CR226

Late submission of claim /Interpretation of contract

Background

The complainant approached our office when two separate claims under two separate policies were declined by the insurer due to late submission.

The policies commenced in October 2002 and August 2003 respectively and made provision for Permanent Total Disablement benefits due to accident. In November 2004 the complainant injured himself when he fell from a ladder. At the time his back felt a bit stiff and it deteriorated as the weeks passed.

In December 2004, he consulted his doctor who prescribed traction. He was also referred for an MRI scan in January 2005. Medical reports revealed degenerative discs in the lower back region.

The policies contained an accident plan providing that a benefit would be paid if the insured person "*sustains injury which, solely and independently of any physical defect or infirmity existing prior to the accident, results within 12 months of the date of the accident in an insured event as stated in the Table of Benefits*".

It was only on 19 January 2006 that the complainant completed claim forms in which he alleged that there was an accident, and that he had sustained an injury which resulted in the occurrence of the insured event "Permanent Total Disablement".

When the claims were declined due to late submission the matter was referred to us for consideration.

Discussion

The late submission clause, which was common to both policies provided:

"*The claim form and all supporting documentation as may be requested will be supplied at Your own expense, and must be received by Us within 180 days of the Accident*."

In his initial letter the complainant explained that he informed the insurer that he delayed submitting his claim because his doctors told him that he had a 50-50 chance of recovery and he wanted to be sure of his disability before claiming payment for it.

Having reviewed the information at our disposal, we were of the view that there were two aspects to the complainant's claim. Firstly, were the claims submitted late and secondly, and if not, did the complainant qualify in terms of the Permanent Total Disablement benefits?

In our view the claim was not submitted late. The contracts defined Permanent Total Disablement to mean:

> "*total and absolute disablement which entirely prevents an insured person from engaging in or giving attention to gainful occupation of any and every kind. The diagnosis and determination of the permanent total disablement must be made by a physician and must be continuous and permanent for at least 24 consecutive months from the onset of the disablement. Documented evidence of the incident that caused the permanent total disablement is required.*
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> *The degree of permanent total disablement will be determined immediately after it is established or as soon as it can reasonably be assumed that there will be no further improvement or worsening of the insured person's condition in consequence of the accident, but not later than 24 months from the date of loss."*

We were of the opinion that the definition in this particular insured event could not be determined to have occurred until 24 months had passed, as the disablement must be continuous and permanent for at least 24 months from the onset before the requirements of the definition of the insured event "permanent total disablement" have been met.

This was at odds with the requirement of the clause that "*the claim form and all supporting documentation as may be requested … must be received by us within 180 days of the accident*".

In other words, there was an inconsistency or ambiguity in the policy wording, which results in an absurdity: to comply with the 180 day clause a policyholder would have to submit a claim for an insured event which by definition cannot yet have occurred.

The *contra proferentem* rule, whereby a contractual provision is construed against the contracting party (the insurer) by which or on behalf of which it was formulated, would be the appropriate principle to apply to resolve the ambiguity. In this case this would mean interpreting the policy to mean that a claim for the insured event "permanent total disablement" would have to be lodged within 180 days of the alleged occurrence of the event as defined. On this interpretation of the policy the claim would not have been lodged late.

However, even if one assumed that the claims were lodged timeously, medical reports submitted by the complainant did not suggest that the requirements for liability by the insurer to pay the benefits were met. As his condition was degenerative it clearly was a physical defect or infirmity which existed prior to his accident. The fall was therefore not the sole and independent cause of the insured event. Even if the accident might have made his condition worse, the degenerative condition which preceded the fall also contributed to the alleged condition of permanent total disablement.

Result

We shared our view with both parties that there was no documented evidence of the incident that caused the permanent total disablement; that there was no evidence that the complainant's disabling condition was so "*total and absolute*" that he was entirely prevented "from engaging in or giving attention to gainful occupation of *any and every kind".* Furthermore, medical reports suggested that there were still treatment options envisaged and therefore a question mark over the permanence the complainant's condition. Both parties were given an opportunity to respond, neither did so and we proceeded to close our file.

DCW
May 2007