Case 24: Credit life claim; submission of documents to assess claim

Credit life claim; claim declined as documents and information outstanding; insurer alleged it could not assess if there had been non-disclosure; found that complainant submitted adequate information for disability claim to be assessed

A. Background

1. The deceased purchased a vehicle through a finance bank and took out an Auto Settlement policy, which commenced on 28 March 2008.
2. He passed away on 18 October 2008. In terms of medical reports he passed away as a result of peritonitis and septicaemia.
3. On 20 November 2008, his wife, who is the complainant in this matter, visited the dealership to lodge a claim for the settlement of the vehicle. She produced a number of documents in support of the claim.
4. On 23 March 2009 the insurer's assessor, dealing with the matter, requested the dealership to obtain and submit further documents.
5. On 21 April 2009 the claim was considered not taken up by the insurer due to the documents not being submitted. There was no further contact with the deceased's wife.
6. In October 2014 the Sheriff of the town successfully served the complainant with a Warrant for the Delivery of Goods to the bank, showing that the relevant Magistrates' Court had ordered the re-possession of the vehicle on 8 June 2010.
7. The complainant alleged that the dealership had indicated to her that the claim had been settled. The insurer holds that neither the bank or the dealership, through which it dealt, could trace the complainant from 2009, regardless of efforts; the outstanding documents were never submitted and therefore the claim could not be properly assessed.
8. When the vehicle was re-possessed and the complainant's claim for the benefit was not approved by Bidvest Life, she submitted a complaint to this office.

B. Provisional determination

9. The matter was submitted to an adjudicators' meeting, the Ombudsman presiding, and subsequently a provisional determination dated 18 January 2016 was issued, upholding the complaint, on the following basis:
    - The complainant had submitted the following documents:
        - Death certificate showing the deceased died of natural causes;
        - Notices of death, Form B1 1163 (this shows that the cause of death was peritonitis, the onset being days before death) and the other significant condition contributing to the death is renal dysfunction, the onset being days before death);
        - Completed claim form;
        - Identity documents of the deceased and the complainant;
        - Customary marriage certificate;
        - Funeral receipt ;
        - Letter dated 7 July 2015 from the family doctor, stating that the deceased never consulted him;
        - Sick leave record from 24/3/2005 to 6/8/2008 - this shows that the deceased had taken 32 days sick leave over a period of 3 years and 4 ½ months- the reasons are not stipulated;
        - Netcare document dated 23 June 2015 indicating that records were no longer in its possession;

- Letter dated 7 October 2008 from Specialists Diagnostic Radiologists indicating chronic peritonitis;
- Medical attendant's certificate in which the doctor states that the deceased passed away as a result of peritonitis and septicaemia, of which the deceased became aware of on 3 October 2008 (about 2 weeks before his death). He adds that the deceased was immunodeficient and death was due directly/indirectly/partially attributable to AIDS/HIV infection.

- The insurer held that the deceased had signed the following mandatory declaration, but there was evidence that he did not disclose his HIV status at application and the insurer had therefore asked for his full medical file and clinical records:

  *"*I am aware that I am not covered for any claim arising out of any injury, disease, or illness which is, in the opinion of the ** (another insurer), related to a previous injury, diseases or illness for which I received medical treatment or advice at any time during the 18 (eighteen) months prior to becoming policyholder."

- The meeting's view was that adequate documents were submitted for the insurer to reasonably assess the claim. The deceased may have had a pre-existing condition but there was no evidence that he had received treatment or advice at any time during the 18 months' period prior to becoming a policyholder, as required in terms of the above declaration.
- The cause of death had been advised by a medical practitioner and there was confirmation that the deceased had only become aware of the condition that caused the death days prior to the date of death.
- Bidvest Life had not proven non-disclosure or the applicability of the exclusion to which the declaration refers.

10. The meeting upheld the complaint and asked the insurer to consider the claim on the documents provided.

C. The insurer's response to the provisional determination:

11. The insurer agreed to assess the claim and subsequently made a settlement offer to pay R40 000.00 of R102 462.53, being the amount due as at the date of loss, provided by the finance bank, and it referred to the following policy provision:

    "Death of the Life/Lives assured
    Payment in a single sum of the outstanding liability under the credit agreement, not exceeding the sum assured and excluding arrear instalments and arrear finance charges."

12. Furthermore, the insurer pointed out the following special condition, set out in the policy:

    "3. no additional debits, arrear instalments or interest thereon is covered."

13. Bidvest Life submitted a detailed statement showing transactions from 28 March 2008 to 11 February 2015, on which date the capital balance amount is shown as R156 292.24. This amount includes costs, such as legal fees, re-possession costs, storage fees at vendor, service fees and interest and also bad debt

amounts written off. The insurer added that given the circumstances and the facts of this matter, R40 000.00 was an equitable offer in final settlement as the complainant should be apportioned some blame to her failure to follow up on this matter over an extended period of time; she had not submitted requested documents and had placed the insurer in a position that the claim could not be properly assessed, while there had been evidence that pointed to non-disclosure of the deceased suffering from HIV at application.

D. The complainant's response to the offer of R40 000.00

14. The offer was rejected by the complainant on similar grounds raised earlier. The complainant's attorneys noted that the outstanding liability to the finance bank had amounted to R321 243.70. It is not clear how this amount had been calculated.

E. Final determination

15. At the adjudicators' meeting held on 29 April 2016, the Deputy Ombudsman presiding, the meeting came to the following unanimous decision:
    - As the insurer had agreed to pay the claim, the only outstanding issue was the amount that is should pay, its offer of approximately 40% of the liability or R40 000, having been rejected by the complainant.
    - The complainant had a responsibility to make enquiries with the insurer about the status of the claim instead of relying on the dealership's alleged oral confirmation that it was settled. She had not produced any evidence of confirmation that the claim had been settled.
    - The complainant is not entitled to the amount of R321 243.70 that she is claiming as the extent of the insurer's liability is provided in the policy provisions, and which are set out in paragraphs 11 and 12 above.
    - According to the insurer their outstanding liability at the date of the event was R102 462.53.
    - The insurer is to make such appropriate arrangements to make payment of the amount of R102 462.53 which may have to be paid to the Estate of the deceased, in view of the vehicle having been re-possessed by the finance bank.

16. The determination was final and Bidvest Life was instructed to comply with this determination within 30 days from the date of this determination.

G: Outcome

17. Bidvest Life paid the amount of R102 462.53 to the Estate of the deceased.

NvC
31 August 2016