Dear Madam

DETERMINATION IN TERMS OF SECTION 30M OF THE PENSION FUNDS ACT, NO. 24 OF 1956 ("the Act"): S JOHNSON ("complainant") v OCEANA GROUP PROVIDENT FUND ("first respondent"), METROPOLITAN LIFE LIMITED ("second respondent") AND OCEANA BRANDS LIMITED ("third respondent")

[1] INTRODUCTION

1.1 This complaint concerns the repudiation of the complainant’s claim for a disability benefit by the respondents.

1.2 The complaint was received by this tribunal on 20 October 2008. On 25 November 2008 a letter acknowledging receipt of the complaint was sent to the complainant. On the same date a letter was sent to the second respondent requesting a response to the complaint by no later than 5 January 2009. A response dated 6 February 2009 was received from the second respondent. On 17 February 2009 a letter was sent to the...
complainant requesting her to submit a reply to the second respondent’s response by no later than 4 March 2009. On 6 November 2009 a letter was sent to the third respondent requesting a response to the complaint by no later than 26 November 2009. A response dated 14 December 2009, which was copied to the complainant, was received from the third respondent on 17 December 2009. No further submissions were received from the parties.

1.3 After considering all the written submissions, it is considered unnecessary to hold a hearing in this matter. The determination and reasons therefor appear below.

[2] BACKGROUND FACTS

2.1 The complainant became an employee of the third respondent from 9 October 2000 and by virtue of her employment became a member of the first respondent until she was dismissed on 16 September 2008. The first respondent paid the complainant’s withdrawal benefit subsequent to her exiting the third respondent.

[3] COMPLAINT

3.1 The complainant is aggrieved by the decision of the first respondent to repudiate her disability claim. The complainant contends that she had been injured on duty on 15 March 2007 and her final medical report was completed on 13 October 2008. She states that on 23 September 2008 she signed her retrenchment papers and a withdrawal form because of her medical condition and her inability to work, which necessitated therapy.

3.2 The complainant further states that she thereafter advised the second respondent to cancel the withdrawal claim and that she wished to be placed on a disability pension. She was advised that the third respondent had to submit the necessary documents. The third respondent refused to submit a disability claim on her behalf despite being aware of her injury.
RESPONSES

Second respondent

4.1 The second respondent filed a response in its capacity as the administrator of the first respondent. It advised that the complainant was retrenched by the third respondent for operational reasons and consequently her membership in the first respondent terminated. Upon her exit from the first respondent she was paid her full withdrawal benefit in terms of the rules.

4.2 The second respondent further states that the first respondent can only be in a position to consider payment of a disability benefit upon submission of a member’s disability claim. In this instance, there was no disability claim submitted in respect of the complainant prior to her withdrawal from the first respondent.

4.3 The second respondent advised that its investigations revealed that all medical specialists who examined the complainant concluded that the nature of her injury did not render her unable to work. For this reason, the employer had no basis to submit a disability claim on her behalf.

Third respondent

Point in limine

4.4 The third respondent submits that all members of the first respondent are eligible for a total and permanent disability benefit as provided for by the first respondent’s re-insurance policy with the second respondent. The schedule of benefits in the first respondent’s rules refers to the disability benefit as a ‘group insurance’ benefit and rule A6 reiterates that the disability benefit is as set out in the schedule. It is subject to the maxima as set out in the policy. In addition, Rule B2.5 makes it clear that insured benefits, such as the disability benefit, are regulated exclusively by the conditions of the insurance policy. This tribunal therefore lacks jurisdiction
to adjudicate the matter because the disability benefit is regulated by a separate insurance policy (see *Kaufman v Fidelity CMS Retirement Fund and Another* [2007] 3 BPLR 320 (PFA)).

**Merits**

4.5 The third respondent advised that subsequent to the complainant’s retrenchment she was presented with a withdrawal form for her signature in order to claim her withdrawal benefit from the first respondent. The complainant duly signed the withdrawal claim form on 22 September 2008 due to her retrenchment.

4.6 The third respondent further states that it received clinical reports from the Hout Bay Day Hospital (in relation to its prior treatment of the complainant), reports from a general practitioner, Dr. Burger, a neurosurgeon, Dr. Domingo, and an occupational therapist, Ms. Henwood, regarding the complainant’s medical condition subsequent to the alleged injury. From the abovementioned reports the following was evident:

- The complainant claimed to have first injured her back at work in November 2003, but the Workman’s Compensation Commissioner had not awarded her any benefits in respect thereof as there were no physical or radiological indications of any significant injury;

- Dr Burger indicated that no “physical independent clinical signs” were found to support the complainant’s alleged injury in March 2007. He further stated as follows:

  "At present it is my opinion that this patient is exploiting the COID act (sic) in an attempt to be given fewer duties, extended leaves of absence and possibly compensation for injuries that simply do not exist."
• Dr Domingo reported that the complainant had no neurological defects and “she may have some spasm related to the injury and this should not interfere with her ability to continue working.”

• Ms Henwood reported that the complainant only attended 8 of the 22 work-hardening sessions and that her commitment to the programme was poor. She reported that the complainant did not attend the last four of her rehabilitation sessions and that she, amongst other things, displayed poor motivation “to improvement of function and return to work” and that she has been discharged upon her request.

4.7 The third respondent submits that by the time the complainant’s employment was terminated, no medical evidence had been submitted to it by the complainant that proved that the complainant was either temporarily or permanently disabled and thus unable to work. To the contrary, the medical opinions indicated either that the complainant was malingering or that she shared no real appetite to undergo the recommended treatment (none of which involved invasive procedures or medical risk) designed to enable her to return to work.

4.8 The third respondent further submits that its reasonable and bona fide opinion based on the medical reports available to it was accordingly that the complainant was not disabled and should be able to work. The complainant had not provided it with medical evidence to the contrary and there was no basis to terminate her employment due to ill health, injury or disability.

4.9 The third respondent submits that the Schedule of Benefits to the rules of the first respondent makes provision for a disability benefit. What will constitute disability for purposes of the benefit is determined with reference to the insurance policy that insures the benefit. Schedule 1 to the policy with the insurer defines total and permanent disability as follows:

“Notwithstanding the provisions of clause 1, DEFINITIONS, “Total and Permanent Disability” shall mean:
(i) ..
(ii) In respect of all other Life Insured Persons:

a condition in which, in the opinion of the insurer, the Life Insured has been so disabled by injury or disease as to be permanently and totally incapable of engaging for remuneration or profit in his own occupation or in another occupation for which he is or could reasonably be expected to become qualified by virtue of his knowledge, training, education, ability and experience.”

4.10 The third respondent contends that the medical reports leading up to and at the termination of the complainant’s employment, showed that the complainant was not disabled permanently, totally, or at all. To the contrary, they indicated that there was nothing significantly wrong with the complainant that affected her ability to work. The complainant may have had some temporary discomfort or condition for which a course of non-invasive and non-risky treatment (through the work programme) was prescribed, but she dropped out of this treatment prematurely. In these circumstances, she did not qualify to be considered for a disability benefit.

4.11 The third respondent further contends that had it received an application for a disability benefit prior to the termination of the complainant’s employment, an assessment of the complainant’s application with reference to the meaning of “Total and Permanent Disability” as set out in the policy and taking the medical evidence available into account, would have inevitably resulted in a rejection of the claim.

4.12 The third respondent submits that at the time of the signing of the withdrawal form, the complainant did not raise a concern or dispute that her employment was being terminated by virtue of her redundancy. The third respondent denies that it forced the complainant to complete the withdrawal form after she requested that it inform the third respondent of her alleged disability.

[5] STATEMENT OF DETERMINATION AND REASONS THEREFOR
5.1 The issue for determination is whether or not the complainant is entitled to a
disability benefit from the first respondent subsequent to the termination of her
membership.

Point in limine

5.2 The third respondent submitted that the disability benefit is regulated by an
insurance policy issued by the second respondent and therefore this tribunal
lacks jurisdiction to adjudicate the matter. This contention is incorrect. Where
the rules of a pension fund make provision for the payment of a disability
benefit in the event of a member becoming disabled as defined, this tribunal
has jurisdiction in respect of complaints relating thereto even if the benefit is
underwritten by an insurer, like in the present instance (see *Mungal v Old

Merits

5.3 The complainant was dismissed because her position became redundant. It is
essential for the complainant and the third respondent to complete the
withdrawal notification form indicating the reason for the termination of
employment (in this instance it was retrenchment/redundancy), this in turn
allows the fund to determine the type of benefit that is payable (see *Rwexwana v Idaho Spur Provident Fund and Others* [2005] 7 BPLR 640 (PFA)
at paragraph [11]).

5.4 The complainant duly signed a withdrawal termination form on 22 September
2008 indicating the reason for the termination of her membership as
retrenchment/redundancy. Therefore, the complainant knew that she was
applying for a withdrawal benefit when she put her signature to the withdrawal
termination form. A disability claim was never submitted to the first respondent
for consideration prior to the complainant’s dismissal.
5.5 As regards the complainant’s claim for a disability benefit, the medical evidence proves that the complainant would not have qualified for a disability benefit in the first instance. A disability benefit is therefore not payable in terms of the rules of the first respondent. The complainant was paid her correct benefit when she exited the first respondent.

[6] ORDER

1. In the result, the complaint cannot be upheld and is dismissed.

SIGNED IN JOHANNESBURG ON THIS DAY OF 2010

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CHARLES PILLAI
PENSION FUNDS ADJUDICATOR

Cc: Attention: Solomzi Gcelu
    Oceana Group Provident Fund
    C/o Metropolitan Life Limited
    P.O. Box 2212
    BELLVILLE
    7535

Fax: (021) 940 5678

Cc: Attention: Wilhelm Van Zyl
    Oceana Brands Limited
    PO Box 26803
    HOUT BAY
    7872
Fax: (021) 790 3460

Registered Address of the Fund
PO Box 2212
BELLVILLE
7535

SECTION 30M FILING: MAGISTRATE’S COURT
No legal representation