



Case law update – Insurance benefits

This update discusses several recent determinations/judgements that have an impact on pension funds in respect of insurance benefits.

A. A v Liberty Life – Ombudsman for Long Term Insurance: Late submission of claims

Mr A was employed as a machine operator for 14 years. He was diagnosed with severe peripheral neuropathy which led to him having to stop working in July 2012. Mr A's employer requested that the company's occupational health doctor assess him to determine the extent of his illness. The doctor recommended that Mr A should apply for 6 months of temporary disability through the Unemployment Insurance Fund (UIF). Mr A claimed from the UIF for a period of 3 months between September and November 2012. In December 2012, the doctor assessed Mr A again and found that there was no sign of improvement in his health and that Mr A should actually be considered for a permanent disability benefit.

The employer submitted Mr A's claim on 3 May 2013. Liberty Life (the insurer), in terms of the disability policy that was issued, stated that a claim must be submitted within 3 months from the date of the disability which was considered to be the date on which the member had stopped his normal occupation due to the disability. The insurer used July 2012 as the date of disability for purposes of this claim and was of the view that the claim was submitted six months after the period that was prescribed in the disability policy. On the grounds of late submission, the insurer repudiated the claim. Mr A was not happy with that decision and decided to lodge a complaint with the Ombudsman for Long Term Insurance (the ombud).

The ombud found that although the insurer had a contractual right to repudiate the claim due to late submission, the ombud can in certain circumstances request the insurer to accept a claim that was contrary to the contractual provision. In making such a decision, the ombud had to consider the explanation for the delay, the degree of lateness, the prospects of success and whether there will be any prejudice to the insurer.

Mr A's employer stated that they never expected 31 July 2012 to be Mr A's last day of service. At the time, Mr A's illness was not regarded as a disability claim, and that was why nothing was submitted to the insurer. As soon as the doctor made the recommendation that Mr A be considered for permanent disability, the employer started the claims process. The insurer stated that they would be significantly prejudiced if they were required to honour the claim. However, they never gave a clear explanation to support that statement.

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In his provisional determination, the ombud found that the late submission should be condoned and that the insurer should be required to process the claim. The insurer did not accept the provisional determination. They claimed that the employer did not provide reasons for the late submission until August 2014 when the complaint was lodged. They also mentioned that the employer had previously submitted two claims that were outside of the claim period and that they clearly informed the employer that future claims would not be accepted if they were submitted outside the claim period.

The ombud made it clear that the fact that the employer never gave any reasons to the insurer at the time of the claim does not make the explanation that was now provided at the time of the complaint unreasonable. The employer's explanation was not that it was unaware of the submission period but rather that it did not expect Mr A's employment to stop on 31 July 2012. It was only once the doctor recommended that Mr A be entitled to permanent disability benefits that the employer started the claim process.

A blanket approach cannot be taken in this context. A 6 month delay in one set of circumstances may be excessive or unreasonable but in another set of circumstances it may not be. In the absence of any proven prejudice to the insurer and taking into account the reasons provided for the delay and the degree of lateness, the ombud ruled that on the grounds of equity, the insurer should honour the claim.

The complaint was successful.

Approach adopted by FundsAtWork

The FundsAtWork Lump Sum Disability benefit policy says that the employer must notify and submit all documents relating to the claim to FundsAtWork within 3 months from the date that the member was last at work attending to his normal duties. FundsAtWork however does not necessarily reject a claim if it is not submitted within 3 months. Each claim is considered on its own merits. However, FundsAtWork encourages the employer to notify FundsAtWork as early as possible so that the insurer can assist the employer and the member in getting all the documents and medical reports required for the submission of the claim, enabling the timeous submission of the claim.

B. Barker v Altrisk (Case number 23841/14): High Court – Non-payment of premiums

Mr Barker was a client of Altrisk (the insurer). In July 2009 Mr Barker took out a life and disability policy with the insurer. All premiums were payable in advance on the first day of the month as per the terms of the policy. The policy also made provision for a one month grace period within which to pay the premium. If the premium was still not paid within the grace period, the policy would lapse.

In 2012, the debit order for the policy premium did not go through. Mr Barker had signed a new debit order form which was presented to his bank. However, the debit order was linked to the wrong insurance policy and as such the premium did not go through. The insurer informed Mr Barker that his policy was in arrears. Mr Barker then made payment in respect of the arrears, but he used the wrong insurance policy number, so the payment was allocated incorrectly.

Due to non-payment of the premiums, the insurer ended the policy. They relied on section 52 of the Long Term Insurance Act (the Act). Mr Barker was not happy with the decision to end the policy and referred the matter to the Ombudsman for Long Term Insurance (the ombud). The ombud found in favour of the insurer. Mr Barker was still unhappy with the decision. He instituted action against the insurer on the basis that the manner in which the insurer implemented the terms of the policy was against public policy.

The court looked at the case of *Barkhuizen v Napier 2007 (5) SA 323 (CC)* where the test in deciding whether a time limit clause was contrary to public policy was discussed. It was a two-part test that was applied. First, an objective test was applied to the clause to assess its reasonableness or unreasonableness. In applying this test, the court found that the clause in the insurance policy was not against public policy as it was applied in terms of section 52 of the Act. If the clause survives the objective

test, a subjective test must then be applied to determine whether on the facts that were provided, the application of the clause was unconscionable.

The court stated that all statutes must be interpreted through the prism of the Constitution. The purpose of the grace period in section 52 of the Act was to allow Mr Barker a reasonable opportunity within the provisions of the insurance policy. The notice that was sent to Mr Barker should have made it clear when the grace period for the payment of the premium would come to an end. An insurer should not delay in giving notice of non-payment until more than one premium was in arrears. In this case, the insurer had delayed until the end of the grace period to inform Mr Barker, and in doing so negatively impacted on Mr Barker's ability to correct the arrears payment within the grace period.

Long term insurers must inform the insured at the earliest possible opportunity of the non-payment of a premium and the insured must be given a reasonable time to correct that non-payment. Insurers should also make sure that the insured is notified of every non-payment of a premium. Insurers are not allowed to delay giving notice of non-payment until more than one premium was in arrears.

The application was successful. The court set aside the lapsing of the policy on the grounds that the insurer never gave Mr Barker a reasonable time to correct the non-payment of the premium.

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