of the Act on the case where the age of a life assured's who qualified for cover, was incorrectly stated, see our website under CR 87.

74 See par 5.2 above.

75 See Nienaber op cit note 36 in par 17.1. Absent any prescribed formalities, the revocation may be by conduct. A claim on the policy by the policyholder or his cessionary may be construed as a revocation by conduct.

76 Cf *Warricker v Liberty Life Association of Africa Ltd* 2003 (6) SA 272 (W) at 278F-J.

77 See par 5.2 above.

78 See our website under CR 86.

(*ii*) Where the nominated beneficiary is deceased or his whereabouts cannot be traced. If the beneficiary predeceased the life assured, the benefit would fall into the policyholder's estate. Where he survived the life assured but died subsequently, the benefit would fall into his estate provided the executor accepted it.[79] If the beneficiary cannot be traced or his existence is disputed, the insurer, to be on the safe side, should keep matters in abeyance until the beneficiary surfaces to claim the benefit or prescription overtakes the insurer's liability to pay out on the policy.[80]
(*iii*) Where the beneficiary nomination is timeously revoked[81] or the benefit has not been accepted by the beneficiary. In that event the nomination has failed and the benefit would devolve on the policyholder or his estate.

Proof of Claims

13.1 The burden rests on a claimant for payment under a policy to prove on a balance of probabilities that:

(*i*) the qualifying conditions for payment of a benefit in terms of the policy have been fulfilled;
(*ii*) the deceased in respect of whom the claim is made was in fact a designated life assured; and
(*iii*) that he is otherwise entitled to payment, be it in terms of the policy or in terms of a later transaction such as cession.

13.2 Claims are sometimes rejected because the document submitted in support does not reflect the names appearing on the application form. In the market in which funeral insurers operate, this is not an infrequent occurrence, compounded by the fact that the

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79 See *Mutual Life Insurance Company of New York v Hotz* 1911 AD 556. For a different view, see Susan Scott 'Begunstigingsaanwysings en Sessie in Lewensversekeringskontrakte' 2002 *Tydskrif vir die Suid-Afrikaanse Reg* 766.

80 This is precisely what happened in two recent cases reported in the *Annual Report 2004* op cit note 3 at 48. The policyholder nominated his son whose date of birth was described as 18 Dec 1997. The policyholder's family did not know that he had taken out a policy and it was only on discovering deductions from his payslips, that they contacted the insurer and discovered the beneficiary nomination. The family was also unaware of, and in fact denied, the existence of the son. The identity of the mother was unknown and neither mother nor son could be traced. Faced with this difficulty, we recommended that the proceeds be paid either into the Guardian's Fund or into a suspense account until the uncertainty was cleared up. This the insurer undertook to do. In a comparable case the policyholder professed to nominate his sister as the beneficiary. When he died, his parents denied the existence of any such sister. The insurer made its own enquiries and could not trace her. It decided to pay out to the policyholder's estate. By making such a payment, the insurer acted at its peril. However, the risk may be discounted if payment is made against an indemnity from the payee to restore the status quo if the beneficiary should ever appear to make a claim. Whether this would be a feasible solution in every case, would depend on the facts.

81 See par 5.2 above and the *Annual Report 2004* op cit note 3 at 46-8.

data of the Department of Home Affairs are not always incorruptible. Our Office has on occasion been able to assist complainants by suggesting that they obtain additional documentation showing that the deceased was in fact the life assured in terms of the application form.

13.3 Some recent cases turned on a standard provision of policies that cover for children only extended to age 21 or, if the child should happen to be a full-time student at a recognised institution, to age 25. In the one case the child died when he was 24 years old. The burden was accordingly on the complainant to show that the child was a full-time student at the time of his death. Since such proof could not be furnished, the complaint could not be upheld. In the other case the child died 10 days after his 21st birthday, but the insurer was persuaded to make an ex gratia payment.[82]

13.4 The burden is on the complainant to prove that the deceased in respect of whom a claim is made, was in fact the designated life assured. We have had several complaints of this nature.[83]

13.5 Where a policy provides for the payment of benefits for a 'still-born child', the burden rests on the complainant to show that the deceased child conformed to the contractual definition of 'still-born child'.[84]

13.6 A frequently recurring problem is this: Who is to be accorded precedence when a policyholder nominates 'my wife' as the beneficiary on the death of his child as the life assured and the policyholder is alive when the child dies? Is his claim superior to that of his 'wife'? Or if the policyholder ostensibly has more than one wife, for instance where there was a divorce and the policyholder remarried or where he married the one spouse in a civil ceremony and the other according to customary rites? The answer to each of these conundrums[85] must, of course, be sought in the terms of the policy. The difficulty is that the terms of the policy may be either silent or ambiguous on the issue. If the policy supports only one claim on the death of the life assured, it can become a matter of 'first come, first serve', to the dissatisfaction of the latecomer. It may well be said that in failing to make adequate provision for the practical needs of the communities in which they operate, insurers fail their policyholders. In one such case, at least, the insurer eventually agreed to pay the legal spouse, having already paid the common-law wife, since it was unclear to which wife its terms referred.

13.7 In all the cases mentioned above, payment was effected by the insurer to the wife before the complaint reached the Ombudsman Office. When payment had not yet been

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82 See our website under CR 95.

83 See our website under CR 25 and CR 84. In one case the complainant alleged that the discrepancies between the name on the policy and the name on the submitted death certificate were simply due to an earlier first name change by the deceased, but since the relevant dates of birth also differed we could not fault the insurer for declining the claim.

84 A recent complaint could not be upheld for that very reason. The child was still-born at 26 weeks whereas the policy defined that payment for a still-birth would only be made 'after the 28th week of pregnancy'. See our website under CR 27.

85 As discussed in the *Annual Report 2004* op cit note 3 at 42 and 45.

made, the insurer, on receiving an enquiry from the Office, finds itself in the position of a stakeholder faced with competing claims. In similar situations the office has advised the insurer that:

> (*I*) it would be unwise for it to effect payment to a spouse unless it had first canvassed the views of all the other potential claimants;
> (*ii*) when any claimant lodges a complaint with this Office, the consent of all the other potential claimants should be obtained permitting this Office to adjudicate the dispute as between all of them; (This would require from parties other than the complainant and the insurer a form of submission to the jurisdiction and orders of the Office. If such an agreement is reached, it would in effect amount to a procedure akin to interpleaded proceedings recognised by the rules of court.)
> (*iii*) the Office would thereupon make a ruling based on what the policy provided and on what it regards as fair and practical as between all the competing parties; and
> (*iv*) as far as the future is concerned, the insurer should redraft its provisions so as to cater explicitly and clearly for the ranking of claims in eventualities such as those described above.

Overinsurance

14.1 Another issue arising in this connection is 'overinsurance'.[86] The problem occurs when banks, in particular, sell funeral policies on behalf of insurers. In terms of such policies, extended members of a family may be covered. It often happens that one family member is covered in more than one policy with the same insurer. So, for instance, a person may be covered by both his brother and his son under different policies. Such policies may have a limitation on the total amount of cover that would be payable in respect of any one life assured. Other policies may limit claims to one per individual. Because names do not always correspond, it is only at claims stage that the insurer would realise that the life assured was covered for more than the restricted amount or individual. The practice by insurers in those cases is to pay out in full to the first of the claimants proving a claim and to refund to the other claimants whatever premiums may have been paid by them in respect of the other policy. This is often the cause for much dissatisfaction by policyholders.[87]

14.2 In a recent case, for instance, Mrs A included Mr A on her policy with company X on 20 June while Mr A's son included him on his policy with company X on 29 June. At the time of the second application, the details of the first policy had not yet been captured by company X and it accordingly did not trace the double insurance. When Mr A died, Mrs A claimed and was paid out in full, but when the son claimed his claim was

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86 See the *Annual Report 2003* op cit note 3 at 24.

87 The PCOF was critical, at its meeting of 7 Sept 2005, of the industry for accepting multiple premiums but declining multiple payments of benefits.

declined.[88]

[88] So, too, in another case, the deceased had taken out cover on her own life with company X. The complainant, her brother, had likewise included her as an extended family member on his policy with company X. Each was unaware of the cover taken out by the other. The brother's policy read: 'Restriction on membership. No individual may apply for membership of more than one policy, and X's liability in the event of a claim shall be limited to one claim/benefit per individual'. On the strength of that clause, payment having been made on the first policy to his sister's estate, the complainant's claim was declined. The complainant, however, maintained that he should have been advised by the insurer, when he applied for insurance, of his sister's cover. Company X responded that 'due to cost implications [the insurer] only validates the date of birth of main members in an attempt to prevent duplicate insurance. Where someone has been insured as a main member and an extended member, the duplication will not be traced. When the duplication is then realised at claim stage, a full refund of premiums is given on a duplicate policy.' We accepted the explanation in that particular case and confirmed the insurer's decision.
In another comparable case, the complainant took out cover for R5000 for his child. Such cover was effective until age 25. When the child was 22 years old, he took out cover himself for R15000 and named his father as a beneficiary. That policy provided, inter alia, that the insurer's total liability 'will not exceed the maximum sum insured per life insured as specified'. The child died at 24 years of age. The father claimed under both policies and was indignant when, having been paid R5000 under the first policy, he was only paid R10000 under the second. In the light of the express provisions of the policy, his complaint could not be upheld.

14.3 In some of these cases we were able to help.[89] Where it could not be shown that the complainant received the policy booklet containing the overinsurance provision and where there were no indications in the application form (or other material to which the complainant reasonably had access) alerting him to such a limitation, we have been able to persuade a particular insurer to make payment, even if only on an ex gratia basis. As a consequence of the problems experienced with overinsurance provisions, some insurers have changed their practices in this regard either by no longer including overinsurance clauses in policies, or by giving due prominence in the pre-policy material to the existence and effect of such a clause.[90]

Insurable Interest

15.1 A different variation on the same theme raises the issue of 'insurable interest' where the list of 'lives assured' is not, otherwise that in the case discussed above, closed. A policyholder may, for instance, take out a policy on a half-sister or, as in two recent cases, a step-child or a step-mother. As there is very real fraud in the market place, our Office looks at the public interest aspect and where we perceive that complainants have insured parties with whom they have no close familial relationship, and consequently where there is no insurable interest, we would not come to their assistance. But where there is a close familial relationship, for instance in the case of siblings, we would in most cases not permit the insurer to rely on the defence of a supposed lack of adequate insurable interest.[91]

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89 For an example of a case where the provisions of the policy could be interpreted in the complainant's favour, see our website under CR 93.

90 See the *Annual Report 2003* op cit note 3 at 25.

91 Idem at 24; the Annual Report 2004 op cit note 3 at 42-5; and our website under 'Papers and Presentations: Reinecke "Insurable Interest" '.

15.2 An issue which sometimes arises in this context is whether a child should be specified by name as a life assured in order to qualify as such. To put the question differently: If the policy caters for the policyholder's children to be lives assured and a single composite premium is charged for 'children', can the policyholder claim if a child of his dies without that child having been named as such in the application form? The answer to the question will of course depend on the interpretation of the terms of the policy concerned.[92] Insurers insist on the specification of a child's particulars as a precaution against ever burgeoning fraudulent claims, but if they fail to make their intention unambiguously clear, the interpretation may well go against them.

Exclusion Clauses

16.1 Policy documents sometimes contain exclusion clauses, not always adequately explained to the policyholder, which could invalidate or neutralise a claim. As stated earlier, funeral insurance is not normally underwritten.[93] Such policies are regularly marketed without the intervention of an intermediary and without knowledge by the insurer of an applicant's personal or medical history. To protect themselves against anti-selection[94] and undisclosed risks, insurers in this field frequently insist on contractual waiting periods and specific exclusion clauses.[95]

16.2 The issue is frequently not so much whether the excluded condition existed, but whether the applicant was or should reasonably have been aware of the particular exclusion and, if he was, whether he fully appreciated its significance.

16.3 Another issue which sometimes arises in this context, is the incidence of the burden of proof. It is well established law that the onus rests on the insurer if it wishes to invoke an exception. Attempts by some insurers to neutralise this rule by contractually reversing the onus, have on occasion been resisted by the Office on the grounds that such a reversal is so unusual as to require proof that the attention of the complainant was specifically directed to its existence. There is, nonetheless, no hard and fast rule. It all depends on the
particular circumstances of the particular case.[96]

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92 See too par 13 above.

93 See par 3.4 above.

94 Cf the *Annual Report 2004* op cit note 3 at 21.

95 See the *Annual Report 2003* op cit note 3 at 26.

96 The exclusion clause in one case (discussed in the *Annual Report 2004* op cit note 3 at 37) read as follows:

> 'The company will have no liability under the policy if any person, upon whose death a benefit is payable, dies by his own hand or as a result of any involvement in unlawful activities within two years of the issue date or the date of any reinstatement of the policy.'

The person who died was the policyholder's son. He was shot dead. The only evidence on file was a police report which stated: 'It is alleged that the deceased was with friends in a motor vehicle and they robbed one of the passengers of his belongings and on an attempt to stab the suspect

the suspect took out a firearm and shot him twice, he dies at the scene.' (By 'suspect' must be understood the person who was robbed and who, in resisting, shot the life assured.) As it happened, the life assured died more than two years after the date of issue but the insurer nevertheless raised a general question, whether the principle that no one is permitted to profit from his own unlawful conduct should not preclude a claim on the policy. The matter was discussed at a full meeting of adjudicators who held the view that:

(*I*) inasmuch as the claim fell outside the two year period stipulated in the clause, the insurer could not rely on it;

(*ii*) while the principle, that nobody should benefit from his own misdeed, applies generally, it does not apply in this particular instance:

> (*a*) because the claimant, as policyholder, was not a party to any alleged criminal or wrongful activity (cf *Weintraub & Weintraub v Josephs* 1964 (1) SA 750 (W) at 755);
>
> (*b*) any criminal activity on the part of the deceased was in any event not established as a matter of probability, and there was no realistic prospect that it would be established within the foreseeable future;

(*iii*) the claim should accordingly be met.

The insurer accepted the ruling and paid the claim with interest.

Waiting Periods

17.1 There is normally no waiting period in respect of benefits payable where the death of the life assured was due to accident, but, in the absence of underwriting, only if it was due to natural causes. The reason doubtless is that if a natural cause is known to exist, imminent death may well be predictable while accident, if it is a true one, never is. The absence of a waiting period would thus encourage the possibility of anti-selection. During a contractual waiting period, the policyholder is obliged to make payment but enjoys no cover in respect of the excluded risk. Even so, waiting periods as such are not unreasonable; they are a necessary counterweight to balance the absence of underwriting. But the period during which premiums are paid while no cover exists, may be unreasonable. This is a matter on which the Office would sometimes venture to express a view. It is all a matter of refining the balance between the extent of risk and the affordability of premiums. The more confined the risk, the more modest the premiums.[97]

17.2 Does a contractual waiting period have any bearing on a possible defence of non-disclosure? Take this imaginary example: Mr A is aware that he has cancer. He deliberately does not disclose it to the insurer when he applies for funeral cover. He joins the scheme with a 12-month waiting period. Assume that he dies within 12 months of his application being accepted. His estate would have no claim. If, on the other hand, he dies after 12 months, his estate would have a claim, unless the insurer is entitled to repudiate liability on the basis of non-disclosure generally or because of a particular exclusion clause relating to cancer. By not insisting on underwriting,[98] the insurer, regardless of any waiting period, in effect waives any defence of material non-disclosure which might otherwise have been available to him. In the absence of an exclusion clause, the claim would have to be paid.

17.3 One of the problems with waiting periods is to determine when they commence. In one case the complainant paid his first premium for April on 2 March when he applied for cover. Since premiums were payable in advance, the policy was only issued to him on 1 April with a six-month waiting period which expired on 30 September. The life assured, unhappily for the complainant, died during September. The complainant, the policyholder, maintained that by then he had paid premiums for six months and that the waiting period had accordingly expired. The complaint could not be upheld since the waiting period commenced on the contractual commencement date and was not predicated on the number of premiums paid. His premium for October was repaid to him. It would doubtless have been a different situation if the contract had provided that the waiting period was to commence on the date of receipt of the first premium after acceptance of the application by the insurer, as some policies do provide.

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97 See the *Annual Report 2003* op cit note 3 at 26.

98 See par 10 above.

17.4 Once a policy, having lapsed for non-payment of premiums, is reinstated, the waiting period is restored.[99] We have nevertheless on occasion been able to assist a complainant on equitable grounds when the policy lapsed due to unforeseen circumstances not attributable to the complainant and death occurred during the revived waiting period.

Payment of Premiums

18.1 As stated earlier, premiums in this section of the market are often modest and benefits commensurately moderate. Being modest, the premiums are frequently collected in person and in cash since not all policyholders are possessed of bank accounts. So, too, not all policyholders, trusting as they sometimes are, insist on or retain written receipts issued in respect of such payments. The door for chicanery and fraud is thus wide open.[100]

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99 In a recent case the policy provided:

> 'Should premiums not be paid within 30 days of the premium due date, the following will apply: ... If the policy has not acquired a cash value, the policy will lapse and all benefits will fall away.'

The life assured died on 30 May. At that point the premium for May was in arrears by more than the contractual period of grace of 30 days. On 1 Jun, the premiums for May and June were paid by the policyholder and the insurer, unaware of the death of the life assured, reinstated the policy. When the insurer, at the claim stage, discovered that the life assured had actually died on 30 May, the claim was correctly rejected. Not only had the policy lapsed, but even if it had not the reinstated waiting period would have precluded any claim.

100 We recently had a case in point (discussed in the Annual Report 2004 op cit note 3 at 44). Liability was declined by the insurer, when a claim was instituted because of the death of a child of the policyholder, because the policyholder was alleged not to have been a member 'in good standing' of the fund concerned at the time his child died. The policy booklet, possession of which was retained by the agent acting on behalf of the administrator, provided that benefits would only be paid to policyholders in 'good standing' which was defined as being policyholders not in arrears with the payment of premiums. The insurer stated that the policyholder, some months previously, had made short and late payments and that he had never made up the shortfall. The agent nevertheless continued to collect payments in person for which he issued receipts which were pasted into the policy booklet. Receipts bore out the insurer's defence that some payments had been short and late and that the shortfall had never been made up. The policyholder, again, alleged that all payments were duly made, in full and on time, and that the receipts which the agent had pasted into the booklet were inaccurate and intended to create a false image. There was thus a clear dispute of fact. Although the probabilities might well have favoured the insurer, we upheld the complaint because, notwithstanding numerous invitations to do so, the insurer consistently and without excuse failed to produce any evidence from the agent to counteract the say-so of the policyholder.

18.2 Premiums are normally required to be paid in advance. A policyholder is covered only for as long as premiums are being paid. Strictly speaking, the moment a policyholder is in arrears with the payment of his premiums, his claim for payment may be resisted.[101] In terms of the Long-term Insurance Act, however, insured are granted a period of grace of 15 days to purge any default.[102] The cover will accordingly continue for that period even if the relevant premium is in arrears. If at the end of the period, a premium is not paid, the policy, if it so provides, will automatically lapse but may be reinstated if the arrears are paid within a given further period.[103] Once that period has expired, no unilateral reinstatement can be made and all the benefits of the policy will be lost since a funeral policy, unlike a typical life policy, commonly has no surrender value. Policyholders sometimes think that their funeral policies are savings schemes. They may be mistaken.[104] If premiums consistently remain unpaid, there is little the Office can or should do to assist recalcitrant policyholders.[105]

18.3 The provision that premiums are to be paid within a given period, is inserted in the contract primarily in the interest and for the benefit of the insurer. The insurer may

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101 With the so-called exceptio non adimpleti contractus. A contract of funeral insurance is not a true bilateral (synallagmatic) contract but a unilateral one, which is to say that while continued payment of premiums is a precondition for a claim by the insured of the benefits, the contract will not support a claim by the insurer in a court of law for payment of arrear premiums. See Reinecke, Van der Merwe, Van Niekerk & Havenga op cit note 5 in pars 121-3, 250-1 and 325-8.

102 Section 52. Insurers generally allow 30 days.

103 See our website under CR 103 and CR 104.

104 Cf Shone op cit note 5 at 21 and 33.

105 In one matter the Office was able to achieve some relief for the complainant. It transpired that: Mrs A took out a policy with company X in 1991 with herself and her husband as the lives assured; she was only given a membership certificate which cross-referenced to the main contract which, however, remained in company X's position; the premiums on the policy were paid by her husband, Mr A, by way of debit order deductions on his banking account; when Mrs A died in 2003, a claim was made on the policy and duly met; and when, some eight months later, Mr A also died payment, was, however, refused on the grounds that payment of premiums had ceased after Mrs A's death and that the policy had accordingly lapsed.
On enquiry from our Office, company X stated that it was incumbent on a spouse, on the death of the main member, to apply for a continuation of the policy and to ensure that premiums continued to be regularly paid, failing which, as in fact happened, so it maintained, the policy would lapse. We engaged with company X on the basis that the policy did not terminate automatically once payment was made on the death of the main member and that the non-payment of premiums was due to company X's unilateral decision not to collect payments on the debit order. Nor was Mr A's estate informed, in terms of s 52 of the Act, that payments on the policy were in arrears and that there was no provision in the membership certificate or, for that matter, in the main contract, obliging the spouse of the main member to re-apply for the continuation of the policy on the latter's death.
This gave rise to a vigorous exchange of views between the Office and company X which eventually culminated in a decision on the part of company X to make a full payment on the policy to Mr A's estate, albeit on an ex gratia basis. We accepted that solution and closed our file. See too par 5.2 above.

enforce it but may also decide to waive compliance. The waiver may be express or by conduct. The conduct may consist of the regular acceptance over a prolonged period of accumulated late payments. Such conduct, even if not intended as a waiver, may be treated as such if the insured would reasonably have been justified in believing, on the strength of the insurer's past conduct, that the latter did not insist on strict and prompt payment and that arrear payments could accordingly be remitted even after the lapse of several months. The insurer's past pattern of conduct, in consistently accepting late payments without objection or caution, could thus be raised by the insured as a replication to the insurer's defence to the insured's claim to a benefit under the policy that the policy had lapsed for non or late payment of premiums.

Late Claims by Policyholders

19 Insurance contracts commonly contain clauses requiring claims for the payment of benefits to be made within a given period of the claim arising. In the view of the Office, such clauses are not in themselves objectionable and will normally be enforced.[106]

Payment of Benefits

20 Many policies promise that payment will be made within 48 hours of the claim being submitted. When this does not happen, because the insurer, for instance, insists on better proof, it places the family of the deceased in an untenable financial position, causing great hardship. When we consider claims that have not been paid within the promised time period, we review the reasonableness of the insurer's request for additional

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106 One exception would be when the period stated is patently unreasonable. This office, unlike a court of law, enjoys equity jurisdiction and would thus be able to intervene in such a case (see, in general, *Napier NO v Van Schalkwyk* 2004 (3) SA 425 (W) at 444). So, too, if fairness to both parties requires that the Office should exercise its equity jurisdiction in favour of the complainant. In that event the complaint would thereafter have to be considered on its merits. In balancing the equities, the circumstances relating to *both* parties are to be taken into account. So, it would be a compelling factor that it would be difficult for an insurer, because of the long delay, to properly consider all the relevant facts surrounding the claim. Other relevant circumstances to be taken into account would include circumstances such as the following:
(*I*) that the complainant was only fractionally late; conversely, the longer and more unreasonable the delay, the less inclined the Office would be to come to the assistance of the complainant;
(*ii*) that the insurer was made aware within the time limit that the complainant seriously intended to claim but the prescribed formalities for lodging such a claim were only complied with after the prescribed period had elapsed;
(*iii*) that the complainant was not to blame for the delay in prosecuting the claim; conversely, if the complainant was lax or unable to explain the cause for his delay;
(*iv*) that where the delay was largely due to the insurer itself, for instance, in not having its own prescribed claim forms available; or if its agent's advice misled the complainant as to the necessity of lodging a claim in due form; or if the insurer, to the knowledge of the complainant, in the past never insisted on strict compliance; or where the insurer, departs from its own past practice and policy in allowing dispensations for late claims; and
(*v*) that the insurer was not significantly prejudiced by receiving the claim after the prescribed period had elapsed.

information causing the delay in payment. If found to be unreasonable, this may be a cause for awarding compensation in terms of the Ombudsman's Rules[107]. But because the claims are usually not large, compensation may be relatively modest. In addition, interest will be ordered on late payments either at the legal rate when mora is established or, if not, on the basis as agreed between the Ombudsman's office and the LOA.[108]

Conclusion

21 The funeral insurance market can be treacherous. Margins are small, premiums are low, operators are many, competition is fierce, and various participants insist on a share of the premium pie. It is not easy to find ready solutions for all the problems that occur on the ground. Some of the excesses in the industry are currently the subject matter of further investigation and debate. Studies by the FSB, the LOA and the FinMark Trust may in due course point a way forward. The Financial Advisory and Intermediary Services Act, moreover, might, in the long run, ensure greater control and regulation within this area of the market. In the meantime the Office of the Ombudsman for Long-term Insurance helps wherever and whenever, in fairness to both parties concerned, it can.

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107 Rule 3.2.5.

108 See the *Annual Report 2004* op cit note 3 at 18-19. See too our website under CR 32.