CASE 1

Income Disability claim – impact of termination of scheme membership

BACKGROUND

1. The complainant was employed at Hollard Life Assurance Ltd ("Hollard") as a risk manager in the Group Benefits Division.

2. In May 2004 the complainant suffered a stroke, although this diagnosis has been subsequently queried because the MRI scan was not conclusive. She instituted a dread disease claim in July 2004, which was paid by Hollard. She recovered and continued to work but during this time there were symptoms, according to her, of impaired concentration, memory loss, irritability and depression.

3. In June 2006 she instituted a claim against Hollard in terms of an income disability scheme to which she belonged by reason of her employment with Hollard and to which Hollard (as her employer) contributed premiums on her behalf.

   In the claim form submitted in June 2006 the complainant mentioned the following problems; "Strokes, causing Short-term memory problems, Depression / anxiety and Thyroid".

   She mentioned that she needed to be reminded to do things, that the handling of finances were handed over to her husband and that she needed supervision for cooking and required assistance when driving to avoid getting lost. Several medical reports were submitted in respect of the claim. A medical legal report was provided by a psychologist, dated 23 May 2006, and reports by her treating physician as well as a report by a psychiatrist confirming that he treated the complainant for major depression from September 2006 were submitted during this time.

   From the reports it transpired that the complainant had experienced work related problems and that her employment was in "jeopardy".

4. The definition of disability in the rules of the scheme reads as follows:

   "10.1 ***Disability definition***

   HOLLARD LIFE will regard a MEMBER as having become disabled if, prior to the attainment of RETIREMENT AGE, due to an injury, illness or a disease, he is totally prevented from following his own occupation or a similar occupation for which he is suited having regard to his ability, training, education and experience, provided that:

   10.1.1 The claim must be notified to HOLLARD LIFE in writing (together with all other documents and evidence as

required by HOLLARD LIFE) within 6 months from date of the injury or the onset of manifestation of the illness or disease, failing which the claim shall not be admitted……."

5. A claim was admitted for the disability benefit following the waiting period under the policy, for the period from October 2006 up to 31 December 2006, with a reassessment after that date. The insurer requested further medical reports, inter alia from a neuropsychologist and an up to date report from the treating physician for the reassessment. After the reassessment the benefit was terminated by letter dated 20 April 2007. On 24 April 2007 the employer sent a letter instructing the complainant to return to work on 2 May 2007, which she did not do on the basis that she was disabled.

6. Hollard had terminated the benefit on the basis that the complainant was not disabled as defined. It stated that the reassessment of the claim took into consideration all the medical evidence provided by the complainant as well as reports received in respect of independent evaluations that were performed by an occupational therapist, a psychiatrist and a clinical neuropsychologist. There were suggestions in these reports that the complainant was malingering. The insurer acknowledged that there was a degree of impairment but stated that "the objective findings overall were not considered to be compatible with the definition of total disability for the performance of her own occupation as required by the policy terms".

7. Meetings were subsequently held between the complainant and Hollard in an attempt to come to some agreement but these were not successful. At the meetings there were allegations that the complainant might be working at the engineering firm where her husband was employed but these allegations were not pursued.

8. The complainant's husband, who was mandated by her, then complained to this office about the fact that the benefit had been terminated. Initially the complaint focused on the question of whether the complainant was disabled as defined. After investigation and an evaluation of the documentation on file a provisional determination was issued by this office in which the decision of the insurer that the complainant was not disabled as defined, was upheld.

9. In accordance with the office's normal procedure the complainant was given the opportunity of providing further information and further arguments to persuade the office to change its provisional ruling. The complainant duly did so and provided more medical information including a recent MRI brain scan and a psychiatric report dated 27 May 2008, as well as further arguments in support of her claim.

10. The further reports were considered by this office, and also sent to the insurer, and were also sent to two medical consultants by the office for their opinion. These opinions were submitted to the insurer for a re-evaluation.

    The medical consultants had expressed the opinion that the claim should be reconsidered in the light of the psychiatric report which confirmed that the complainant's major depressive disorder was refractory to treatment and

rendered her disabled. The same psychiatrist had been seeing her since 26 September 2006 and had "booked her off" work for the duration of the claim period up to December 2008.

11. Hollard's response

Hollard stated that the cover in respect of the complainant had terminated in terms of the scheme as no premiums had been received from the complainant from May 2007. Membership ceased immediately on premiums not being paid in terms of section 2.6.5. of the Rules which states:

> *"2.6 MEMBERSHIP ceases immediately upon the earlier of:*
> *……*
> *2.6.5 premiums not being paid."*

12. Hollard, therefore, was of the opinion that it was unable to review the claim for what it termed the new medical condition of depression which according to it had not formed part of the original claim for disability. According to the insurer this was not recurrent disability as set out in section 12.3 of the Rules, which reads:

> *"**12.3 Recurrent disability***
>
> *After payment of the SUM ASSURED has ceased, repayment of the SUM ASSURED will commence automatically with no WAITING PERIOD, if:*
>
> *(a) the MEMBER becomes disabled again within 90 days of the cessation of his previous claim, and*
>
> *(b) HOLLARD LIFE deems both the current and earlier disability to have resulted from the same cause."*

13. The waiting period which applied to any new claim would mean that the "new" claim fell outside the period when the complainant was covered. (Hollard stated it was a 6 month waiting period but the Rule on file states 3 months).

14. Hollard advised that although the complainant was still in service of her employer she was on unpaid leave and as a result of that no contributions were paid by the employer (as would normally happen) in respect of the income disability scheme.

According to Hollard the complainant had been advised that she would therefore herself be responsible for the premiums to the scheme. She had not paid the premiums. Hollard relied on the letter sent by the employer to the complainant, care of her attorney, as proof that the complainant had been advised that she should pay the premiums in order to remain covered.

The letter stated:

> *"……..*

Furthermore, I refer to our letter dated 31 May 2007 in which you were informed that your client is currently on unpaid leave. Her benefits were frozen with immediate effect and we have not been making any payment on your client's behalf to the medical aid and provident fund. Should your client wish to keep her membership with the fund and medical aid active, she is required to make the necessary monthly payments out of her own pocket.

The amount needed for the provident fund is R966,94; and the medical aid amount is R4393,00 per month. These payments must reach our account by the 25th of every month to be included in our payment. If we do not receive it as at the 25th of every month we will suspend her membership."

15. Hollard therefore made the point that the major depressive disorder and/or mental disorder which was referred to by her treating physician in the most recent report was unrelated to the original claim submitted by the complainant and constituted a new claim which could not be considered owing to the lapse of her membership of the scheme.

16. According to Hollard the original claim submitted by the complainant was based on her "CVA and Short Term Memory Impairment" and that although she reported in her claim form that one of the symptoms of the stroke was depression/anxiety, the depression itself was not the foundation of the claim.

17. Provisional ruling

Our office made a provisional ruling on this aspect in favour of the complainant stating that the insurer could not rely on the fact that the complainant's cover under the policy had terminated as the insurer's reliance on the letter quoted above did not assist. The letter did not mention the fact that the complainant was responsible for paying premiums towards the income disability scheme.

The fact the letter only referred to the provident fund and the medical aid scheme could not be read to include the contributions that were required for the income disability scheme.

18. The insurer did not accept the provisional determination and stated that the complainant and her husband were aware of the fact that she was on unpaid leave and that she had to make contributions out of her own pocket in respect of the income disability scheme.

The insurer advised that it did not agree with the office's interpretation of the letter in question and that as the complainant was fully aware of the workings of the risk policy she would be familiar with processes and would have understood that a provident fund contribution "would include all insurance premiums".

The insurer attached copies of the complainant's letter of appointment and relied on these to be read in conjunction with the letter of April 2007, which it

stated would have informed the complainant of her obligation to pay the premiums for the income disability scheme to receive continued cover.

The office then had to make a final determination.

19. Determination and reasons

The issue for decision at this stage is not the validity of her disability claim but a preliminary question of whether the complainant was covered under the policy as at 27 May 2008 when the new medical evidence was presented. The matter was discussed at an adjudicators' meeting.

20. The employer and the insurer in this particular case are not at arm's length as it is in fact the insurer that employs the complainant. The blurring of the different roles is even more pronounced because the complainant was employed in the Group Risk Department. Furthermore given the relationship between the employer and the insurer the letter written by the employer to the complainant care of her attorney, would not have been sent without the knowledge of the insurer.

The letter clearly refers only to the complainant's obligation to contribute the R966,94 in respect of the contributions to the provident fund. No mention is made of the income disability premiums. Given the fact that the complainant had started receiving a benefit in terms of the income disability scheme one would have expected Hollard to specifically mention the contributions in respect of the particular scheme, as the claim was still in contention at the time when the letter was sent out to the attorney.

21. Having looked at the salary slip of the complainant, the letter of appointment and/or other documentation relating to her benefits, the adjudicators' meeting was of the opinion that it would not have been clear to the complainant that the R966,94 was in respect of the income disability scheme premiums when it specifically mentioned the provident fund as the recipient of the premium. In the view of the meeting the letter was not clear in this regard and without specific reference to the need to contribute the premiums in respect of the disability benefit, Hollard could not have expected the complainant to know that in the circumstances she was required to assume the obligation to pay the premium, the more so because only the provident fund and the medical aid scheme were specifically mentioned.

22. It may well have been the intention of the writer of the letter to convey this requirement but it was not clearly expressed. In the circumstances the complainant could therefore not be expected to have realised the need for continuing to pay premiums herself, particularly because the termination of other benefits was mentioned but not of the income disability benefits.

23. Given her circumstances, if the complainant had understood the letter to have referred to income disability premiums one would have expected that the necessity for paying the premiums would have been so obvious that she would have complied with the obligation. It was reasonable for her to have expected her membership of the income disability scheme to have

continued as this was never mentioned in any correspondence to her by Hollard.

24. We wish to point out that in terms of our equity jurisdiction we cannot uphold Hollard's argument. In a situation such as this where the complainant had already lodged a claim and was still in the employ of the employer and was disputing the right of the insurer to terminate the benefits, it would simply not be fair/equitable to terminate membership of the scheme on the basis that premiums were not received, without first making this fact known to the member in very clear terms, so that there could be no doubt, that there was an obligation on the complainant to pay the premiums.

25. It is therefore our final determination that the insurer cannot rely on the non-payment of the premiums to terminate the cover for income disability benefits as the complainant had not been informed of the need to pay such premiums.

26. In addition Hollard's argument that the depression/anxiety was a new cause for a claim which only arose after the cover was "terminated", is not convincing. It is clear from the original claim form that the cause for the claim is far more broadly stated than the insurer had interpreted it to be. It would require very narrow reading of the claim form to interpret it in the manner that the insurer has done. In any event it has not been shown that the original medical problem in 2004 and in 2006 was not the start of the complainant's problems with depression and the anxiety.

    In our view the vascular part of the diagnosis (whether a stroke or otherwise) co-existed with the depression from the time the claim arose. The complainant had been under treatment of a psychiatrist throughout the period, had been hospitalised and received psychotherapy. It could not be said that depression was not part of the claim in June 2006. It was not a "new" claim as suggested by Hollard.

27. Hollard is therefore instructed to assess the claim on the basis of all medical information submitted including the medical information in support of a claim based on depression/anxiety and including information submitted after 30 April 2007. Hollard is to assess the claim within 30 days of the date of this determination and then revert to this office with its reasoned evaluation of the complainant's disability.

JP
15/04/2009