10 things you should know about life assurance

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Most of us who insure against death, disease or disability expect that, as long as we pay our premiums, we will be paid out promptly if disaster strikes. But, as the complaints that reach the ombudsman testify, life (assurance) is not that simple. We look at what you can do to avoid falling foul of the "terms and conditions".

The world of long-term insurance can be an Alice in Wonderland place where a heart attack may not be a heart attack and where a woman who donates a kidney to save her brother's life has to fight for her benefits because the assurance company views her bodily damage as self-inflicted.

The good news is that the life assurance industry has been repeatedly challenged and is slowly changing its ways, resulting in better products and service.

First prize is for you, the insured, to have your claims settled speedily and in full. If this doesn't happen, you can take any complaint to the office of the Ombudsman for Long-term Insurance, which mediates between life assurers and their policyholders to resolve disputes.

To help you understand your rights and responsibilities, and the reach and limits of the ombudsman's office when it comes to funeral cover and insurance against death, dread disease and occupational disability, here are 10 things you need to know. This article doesn't deal with investment products that fall in the life assurance category; these are beyond the scope of this article – and beyond this writer's expertise.

1. Justice

For the past decade, the office of the Ombudsman for Long-term Insurance has been obliged, when considering a complaint brought before it, to overlook the letter of an insurance contract if, by rigidly enforcing the contract, the result would be unjust.

In 2007, Judge Brian Galgut, the ombudsman, wrote in his annual report that what these greater powers are intended to achieve "is simply that justice is done".

There have been many problems with the conduct of assurers that have abused credit life policies, taken advantage of vulnerable buyers of funeral cover, given poor service and exploited technicalities to avoid paying out what is due to policyholders.

Consumer dissatisfaction with this sort of conduct is reflected in the number of cases brought to the ombudsman every year. Galgut's office received almost 8 000 complaints in 2007, and Galgut said in an interview in February that the number rose last year, although the actual figures had not been released at the time of going to press.

But if some consumers see equity as a blank cheque to be negligent when dealing with their assurer – or even to cheat – they will be disappointed. Assurers have rights, such as the right to know what risk they are taking when they grant you cover.

Galgut says in the 2007 annual report that he has little space to apply equity or to see that justice is done if "a provision that might otherwise be considered unfair is intentionally and clearly stipulated in a policy" (and you have accepted the provision by signing the contract).

In addition, "it is as necessary and important to take account of equitable features favourable to the insurer as it is of those that favour the insured; a proper balance must … be struck between them".

2. Failure to disclose

The practice by assurers of rejecting claims because policyholders did not disclose all the information required of them when they applied for cover is one of the main causes of policyholder resentment, Galgut says in the 2007 report.

Resentment arises because in many cases you, as a policyholder, do not intend to deceive, but the assurer is still entitled to rely on non-disclosure as a defence because misrepresentation distorts the assurer's assessment of risk.

Galgut writes: "An applicant for assurance is not expected to disclose a fact of which he was not aware; but he is expected to disclose a fact of which he was aware even if he did not appreciate its full significance for the insurer – provided that a reasonable person in his position would have appreciated its materiality for the insurer in assessing the risk."

In the case of life assurance, risk often revolves around medical conditions, although it also involves factors such as lifestyle and occupation.

Here are three tips on disclosure gleaned from cases reported by the ombudsman:

- Medical questions in application forms for assurance refer to the presence of symptoms, not whether you have received treatment for a condition, so do not report only conditions for which you have received treatment;
- Disclose a visit to a specialist, even if there was just one visit and the visit did not seem to lead to further treatment; and
- Use your common sense and knowledge of what information an underwriter needs in order to accurately assess risk.

In 2003, the annual report took the position that if a condition was not material to the claim (for example, if a person failed to disclose a heart condition but died in a motor vehicle accident), the assurer was still entitled to repudiate the claim and cancel the contract. The following year, the annual report concluded: "This can be unduly harsh."

The thinking now is that it is fair to reconstruct policies in cases where the non-disclosure was not intentional. Galgut describes reconstruction in this way in the 2007 annual report: "If the insurer concedes that, had it known the truth at the time, it would still have entered into the contract but on different terms, for example, with an exclusion clause or loaded premiums, why not reconstruct the policy along those lines and keep it alive?"

Some assurers have adopted this practice.

Galgut said in an interview in February: "There are moves afoot to consider amending legislation to provide for cases of unintentional non-disclosure where the non-disclosure has nothing to do with the claim – for example, non-disclosure of a heart condition and a claim related to a vehicle accident."

He would not be drawn on providing more details.

There are instances where the duty to disclose is curtailed, and in these cases an assurer can't use the defence of non-disclosure to avoid paying out a claim. The duty may be curtailed when:

- Specific questions in an insurance proposal document lead you to believe that all you have to do is answer the questions in order to make full disclosure; and
- You leave questions incomplete and/or you give clearly inadequate answers and the assurer does not come back to ask you for more details.

Is it enough?
How do you know whether you have satisfied your duty to disclose? The disclosure rule is "satisfied if the assured discloses sufficient to call the attention of the insurers in such manner that they can see that if they require further information they ought to ask for it", Peet Nienaber wrote in the 2003 annual report. Nienaber, who was the ombudsman at the time of the report, was quoting from *MacGillivray on Insurance Law* (seventh edition).

3. Update your details
Galgut points out that the duty to disclose does not end with your application for cover. "If after the application is completed but before the commencement of the cover you, for example, go for medical treatment or investigation, or you develop some relevant health condition, it is your duty to disclose it to the insurer," he says.

Once your cover is in place, you still need to keep your life assurer up to speed on certain changes to your circumstances.

Galgut says: "In order to ensure that the policy stays current, check its details regularly, at least every year. As a regular exercise, make sure that the insurer has your correct address and check whether your beneficiary nominations reflect your wishes."

You should also update your details after a life-changing event (such as divorce) and if your risk profile changes because of actions that are in your control. For example, if you were a non-smoker when you took out cover but you began or resumed smoking at some point after cover was in place, you need to tell your assurer of this immediately. If you plan to do a spot of high-altitude rock climbing or skydiving while on holiday, you should tell your assurer and, if necessary, get your premiums adjusted.

Even if you keep your assurer informed, you may still have to fight for your rights.

In the case of the kidney donor mentioned above, Galgut said in his interview with *Personal Finance* magazine that the woman checked with her assurer before undergoing the procedure. The company accepted that the woman was the only available compatible match and that her brother's life was in danger. Nonetheless, when the reckoning came, her life assurer denied her claim under a policy for sick pay benefits because her "injury" was self-inflicted. The ombudsman agreed with the assurer that the law allowed it to do so, but in this case, equity trumped law. The assurer was prevailed on to pay.

You do not have to update your assurer about medical conditions and symptoms that you develop after your cover has begun. The assurer has to rely on the answers you provide at the application stage in order to assess your long-term health prospects. Obviously, you would have to disclose the new information if you stopped one policy and took out another.

"Any action on a policy has a consequence," the ombudsman warns. "Check which options are available and obtain advice before making any changes. If you replace a policy, be aware of any negative consequences, such as exclusions, which may apply to a new policy as your health may have deteriorated over time."

Insurance such as disability cover is typically long-term, so you are not forced by the conditions of the policy to terminate it. Funeral insurance is usually term insurance, which means it expires at the end of an agreed term. The problem is that as you get older and sicker, the less likely you are to have your policy renewed, or the more expensive it becomes to renew.

Galgut cautioned that if you have occupational disability cover and if the policy stipulates it, you may have to inform the life assurance company when you change occupations.

The 2003 annual report gives the case of a woman who indicated in her application for insurance that she was an "administration official: 100 percent administration". When she submitted her disability claim, her occupation was indicated as a "marketing consultant: 20 percent administration; 10 percent manual; and 70 percent travel".

The assurer declined to pay out on the basis that it had not been informed of the change in her occupation, which affected the risk that it was asked to undertake. The assurer said had it been aware of the change, different terms would have been offered to the policyholder. The ombudsman upheld the assurer's decision.

4. Exclusions
When one-size-fits-all assurance is sold, such as funeral insurance and group risk policies, the assurer does not always ask you specific questions in order to calculate the risk. In other words, it does not underwrite the policy in the sense of varying the premiums according to the risk that each policyholder poses as an individual. Instead, the assurer manages the risk by using waiting periods and exclusions.

There is normally no waiting period for benefits that arise from an accident. But for cover that is not underwritten, such as funeral cover, there will be a waiting period for death from natural causes.

If an assurer repudiates a claim on the grounds of an exclusion clause, it must show that it has grounds to do so. In other words, the company must show a causal link between the excluded circumstance (for example, a medical condition) and the insured event (for example, disability).

A man took out a life policy that would pay R10 000 when he died, and another R10 000 if he died accidentally. But there was a clause that the policy would not pay out if death resulted from "purposeful and wilful exposure to unnecessary danger". The man was killed when he was hit by a car while crossing a country road. The assurer denied liability on the grounds that the exclusion applied.

The ombudsman's office, using a comparable case from the Supreme Court of Appeal, felt that the man's exposure to danger was not of the day-to-day sort, and that the assurer had to prove that the policyholder's conduct was perverse and obstinate. The assurer couldn't prove this, and the ombudsman ruled that the accident benefit had to be paid.

5. Pre-existing conditions
Another defence that life assurers rely on when refusing a claim is the existence of pre-existing conditions. These are physical or mental conditions that existed before you took out insurance cover.

A common condition such as high blood pressure can lead to the repudiation of a claim for a number of events, such as a heart attack or a stroke.

Judge Peet Nienaber, who was the ombudsman from 2003 to 2007, says in the 2006 annual report that exclusion clauses that are unambiguously worded "are not inherently bad", but then he adds that they also "raise the abiding problem of 'underwriting at claim stage', which in effect means casting around for reasons not to pay claims".

He goes on to say: "In fact, if the life insured suffers from any serious medical condition, such policies may in effect provide little more than

accident cover."

This point was repeated in the office's written submission to the 2007 commission of inquiry into credit life insurance. The office also told the commission that, among other things, it was concerned about "sometimes excessively wide exclusion and pre-existing clauses effectively neutralising the extent of cover".

It said a common complaint is that exclusion clauses are not properly explained when cover is offered or applied for. This appears to be aggravated by the trend towards direct marketing, when cover is offered over the phone.

6. Burden of proof
This may be surprising, but a heart attack may not be a heart attack when assurers need to pay up for dread disease cover.

Nienaber says in the 2003 annual report: "Dread disease contracts usually stipulate that the three criteria needed to substantiate a diagnosis of a heart attack are an episode of chest pain consistent with cardiac pain, new electro-cardiographic (ECG) changes and elevation of cardiac enzymes."

In one case, a complainant said he was admitted to hospital with severe chest pain. At the hospital, the heart attack was confirmed by the presence of elevated enzymes and the ECG, but when the time came to claim, the ECG proof could not be produced.

The assurer repudiated liability on the grounds that only two of the qualifying criteria were present. The ombudsman says the case presented "unusually compelling clinical and enzymatic evidence of severe myocardial infarction without any alternative diagnosis. As a result, the insurance company agreed to pay the claim."

Make sure you know what proof is required, especially when you take out cover for dread disease and income protection.

However, as noted in Exclusions (point 4), if an assurer wants to rely on an exclusion clause, the onus is normally on the assurer to prove that it is entitled to do so. The assurer has to obtain the medical evidence that it wants to rely on.

Alcohol aggravates risk, and provisions relating to alcohol consumption are often found in life contracts, usually in the form of exclusions. As stated earlier, exclusions apply when the assurance company is able to establish a causal link – in this case between the consumption of alcohol and the insurable event, such as disability.

This can be difficult, so some assurers opt to write into their contracts a "temporal requirement". Typically, the wording would appear in a contract something like this: "The benefit shall not come into operation where death or bodily harm arises directly or indirectly or is traceable to an act of the insured while the alcohol content of his or her blood is 0.05g or more per 100ml."

Note that temporal requirements do not relieve the life assurance company of the need to establish a cause-effect relationship between the insured person's actions (for example, drinking alcohol) and the insured event (for example, death). The clause just makes it easier to do so.

7. Insurable interest
If you've ever flicked through a pamphlet advertising funeral insurance, you may have noticed that the range of people you can cover on one policy is quite large: you can buy benefits for your parents and children as well as yourself and your spouse and possibly for other relations as well. How wide does the net spread? In other words, whose interests can be considered insurable by you?

In the Middle Ages, insurance was only for indemnity purposes. It covered the insurance-taker for loss or damage if he could prove he had a financial interest in the insurable event, because "there could be no loss without an interest". This is according to an article by Professor Giel Reinecke, one of the assistant ombudsmen. The article, entitled "Insurable Interest", can be found on the ombudsman's website (www.ombud.co.za).

Later, the English courts decided that it did not matter if the interest fell away after the insurance agreement was concluded. (So at this point the distinction between indemnity and non-indemnity insurance was introduced). Important aspects of English law have become entrenched in South African law, including rules on insurable interest. This means you can insure a person who is connected to you in some way, but that person does not have to be a blood relative. So you can insure the life of your former husband, or your mother in law, but in these cases the payment of your claim may depend on your being able to prove that bonds of affection exist, otherwise it could be construed as if you plan to benefit financially from that person's death.

The ombudsman's 2006 annual report covers the case of a complainant who was granted life cover for his wife but some time afterwards the couple divorced. After his ex-wife died, the man felt obliged to cover the cost of her funeral.

The assurer rejected his claim for death benefits on the grounds that its cover for her stopped when the couple divorced. Its reasoning was that the divorce terminated any insurable interest that existed between the insured man and his (former) wife.

The ombudsman says that line of reasoning works for indemnity insurance, whose purpose is to compensate for loss or damage.

But life assurance is non-indemnity insurance.

Insurable interest has to be in place only when you take out insurance, not when the claimable event takes place, unless your policy states as much.

So if you are divorced and you want to keep your former spouse's benefits in place, you will be okay on the insurance front as long as there is some indication that ties of affection and care continue to exist.

You, of course, have an interest in your own life and that of your spouse (by either a civil or a customary marriage). Among other examples of interests that can be considered insurable are your:
- "Putative" spouse (the person generally considered to be your spouse);
n Cohabiting partner; and
- Parents.

You also have an interest in the following, but you need to show that bonds of affection exist:

- Your children (your ties of affection would be confirmed by the provision of support);
- Your fiancé/fiancée;
- Family members, such as siblings, grandparents, grandchildren, stepchildren, foster parents, uncles and aunts, cousins, and nieces and nephews; and

- Parents in law and family in law.

Insurable interest extends beyond family ties. Employers have an interest in the life of employees (and vice versa). You also have an interest in the life of any person against whom you have a contractual or common law right of support. The interest may even extend "to any person who de facto maintains the insured", Reinecke says.

You have an insurable interest in the life of any person whom you reasonably expect to bury (whether or not it is a legal duty).

Reinecke says parties embroiled in litigation may need to insure the life of the presiding judge to protect them from financial loss and inconvenience if the judge were to die before the case was finished.

8. Timing
Once you have taken out cover, Galgut's advice is to make sure you obtain a copy of your policy and read it "to ensure that it reflects what you applied for and what you want. Make certain that you understand it."

There is a 30-day cooling-off period after you receive your policy or policy summary, during which time you can cancel your policy.

Make sure your premiums are paid on time every month. Regular, timely payments are your responsibility, even if they are made through a third party, for example, by means of a stop order or debit order.

If you fail to pay on time, the Long Term Insurance Act requires a grace period of 15 days during which time cover continues. (You may have longer, but that will depend on your policy.) After that point, the policy will lapse and no benefits will be paid.
You can reinstate a policy that has lapsed because of unpaid payments, but if there are waiting periods, these will kick in again.

In one case, a person – let's call him Mr M – missed two debit orders, and his funeral policy lapsed. Mr M applied for reinstatement and the waiting period started on February 1, 2006. Sadly, he died of natural causes on July 31, 2006, which meant it was still during the six-month waiting period, which would have expired at midnight. The life assurer was within its rights to refuse to pay the claim, and also refused to give effect to the ombudsman's request for an ex-gratia payment.

Your policies will probably have limits on how much time you have to submit a claim after the event. The ombudsman's website contains practice notes on late submissions. Practice notes are a rule of thumb to help guide the ombudsman's staff when making decisions on difficult cases. But the notes do not set precedent for the office – it still treats each case on its own merits. The value for consumers is that the notes are a useful insight into the thinking behind the decisions of the ombudsman.

The notes say some policies allow for exceptions to the late-submissions rule. They would contain language such as: "in the discretion of the insurer"; "unless special circumstances exist"; or "provided the insurer is not prejudiced thereby".

Some policies allow no leeway in the deadline for claims submissions. An example in a funeral policy would be: "Notice of the claim and supporting documents must be sent to the insurer within six months of the date of death."

The practice notes say that if your policy contains such a clause, then the ombudsman will, in principle, enforce the clause.

"The only exception will be if the circumstances of the case are such that fairness to both parties requires that the office should exercise its equity jurisdiction in favour of the complainant. In that event, the complaint would have to be considered on its merits.

"It is important, in considering the exercise of equity jurisdiction, that the circumstances relating to both parties are taken into account."

It will count in your favour if:

- The claim was only slightly late.
- You told the assurer, within the time limit, that you intended to claim. Only the formalities of lodging the claim were late.
- You were not to blame for the late submission.
- The delay was largely due to the assurer itself.
- The assurer was not significantly prejudiced by receiving the claim beyond the prescribed period.

9. Funeral insurance
About 15 percent of the complaints received by the ombudsman's office relate to funeral insurance. Poorer people in South Africa make much use of funeral policies, and the potential for exploitation and their difficulty in obtaining redress is of great concern to Galgut.

A life policy of R10 000 or less for each life assured is called an "assistance policy". There is no limit to the commissions that can be charged on an assistance policy, so administration, distribution and marketing costs on these policies may be high.

Some assistance policies provide for a funeral ser-vice as the benefit, but the policy must always give you the option to be paid money as an alternative to a funeral.

"The failure on the part of insurers to advise consumers of that option is one of several identifiable abuses encountered in practice," Nienaber and Deputy Ombudsman Jennifer Preiss write in an article entitled "Funeral Insurance" on the website.

If the funeral policy is of a non-indemnity nature, any shortfall between the cost of a funeral and the sum stipulated in the policy must be paid to the appropriate recipient, be it to the principal policyholder, to beneficiaries or to an estate.

In the case of an indemnity funeral policy, the administrator is not obliged to pay out any difference between the cost of a funeral and the sum stated on the funeral policy.

In the past, little-known or ill-understood conditions around over-insurance for funerals gave rise to consumer dissatisfaction, but assurers are now moving to avoid the worst situations.

Over-insurance occurs when you or a family member is covered by more than one policy. You may be covered by your own policy, and your daughter may also have you covered on her funeral policy. But some policies limit the total amount of cover payable to any one life assured, and others limit claims to one per person. Nienaber and Preiss say these conditions have been the cause of considerable dissatisfaction among consumers.

10. Service
The four largest life assurers in South Africa have 70 percent of market share but generate only about 31 percent of cases. This shows that a disproportionate number of complaints come from the clients of the smaller assurers.

The ombudsman is allowed to make a compensatory award of up to R20 000 regardless of whether the decision went in favour of the claimant. This is to compensate for unacceptable service from assurers. The ombudsman's office can also penalise assurers for any shoddy service the office experiences when pursuing claims, especially "unexplained delays or mediocre responses". The office charges assurers a standard rate per case, but when the matter is handled incompetently, the rate is doubled.

In one case, a man took out a policy telephonically. Among other things, the policy covered his wife and him for death as a result of an accident. His wife died from unnatural causes the following year, but the claim was repudiated because debit orders were never paid. The assurer had captured the policyholder's bank details incorrectly, but the policyholder never picked up the lack of deductions because he had more than one policy with the assurer.

The ombudsman's office decided that it was the man's responsibility to check the deductions were correct, so it had to uphold the repudiation. But the assurer was at fault for capturing the bank details incorrectly and should have notified the client that the debit order had been returned. The ombudsman's office found that the assurer should pay R10 000 in compensation for its poor administration.

Stay-out-of-trouble quick guide
Judge Brian Galgut, the Ombudsman for Long-term Insurance, has some advice for you in the light of common mistakes he has come across since he took up his post:

- Read every document before you sign it. By signing a document you represent to its reader that you accept responsibility for its contents even if someone else, such as an intermediary, completes the document on your behalf. You may be held responsible for inaccurate or incomplete assertions in it, or for omissions.
- Make sure that the intermediary you are dealing with is licensed in terms of the Financial Advisory and Intermediary Services Act. You can check whether a financial services provider is registered with the Financial Services Board (FSB) by calling the call centre on 0800 110 443 or by checking on its website (www.fsb.co.za). You can also check to see whether he or she is registered to sell the sort of product you are being sold.
- Make sure that your intermediary does a risk and needs analysis to find out what you require before you consider which product to buy. It may be helpful to shop around before deciding on a product, but remember that an assurer also has the right to decline your application.
- Know which company is underwriting your policy. (This is particularly important for funeral policies, which are often administered and sold by third-party funeral administrators, not insurers.)
- Tell your family where you keep your life assurance documents. It may become vital in the event of your death, because time-barring provisions may affect your ability to claim.