NORTON ROSE FULBRIGHT

The Big Read Book series Volume 11

Norton Rose Fulbright South Africa's review of South African insurance judgments of 2022

February 2023

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Welcome to Norton Rose Fulbright's The Big Read Book Series.

This is Volume 11 of the Series – A review of South African insurance judgments of 2022.

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You can access Volume 1, which covers South African insurance judgments of 2018, here.

For more about avoidance and cancellation of non-life insurance policies see Volume 2 of The Big Read Book Series.

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Interpretation of policy wording

Transnet SOC Limited v Santam Limited

(30445/2014) [2022] ZAGPJHC 918 (November 9, 2022)

Keywords: pollution / exclusion / sudden

This judgment considered whether the insured was provided with an indemnity under the insurer's general liability policy for the costs of pollution rehabilitation.

The insured, Transnet, sought to recover money it had expended in the rehabilitation of soil contaminated by aviation fuel escaping from an underground pipeline belonging to it. The pollution happened as a result of a deliberate act of unknown thieves who excavated a hole above the pipeline and punctured the pipeline to siphon off aviation fuel.

The operative clause of the policy read:

> "The insurers will indemnify the insured against their liability to pay compensation (including claimant's costs, fees and expenses) … in accordance with the laws of any country. … except and to the extent and subject to the conditions specified herein."

The insured sought an indemnity on the basis that it had arranged and paid for the rehabilitation of the polluted soil in compliance with its responsibilities under the National Environmental Management Act, 1998 (NEMA).

The insurer, Santam, stated that no demand was ever made against the insured by the owner of the property damaged by the pollution. The insurer, Santam did not consent in writing to the insured Transnet incurring costs or accepting or agreeing to be responsible or liable for the costs of dealing with the pollution.

The relevant clause provided that the insurer would indemnify the insured against their liability to pay compensation. The insured argued that it was irrelevant whether the legal liability arose from a statutory obligation or a third-party claiming compensation against it.

The court agreed with the insurer that 'compensation' has a more limited application because it envisages a party claiming against the insured, and not seeking reimbursement of money spent as a matter of statutory obligation.

The policy also contained a pollution exclusion with the proviso that the exclusion did not apply where the pollution was caused by a 'sudden, unintended and unexpected happening' during the period of the insurance.

It was common cause that the contamination was caused by fuel escaping from the insured's pipeline by way of an incision, which was deliberately controlled by thieves causing fuel to leak over an extended period.

The court interpreted the word 'sudden' in its temporal sense, namely meaning 'abrupt', 'occurring quickly', or 'taking place all at once'. The court rejected the insured's argument that 'sudden' ought to be understood to mean that the seepage did not happen as a result of wear and tear, such as corrosion.

The insurer asserted that the claim was not notified quickly enough, but the court said that the phrase 'as soon as reasonably practicable' is 'nebulous'. This clause was therefore interpreted against the insurer, with the court accepting that the insured's notification, two months after the occurrence, was not fatal to the claim (although the other factors discussed above, were).

The insured's claim failed.

Zurich Insurance Company South Africa Ltd v Gauteng Provincial Government

(Case no. 734/2021) [2022] ZASCA 127
(September 28, 2022)

Keywords: tunnel / interpretation / expert evidence

The insured claimed for damage to rock mass when tunnels for the Gautrain Rapid Rail Systems were constructed. One of the issues in dispute was whether the rock mass surrounding the tunnel void was part of the property insured.

It was common cause that damage was caused to the rock mass that surrounds the tunnel. Whether the rock mass formed part of the property insured depended on the interpretation of the policy, and the answer to the question 'what is a tunnel?'

The court held that the operative clause, including definitions of 'Property Insured', 'tunnel works' and 'civil works', was intended to give the insured extremely wide cover. It was clear that the tunnel works, being permanent works, fell within the definition of the property insured, and that tunnel works specifically include tunnels. The tunnel works were subject to specific exclusions and limitations, and would only be subject to those exclusions and limitations if they were part of the property insured.

The policy did not however define what was meant by a tunnel. The court considered both the dictionary definition and the insured's expert evidence as to what a tunnel is in civil engineering terms. The court held that the context within which the policy and the word 'tunnel' appear must be interpreted as a massive civil engineering project, involving the excavation of tunnels through rock. When the word 'tunnel' was used in the policy, it must have been used as a technical, civil engineering term. Therefore expert evidence was admissible on the meaning of the word.

The insured's experts said that rock mass is an essential component of a tunnel because of its load-bearing capacity. It is crucial to the stability of tunnels, whether constructed or naturally formed. In civil engineering terms, a tunnel is more than the void left after the excavation process. It includes the natural support for the void without which there could be no tunnel. The court accepted the expert evidence that the relevant tunnel was therefore a void surrounded by its own load-bearing cylinder of rock.

The contextual evidence of the insured's experts resulted in a commercially sensible interpretation and avoided an absurdity – the contrary interpretation of only a void being part of the property insured would not make sense, because by definition no damage could ever be caused to a void.

The court concluded that the property insured included the rock mass that surrounds the void created by the process of excavation, with the result that the damage caused by the failure to pre-grout the tunnels was indemnifiable as damage to the property insured in terms of the policy.

Brokers

Savvy Insurance Brokers (PTY) Ltd v Fourie and Another

(J 722/2022) [2022] ZALCJHB 222 (August 8, 2022)

Keywords: broker / restraint of trade / protectable interests / customer connections / confidential information

An insurance broker filed an urgent application seeking to interdict and restrain a former employee from sharing confidential information with her new employer (also an insurance broker) or any other party competing with the business of the applicant. They also sought to interdict the former employee from being employed by the other broker or any other entity engaged in any activity relating to brokering or selling non-life insurance products.

Through its employees, the applicant brokered the sale of non-life insurance to clients that were referred to the applicant by motor dealerships.

The applicant's case was that its business depended on the sale of motor vehicles for which insurance products were sold, and the relationship that was built up with the dealerships.

The applicant placed specific reliance on one of the respondent's key duties, as contained in the contract, that is, to "maintain, grow and expand relationships with existing policyholders and also with the referring agents (dealers and dealerships), last of whom it may be expected from time to time to interact on a social level such as informal functions or on-site visits."

The applicant alleged that the respondent had access to sensitive information that is both confidential and proprietary to the applicant. This was knowledge of the applicant's pricing strategies, sales techniques, how staff were trained and incentivised, customer connections and details, customer needs and the products they purchased.

Restraints of trade can be used to protect confidential information that, if disclosed to a competitor, will grant the competitor a relative competitive advantage. This information is referred to as "trade secrets". The relationships with customers, potential customers, suppliers and others that make up what is referred to as "trade connections" can also be protected.

The existence of protectable interests in restraints of trade must be balanced against the reasonableness of the restraint and whether the restraint goes further than necessary to protect the relevant interest.

The respondent stated that the applicant did not have protectable interests. She pointed out that the applicant did not specify what is meant by "pricing strategies". She knew of no "sales techniques" that the applicant used other than sales scripts, which are simply prescribed sets of talking points that are used by sales consultants when engaging with a prospective client. The respondent's primary function was not to make sales, and so she was never given a sales script to use. Further, there was nothing special about the sales scripts because they could be downloaded for free from the internet. The respondent stated that she did not have any knowledge of confidential staff training and incentives, and that the nature of the industry is such that there is no need for specific skills and knowledge in respect of every different insurance brokerage, as the non-life insurance business is virtually the same across the board.

The applicant did not provide detail to the court on what specifically the confidential information was that the applicant sought to protect, whether it was capable of application in the industry or whether it would be useful to a competitor or be of any economic value to the applicant. Therefore the court found that the applicant had not made out a case in respect of the confidential information it sought to protect.

The applicant had to show that customer connections existed and that they could be exploited. This was not done.

The respondent stated that the applicant's business within the non-life insurance industry was that of direct marketing insurance brokering and dealer sales. Once a product was sold to a client, the applicant's business with that client was concluded, and contact after the sale was uncommon as there is no after-sale service and relationships are not developed with the clients.

The applicant did not to show that the relationship between the respondent and the applicant's dealers or clients was such that the respondent acquired personal knowledge of and influence over the customers of the applicant to enable her to take advantage of that trade connection. Merely interacting with these clients was not enough.

The applicant did not demonstrate that the respondent had the ability to take customers with her to her new employer.

The court found that the applicant had not proved that it had a protectable interest being prejudiced. The restraint of trade was therefore not upheld.

Dalmar Plant Hire (Pty) Ltd v RMB Structured Insurance Ltd and Another

(A219/2018) [2022] ZAGPPHC 454 (June 24, 2022)

Keywords: broker duty / material change in policy

The trial court had granted absolution from the instance of an insured's claim against its broker, and the appeal court reconsidered the judgment.

The insured claimed that the broker, in advising the insured to change its insurer, failed to bring a material difference between the two polices to the insured's attention. The first policy required one tracking device to be installed in the insured vehicle, whereas the new policy required two devices to be installed.

It was common cause that the broker was obliged to exercise its duties with reasonable skill and care, and without negligence and that, in terms of the agreement, it would take all reasonable steps to convey material changes to the insurance agreement to the insured.

The broker's case was that the change was not material.

The trial court concluded that the two insurance agreements were totally separate and independent of each other and should be interpreted separately.

The appeal court noted that interpretation of the policies was not contentious. What was of importance was the difference in requirements, which placed a duty on the broker to inform the insured of the difference in the new policy.

The trial court's finding implied that the insured, who signed the insurance agreement, fully appreciated its contents. However, despite the fact that the insured was legally bound by the terms of the policy, this case deals with the duty of a broker towards their client, and their duty to communicate material changes in cover. The appeal court noted that if that duty is not recognised, there would be no point in appointing a broker.

The court noted that if there was no material change in the policies' requirements, then there was no duty on the broker to point out the wording of the endorsement. But if there was a material change, then there was undoubtedly such a duty. On the evidence, the court held that there was, on the face of it, a material change between the policies' requirements.

The case was therefore referred back to the trial court for full consideration of the merits.

KeyHealth Medical Scheme v Glopin (Pty) Ltd

(1265/2021) [2022] ZASCA 147 (October 28, 2022)

Keywords: broker / mandate / agent

In a decision involving a broker who introduced business to a medical scheme, the court drew an important distinction between a mandate to enter into contracts on behalf of the medical scheme as the principal, and a mandate or authority to introduce business to the medical scheme.

Where a principal appoints someone to perform juristic acts (such as entering into contracts) on behalf of the principal, the mandate may be revoked at any time subject to the terms of the contract or the applicable law. Where it is an agency agreement with no such authority, the appointment may generally be terminated at will (again, subject to the statute and the contract).

The broker was not an empowered agent and had no authority to bind the medical scheme. The contract with the broker only entitled the medical scheme to cancel under certain circumstances, which were not met. Until it was cancelled, the agreement would continue as long as the broker had accreditation from the Council for Medical Schemes.

This decision is important in relation to insurance brokers as well. An insurance broker that introduces business from its clients to an insurer in terms of an agreement by which the insurer agrees to accept that business (subject to its underwriting discretion) is not a mandate for the broker to enter into insurance agreements for the insurer, and cannot be revoked except in terms of the agreement between the insurer and the broker or the applicable law. This illustrates an important distinction between the intermediary service of 'performing acts as result of which someone enters into a policy' (which is not a mandate to bind the insurer) and the binder arrangements where the intermediary can actually enter into policies on behalf of the insurer.

There is a difference between broking medical scheme business and broking insurance business. Medical schemes have to accept members in most circumstances whereas insurers have a discretion.

Subrogation

Van Heerden v Road Accident Fund

(845/2021) [2022] ZAECQBHC 37 (October 4, 2022)

Keywords: medical schemes / indemnity / subrogation

A plaintiff claimed against the Road Accident Fund (RAF) for injuries sustained in a motor vehicle accident. The RAF denied that it was liable for past medical expenses, since the plaintiff's medical aid had covered those costs.

The court reiterated that the payment by the medical scheme arose from a contract between the plaintiff and the scheme. The RAF cannot avoid liability nor benefit from the fact that the scheme fulfilled its contract with the plaintiff.

The scheme has a contingent right of recourse against the claimant for reimbursement, once they receive payment from the RAF for past medical expenses. Alternatively, the scheme can elect to proceed against the RAF on the basis of subrogation. While the doctrine of subrogation may cause confusion as to who the real plaintiff is, the court noted that it would be wrong to abolish the practice of subrogation through a judicial order.

The court continued that subrogation is a procedural device and that "the plaintiff cannot be non-suited by litigating in his own name." The RAF was ordered to pay the plaintiff's past medical expenses.

Discovery Health (Pty) Limited v Road Accident Fund and Another

(2022/016179) [2022] ZAGPPHC 768 (October 26, 2022)

Keywords: medical schemes / subrogation / insurance

This case is related to the issues in the *Van Heerden* judgment above.

The RAF's acting Chief Claims Officer issued instructions to claims managers to reject medical expenses claimed if a medical scheme had already paid for those expenses. A template rejection letter was attached to these instructions.

Discovery Health applied to court to challenge these instructions, in its own interests and in the public interest.

The court noted that, while the RAF may exclude benefits a claimant receives from the state (in relation to their claims against the RAF), they cannot exclude benefits received from private medical schemes for past medical expenses. The instructions to reject claims for past medical expenses covered by medical schemes therefore fell outside the authority given in the statute governing the RAF.

Discovery's rule, which requires members with claims for damages against third-party indemnifiers (such as the RAF) to reimburse the medical scheme for payments made in respect of their past medical expenses, is in line with the Council for Medical Scheme's model rule in that regard.

The instructions to reject claims for past medical expenses covered by medical schemes was therefore found to be unlawful.

Medical schemes are governed by separate legislation and are not classified as insurers. However, medical schemes are in effect insurers and general indemnity principles apply (unless medical scheme legislation states otherwise), including in respect of subrogation.

Business interruption

Slabbert N O & 3 Others v Ma-Afrika Hotels t/a Rivierbos Guest House

(772/2021) [2022] ZASCA 152 (November 4, 2022)

Keywords: business interruption / supervening impossibility

In this case, the appellate court held that a lessor was entitled to evict its tenant as a result of non-payment of rental, because the tenant's plea that it could not pay rent because of the Covid-19 pandemic could not excuse non-payment from September 2020.

The court said that it was unnecessary to decide whether the restrictive regulations applicable during the period 26 March 2020 to 20 September 2020, which prevented or restricted the operation of the tenant's business as a guesthouse, constituted a supervening impossibility of performance that discharged the tenant from liability to pay the full rental amount.

Even if the court accepted that Covid-19 regulations prevented or restricted trade and caused the tenant's default, there was no justification for that default beyond 20 September 2020, despite alleged diminished commercial ability resulting from the Covid-19 pandemic. The appeal court said that the doctrine of impossibility to performance could not conceivably have been triggered beyond 20 September 2020 because there was no government-imposed bar to trading at that stage.

The tenant failed to pay rental in October, November and December 2020, thereby breaching the payment clause in the lease agreement and entitling the lessor to cancel the lease and evict the tenant.

The judgment does not determine whether Covid-19 regulations operating up to mid-September 2020 constitute applicable *vis major* entitling the tenant to remission of rental.

This judgment will have implications for insurance business interruption claims.

Time-bar clauses

Blackspear Holdings (Pty) Ltd v Bryte Insurance Company Ltd and Another

(26150/2020) [2022] ZAGPJHC 332 (May 16, 2022)

Keywords: Causation / time-bar clause / prescription

Causation

The insured sued the primary insurer and SASRIA in the alternative, seeking an indemnity for irreparable damage to underground mining earthmoving equipment when the mine in which the equipment was operating was flooded following vandalisation in the course of labour unrest.

The primary policy excluded SASRIA perils. The SASRIA policy covered a labour unrest peril.

The question was whether the loss of the equipment was caused by labour unrest. The mine's management had switched off a generator used to power pumps at the mine that extracted underground water. Those generators were removed by their owner, which had not been paid. SASRIA contended that this caused the insured's loss.

The court held that the presence or absence of the generator was irrelevant to the loss. The question was who was responsible for the failure to maintain the pumps while in operation.

It was not the removal of the generator that caused the losses, but rather the workers' vandalism, which rendered the pumping operations impossible and which, in the chain of causation, resulted in the mine being lost to flooding. This was not a case where it could plausibly be argued that there was more than one cause.

The body of evidence proved that the cause of the losses suffered by the insured was the labour unrest, which was a peril for which SASRIA was liable to the insured.

The total loss clause

In a sequel to the above case, the court had to interpret the total loss clause. The case is Blackspear Holding (PTY) Ltd v Bryte Insurance Company Limited and Another (26150/2020) [2022] ZAGPJHC 585 (August 22, 2022).

It was common cause that the insured had suffered a total loss underground, that it was uneconomical to recover the insured property from the mine, that the insured would not be indemnified for the cost of removing the equipment, and that the damaged equipment had no residual value.

The court said that, when striving for businesslike sense, the concept of a total loss or total destruction relates to the utility of the insured property. This construction accommodates the notion of residual value and scrap. A total loss does not necessarily require that the property has to have literally disappeared. Where scrap is accessible and may have another use then it has a residual value, which can be set off against the utility value of the property. Where the scrap is inaccessible however, that factor has no practical application.

Where the contract of insurance was concluded to provide for equipment situated underground, the parties to the contract must be taken to have contemplated the circumstances of those goods. On the facts, the compensation was not required to take account of the cost of removing the equipment from the underground site nor its scrap value.

Prescription and time-bar clauses

The primary insurer was found not to be liable for the loss. However, the arguments relating to the primary insurer and prescription are still noteworthy.

The policyholder unsuccessfully argued that the Prescription Act did not apply because the insurer was confined to the policy's time-bar clause that provided for a period of prescription from the date of the rejection of the claim, and, because no rejection was ever issued, the clause could not be invoked. The action had been instituted more than three years after the date of the loss.

The court held that there was no doubt about the identity of the insurer against whom the claim should be made. Nor was there any uncertainty about the facts that the insured would have had to have known in order to bring a claim. In finding that the insurer's plea of prescription was good, the court referred to previous authority that held that there is no authority for the proposition that until a claim has been rejected by an insurer, the debt had not become due.

The judgment confirms the position that prescription of an insurance claim runs as soon as the debt is due which may or may not (for example, in a liability claim) be the date of the occurrence. The prescription date applies to insurance contracts like all other contracts.

It is not incumbent on an insurer to accept or reject a claim on a policy. It is only when court process is served on the insurer in terms of the Prescription Act that it is obliged to defend the claim.

Where an insurer neither accepts nor rejects a claim, the insured must nevertheless institute action for the payment of loss within the three years referred to in the Prescription Act, or a shorter period if the policy provides for a lesser prescription period.

Standard Bank Insurance Limited v Richard Klaas

A3063/2022 (December 5, 2022)

Keywords: time-bar clause

The insured sued the insurer for damages after the insurer rejected its insurance claim. The case dealt with whether the claim was time-barred due to the insured's failure to institute action within six months from the rejection of the claim.

The insured claimed under a motor vehicle policy for the repair of his car, which was damaged in an accident. The claim was rejected and so the insured, in order to mitigate his loss, had the car repaired for around R208 000.

The policy provided that the insured had 90 days from receipt of the rejection letter to ask the insurer to reconsider the claim, or to write to the relevant ombud to deal with the matter. After reconsideration, if the insured was still not satisfied, he had six months to institute legal action against the insurer. The insured loses the right to claim after this six month period.

The insured alleged that he was not aware of the time-bar clause and was not made aware of the clause. He argued that in the circumstances of the case, there was good reason why he failed to comply with the time limitation clause.

The court reiterated that the onus falls on the party seeking to avoid a time limitation clause, and once it is shown that the clause does not violate public policy, that party must show that there is good reason why they did not comply with the clause. Nothing was set out in the insured's particulars of claim to justify his failure to comply with the clause. The evidence that was led in court was not prefaced in the particulars of claim, and therefore the insurer was ambushed by this evidence.

The court held that it would prejudice the insurer for the court to afford weight to the insured's testimony on aspects that were not pleaded. The particulars of claim merely stated that there was no time limitation clause. At trial however, it was not disputed that the insurance contract contained a time limitation clause. The fact that the insured could not remember whether his attention was specifically drawn to that clause cannot support a finding that he should not be bound by it. The contract was reviewed during its existence, and the insured had an opportunity to read the terms of the contract, which he failed to do.

Therefore, the insured's claim failed and the insured was time-barred from pursuing a claim against the insurer.

Mkansi v Legal Practitioners Indemnity Insurance Fund

(61050/21) [2022] ZAGPPHC 1019 (December 8, 2022)

Keywords: prescription / contingent claim

The Attorneys Fidelity Fund is a statutory insurer, providing cover for claims that may arise from the professional conduct of attorneys.

The attorney was sued by a client for allegedly negligently allowing a claim in the amount of R3 million to prescribe. The attorney lodged a claim with the Attorneys Fidelity Fund, and wrote "countless letters" to the Fund, trying to confirm the status of his claim. Eventually, after receiving almost no communication from the Fund, he sued for indemnification.

The Fund alleged that the attorney's claim had prescribed. The court, in quoting the SCA judgment in *Magic Eye Trading 77 CC v Santam Limited (775/2018) [2019] ZASCA 188; 2022 (6) SA 120 (SCA)*, noted that

> "A claim for indemnification insurance under an insurance contract can only arise when liability to the third party in a certain amount has been established. The debt, for purpose of prescription, therefore, becomes due when the insured is under a legal liability to pay a fixed and determinate sum of money. Until then a claim for indemnification under the policy does not exist, it is only a contingent claim."

The court therefore held that the claim against the insurer had not prescribed – part of the third-party's claim against the attorney was determined in June 2021 and a portion of the claim had yet to be determined.

The court ordered the parties to refer the matter to a senior legal practitioner to begin the process of alternative dispute resolution, as required by the provisions of the policy.

Motor vehicle policies

Musa v King Price Insurance Co

(33559/2020) [2022] ZAGPJHC 295 (May 9, 2022)

Keywords: motor vehicle policy / claims co-operation obligation

It was common cause that the insured had declined, despite numerous requests and deadlines, to provide the insurer with permission and consent to approach the insured's cell phone operator to enable the insurer to establish a beacons and billing report. The report was necessary in order to verify the insured's version of events relating to a motor vehicle claim.

This rather cryptic judgment confirms that in appropriate circumstances an insurer may both reject the relevant insurance claim and cancel the policy by reason of the breach of the insured's claims co-operation obligations under the policy.

The judgment does not identify the particular claims co-operation clause, its wording, nor which portion of the obligation the insured breached.

The court held that the insured, by his own action, failed to comply with the condition of the policy and breached the agreement. The insurer was entitled to accept the breach, reject the claim and cancel the policy, as it had done.

King Price Insurance Company Ltd v Mhlongo

(A159/2021) [2022] ZAGPPHC 463 (June 27, 2022)

Keywords: motor vehicle policy

A motor vehicle was damaged beyond repair in an accident. It was insured under a policy covering "any risk and/or loss" of the vehicle. The claim was rejected by the insurer.

The court quoted *Klipton Clothing Industries (Pty) Ltd v Marine & Trade Insurance Co of South Africa Ltd* in noting that courts will favour an interpretation of an insurance policy that inclines towards upholding the insured's cover. An insurer cannot escape liability by relying on an immaterial non-disclosure.

The court found that the insured had complied with the terms of the policy.

The insurer indicated that it had rejected the claim on the basis that the insured had failed to disclose his whereabouts, including the alleged purchase of liquor after the accident. The court held that even if these submissions were accepted, they did not affect the validity of the claim because the vehicle was covered for any damages that may arise including those damages that are caused by insured's own negligence.

The court also agreed with the insured's submission that if speeding (which was raised by the insurer at the trial) was a material issue, the insurer would have stated this in the rejection letter. However, this would not have changed the position because the vehicle was covered against all risks including those arising from the insured's own negligence, including excessive speeding. There were no exclusions relating to speeding.

Regarding the insurer's allegation that the quantum of the claim was not proved, the court accepted that the settlement owed to the bank that financed the car was sufficient, especially in light of the policy, which clearly set out how compensation would be paid. This included first paying out any outstanding settlement amount to any financial institution that had financed the vehicle.

The insured's claim was upheld.

Life policies

Crossman v Capital Alliance Group Risk and Others

(34636/2020) [2022] ZAGPJHC 257 (April 21, 2022)

Keywords: death benefit / nominated beneficiary / discretion / stipulatio alteri

Crossman argued that she was the correct beneficiary nominated by Mr Gregory Bezuidenhout (the deceased) to receive his death benefits payable under a death policy, as opposed to the fourth respondent, Mr Gareth Bezuidenhout, to whom the benefits were instead paid. Crossman applied for the nomination of Gareth Bezuidenhout as beneficiary to be declared null and void, alternatively that the matter be referred back to Capital Alliance to deliberate on an equitable distribution of the death benefits payable in terms of the policy.

Crossman was nominated as the beneficiary in 2014. The deceased changed the beneficiary to Gareth Bezuidenhout in 2019. The 2019 nomination had not been submitted to the insurer, but was found on his desk after his death.

The court held that conferring a benefit, such as in the case of a death policy, is not the same as a contract for the benefit of a third party (*stipulatio alteri*). In the case of a policy benefit, the beneficiary does not usually become a party to the contract with the insurer (unless the policy wording provides for this). The policy in question indicated that members and beneficiaries would not become parties to the contract, and so Crossman had no legal standing to sue the respondents.

The court noted that the nomination form was not part of the policy and that the deceased was entitled to change the nominated beneficiary at any time. The requirement was only for the nomination to be in writing. It did not even have to be submitted to the participating employer, for onward submission to the insurer.

The request for alternative relief was also misplaced because the death benefit was payable to the nominated beneficiary and the employer and insurer had no discretion nor statutory requirement to consider dependents of the deceased prior to making payment to the nominated beneficiary. That type of obligation relates to pension and provident funds, governed by the Pension Funds Act.

Liberty Group Ltd v Cornelius N.O and Another

(1989/2020) [2022] ZANCHC 66 (October 28, 2022)

Keywords: life insurance / death of beneficiary

This matter involved the determination of which deceased died first, in a car accident. Mrs Becker was the nominated beneficiary on Mr Becker's life policy, but they both died in the same car accident. The court had to determine, on the facts, which of the couple pre-deceased the other.

If Mr Becker had died first, the benefit would accrue to Mrs Becker's estate. If Mrs Becker had died first, the benefit would be payable to Mr Becker's estate.

The evidence showed that the deaths were not simultaneous and that Mr Becker pre-deceased Mrs Becker. Therefore the benefit was payable into Mrs Becker's estate.

Slabbert v Liberty Group Limited

(3281/2019) [2022] ZAECQBHC 40 (October 31, 2022)

Keywords: disability claim / Policyholder Protection Rules / fairness

The insured submitted a claim for a 100% impairment benefit in terms of a disability policy. The policy specified various impairment benefit categories linked to a list of health conditions. The benefit was payable if the insured was diagnosed as having been permanently impaired due to one of the specified health conditions. The last category of the impairment section was a catch-all provision dealing with the inability to perform Activities of Daily Living (ADLs). This benefit category covered all diseases or injuries that cause a permanent functional impairment, but which may not be covered in the list of specific health conditions.

The impairment is measured by assessing the insured's ability to perform basic and instrumental ADLs. The former includes activities such as washing, dressing, eating and mobility while the latter refers to housekeeping, communication, food preparation, transport, handling finances and the like. To qualify for a 100% benefit, three or more basic ADLs or four or more instrumental ADLs must be permanently impaired.

The insured was diagnosed with malignant hypertension and blackouts. These conditions were not included in the list of health conditions covered under the policy. The insured claimed that he was unable to continue performing his work as a transport operator due to the blackouts. The medical records show that the insured was restricted from driving and he was showed for a social grant.

The insurer rejected the claim for the impairment benefit, because malignant hypertension was not included under the listed benefit categories and that only one (as opposed to four or more) of the instrumental ADLs, namely driving (transport) was restricted.

The insured demanded payment again, and the insurer requested an updated medical report. The updated medical report indicated that the insured was permanently unable to perform four instrumental ADLs.

The insurer requested that the insured attend a specialist medical appointment, and stated that it was unable to finalise the matter without a specialist medical report. The insured refused, and the parties reached a deadlock.

The issue was whether the insured had established that the insurer acted in breach of a duty of fairness (which he alleged arose out of the Policyholder Protection Rules) in rejecting his claim. The insured tried to raise aspects of the Policyholder Protection Rules but the court found that these could not be applied to the matter, because they were not in force at the relevant times.

The insured contended that fairness required that the insurer be held to the initial reasons for rejecting the claim, and should not be allowed to raise any further reasons. The insured also argued that the initial reasons were demonstrated to be unfounded by the subsequent medical report, which confirmed that four instrumental ADLs were in fact permanently impaired.

The court accepted that the insurer had assessed the claim as submitted on face value. The claim patently did not fall within the policy and required no further investigation in accordance with the policy terms that regulated the submission and assessment of claims. It was correctly declined. The review process however required a reconsideration of the claim. The new evidence presented prompted a further investigation of the claim. This was regulated by the express policy terms, which required that the diagnosis and management of all impairments be confirmed by appropriate medical specialists. The insurer's request for medical evidence from the insured's treating specialist confirming his condition was thus not unreasonable and was in line with the policy terms. The request that the insured be assessed, at the insurer's expense, by a specialist was also reasonable.

The insurer's actions could not be characterised as a breach of the duty to treat the insured fairly. No adequate reason was provided as to why the insured refused to cooperate. The insurer was not obliged to accept the new evidence on face value. It was entitled and in fact required by the policy to have this new evidence confirmed by appropriate medical specialists. This is particularly so in view of the medical advice that hypertension is a treatable condition that generally does not result in permanent impairment. Moreover, the specialist assessment could only have been to the insured's benefit. His failure to submit to the specialist assessment was the real reason why the review of his claim could not be finalised.

Therefore the insured failed to establish that the insurer acted in breach of the policy terms in rejecting the claim or not having finalised the review of such rejection.

The court noted that the application was brought in the form of a test case in an attempt to clarify the obligations of a life insurer with regard to providing reasons for repudiating a claim in light of the 2017 Policyholder Protection Rules. The fact that Policyholder Protection Rule 17.6.3 did not apply in this instance and accordingly obviated the need to grapple with these challenges, did not detract from the application's broader objective, which was not confined only to the present parties. Therefore costs were not awarded against the insured.

Fraud and moral risk

Ioannides N.O. and Others v Western National Insurance Company Limited and Another

(5056/2021) [2022] ZAFSHC 113 (May 23, 2022)

Keywords: moral risk / fraud / voidable policy / materiality / non-disclosure

The applicant claimed for fire damage to its property. The insurer rejected the claim on the basis that the policy was void due to the applicant's non-disclosure of a relevant aspect of its previous claims history.

The applicant's property was damaged by water a few years prior to the insurance in question being in place. The applicant lodged a claim with its then-insurer as well as the insurer of the contractor involved in the property, for the same damage. Both insurers indemnified the claim at the time. When the applicant's insurer found out about the double compensation, it wrote to the applicant, alleging that the claim was fraudulent and claiming repayment. The applicant paid an undisclosed amount to this previous insurer, who then cancelled future business with the applicant.

This history was not disclosed to the current insurer. The insurer argued that had it been aware of the previous double claim, it would not have insured the applicant. This is because the industry treats such actions as a "moral risk", and they are not prepared to cover applicants with high moral risk. Moral risk was described in the case as "the possible propensity of an insured using dishonest means to extract insurance monies".

The applicant argued that it was only asked, on the application form, to disclose its full claims history and losses and that the duty was on the insurer to clearly spell out which risks it wished to exclude or limit.

The court accepted that the insurance industry treats conduct that causes two insurance companies to make payment in respect of the same damage to be a moral risk that insurers are not prepared to insure. There was no basis upon which the court could reject such evidence as palpably false.

The court therefore accepted that the information not disclosed was material and therefore should have been disclosed to the insurer. There was support for the fact that the previous insurer terminated its business agreement with the applicants on realising the double claim.

The insurer explained that before it determines a premium at which it is prepared to insure a risk, it determines the insured's risk portfolio, which includes the insured's moral risk. The court accepted that the insurer would likely have declined to accept the risk if it had been aware of the insured's moral risk.

The insured's claim therefore failed.

The insured applied for leave to appeal in Ioannides N.O and Others v Western National Insurance Company Limited and Another (5056/2021) [2022] ZAFSHC 330 (November 22, 2022), but this application failed.

Maharaj N.O and Others v Discovery Life Limited

(8713/2015) [2022] ZAKZDHC 52 (December 2, 2022)

Keywords: life policy fraud / non-disclosure

The insured had two life policies with the insurer, which included life cover, severe illness benefits, and income continuation benefits.

The insured amended the policies a number of times, but on none of these occasions did the insured disclose that he had been diagnosed with clinical depression. The court found that the depression diagnosis was material to a life insurance policy and should have been disclosed, in order for the insurer to form its own view as to the effect of the diagnosis on the risk. The policy forms specifically required disclosure of "seeing a medical professional for any reason whatsoever" and depression is a notifiable diagnosis under the policy.

The consideration of risk in respect of life cover is fundamentally affected by the risk of suicide. The insurer's evidence established that if the insured had disclosed his depression diagnosis, the result would have been a special assessment of risk. In such a case, the underwriter would usually decline the request for an increase in benefits.

Therefore the court upheld the insurer's right to avoid the contracts by which the insurance policies were amended after the insured was treated by a psychologist.

The next issue was whether the insured truthfully represented his medical conditions in relation to his continued ability to work. The insurer alleged that the insured did not tell either the insurer or the examining doctor that he could perform the full duties of is occupation. Therefore, both the approval of pre-litigation claims and the payment of some of them was induced by fraud. However the insurer's evidence could not support the claim of fraud, and therefore this allegation was rejected by the court.

The insurer also questioned the validity of the insured's claim for loss of revenue. The insurer relied on the alleged fraudulent misrepresentation, in that the insured hid his ability to perform the full duties of his occupation (which was held not to have been proved) and not on misrepresentation as to loss of earnings. Further the insured was not able to provide any loss of revenue. The insurer also did not seek an order declaring the policies void in their entirety by reason of the use of "fraudulent means or devices" to make the claims. The claim for fraud was directed at the repayment of claims paid.

The court therefore held that the amended contracts to the policies were void with effect from the conclusion of each such contract.

The original policies otherwise remain in force, subject to payment by the insured of outstanding premiums (the insurer having rejected tenders of premiums), the amounts of such outstanding premiums to be computed after set-off against the insured's rights to repayments of premiums paid to and accepted by the insurer in respect of the void amended contracts.

The insured was held liable and ordered to pay the difference between the amounts paid on claims premised on the validity of the amended contracts, and the amounts that would have been calculated under the provisions of the original policies, to the insurer.

The insured's claim for the payment of severe illness benefits was upheld to the extent that the claims were covered by the original policies.

The parties were ordered to debate and agree on the outstanding financial consequences of the court order. If they failed to reach agreement, the dispute could be set down for hearing again for adjudication on the financial consequences of the court's orders.

Requests for documents and privilege

Thanda Manzi CC t/a River Place v Guardrisk Insurance Company Limited and Another

(22179/16 ; 953214/16) [2022] ZAGPPHC 538
(June 22, 2022)

Keywords: costs / investigation reports / withdrawal of claim / reasons for rejection

This case involved a dispute on legal costs between an insurer and an insured. The insured claimed against the insurer for fire damage but the claim was rejected. The insured then sued the insurer, but later withdrew the action and tendered to pay costs for a limited portion of the claim.

The plaintiff asked for an order that the insurer pay its own costs before 2 September 2019 because, had the insurer disclosed the contents of the reports and the conclusion reached, the insured would have been better placed to make an informed decision on the appropriateness of instituting action.

The insurer had rejected the claim on the grounds that the insured had failed to take reasonable steps to safeguard the insured property, had failed to comply with the National Building Regulations and to supply the necessary plans to the local authority, and had failed to install, maintain and service firefighting or fire protection equipment on the insured property. The provisions of the policy were also raised in the insurer's plea to the insured's claim.

The insurer had failed to disclose its investigation reports, which the insured had requested in order for their own experts to advise on the claim. The reports were held back between May 2018 and August 2019, and the insurer released the reports to the insured in September 2019.

It was concluded at a joint meeting of the experts in February 2021 that the fire was caused by incorrect installation of an extractor unit.

The insurer argued that the insured had sufficient particularity regarding the reasons for the insurer's rejection of the claim from its rejection letter and its plea, and that the investigation reports were irrelevant to the plaintiff in making a decision on whether to pursue the claim. The insured took 18 months after receiving the reports to withdraw its claim. The insured could have also conducted its own investigations.

The court noted that a successful litigant may be deprived of a costs order in its favour if its actions misled the unsuccessful party into continued litigation.

The court ordered the insurer to pay the costs from the date of inception of the matter up to 2 September 2019, when the reports were made available. The court found, on the evidence, that the insured had not acted in bad faith in continuing to pursue the claim, but the insured was liable for costs after 2 September 2019, when the action could have been withdrawn.

Guardrisk Insurance Company Ltd v IFS Risk Consultants CC and Others

(11799/2021) [2022] ZAGPPHC 860 (November 7, 2022)

Keywords: particulars of claim

The insurer sued the insured's broker for failing to disclose an insured's previous claims. The damages claim related to over R7 million paid by the insurer to its insured under an insurance contract. The broker had represented the insured in securing the cover. The insurer alleged that, had it been aware of the previous claims, it would not have issued an insurance policy to the insured.

The defendant brokers applied for an order compelling the insurer to furnish further particulars regarding the claim, which, they alleged, were necessary for them to prepare for trial.

The defendants sought particularity regarding the "numerous previous insurance claims" alleged by the insurer. In particular, they asked precisely how many previous insurance claims the insurer contended were not disclosed, when were these claims submitted, to which insurers were these claims submitted, what the outcome of these claims was, and when the insurer contended that it first became aware of these claims.

The insurer argued that the particulars sought were not strictly necessary to prepare for trial and could be considered as particulars sought for the defendants' convenience. The defendants were not entitled to particulars in order for them "to decide upon a version".

The court said that the particulars sought did relate to the issues pleaded and did not raise further or new issues, and the defendants were justified in seeking these details from the insurer. A defendant is entitled to know what case it is to meet.

The court ordered the insurer to provide a full response to the defendants.

VBS Mutual Bank (In Liquidation) v KPMG Incorporated

(2021/8826) [2022] ZAGPJHC 567 (August 18, 2022)

Keywords: privilege / insurance documents

VBS applied to court to compel KPMG to provide documents required for the purpose of litigation. These documents were audit working papers, KPMG manuals, and insurance documents. KPMG alleged that these documents were all legally privileged.

A court will not easily go behind the affidavit of a deponent who asserts that documents are privileged unless it is clear that that assertion is incorrect or mistaken. Documents are privileged if they were obtained or brought into existence for purposes of a litigant's submission to a legal advisor for legal advice and litigation was pending or contemplated at the time.

KPMG claimed that the insurance documents were sent to its legal advisors for advice, and that litigation was contemplated. It submitted that even disciplinary hearings and criminal proceedings classify as "litigation".

The court did not agree that internal disciplinary hearings qualify as litigation, nor that criminal charges against a specific individual gives the right to claim that it envisaged litigation. If a claim of privilege in criminal proceedings exists for purposes of a civil claim, it is a claim for the accused to raise. It was not suggested that KPMG was the accused in that "litigation" and the claim that the documents were brought into existence for purposes of the criminal charges or disciplinary hearings were not covered by the rule of privileged documents as far as KPMG was concerned.

KPMG's affidavit was considered. The affidavit stated that KPMG had contemplated litigation since VBS was placed under curatorship on 10 March 2018. Since that time, it was necessary to seek legal advice and communicate with its insurers, should a claim against it come to fruition. The court accepted this statement, and held that all documents that passed between KPMG and its insurers after 10 March 2018 were covered by privilege. The documents in existence prior to 10 March 2018 and all documents that were brought into existence after that date, and having a bearing only on the criminal and disciplinary proceedings against individuals that were in KPGM's possession, were not privileged by reason of the contemplated litigation against KMPG. Therefore the court ordered a limited release of the documents.

Property insurance

SixBar Trading 645 CC v ABSA Insurance Company Limited

(9855/2015) [2022] ZAKZDHC 21 (April 19, 2022)

Keywords: loss of rental income

The insured owned a building in the name of one of its companies, and leased that building to another one of its companies. A fire damaged the building and the insured claimed for loss of stock and rental. The insurer indemnified the loss of stock, but refused to indemnify the loss of rental, alleging that the lease agreement was a forged document created to substantiate a claim for loss of rental. Similarly, the insurer challenged the financial statement relied on by the insured to prove the rental agreement.

In considering the lease agreement and the financial statements, the court found no evidence to suggest that the lease agreement was not a genuine agreement. Other surrounding evidence also pointed towards the lease agreement being valid.

The court ordered that the claim for lost rental be indemnified.

Guarantees

Maziya General Services CC v Leroko Brokers (PTY) Ltd and Others

(2022/009190) [2022] ZAGPJHC 573 (August 18, 2022)

Keywords: on-demand guarantee / conditional guarantee

The insured sought to interdict the implementation of a demand made by the named beneficiary under a guarantee policy.

The central dispute was whether or not the guarantee was an on-demand guarantee or a conditional guarantee. If it was the former, the guarantee had an existence independent of the underlying obligations of a debtor, because the guarantee would constitute an independent and autonomous contract between the guarantor and the beneficiary. If the latter, the question was whether the terms of the guarantee required the beneficiary to establish the insured's liability to it under the sub-contract concluded between those parties and if so, whether the beneficiary's demand complied with the terms of the bond.

Numerous clauses in the guarantee policy provided that the guarantor's liability was expressly stated to be principal in nature (and not dependent on the liability of the debtor), as it would not be affected by any agreement or arrangement made between the insured and the beneficiary, and was payable on demand. Further, the guarantor was not obliged to determine the validity of the demand nor the correctness of the amount demanded, nor would the guarantor become party to any claim or dispute of any nature as alleged by any party. Consistent with these provisions, the guarantor irrevocably and unconditionally undertook to pay the beneficiary within three business days following the day on which it received a demand from the beneficiary in accordance with the guarantee. The preamble specifically recorded that the guarantor had agreed "at the request of the Principal, to enter into this on-demand Bond" with the beneficiary.

The express terms of the guarantee required no more than a statement in the demand that the insured was in breach of its obligations under the terms of the sub-contract. That no more than an allegation to that effect was required, is not only consistent with the tenor and nature of an on-demand guarantee, but also with the fact that the guarantor was not obliged nor equipped to become involved in any evolving disputes between the parties, nor was it obliged to verify the validity of the claim.

The court concluded that the guarantee was an on-demand guarantee, and since the terms of the guarantee were complied with, the guarantor was obliged to make payment. The insured had no right to interfere in this relationship.

Constantia Insurance Company Limited v The Master of the High Court, Johannesburg and Others

(512/2021) [2022] ZASCA 179 (December 13, 2022)

Keywords: guarantee / financial assistance / Companies Act

The SCA held that an indemnity provided by one group company to support an insurance guarantee obtained by another group company was void where the requirements of section 45 of the Companies Act, 2008 were not complied with because it amounted to "financial assistance".

The insurer was approached by a group of eight companies to provide performance guarantees in respect of the contractual obligations of the operating companies in the group towards third parties.

The insurer undertook to do so provided that each of the companies in the group signed an indemnity in its favour. The group CEO signed the indemnity on behalf of the group companies. The consequence of the indemnity was that each company in the group undertook an obligation to indemnify the insurer in respect of any demand under any guarantee issued to third parties for the obligations of any company in the group.

The insurer's claims under the guarantees amounted to R182 million and the insurer called on one of the group companies, in liquidation, to indemnify it in respect of these claims under their indemnity. The liquidators disputed the claims, stating that the indemnity constituted financial assistance by the company and they were unable to locate a resolution of the company's board authorising the indemnity or indicating compliance with the requirements of section 45 of the Act. According to section 45(1)(a) of the Act, financial assistance includes lending money, guaranteeing a loan or other obligation, and securing any debt or obligation.

The court found that all matters mentioned in section 45(1)(a) are exhaustive of the meaning of 'financial assistance.' The company had put its property at risk to ensure that the insurer provided the guarantees and therefore the company indirectly secured the obligations of its fellow subsidiary within the meaning of section 45(1)(a) of the Act.

Section 66 of the Act provides that a company's business affairs must be managed by its board. The expression "the board may authorise" means the board must adopt a resolution to provide financial assistance to a company or person in terms of section 45(2). The board may not take such a resolution unless the two requirements set out in section 45(3)(b) of the Act are met, namely that the company meets the solvency and liquidity test, and the terms of the financial assistance are fair and reasonable to the company.

The court was satisfied that there was no resolution by the board and found that there was no evidence that the board contemplated the provisions of section 45(3)(b) of the Act when it undertook to indemnify the contractual obligations of the other group company. The court concluded that the company had provided financial assistance but had failed to comply with the requirements of section 45 of the Act, rendering the indemnity void.

Millenium Aluminium and Glass Services CC and Others v Group Five Construction (Pty) Ltd and Another

(693/2021) [2022] ZASCA 180 (December 14, 2022)

Keywords: construction guarantee

A construction company, Group Five Construction, claimed payment under a guarantee from the subcontractor and its insurer. The question was whether the construction company had complied with the terms of the guarantee when it demanded payment.

The subcontractor was contracted to carry out the design, supply and installation of the residential windows and shopfronts of a development.

The subcontract sum was fixed and not subject to contract price adjustment for the duration of the contract. The subcontractor was required to provide and maintain performance guarantees in favour of the construction company, which it did.

The construction company called on the guarantee, arising from the subcontractor's refusal to make payment in terms of a payment certificate. The subcontractor argued that the demand from Group Five Coastal (and not Group Five Construction) was invalid because Group Five Coastal was not a party to the contracts.

The court held that this defence should fail. The issue was about the interpretation of the demand guarantee and the question was whether there was compliance with the terms of the guarantee in circumstances where an entity that made a demand on guarantee is not the same as an entity that issued the payment certificate. The guarantee contract stipulated the requirements that should be met first in order to establish the liability of the guarantor under the guarantee. It stated that there must first be a written demand issued by the contractor to the subcontractor, stating that the payment of a sum certified by the contractor in a payment advice was not made. The payment advice was issued by Group Five Coastal, which was in terms of the guarantee the appointed Group Five Construction's agents.

The insurer was in no doubt about the contractor's identity, because that was easily ascertainable from the guarantee itself. The demands for payment were made to the subcontractor and to the insurer on the basis of the payment advice that identified the contract in respect of which it related. The subcontractor was identified in the payment advice. The purpose of the guarantee was to enable Group Five Construction to obtain payment from the insurer in the event of default by the subcontractor.

The court found that Group Five Construction had properly presented the demand to the insurer and that it had met all of the jurisdictional requirements set out in the guarantee. The demand triggered the subcontractor's obligations to the insurer to indemnify it against Group Five Construction's demand and to pay to the insurer an amount equal to Group Five Construction's demand.

EBS International (Pty) Ltd and Another v Wright

(19128 / 2020) [2022] ZAWCHC 69 (May 9, 2022)

Keywords: indemnity / warranty

EBS International had purchased a company from the respondent. The seller had represented that its tax affairs were in order. Those representations were underpinned by way of warranties with an indemnification to make good any liabilities, costs, expenses or damages suffered as a result of the breach of the warranties in the agreement of sale.

It was subsequently determined that the seller had significantly understated its tax liabilities and the buyer claimed against the seller.

The court said that compliance with the tax laws is a non-negotiable imperative for any business and that the sole shareholder (who was also the sole director) was fully aware that it was imperative for the seller to be a law-abiding taxpayer. That is precisely why the warranties and indemnities were negotiated in the sale agreement.

Where a breach of a warranty has been indemnified, the injured party's claim under the indemnity is not based on the breach of the warranty but on the indemnity clause itself.

The shareholder director had furnished warranties and indemnities to the buyer to the extent that he would make good any undisclosed tax liabilities that came to light after the conclusion of the sale agreement. These included the cost consequent upon the institution of a claim for a breach of the warranty set out in the agreement of sale.

Any fiduciary duty damages that may have been suffered by the seller and which may in turn be recoverable from the shareholder director are an entirely discrete issue and essentially a pure damages claim.

The court held that the particulars of the tax assessments in connection with the indemnity claim amounted to conclusive evidence that the shareholder director breached the contractual warranties and that in turn triggered his obligation to make good on his indemnity. An indemnity is a contractual agreement between two parties where one agrees to pay for potential losses or damages claimed by a third party. These findings are relevant to subrogated recoveries under warranty and indemnity policies.

Competition

Swanvest 120 Proprietary Limited v Indwe Broker Holdings Proprietary Limited

(LM120Nov21) [2022] ZACT 66; [2022] 1 CPLR 14 (CT) (May 12, 2022)

Keywords: competition / merger

The Competition Tribunal conditionally approved a large merger in terms of which Swanvest intended to acquire an additional 76% of the issued share capital of Indwe Broker Holdings. Following implementation of the proposed transaction, Swanvest would solely control Indwe.

The acquiring group is a non-life insurer and the target firm is a non-life insurance broker.

The Tribunal noted that post-merger, there remain ample alternative independent non-life insurance brokers. The proposed transaction was unlikely to result in substantial lessening of competition concerns.

During investigation, the Competition Commission received various concerns from competitors. The competitors stated that the proposed transaction would result in the target firm becoming a broker tied to the acquiring group which may result in the acquiring group no longer underwriting business with other independent brokers, that the trend of large insurers acquiring independent brokers reduces the market within which independent brokers can contest, that the acquiring group would be able to share confidential information from its interactions with other independent brokers with the target firm, and that the merger was inconsistent with the Financial Sector Conduct Authority (FSCA) requirements regarding conflict of interest because post-merger, the target firm would be unable to provide independent advice to clients as to the best insurance cover for their needs, given that only the acquiring group's offerings would be available.

The merging parties explained that there was no incentive for the insurer to share other brokers' confidential information with Indwe, and that it would be to their commercial detriment to disclose confidential information of the independent brokers, given that independent brokers account for the vast majority of the acquiring group's non-life insurance revenues. Also, the insurer already controlled Indwe pre-merger, so that concern (to the extent that it was material) existed pre-merger.

The Commission interacted with the FSCA, which indicated that it was satisfied that the proposed transaction did not raise any conflict of interest, because all insurers and brokers are expected to treat customers fairly. Moreover, as part of the Prudential Authority's (PA) approval process, the merging parties are required to provide clients of the target firm with the option to remain with their existing non-life insurance insurer, or to transfer to the acquiring group's cover. This process is under the oversight of the PA, which confirmed its satisfaction that the merging parties had provided clients with the opportunity to exercise this option.

The proposed transaction therefore did not raise material concerns, and was conditionally approved.

Old Mutual Insure Limited v Genric Insurance Company Limited

(LM127Oct22) [2022] ZACT 56 (November 30, 2022)

Keywords: merger / competition

The acquiring firm, Old Mutual Insure, provides non-life insurance for property, transportation, motor, accident and health, guarantee, liability, engineering and miscellaneous insurance in South Africa. The Target Group is a licensed non-life and specialist insurer. The Target Group's product portfolio includes appliance warranty, brick and mortar, car hire insurance, gadget insurance and excess waiver insurance.

Vertical and horizontal overlaps are present between the merging parties, but the Commission found that based on the market share of the parties, combined, the merger was unlikely to result in a lessening of competition. The merger was therefore approved.

Debarment/Curatorship/Liquidation

Becker and Others v Financial Services Conduct Authority and Others

(23807/2020) [2022] ZAGPPHC 22 (February 1, 2022)

Keywords: administrative action / debarment / insurance without a licence

The Financial Sector Conduct Authority's (FSCA) predecessor, the Financial Services Board, found that the applicants and their company, Fusion, conducted an unregistered insurance business by issuing guarantee policies in contravention of the Short-term Insurance Act (STIA). Fusion was not registered as a non-life insurer, and argued that registration as an insurer was unnecessary because the guarantees and deeds of surety did not constitute insurance business as contemplated in the STIA. The applicants submitted that they had presented a response to the FSCA setting out arguable grounds of opposition to the directive.

The FSCA had not yet taken any final decision on the debarment order or imposed an administrative penalty.

This application did not deal with the factual dispute. The question was whether the applicants would have remedies at their disposal to challenge any debarment order or any administrative penalty if those decisions are made and if so, whether the applicable remedies met constitutional muster.

The applicants argued that the Financial Sector Regulation Act (the FSR Act), specifically sections 154 and 167, are inherently unfair because the sections do not require an open public hearing prior to making a debarment order or the imposition of a fine. The applicants submitted that section 153 requires the FSCA to invite applicants to make submissions on the matter, but the section does not afford a right of access to an impartial and independent tribunal to assess the merits of each order objectively.

The constitutionality of the FSR Act's sections were weighed against the provisions of sections 22, 33 and 34 of the Constitution, which ensure that everyone has the right to freedom of trade, occupation and profession, to administrative action that is lawful, reasonable and procedurally fair, and to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, by an independent and impartial tribunal or forum.

Having regard to all the relevant factors, the court found that the applicants' challenge to the constitutionality of sections 154, 167 and 231 of the FSR Act was not well founded and was speculative in the extreme.

The applicants' contention that a finding regarding the contravention of law can only be determined by impartial and independent adjudicators or courts cannot be correct. If this were to be correct, it would mean that almost all administrative actions would be unconstitutional because countless similar decisions are taken by decision makers that do not operate as independent tribunals. The FSR Act also entitles a party to proceedings to apply for reconsideration of a decision if they are dissatisfied with an order of the Tribunal, and they may institute proceedings for judicial review of the order in terms of the Promotion of Administrative Justice Act.

The Prudential Authority v 3Sixty Life Limited and Others

(58950/2021) [2022] ZAGPJHC 732 (September 30, 2022)

Keywords: confirmation of curatorship

This application concerned the confirmation of a provisional curatorship order sought by the Prudential Authority (PA), of 3Sixty, a licensed life insurer. The insurer was placed under provisional curatorship and the third respondent was appointed as provisional curator.

The insurer and the provisional curator sought the discharge of the curatorship order. The PA sought confirmation of the curatorship and variation of the order to replace the provisional curator with another person.

The main issues to be determined were whether the curatorship order should be confirmed or discharged and whether the provisional curator should be appointed as final curator.

The court held, on an ancillary issue, that it would be contrary to the interests of justice and the right to a hearing to deprive an entity in the position of 3Sixty of the right to be heard in order to oppose the granting of a final curatorship order. Therefore, the court did not deprive 3Sixty's board of that power by leaving it vested in a curator who acts under the control of the PA. The court therefore held that 3Sixty's board of directors would have the residual power to oppose the confirmation of the provisional curatorship order.

The PA alleged that 3Sixty was guilty of various statutory transgressions of the Insurance Act, was not in a sound financial position, and could not be restored into compliance with the regulatory regime. The Financial Sector Conduct Authority (FSCA) supported the application.

The parties disagreed on 3Sixty's proposed Internal Recapitalisation Plan (IRP). The stance adopted by the PA was that the IRP would not result in 3Sixty achieving financial soundness. It further argued that based on the common cause facts it was desirable for 3Sixty to remain under curatorship and good cause had not been shown for the setting aside of the provisional order. There were numerous issues surrounding the IRP on which the various experts expressed differing views. It was common cause there may be areas of uncertainty from legal and accounting perspectives.

The court held that it remains within the prerogative of the PA to consider and approve a recapitalisation plan under sections 39(6) to 39(10) of the Insurance Act. The court continued that it was not for the court to determine the viability of the IRP and this was not a review application regarding the exercise by the PA of its discretion on this issue. Moreover, the PA need not resolve the factual disputes by litigation, but must illustrate that its concerns are legitimate and that the appointment of a curator would assist in resolving its concerns. It was therefore not necessary for the court to resolve the factual disputes or make a definitive determination on the IRP.

The evidence showed that 3Sixty failed to prepare audited annual financial statements in accordance with the Companies Act and the International Financial Reporting Standards. Many other reportable irregularities were not addressed. 3Sixty also experienced governance issues, which existed for at least two years before the provisional curatorship order was granted.

The court was persuaded that the PA illustrated that its concerns were legitimate. The regulatory breaches would itself be sufficient to justify a curatorship order, combined with the governance issues and the liquidity issues that appeared not to have been rectified, and so the court found that curatorship was required to address these issues.

In regard to the protection of policyholders, the court held that the confirmation of the curatorship could well avoid liquidation and the risk of value destruction and prejudice. Confirmation would have beneficial consequences to the 3Sixty policyholders.

The court found that there were no preferable alternatives to curatorship.

At the hearing, the PA left it in court's hands to determine whether the provisional curator should remain or be removed. The court held that her unwillingness to continue acting as curator rendered it undesirable for her to be confirmed as curator, as it would force her to remain in that position against her will, a concept difficult to reconcile with our constitutional values. 3Sixty did not suggest an alternative candidate for appointment as curator and argued that a curator should be appointed by agreement between it and the PA. It objected to the appointment of the PA's preferred candidate on the basis that he lacked independence, having given an affidavit supporting the confirmation of the curatorship order and that his appointment would be detrimental. No other reasons were advanced why he would not be a suitable candidate. However, the court noted that this candidate's appointment was already raised in the PA's papers, prior to the hearing regarding the provisional curatorship. His credentials identified him as a person with the necessary qualifications for appointment. The court concluded that it was not desirable that appointment of the provisional curator be confirmed and that the proposed candidate should be appointed as final curator.

Lebashe Financial Services (Pty) Ltd v The Prudential Authority and Others

(346/2021) [2022] ZASCA 141 (October 24, 2022)

Keywords: liquidation / curatorship

A life insurer's parent company was placed in liquidation, resulting in the Prudential Authority (PA) investigating the financial health of the life insurer, since part of its assets would be lost due to the liquidation. The PA asked the insurer to prove that it could maintain sufficient funds to meet its capital requirements, but this could not be done. The PA then applied for the insurer to be placed under curatorship. The provisional curator reported that the insurer had limited prospects of successfully escaping its financial difficulties.

The PA then applied for liquidation of the insurer. The insurer argued that in terms of the Insurance Act, liquidation could not be sought while the insurer was under curatorship. Section 54(5) of the Insurance Act states that an "insurer or a controlling company may not begin or enter business rescue or be wound-up while under curatorship within the meaning of the Financial Institutions (Protection of Funds) Act, unless the curator applies for the business rescue or winding-up". Therefore the section provides that only the curator was competent to apply for liquidation of the company under curatorship. Section 57 of the Insurance Act provides that the PA may apply for the winding up of an insurer.

The court had to reconcile the two conflicting sections. The court noted that, having regard to the powers and duties of curators and liquidators respectively, curatorship and liquidation cannot co-exist. The court held that the Insurance Act does not seek to prohibit the institution of proceedings, but rather it stays the commencement of business rescue or winding-up by a resolution or court order while the insurer is under curatorship. The liquidation applications were not themselves rendered null and void. The provisional liquidation order was incompetent, but the application for liquidation was not. By operation of the law, the liquidation order was stayed while the curatorship was in place. It followed that the liquidation application could be proceeded with once the curatorship came to an end.

On the issue of whether the liquidation of the insurer would be premature, the court held that the curator had no duty to effect recapitalisation of the insurer. It merely had to take control of the business, investigate, and report its findings.

Financial service tribunal

Dlulane v Clientele Life Insurance

(FAB81/2022) [2022] ZAFST 105 (September 30, 2022)

Keywords: funeral policy / interpretation of the word "days" / grace period

The insurer rejected a claim under a funeral policy because the insured had not made payment of the premium for the month of December 2021, the month before the death of the life insured (she died on January 12, 2022).
The insured approached the FAIS Ombud, which dismissed the complaint.

The premium was due monthly and the policy stated that cover would not exist when death occurs in a month when the premium was not received. There was a 15 day grace period and the policy would lapse if the premium was not paid for three consecutive months.

The insurer stated that the monthly debit date was the 25th of every month, and the premium was paid on January 14, after the insured died. This was more than 15 days after the debit date.

The Tribunal could not find anything stating that the monthly debit date was the 25th of every month. Even if that was the case, December 25 is Christmas day and there were also other public holidays between then and the date of payment. Bank statements showed that the insurer tried to debit the account on December 31 (not December 25).

There was debate on whether business days or calendar days applied to the grace period. The Tribunal held that the word "day" is inherently ambiguous and its interpretation depends on the context and the understanding of the parties to the contract. The Tribunal found that there was no reason to assume that the applicant or an uninterested bystander would have attached a limited meaning to the word within the context of the policy.

The Tribunal therefore referred the matter back to the Ombud for further consideration.

Burns and Another v Financial Sector Conduct Authority

(A47/2020; A51/2020) [2022] ZAFST 128
(November 10, 2022)

Keywords: debarment / premium collection

The applicants were controlling shareholders of a premium collection corporation.

It was found that they contravened the Financial Institutions (Protection of Funds) Act for years, before their company was placed under statutory management, by failing to observe utmost good faith and failing to exercise proper care and diligence with regard to the premiums held and controlled by the company on behalf of various non-life insurers. This was because they improperly caused or permitted the company to use those premiums contrary to the provisions of section 45 of the Short-Term Insurance Act and the relevant regulations, by investing the funds in illiquid assets for the benefit of their companies.

They also therefore failed to continuously comply with the fit and proper requirements relating to the personal character qualities of honesty and integrity as evidenced by these unauthorised investments to the detriment of the insurance companies, which amounted to misappropriation of the premiums. This caused systemic risk to the non-life insurance sector and the financial services industry.

The applicants admitted that they required the consent of the insurers to use the premiums because the insurers, not the insureds, owned the premiums.

The insurers were aware that premium collectors usually held the funds in interest-bearing accounts and that they retained the interest. However, 'interest' in normal business language does not indicate returns on illiquid investments.

The application for reconsideration of the debarment was dismissed.

Million Dollar Farms (Pty) Ltd v Old Mutual Insure Ltd and Another

(FAB79/2021) [2022] ZAFST 143 (November 28, 2022)

Keywords: prescription / notification obligation

The insured had a property policy with the insurer covering loss or damage to the buildings on a farm as well as the owner's liability to third parties for bodily injury. The farm was occupied by a tenant. During a windstorm, the tenant's fianceé and a visitor sheltered near a wall which collapsed, killing the fianceé and injuring the visitor. The third-party visitor sued the insured a few days before her claim would have prescribed. The insured then notified the insurer of the claim about a month thereafter.

The insurer rejected the claim, alleging that the claim had not been notified to it at the time of the incident and that the claim had prescribed. The insured approached the Ombud, who dismissed his claim. He then approached the Tribunal for reconsideration of the matter.

The insurer stated that the claim was reported three years after the incident (whereas it should have been notified as soon as reasonably possible after the incident) and the insured had failed to inform the insurers of the incident when the policy was renewed. The insurer also argued that the buildings were not properly maintained, which was a condition for cover.

The insurer alleged that the requirement to notify as soon as reasonably possible was a condition precedent that places the obligation to prove compliance on the insured, but the Tribunal interpreted the provision as a term of the contract, which places the onus to prove breach of the term on the insurer.

On the facts, the Tribunal found that there was no evidence why, in the circumstances of this incident, it was reasonably possible for the insured to have notified the insurer of the incident earlier than it had done. The insured claimed that the tenant had not mentioned the possibility of a claim, the third-party had not had contact with the insured and they were not aware of the extent of the third-party's injuries. Further, despite being insured, the insured often carried small losses and was not in the habit of claiming for smaller losses.

In response, the insurer argued that the severity of the incident alone should have prompted notification. The Tribunal found this argument insufficient to prove a breach of the notification obligation and held that the insurer had not discharged the onus resting on it to prove its exemption from liability.

The Tribunal found that the insured's claim against the insurer and the running of prescription only arises once liability to the third-party in a fixed amount has been established.

The matter was remitted back to the ombud for further consideration.

Land Bank Insurance Company Soc Limited v The Prudential Authority

(PA1/2022) [2022] ZAFST 155 (December 19, 2022)

Keywords: administrative penalties

The Prudential Authority (PA) levied administrative penalties on the insurers for contraventions of the Short-Term Insurance Act (while it was in force) and contraventions of the Insurance Act. The Tribunal found that there was no provision in the Short-term Insurance Act that allowed for the imposition of an administrative penalty for a contravention of the relevant section. This was different for the contraventions under the Insurance Act.

The problem with adjusting the administrative penalties (of R5 million and R2 million) is that it was difficult or almost impossible to determine which portion was to be allocated to the contravention of the Insurance Act, and which portion was erroneously imposed for the contravention of the Short-Term Insurance Act. The penalties were also held to be excessive.

The Tribunal held that there was no indication that the Prudential Authority (PA), the companies, their shareholders or policyholders were in any way affected by the breach. It was apparent that the PA was more concerned about the general problems with the administration of the companies than with the seriousness of the particular contravention. In addition, the two companies were in effect twice penalised for the same omission.

The Tribunal therefore decided that a financial penalty was justified but in a lower amount. Penalties are discretionary matters and are not subject to calculation and in the Tribunal's estimation a penalty of R250 000 was appropriate.

Tax

F Taxpayer v Commissioner for the South African Revenue Service

(IT 45842) [2022] ZATC 1 (February 25, 2022)

Keywords: tax on insurance premiums

The issue to be determined was whether payment of insurance premiums to insurers qualified as an "expense" as contemplated in IFRS for SME's.

SARS refused a deduction of insurance premiums paid by the taxpayer to RMB Structured Insurance Limited (RMB) based on the application of s 23L(2) of the Income Tax Act which provides that "No deduction is allowed in respect of any premium incurred by a person in terms of a policy to the extent that the premium is not taken into account as an expense for the purposes of financial reporting pursuant to IFRS in either the current year of assessment or a future year of assessment".

SARS explained that the section was introduced to curb avoidance in the case of disguised investments in the wrapper of non-life insurance policies. More specifically, section 23L targets non-life insurance policies where RMB fails to accept significant risk from the policyholder. This type of policy is viewed as an investment policy, meaning that the policyholder may not deduct premium payments in respect of the policy.

The total risk identified by the taxpayer was R106 million. The taxpayer bought non-life insurance for R3.98 million being 3.76% of the identified risk, with the condition that the first loss incurred up to R19.9 million would be for the taxpayer. The remaining loss over the policy indemnity limit of R82 million would also be for the taxpayer's account. SARS concluded that the risk of 3.76% transfer to RMB is not significant as RMB did not accept the first loss from the taxpayer. The premiums must be linked with the risks, in that it must be consideration for the risks undertaken by RMB which is not the case with the taxpayer.

According to the taxpayer, RMB administered the policy through a so-called "experience account," with the balance accumulated at any given time being used to pay claims up to the maximum of the policy indemnity limit. In the event that the claim exceeds the balance of the experience account, the maximum claim is restricted to the policy indemnity limit.

The parties agreed that there was no specific IFRS standard dealing with the accounting treatment of insurance contracts from the perspective of the policy holder. The taxpayer thus obtained the expert opinion of accounting specialists on the application of IFRS. They advised that in circumstances where there is no specific standard that applies to a particular transaction, the International Accounting Standards Board had developed the Conceptual Framework for Financial Reporting (CFFR) to assist preparers of financial statements to develop consistent accounting policies.

The CFFR defines "expenses" as "decreases in assets" or "increases in liabilities" that result in a "decrease in equity" other than those relating to distributions to holders of equity claims. The question was therefore whether the payment of the premium to RMB by the taxpayer constituted an "asset" and, if not, whether such payment resulted in a decrease of the taxpayer's equity.

The CFFR defines an asset as a present economic resource that is controlled by an entity as a result of past events. Therefore the taxpayer submitted that to determine whether the premiums and the obligation to pay thereunder constitute an asset, two questions must be asked: first, whether there is an economic resource and second, whether the taxpayer controls the economic resource.

In terms of the CFFR, an economic resource is a right that has the potential to produce economic benefits. Under the policies, RMB would either have to settle claims from the experience account (if any) or if no claim was submitted, pay out the sums held by it to the taxpayer at the end of the policy period. Consequently, and so the argument goes, the taxpayer could receive either the remaining balance on the experience account or the insured amount if a risk materialised. In the circumstances, it appeared that an economic resource can be said to exist in the form of the potential remaining balance on the experience account or the insured amount if a risk materialises.

However, the taxpayer argued that it was clear that it did not control the economic resource. In terms of the CFFR, an entity controls an economic resource if it has the present ability to direct the use of the economic resource and obtain the economic benefits that may flow from it. Under the policies, it was RMB and not the taxpayer that directed the use of the insurance premiums for the duration of the policy. Put differently, the taxpayer had no access to the funds accumulated and no control over the credit risk. Accordingly, the taxpayer contended, payment of the insurance premium by it resulted in a decrease in its asset base and thus constituted an expense.

Against this, and despite SARS having previously agreed that IFRS 4 does not apply, reliance was placed squarely on IFRS 4. SARS quoted IFRS 4 in stating that the "definition of an insurance contract refers to insurance risk, which this IFRS defines as risk, other than financial risk, transferred from the holder of a contract to the issuer. A contract that exposes the issuer to financial risk without significant insurance risk is not an insurance contract." In essence, a contract will not be classified as an insurance contract under IFRS unless RMB accepts a significant risk to RMB in the event of the happening of the event that is insured.

During argument counsel for SARS confirmed that in its view, IFRS 4 did not apply, but that the dispute centres around "what then does apply". Put plainly, the defence SARS raised in its papers was contradicted by, and was at odds with, its own argument. In the circumstances, the only reasonable inference to be drawn was that, on its own version, SARS lacked prospects of success on the merits on its defence as it was formulated.

It was found that the taxpayer's case had sufficient merit to enable the granting of final relief. The taxpayer's case was supported by independent expert opinion. The taxpayer was successful.

Donald Dinnie
February 2023

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