IN THE TRIBUNAL OF THE PENSION FUNDS ADJUDICATOR
HELD IN JOHANNESBURG

CASE NO: PFA/ WE/10369/2006/CN

In the complaint between:

FRANK FISH Complainant

and

ISCOR EMPLOYEES PROVIDENT FUND First Respondent

SANLAM LIFE INSURANCE LIMITED Second Respondent

DETERMINATION IN TERMS OF SECTION 30M OF THE PENSION FUNDS ACT NO 24 OF 1956 ("the Act")

INTRODUCTION

[1] This complaint concerns the amount of the lump sum disability benefit that was paid to a member of a fund, and essentially amounts to a challenge to the decision of an insurer that the member's disablement is partial rather than total.

The complaint was received by this office on 7 September 2006 and a letter acknowledging receipt thereof sent to the complainant on 23 October 2006. On the same date a letter was dispatched to the first respondent giving it until 24 November 2006 to file a response to the complaint. The response dated 21 November 2006 was received on 23 November 2006. On 22 August 2007 the second respondent was joined as a party to the proceedings in terms of section 30G(d) of the Act, and was requested to submit its response to the complaint by no later than 5 September 2007. An initial response was received on 31 August 2007, and a further response dealing with the merits was received on 20 September 2007. All the responses were forwarded to the complainant's legal representative for a reply, which was received on 9 October 2007.

[2] After considering the written submissions received, it is considered unnecessary to hold a hearing in this matter.

FACTUAL BACKGROUND

[3] On 29 January 2004 the complainant, a member of the first respondent since 1 December 2000, sustained an injury to his lower back while lifting a heavy metal object at work.

[4] His employer lodged a claim for a disability benefit with the first respondent on his behalf. Relying on the medical assessment conducted and reports submitted by among others Dr. Marais, the Libertas Rehabilitation Centre and Dr. GJ Vlok, an orthopaedic surgeon, the respondents concluded that the complainant was permanently disabled. Based on a medical incapacity assessment conducted by Dr. C De Beer on 22 June 2005, the second respondent came to the conclusion that although the complainant's

disablement was permanent, it did not render him totally incapable of carrying out his own occupation and any other occupation that he could reasonably be expected to follow.

[5] Having decided that the complainant was partially incapacitated and that the percentage of his disability was 20-40%, the second respondent paid the complainant a lump sum disability benefit in the sum of R10 266.00, which is equivalent to 0.50 (or 50%) of his annual remuneration of R20 532.00. In addition thereto, the first respondent paid him an amount of R7 818.50 in respect of his accumulated fund credit.

[6] Had the second respondent decided that the complainant was totally and permanently disabled, he would have become entitled to an amount equivalent to his fund credit, as well as an insured benefit of R51 840.00.

THE COMPLAINT

[7] The complainant is dissatisfied with the decision of the second respondent and contends that he is in fact entitled to the entire amount of the lump sum disability benefit.

THE RESPONSES

Point in limine

[8] The respondents, placing reliance on various previous determinations that were handed down by this Tribunal, among which are *Ndlovu v Frame Group Provident Fund & Others* [2003] 9 BPLR 5108 (PFA) (“the *Ndlovu* case”);

Adonis v Hortors Group Provident Fund & Others [2004] 4 BPLR 5612 (PFA) ("*Adonis*"), and *Hildebrand v Telkom Retirement Fund & Others* [2005] 5 BPLR 405 (PFA) ("the *Hildebrand* case"), submit that this Tribunal lacks jurisdiction over insurance companies and in respect of insurance policies.

[9] In elucidation, they submit that the board of trustees of the first respondent has assured the disability benefit with a long term insurer, namely, the second respondent, and that the benefit is therefore subject to the limitations imposed by the second respondent and its underwriting requirements as set out in the insurance policy underwriting the disability benefit.

[10] The respondents further state that while the rules state that both respondents have to be satisfied that the member is permanently disabled before he can qualify for a disability benefit, it is the second respondent which determines the degree or extent of such disablement. That being the case, so the argument goes, a dispute of this nature is one between the complainant and the second respondent *qua* insurer regarding the application of the provisions of the policy. Such a dispute, it is contended, is not a complaint against a pension fund organization and thus falls outside the jurisdiction of this Tribunal.

THE MERITS

[11] The respondents state that the second respondent investigated the complainant's claim, relying on the medical reports of Dr. Marais, Professor GJ Vlok and the Libertas Rehabilitation Centre, and found that the complainant was only 20%-40% disabled. It is stated that Clause 4 of the second respondent's policy on death and disability sets out a scale in terms of which the amount of the disability benefit is determined with reference to the

percentage of the member's disablement, and provides that where the member is 20% and more but less than 40% disabled, the benefit due to him will be an amount equivalent to 50% of his salary.

[12] The respondents further state that the complainant received an insured lump sum disability benefit from the second respondent in the sum of R10 266.00, which is equivalent to 50% of his annual remuneration of R20 532.00.

[13] They further submit that the second respondent's decision in this regard can only be set aside if, on the basis of the medical evidence that was placed before it, no reasonable person could have come to the conclusion that the complainant was 20%-40% disabled.

[14] The respondents conclude that Rule 10.5, which *inter alia* vests the fund with the right to reduce the member's benefits in the event of the insurer failing to pay the benefit to which a member is entitled to in terms of the rules, or of failing to pay it to the full extent that it has been insured, is not applicable in this instance. In explanation, they state that the said rule would come into operation in a situation where the insurer, because of some exclusion in the policy, pays less than the member is entitled to with reference to the degree of his disablement. In such a case, it is stated, the fund would be entitled to reduce (not increase) the benefit to the amount paid by the insurer.

DETERMINATION AND REASONS THEREFOR

Technical point

[15] The payment of the disability benefit in this case is governed by both the rules

of the first respondent and the policy of insurance in terms of the provisions of which the benefit is assured with the second respondent. Rule 10 governs the entitlement to and payment of a disability benefit, and it provides:

> "If a MEMBER who has not yet attained the NORMAL RETIREMENT AGE is permanently disabled and provided that satisfactory proof of such disability is submitted to the FUND and the INSURER, the following provisions shall apply:
>
> 10.1 **QUALIFICATION FOR DISABILITY BENEFIT**
>
> 10.1.1 Subject to the provisions of rules 10.4 and 10.5, if a MEMBER has, for an uninterrupted period of 26 (twenty-six) consecutive weeks, as a result of an injury, surgical operation or disease been prevented from carrying out his own occupation and any other occupation which the MEMBER could reasonably be expected to follow, taking into account his education, training, status, ability or experience and *provided that the TRUSTEES and the INSURER are satisfied that such disablement is permanent*, such MEMBER shall qualify to receive a disability benefit" (Emphasis added).

[16] Thus, the power to decide whether or not a member is permanently disabled as envisaged in the rules vests in both the first and second respondents.

[17] Of further significance is sub-rule 10.2, which provides as follows:

> "10.2 **AMOUNT OF DISABILITY BENEFIT**
>
> Subject to the provisions of rules 10.4 and 10.5 a lump sum benefit equal to a multiple of the MEMBER'S annual PENSIONABLE SALARY as at the date of his disablement shall become payable.

> *The amount of such benefit*, which shall be paid to the MEMBER in addition to the benefit in terms of rule 6.3, *shall be determined by the INSURER* by reference to the degree of the MEMBER'S disablement in accordance with the following scale:…" (Emphasis added).

[18] From the above-quoted rule it is clear that the extent of the member's disablement and thus the amount of the benefit due to him is determined by the second respondent. Another relevant provision is sub-rule 10.5, which provides as follows:

> "The FUND may insure the benefits set out in rule 10.2 with an INSURER of its choice on the basis and to the extent recommended by the ACTUARY. Should the INSURER for any reason, fail to pay the full benefit to which the MEMBER is entitled in terms of these rules or fail to pay the benefit in respect of a MEMBER to the full extent to which such benefit has been insured, the FUND shall have the right to reduce the MEMBER'S benefits; provided that the reduced benefits shall be at least equal to the amount paid to the FUND in respect of the MEMBER by the INSURER."

[19] While the sub-rule empowers the first respondent to insure the benefits set out in rule 10.2 with an insurer of its choice on the basis and to the extent recommended by the actuary, nowhere is it stated that in such an event the provisions of the insurance policy shall override those of the rules. Nor is it stated that the entitlement to the benefit will be subject to acceptance of the claim by the insurer and to the terms and conditions set out in the policy of insurance to the fund by the insurer.

[20] The respondents' submission that because the extent of the member's disablement and the amount of the benefit are determined by the second respondent, and also since the insured portion of the benefit is payable by the second respondent this Tribunal does not have jurisdiction over the matter,

cannot be sustained. This is because the member's entitlement to the disability benefit arises out of the provisions of the rules. The fact that the provisions of the policy are also applicable in determining the amount of the benefit payable does not detract from the fact that the entitlement to the benefit arises out of, and is governed by, the provisions of the rules. A complaint relating thereto thus relates to the application and/or interpretation of the rules of the first respondent.

[21] If the respondents' contention that this Tribunal does not have jurisdiction over the insurer in this instance were to be upheld, an anomalous situation would arise as a result of which a complaint challenging the decision of the fund and the insurer that a member is not permanently disabled would qualify as a complaint over which this Tribunal has jurisdiction only insofar as it relates to the fund's decision and not to the insurer's. A further anomaly would result if it is ruled that this Tribunal's jurisdiction extends only to complaints which challenge a decision taken in terms of rule 10.1 but not to those challenging a decision taken in terms of rule 10.2. Were that to be the case a member who has approached this Tribunal to challenge the repudiation of his claim on the grounds that he does not qualify for a disability benefit in terms of rule 10.1, and whose complaint has been upheld, would then have to go to the trouble of approaching a different forum if he wishes to challenge the insurer's decision taken in terms of rule 10.2. Such absurdities could not have been intended by the drafter of the rules.

[22] The rulings of my predecessors in previous determinations were not blanket rulings that this Tribunal has no jurisdiction over insurers, but were rather that within the context of those specific rulings, this Tribunal lacks jurisdiction. It is worth noting that this matter is distinguished from the *Ndlovu* case, *Adonis* and the *Hildebrand* case because in all three of those previous determinations the

relevant rule provisions contained clauses to the following effect: that "*the disability benefit is only payable on acceptance by the insurer of the disability claim"* (*Ndlovu*); that *"the entitlement to the disability benefit will be subject to acceptance of the claim by the insurer and to the terms and conditions set out in the policy of insurance to the fund by the insurer"* (*Adonis*) and that *"the said benefits shall be subject to the conditions imposed by the insurer concerned and each member shall only be entitled to the said benefits to the extent that he is accepted by the said insurer for such benefits"* (*Hildebrand*).

[23] In the result, the preliminary point cannot be upheld.

The merits

[24] As pointed out by the respondents, where a particular aspect in an insurance policy or rule provision is subject to an insurer's or the board's opinion as the case may be, the test to be employed is not whether or not the insurer's or board's opinion was wrong, but rather whether that opinion was both honestly held and one which a reasonable person could arrive at on the evidence (See *The Southern Life Association Ltd v Miller* [2005] 4 BPLR 281 (SCA) at [34]).

[25] I now turn to examine the evidence forming the basis of the second respondent's opinion that the complainant was not totally disabled, but was rather 20%-40% disabled.

[26] A medical incapacity evaluation was performed by Dr. C de Beer on behalf of the second respondent. In addition to conducting his own examination on the complainant, he apparently also used the reports of Dr. Marais (dated 14 September 2004), the Libertas Rehabilitation Centre (dated 1 September 2004) and Professor Vlok (dated 23 May 2005) during the assessment. No

copies of the reports of the first two specialists were furnished to this Tribunal, but summaries of the same are set out in Dr. de Beer's report. The former only mentions that the complainant had two back operations, as well as the medication that was prescribed for him.

[27] The latter sets out the areas of capability in which the complainant was assessed during a 15-day rehabilitation session and the findings made. In summary: the complainant was reportedly able to lift an object weighing 4kg, but with pain. He was able to carry a 10kg object for 30 metres before stopping. He reported experiencing pain while kneeling or crouching, but could alternate his legs while keeping the position. The complainant was able to stand for 60 minutes without using his crutch, and could climb 5 flights of stairs without using his crutch. He was able to walk 800 metres without using his crutch before reporting pain in his hip. The conclusion was that the complainant was not motivated to return to work.

[28] In Dr de Beer's report, the complainant's job title is set out as being a general labourer, and his job specifics as handling and sorting of scrap; loading and downloading of trucks; operating machines; cleaning the driveway; working in the garden; general cleaning of e.g. bathrooms, dining-rooms. Dr. de Beer observed that the complainant would not be able to do any heavy physical work, including work involving repetitive motions. Regarding his work capacity, he stated that based on the report from the rehabilitation centre, the complainant might struggle with compliance to rehabilitation programmes, and that there may also be an exaggeration of existing symptoms. He further expressed the opinion that the complainant had achieved significant improvement with only three weeks of rehabilitation, which, in his view, strongly indicated that the complainant could still improve if he complied with structured programmes.

[29] Regarding the complainant's disability, Dr de Beer opined that the complainant would have a marked impairment for heavy physical work and work that requires awkward spine positions and repetitive motions. However, he concluded that due to the inadequacy of information, he was unable to assess his real ability to work. He recommended that the claim be deferred pending the furnishing of further medical evidence.

[30] Professor GJ Vlok, an orthopedic surgeon, examined the complainant and compiled a report on 23 May 2005. His clinical findings were:

[31] At the time of the examination the complainant was using a crutch on the right side; and was walking with his right leg in slight external rotation, without the normal heel-toe step.

[32] His back movements were slow, sluggish and approximately 50% impaired.

[33] The straight leg-lifting exercise was 70° on the left side and 50° on the right.

[34] No abnormality was found in the motor system on both the left and right sides.

[35] There was a slight change in sensation in the L5 area on the right side.

[36] All reflexes were normal and present on both the left and right sides.

[37] There was full and pain-free movement of the hips to both sides.

[38] There was tenderness over the whole lumbar region.

[39] No other abnormalities were found.

[40] The diagnosis was chronic residual back and leg pain post-surgery, with possible arachnoiditis. The orthopaedic surgeon concluded that in light of a previous work evaluation that had been performed, where it had been opined that the complainant had poor work motivation, the chances of his returning to the labour market were virtually nil, especially in light of his being uneducated and being a labourer.

[41] He recommended that the complainant undergo intensive back rehabilitation, but expressed the opinion that he was not optimistic that a good prognosis would be achieved. He also concluded that the degree of the complainant's impairment was not more than 20%. After receiving Professor Vlok's report, Dr. de Beer made his final assessment on 22 June 2005, where he opined that the complainant had a partial disability, the extent of which was 20%-40%.

[42] The foregoing is the sum total of the medical evidence that was furnished to the second respondent, and the complainant did not furnish any other medical evidence to the second respondent supporting his contention that he is totally disabled. The question that this Tribunal must decide is whether, on the basis of the medical evidence that was before the second respondent at the time, its opinion that the complainant was only partially disabled was honestly held and one that a reasonable person in the second respondent's position would hold.

[43] On the available medical evidence, a reasonable person in the second respondent's position would also have come to the conclusion that the complainant was indeed partially disabled.

[44] In the result, the complaint cannot succeed.

ORDER

[45] In the instance, the complaint cannot succeed and it is hereby dismissed.

DATED AT JOHANNESBURG ON THIS 30TH DAY OF NOVEMBER 2010

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DR EM DE LA REY

ACTING PENSION FUNDS ADJUDICATOR

Appearances:

For the Complainant: Ms S Stelzner, of Messrs Edward Nathan Sonnenbergs Inc.

Both respondents not legally represented.

Cc: The Principal Officer
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