The Big Read Book Series Volume 15

Norton Rose Fulbright South Africa's review of South African insurance judgments in 2023

March 2024

Introduction

Dearest Reader

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

This is volume 15 of the series – A review of South African insurance judgments in 2023.

An online version of this publication is available through our Financial Institutions Legal Snapshot blog at https://www.financialinstitutionslegalsnapshot.com/ with links to the judgments. You can also keep up with developments in insurance law including South African judgments and instructive judgments from other countries by subscribing to our blog through that link.

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Norton Rose Fulbright South Africa Inc

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Brokers

TWK Agri (Pty) Ltd v Botha and Others

(J125/2023) [2023] ZALCJHB 42
(March 7, 2023)

Keywords: broker / restraint of trade

The applicant, a broker of non-life and life insurance broker, marketed products through a network of brokers. The first and second respondents had been in an entity call Platorand Makelaars (Pty) Ltd and the third respondent was a competitor broker.

The applicant purchased Platorand's business (a non-life insurance book) as a going concern, including goodwill. The sale agreement included confidentiality clauses. The respondents became employees of the applicant, and their employment contracts included confidentiality clauses and a restraint of trade.

The respondents resigned from the applicant and attempted to buy a portion of the applicant's insurance book. This offer was rejected and the respondents allegedly contacted some of the applicant's clients to solicit their business. Seventy-two of the applicant's clients cancelled their policies, and allegedly joined the third respondent. The applicant sued the respondents for breach of contract and sought to enforce the restraint of trade.

The court considered whether the information the respondents had shared was confidential and a protectable interest. The information had clear economic value to the applicant because the respondents had offered to buy that information from the applicant. Part of the client list was originally purchased from Platorand and could not easily have been sourced from on Google, as the respondents alleged. The applicant's interests were therefore worthy of protection, and the court found that soliciting the applicant's clients was dishonest.

The respondents did not provide any reasons as to why enforcing the 12-month restraint of trade would be unreasonable, and the restraint was therefore upheld.

Business interruption insurance

43 Air School Holdings (Pty) Ltd and others v AIG South Africa Ltd

Case number: 30404/2021
(February 20, 2023)

Keywords: business interruption insurance / composite policy / joint policy / Covid-19

This judgment dealt with a Covid-19 business interruption claim under the business interruption non-damage extension and considered the nature of a composite and joint insurance policy.

On the facts, the court was satisfied that the third applicant was a joint insured under the policy. The court also found that the second, third and fourth applicants (all separate juristic entities insured under the policy) could seek relief where only the second applicant had submitted a claim for business interruption.

The insurer had argued that because the second to fourth applicants were separate juristic entities carrying on business at different locations, they could not rely on the second applicant's claim under the policy to claim for the same incident.

The court found that where there was a case of Covid-19 within the relevant radius of some (but not all) of the second applicants' premises, the parties were all affected by the loss. It was evident that the event affecting one facility had affected others as well.

On a reading of the policy, the "business" was all of the places where business was conducted, and "where business was conducted" was a factual determination.

The court held that on the flexible, common-sense approach to interpretation set out by the Supreme Court of Appeal in *Guardrisk v Café Chameleon*, there was no bar to the claim where the businesses shared the same facilities to conduct training, to provide support, and to conduct on-going or secondary training.

Note that the court granted the insurer leave to appeal the judgment to the Supreme Court of Appeal, particularly on the issues of joint and composite insurance and on the interpretation of the insurance contract.

Competition law

Sanlam Emerging Markets Proprietary Limited and Another v SAN JV (RF) Proprietary Limited

(LM100Aug22) [2023] ZACT 40; [2023] 3 CPLR 44 (CT) (August 17, 2023)

Keywords: merger / competition law

In August 2023, the Competition Tribunal conditionally approved the large merger through which Sanlam Emerging Markets Proprietary Limited (**SEM**) and Allianz Europe B.V. intended jointly to acquire control of SAN JV (RF) Proprietary Limited. SAN JC is a holding company for the Sanlam Group's strategic investments in Africa and does not carry out any direct commercial activities in South Africa. SEM already had a 90% shareholding in SAN JV.

The proposed transaction envisaged the Sanlam and Allianz groups contributing some of their respective African operations to a South African joint venture holding company called Sanlam Allianz Africa, operating as a pan-African life and general insurance joint venture across Africa (but excluding South Africa).

Although the parties would not carry out any operations together in South Africa, the Sanlam and Allianz groups have an ongoing competitive relationship in South Africa. The Commission was therefore concerned that the joint venture could be used to exchange competitively sensitive information in South Africa. The approval of the proposed merger was therefore given subject to limits on the flow of competitively sensitive information between the Sanlam and Allianz groups.

To guard against Sanlam Allianz Africa introducing any activities in South Africa other than those related to aYo SA (the parties' distribution and marketing intermediary), an express condition was imposed. The condition limits Sanlam Allianz Africa's activities in South Africa to the distribution of insurance products on behalf of the Sanlam Group through aYo SA. The merging parties agreed to the condition being imposed.

Sanlam Ltd and Sanlam Life Insurance Ltd v AfroCentric Investment Corporation Ltd

(LM165Dec22) [2023] ZAFST 22 (May 17, 2023)

Keywords: merger / competition law

In April 2023, the Competition Tribunal unconditionally approved the proposed acquisition of AfroCentric Investment Corporation Ltd by Sanlam Ltd and Sanlam Life Insurance Ltd. Sanlam already indirectly controlled AfroCentric's operating assets, which in turn controlled the majority shares in ACT Healthcare Assets (Pty) Ltd. Once the proposed transaction was implemented, Sanlam would have sole control over the AfroCentric Group. The parties had already been providing services to each other and the merger deepened Sanlam's investment in AfroCentric.

Santam Ltd v Mobile Telephone Networks (Pty) Ltd and Others

LM175Jan23) [2023] ZACT 15; [2023] 2 CPLR 23 (CT) (April 24, 2023)

Keywords: competition law / acquisition approved

In March 2023, the Competition Tribunal unconditionally approved the large merger through which Santam Limited intended to acquire the device insurance policies marketed and distributed by MTN South Africa (and at that time underwritten by Guardrisk Insurance Company Limited through a cell structure), together with certain assets and liabilities related to the policies (the **MTN Portfolio**). Once the proposed transaction was implemented, Santam would become the underwriter of, and therefore acquire sole control over, the MTN Portfolio. The MTN Portfolio comprises the device insurance policies marketed and distributed by MTN to its clients.

Telesure Investment Holdings v Renasa Holdings Proprietary Limited and Others

(LM107Sep22) [2023] ZACT 31 (January 23, 2023)

Keywords: competition law / merger

The competition tribunal conditionally approved the large merger in terms of which Telesure Investment Holdings acquired all of the issued shares of Renasa Holdings Proprietary Limited, Concourse Holdings Proprietary Limited, and Summit Risk Holdings Proprietary Limited. Once the merger was implemented, Telesure Investment Holdings would have sole control over the target firms.

The tribunal noted that the proposed merger was unlikely to prevent or lessen competition in any relevant market. The transaction was approved, subject to the parties addressing potential public interest concerns and creating a development fund to provide education funding for historically disadvantaged learners at historically disadvantaged tertiary institutions. The Commission found that this commitment will ultimately result in a positive public interest outcome and the merging parties agreed to the condition.

Fraud

Discovery Insure Limited v Masindi

(534/2022) [2023] ZASCA 101 (June 14, 2023)

Keywords: fraud clause / retrospective cancellation

In this Supreme Court of Appeal judgment, the court reaffirmed that insured persons have a duty to act in good faith in their dealings with insurers. Wilfully lodging a false claim constitutes a breach of the duty of good faith, which entitles the insurer to terminate the policy.

In the absence of an express term to the contrary, wilfully lodging a false claim relieves the insurer of liability under the policy from the time of termination of the policy, although rights and obligations that accrued before termination remain unaffected by the termination.

The insured submitted a single claim under the building section of the policy for losses caused by storm damage to his residence. The claim was made up of two components. The first was for the cost of repairs to the insured's residence and damage to household contents. The second was for emergency accommodation. The claim for emergency accommodation was tainted by fraud. That was not in dispute.

The insurer paid the claim, but once evidence of fraud came to light, the insurer notified the insured of cancellation of the policy with retrospective effect from the date of the incident that had triggered the claim, as it was entitled to do in terms of the policy. The insurer also claimed repayment of the full amount it had already paid out to the insured for the physical damage.

Fraud clauses, including forfeiture clauses, are common features in insurance contracts and they are enforceable. They are designed to protect the insurer against fraudulent claims and to discourage inflated claims. If the insured submits a fraudulent claim which is then paid out, the insurer is entitled to recover the full amount paid out to the insured.

The relevant clause was clear and unambiguous and created the right for the insurer to terminate the policy retrospectively from the date of the incident giving rise to the claim and not only on discovery of the insured's fraud. This led to the insured forfeiting all amounts already paid after the date on which the incident giving rise to the claim had occurred.

No insurance policy existed when the insured purported to submit his claim because it had already been terminated with retrospective effect from the date of the incident (the day before the claim was notified).

The insurer was therefore entitled to a refund of all amounts paid to the insured.

The court declined to deal with the argument that the forfeiture clause was a penalty clause in contravention of the Conventional Penalties Act because the issue had not been pleaded or canvassed at trial but emerged for the first time in lower court's judgment. Whether such clauses are penalty clauses, and the application of the Conventional Penalties Act remains to be dealt with in the context of fraud clauses if and when properly pleaded and canvassed at the trial.

Molefe v Miway Insurance Company Ltd

[2023] ZAGPPHC 2238; A189/2022 (June 20, 2023)

Keywords: motor vehicle theft / fraud / dishonesty / materiality

The insured instituted a claim against the respondent insurer for payment of the replacement value of his stolen motor vehicle. The insurer rejected the claim, alleging that the insured had supplied dishonest information when making the claim.

The insured alleged that he had given a lift to two women and had stopped to purchase food along the way. The insured could not remember what happened next, only that he awoke the next morning in an unknown location – without his vehicle, cell phone, keys, and wallet. His evidence was that he was dizzy but managed to return home. He then went to the police station to open a case of theft of his motor vehicle. He suspected that the women had drugged him.

The insured cooperated with the insurer in its assessment and verification of his claim, but the insurer alleged that the insured had provided dishonest information, and rejected his claim.

The insured had provided information to the insurer that, at a later stage, was found to be incorrect. This related to whether the insured dropped the two women off before or after he lost consciousness, where the alcoholic beverage was in his vehicle, and the time he left the social event. The trial court therefore found the insured to have acted fraudulently and dismissed his claim.

The appeal court however noted that the insurer's pleaded case was that the claim had been "dishonest" – it had not alleged fraud, at the trial court had therefore misdirected itself in considering fraud. The appeal court considered whether the discrepancies in the insured's information were so material and prejudicial to the insurer that they entitled the insurer to reject the claim. On the evidence, the court found that the insured's vehicle had been stolen.

The court stated that the test is therefore whether any dishonesty or discrepancies in the insured's version are material to the insurer's obligation to indemnify the insured. The insurer did not lead any evidence establishing how and on what basis it was allegedly prejudiced. The court therefore concluded that the discrepancies in the insured's version were not material and ordered the insurer to pay his claim.

Group insurance

KGA Life Limited v Multisure Corporation (Pty) Ltd and others

[2023] ZASCA 122 (September 20, 2023)

Keywords: group insurance scheme / funeral insurance / unenforceable / Insurance Act 2017 / s67

The Supreme Court of Appeal held that, where 8 000 individual funeral policy members had formed part of a group scheme under the Long-term Insurance Act 1998 (which, since July 1, 2018, was no longer a "group" scheme as defined in the Insurance Act 2017), the insurance policies and related intermediary agreements became invalid and unenforceable. The insurer and the intermediary had the duty to change the terms on which they conducted business within the two-year window period after July 1, 2018, to preserve the rights of policyholders.

From July 1, 2018, the scheme did not qualify as a group scheme under the 2017 Act, which requires:

> *"an autonomous association of persons united voluntarily to meet their common or shared economic social needs and aspirations (other than obtaining insurance), which association is democratically controlled."*

The insurer and the intermediary (which sought to move the business and related debit orders to another insurer) conceded that the group did not comply with the current legislative provisions. It therefore became unlawful for both insurer and intermediary to continue with the group arrangement. The legislature has expressly prohibited group schemes that do not comply with the requirements set out above. The contracts were therefore afflicted by supervening illegality of performance, and performance under these kinds of contracts is impossible.

The fact that the judgment found in favour of the insurer does not amount to the court sanctioning the insurer's non-compliance with the 2017 Act. It also does not sanction the insurer's subsequent conduct in continuing to receive premiums and carrying on business as usual without making substitute arrangements under section 67 of the 2017 Act.

The Funeral Federation of South Africa was a friend of the court during the trial. The court, in considering the Federation's submissions on the consequences of the outcome for the funeral industry, directed that a copy of the judgment be referred to the Prudential Authority. These issues have existed for some time and the hope is that problems will be dealt with constructively.

The important issue of what arrangements could be made under section 67 was not addressed. A group scheme under the 1998 Act only required a scheme or arrangement that provided for entering into one or more policies in terms of which two or more persons without an insurable interest in each other were the lives insured. A possible remedy under section 67 would be to substitute the premium-paying member lives assured as the policyholders, thus allowing the premium collection to continue for their individual policies and the insurance to be maintained.

Treating customers fairly principles also demand that there should be no unnecessary barriers to insured persons moving their policies to another insurer offering better terms (as was the case in this matter). Leaving the policyholders with invalid insurance instead of better insurance does not fulfil any objective of the insurance legislation. The best solution would be for the Prudential Authority to endorse the use of the provisions of section 67 to achieve such an outcome. This is not an issue affecting only the 8 000 policyholders in this matter. It affects members throughout the funeral insurance industry. Each policyholder in this case paid their premiums directly to the insurer from their SASSA grants, and in everything but strict name they are the policyholders and can be accommodated as individual policyholders under section 67 arrangements.

Life insurance

Navigare Securities (Pty) Limited and Another v Vickers and Peters Financial Planning (Pty) Limited and Another

(29108/2022) [2023] ZAGPPHC 727 (August 21, 2023)

Keywords: life insurance / conditions precedent

The plaintiffs sued the defendant insurer under a group life scheme insurance policy. The first plaintiff entered into the policy for the benefit of its existing and future employees.

The claim related to the first plaintiff's CEO. The insurer partially paid the income continuation benefit under the policy when the CEO became ill in 2016. The CEO died in 2021, and his deceased estate claimed payment of a life cover benefit under the policy. This benefit was partially paid by the insurer.

The insurer rejected the claim for full life cover benefit, alleging that the CEO had failed to provide medical evidence showing that he was in good health when he was added to the policy. The plaintiffs alleged that the insurer should have requested medical evidence within a reasonable time after the CEO was added.

The insurer objected to the plaintiff's particulars of claim on the basis that they did not clearly set out whether the claim was for specific performance or for damages. The insurer also argued that those two claims were mutually destructive.

The court considered the Group Risk Life Plan, which it said was fundamental to the claim. The conditions of the plan required written notice of acceptance of the benefits being given to the insurer before liability would arise. Medical evidence was also necessary for cover in excess of the free cover limit.

The court found that these were conditions precedent to the insurer assuming liability and therefore that the insured had to prove that it had fulfilled these conditions. The court found that the plaintiffs failed to plead fulfilment of those conditions and provided no evidence that they were fulfilled. Failure to plead fulfilment of all conditions precedent to full cover would be fatal to the plaintiff's claim.

The court found that the plaintiff's particulars of claim were vague and embarrassing in that they failed to disclose a cause of action. The court ordered the plaintiffs to amend their particulars of claim, failing which the defendant could apply to have the claim set aside.

Delpaul v Hollard Life Assurance Co Ltd

(18301/2018) [2023] ZAGPJHC 745 (June 30, 2023)

Keywords: life insurance / benefit groups / multiple claims

A life insured, who suffered from heart and arterial disease in April 2012 (which required a coronary stent), was paid 10% of the benefit amount, received a bi-femoral bypass, and was paid 90% of the benefit amount in July 2012. The insured was paid another 100% of the benefit amount following an acute heart attack on August 15, 2015.

The policy provided that the benefit specified in the schedule (the total benefit amount) was payable if the insured suffered one of the "events or conditions" described in the policy under thirteen separate benefit groups.

A reinstatement clause automatically reinstated the benefit amount after a 14-day survival period, if an event, totally unrelated to the condition or event for which a previous claim was paid, occurred.

The benefit groups included a cardiovascular benefit group, a cancer benefit group, other benefit groups, and a catch-all benefit group. The cardiovascular benefit group identified 12 events and provided that only one payment would be made per cardiovascular event, with a single event being defined as all cardiovascular conditions or procedures that occurred within a 30-day period.

According to the reinstatement of benefit clause, if the conditions giving rise to the two claims were unrelated, then only 14 days would have to expire between the first and second claim. Both claims could then be paid up to 100% each, as the benefit amount automatically topped up for unrelated claims after 14 days. The policy did not provide that once 100% of the benefit amount in a particular group had been paid, no further payments would be made for such group. Because there were 12 events described under the cardiovascular group, the insured could claim for each event once. The insured could, in principle, claim for a different event every six weeks. A single event was defined as all cardiovascular procedures occurring within a 30-day period, and a claim would only be admitted after a 14-day survival period.

According to the express wording, the policy responded per event. Therefore, despite the insured having been paid 100% of the benefit amount for the first two events, the court found that he was entitled to 100% for the third event.

This was an unusual case where a number of conditions resulting from heart disease occurred. It is difficult to rely on the judgment as a precedent because of how the case was presented to the court. For instance, no medical opinion evidence was led as to whether the cardiovascular events were related or not.

Saaiman N.O and Another v Suidwes Landbou (Pty) Ltd

(KP177/2018) [2023] ZANWHC 87 (June 23, 2023)

Keywords: credit insurance / life insurance

The plaintiff (a Trust) applied for credit from the defendant, Suidwes Landbou. One of the conditions for granting the loan was the procurement of a life insurance policy on the one life of the trustees (either credit life insurance or life insurance, with the latter being the cheaper option). The credit life insurance was a product of Suidwes, while life insurance would be taken with Liberty. The Trustees opted for the life policy, with premiums payable annually. The policy was to be ceded to Suidwes to cover the Trust's indebtedness to it. It was agreed that Suidwes would pay the annual premiums to Liberty on behalf of the Trust. The Trust would then repay the premium.

Suidwes paid the first and second annual premiums but did not pay the 2016 premium, allegedly due to non-payment by the Trust in relation to its loan obligation. The insurer cancelled the policy, and when the relevant trustee died, the policy did not pay out. The life insurance policy was meant to be used as cover for the loan. The Trust then sued Suidwes for its failure to pay the premium. The Trust alleged that the loan amount would have been settled had the premium been paid and the policy paid out.

The court interpreted the agreement between the parties and found that the Trust was obliged to take out and maintain the insurance to cover the loan – the premiums would be for the Trust's account but would be paid on behalf of the Trust by Suidwes and recovered from the Trust by debiting the premiums against the Trust's account with Suidwes. The agreement contained a clause in which the Trust indemnified Suidwes against any liability whatsoever if, for any reason, the life insurance was not secured or if the insurance company for any reason failed to make payment in terms of the contract of insurance.

The court found that it was clear that the obligation to secure insurance vested with the Trust, which it was obliged to cede the proceeds to Suidwes. The Trust was also obliged to ensure that the insurance remained in force and maintained for the duration of the agreement with Suidwes. The Trust's claim was therefore dismissed.

Majiedt N.O and Another v Prinsloo

(641/2021) [2023] ZAFSHC 201 (May 19, 2023)

Keywords: life benefit / interpretation of the Long-term Insurance Act / s63

The court had to determine whether the proceeds of a life insurance policy received by a deceased life insured's wife were protected in by section 63 of the Long-term Insurance Act.

The deceased life insured and his wife were married in community of property. The deceased died in 2018, and the court placed the deceased joint estate under sequestration in 2020. The defendant was the son of the deceased and his wife.

The wife received a benefit of R10 million in April 2018, two months after the deceased's death. She transferred that benefit to the defendant. The plaintiffs (the insolvency practitioners in charge of the insolvent joint estate) applied to have that transfer of benefits set aside.

The defendant alleged that the benefits from a life insurance policy are protected under section 63(1)(b) of the Long-term Insurance Act and are therefore not available for the purpose of paying the deceased insolvent joint estate's debts.

Section 63 states:

"Protection of policy benefits under certain long-term policies

1. Subject to subsections (2), (3) and (4), the policy benefits provided or to be provided to a person under one or more-

    (a) in respect of a registered insurer, assistance, life, disability or health policies; or

    (b) in the case of a licensed insurer, policies written under the risk, fund risk, credit life, funeral, life annuities, individual investment or income drawdown class of life insurance business as set out in Table 1 of Schedule 2 of the Insurance Act, in which that person or the spouse of that person is the life insured and which has or have been in force for at least three years (or the assets acquired exclusively with those policy benefits) shall, other than for a debt secured by the policy-

        (i) during his or her lifetime, not be liable to be attached or subjected to execution under a judgment of a court or form part of his or her insolvent estate; or

        (ii) upon his or her death, if he or she is survived by a spouse, child, stepchild or parent, not be available for the purpose of the payment of his or her debts.

2. The protection contemplated in subsection (1) shall apply to policy benefits and assets acquired solely with the policy benefits, for a period of five years from the date on which the policy benefits were provided.

3. Policy benefits are only protected as provided in-

    (a) subsection (1) (b}, if they devolve upon the spouse, child, stepchild or parent of the person referred to in subsection (1) in the event of that person's death; and

    (b) subsection (1) (a) and (b), if the person claiming such protection is able to prove on a balance of probabilities that the protection is afforded to him or her under this section.

4. Policy benefits are protected as provided for in subsection (1) (a) and (b), unless it can be shown that the policy in question was taken out with the intention to defraud creditors."

The court held that the word "person" in section 63 must be interpreted as a reference to the policyholder. Similarly, the words "his/her" and "he/she" are linked to the word "person" and should therefore also be interpreted as references to the policyholder.

Section 63 is therefore only applicable in instances where the policyholder (or their spouse) is the life insured and the policyholder is also the beneficiary in terms of the policy. Where a third party is appointed as beneficiary and the beneficiary accepts the appointment upon the death of the policyholder, section 63 is not applicable.

Since the wife was not the policyholder, the court found that the benefits were not protected under section 63.

PWR v Discovery Life Limited and another

Case no: 17/18098 (March 31, 2023)

Keywords: life insurance / disability / totally and permanently unable to work / reasonable insurer

The life insurer rejected the life insured's claim both on the basis that the cover had expired and because there was no evidence that the insured had become totally and permanently unable to perform his work as at that date. Alternatively, if the insured's condition had become permanent, the insurer was nevertheless justified in rejecting the claim because the insurer had to be satisfied regarding permanence by that date.

The court was satisfied that, on a balance of probabilities, the insured suffered from post-traumatic stress disorder and unspecified bipolar mood disorder. Despite treatment, the insured's condition rendered him totally and permanently unable to resume his occupation as a stockbroker.

The court said that there was plainly a difference between the fact of a condition and the evidence necessary to establish the facts. While nobody could have identified the permanency of the insured's condition on November 30, 2015, it was clear on the evidence before the court that the condition was in fact permanent by that date – even if the evidence necessary to establish that permanence only came to light later.

The insurer's alternative argument was that, even if on the evidence the insured was "totally and permanently unable" to work before his policy expired, the question was not whether, as a fact, the insured had become permanently incapacitated by that date. Instead, the question was whether the insurer had unreasonably concluded that he had not. The insurer relied on the policy text which provided that the insurer would pay out a capital sum "once it is established to the *satisfaction of the insurer* that the life insured is totally and permanently unable" to work as a stockbroker.

The parties agreed that the text meant that the insured had to establish facts that would satisfy a "reasonable insurer in the position of the insurer of the insured's total and permanent inability to perform the plaintiff's nominated occupation as a stockbroker due to sickness, injury, disease or surgery".

The question was therefore whether the insurer's opinion was reasonable. The court said that the reasonable insurer test can only be applied where justified by the text of a particular policy.

Although the relevant clause stated that the insurer would pay out on being satisfied of the insured's incapacity, that clause had to be read in the context of the policy as a whole. Clause 6.1.1 of the policy described the Capital Benefit as one that pays "a capital amount in the event of the insured being medically impaired to a degree that he is unlikely to be able to generate an income". The court said that that language is objective. The benefit accrues at the point that impairment comes into existence and does not depend on the insurer forming any particular opinion.

The court said that there will often be a lag between the onset of permanent incapacity and the point at which anyone can say that the incapacity is permanent. By drawing a distinction between the onset of the incapacity and proof to the insurer's satisfaction that the incapacity is permanent, the policy recognised this lag.

The court held that the insurer's liability under the policy was triggered when the insured's inability to perform as a stockbroker objectively became permanent.

But the duty to pay out on the policy was only triggered once the insurer could be reasonably satisfied that the insured's condition had become permanent (once there were facts in existence that would have satisfied a reasonable insurer that the insured's incapacity had become permanent). The court said that this occurred in April 2019, when the relevant treating expert formed the view that there was no realistic prospect of significant improvement in the insured's condition. In order to assess whether the insured's condition was permanent, the insurer therefore had to have regard to evidence generated well after the policy had expired. Closing the door to that evidence when it rejected the claim was "plainly unreasonable".

Judgment in the amount of R25 million was given in favour of the insured.

Litigation insurance

Various parties obo minors v Anglo-American South Africa Limited and Others

(2020/32777) [2023] ZAGPJHC 1474 (December 14, 2023)

Keywords: class action / litigation funding / ATE (After-the-Event) insurance

The applicants had failed to have the class certified during the preliminary stages of the class action. The application was dismissed with costs.

While the applicants argued that an adverse costs order would have a chilling effect on class actions raising human rights issues, the court rejected this argument. The court noted that the prospect of an adverse costs order had had no effect on the applicant's funders – the funders had insurance for costs and were "litigating with gusto". Neither the applicants, nor their attorneys, nor their funders would pay an adverse costs order out of their own pockets.

Class actions are huge undertakings and, given the breadth and complexity of the proposed litigation, they may be litigated through multi-jurisdictional legal teams. The estimated costs to trial are substantial. The applicant and prospective class members, most of whom are indigent, could not meet these costs. This necessitated third party litigation funding and contingency fee arrangements to make the litigation possible.

First, third party funding was secured from one of the UK's largest litigation funders. Second, the funder secured After-the-Event (ATE) insurance coverage from an international insurer, with an indemnity of £2 million. This coverage would protect the applicants and the class members in the event of an adverse costs order. The policy schedule reflected the class members and the funder as the insured. Finally, there was a contingency fee agreement with the attorneys.

The respondents argued that the indemnity limit of £2 million was not sufficient to meet the potential adverse costs order. The court found this complaint to be without merit because the respondents did not explain why the amount was inadequate. The respondents then criticised the fact that it was not a beneficiary of the insurance policy, despite recognising that its interest in honouring adverse cost orders deserve consideration. The respondent's potential to recover costs is one consideration, but it is not the main consideration. The existence of any measures to satisfy costs counts in favour of certification.

The respondents then alleged that there were restrictions in the insurance policy which meant that a favourable costs award for the respondent was unlikely to be honoured. It relied on an Australian judgment dealing with security for costs, which concerned whether a litigant could rely on an ATE policy instead providing security for costs. The court stated that that judgment was irrelevant because this court was not hearing a security for costs application. Class certification does not require security for costs to be provided. Arrangements made for adverse cost orders to be honoured is one factor to be weighed. The court found that the ATE insurance policy provided an additional safeguard to the respondent.

Costs were therefore granted in favour of the successful defendant.

Misrepresentation and non-disclosure

Samchem Corporation (Pty) Ltd v Compass Insurance Company Limited

2021/27074) [2023] ZAGPJHC 1233 (October 30, 2023)

Keywords: breach of warranty / material misrepresentation

The insurer unsuccessfully rejected policy liability on the basis of a material misrepresentation, alternatively, breach of a warranty.

Insurance had been obtained for a once-off all-risks transit cover for personal protective equipment.

In proposing for the insurance, it was recorded that the goods would be transported by professional third-party carriers. They were not. The insured had hired a truck and a driver. The truck and goods were hijacked. The truck was later recovered but the goods were not.

The insurer's evidence was that had the insured not represented that the goods would be conveyed by professional third-party carriers, the proposal would have been escalated to determine whether the risk was acceptable. If it had accepted the risk, the premium and excess would likely have been increased.

The court rejected the insurer's submission that there had been an actionable misrepresentation. On a sensible and business-like interpretation of the policy, the insurer expressly permitted the insured to convey the goods in a conveyance owned, hired, or operated by the insured. It was therefore the insurer who chose to contract with the insured in the manner that gave it the choice to hire the truck and appoint its own driver instead of conveying the goods with a professional third-party carrier. The insurer had the opportunity to include all relevant terms and conditions that deemed it essential to protect itself but did not do so.

It was undisputed that the policy contained an express warranty that there had to be live tracking of the relevant motor vehicle. There was no provision that the satellite tracking device had to be monitored at all times. It was common cause that after the claim, the insurer changed its policy wording to insert the requirement that the satellite tracking device had to be monitored.

On the facts, the court said that there was no basis to read the monitoring requirement into the warranty. The amendment to the wording after the claim was made was a result of the insurer realising that the wording was ambiguous. The insurer could have, but failed to, remove that ambiguity when it contracted with the insured.

A court will not easily read additional terms into a warranty where the insurer had the opportunity of recording the insured's obligations under the warranty clearly, and did not do so.

Normadien Farms (PTY) Ltd v SAFIRE Crop Protection Co-operative Limited

(8960/2016P) [2023] ZAKZPHC 6 (January 26, 2023)

Keywords: fire insurance / misrepresentation / non-disclosure / materiality

The insured instituted action against the insurer in relation to a claim arising from a fire on the insured farm in May 2015. The plaintiff alleged that the fire caused damage in the sum of about R14 million. The plaintiff's claim was rejected in June 2016, on the grounds that the plaintiff had misrepresented which portion of the farm the fire had originated from. The insurer alleged that the fire started in a sawdust and timber waste area and that the plaintiff had failed to mention this waste area in the insurance renewal form. The waste area required a fire break of at least 30 meters wide around the immediate exterior perimeter, and the plaintiff failed to maintain that fire break. The evidence of both parties was voluminous and a number of witnesses were called.

The court noted that the insurer had to prove the materiality of a misrepresentation or non-disclosure, and that the test is objective – would a reasonable person think that the risk should have been disclosed to the insurer? The test for inducement to enter into the contract remains subjective: was the particular insurer induced to issue the policy by the material non-disclosure?

On the evidence, the court concluded that the sawdust heap must have been the origin of the fire, and it was common cause that the plaintiff had not informed the insurer of the sawdust heap. The plaintiff's evidence was that it had been dumping at the site since 2003, to fill up the area to allow it to plant more trees there. The insurer alleged that allowing sawdust and timber waste to be dumped in that area increased the risk of fire.

The policy was taken out in 2001. In the 2015 renewal proposal form, the plaintiff answered "no" to the question of whether there were any factors that had increased the farm's fire risk since the last proposal form was completed. The court accepted that this was a reasonable response because the plaintiff had been dumping at the sawdust site since 2003 and there had been no fire in that area since then. The court therefore did not find the answer to have been a misrepresentation or fraudulent.

It was never disputed that the dumping had taken place at the sawdust dump area. The question that the court had to consider was instead whether there was a duty to disclose the dump site to the defendant. The court noted that there was no specific mention in the insurance certificate or in any other documents indicating that dumping sawdust waste was not allowed. The plaintiff was of the view that it was not a fire hazard, while the insurer alleged that it was a fire risk that had to be disclosed.

The court noted that the insurer alleged that it was convinced in November 2015 (or latest by December 2015) that the fire had originated from the sawdust site but did not mention this to the plaintiff until March 2016. There was an inquiry in this regard in February 2016, but there was still no indication that the insurer was of the view that there was a possible breach of the conditions of the policy, which would entitle the insurer to cancel the agreement. On the contrary, the insurer had asked the plaintiff what the salvage value of the timber that remained would be. By the end of April 2016, the claim had still not been paid and so the plaintiff took out cover with another insurer. The defendant insurer only rejected the plaintiff's claim in June 2016.

The court asked why, if the insurer was, in November 2015, of the view that a breach allowing termination and rejection had occurred, it did not terminate or reject the claim until June 2016. The court found that it was not necessary to conduct such a lengthy investigation to come to that decision. The court therefore concluded that the defendant insurer was itself not convinced about the origin of the fire and its decision to reject the claim.

In determining whether a reasonable person in the plaintiff's position would have considered it necessary to inform the insurer of the waste site, the court noted that the plaintiff had been dumping at that site for approximately 12 years. It would be reasonable that a person in that position, in circumstances where no fire had occurred, would not regard it necessary to inform the insurer of the site.

Even if the waste site did increase the farm's fire risk, the insurer's witnesses accepted that trees were pruned and trimmed and waste was left on the ground, which increased the risk of fire, and it was not considered necessary that that risk be reported. The insurer also did not think the risk was sufficiently material to raise it with the plaintiff immediately. Further, if it was considered to be such a serious fire risk, the court was of the view that one would expect it to be specifically contained in the policy document.

The court found that the insurer failed to prove that the disclosure of the dump site would have affected its decision to insure the property. The plaintiff was not guilty of material misrepresentation or non-disclosure and the insurer was ordered to pay the claim.

Motor vehicle insurance

Seepi v King Price Insurance Company Ltd

(72341/2018) [2023] ZAGPPHC 2044 (December 21, 2023)

Keywords: motor vehicle accident / non-disclosure / evidence of damage / quantum

The plaintiff claimed R300 000 from his insurer, which he alleged was the value of his motor vehicle after it had been written off, less the value he received for selling the wreck. The insurer rejected his claim due to non-disclosure of material information at the inception of the agreement.

During the trial, the plaintiff conceded that he was involved in two incidents in 2014, the first being a windscreen chip after being hit by a stone, and the second being damage to his side mirror glass when a cyclist drove into him. He confirmed that he did not inform the insurer of these two incidents during a 2017 sales call and alleged that this was because, while he had lodged a claim for the two incidents with his previous insurers, he had decided to fix the damages himself at a rate lower than his excess. The plaintiff conceded that a reasonable person would understand that this information is required for the proper assessment of risk by the insurer.

Even though the insurer rejected the claim on the basis of material non-disclosure, the court found that the plaintiff had failed to prove any facts to support his claim of indemnity in terms of the insurance policy.

The plaintiff had testified that there was an accident, yet was reminded during cross-examination that there was a dispute as to whether an accident had occurred, the damages that resulted, and in relation to the quantum claimed. The plaintiff did not respond to those issues in dispute, and as a result, no evidence of the actual accident and damages suffered was before the court.

Therefore, the plaintiff failed to prove facts necessary to bring his claim within the terms of the insurance contract, and, with no claim to meet, the insurer never attracted an onus. The plaintiff's claim was dismissed.

King Price Insurance Company Limited v Mhlongo

(Case no 1016/2022) [2023] ZASCA 152 (November 15, 2023)

Keywords: motor vehicle accident / proof of quantum

The appeal court dealt with an insurance claim in which the insured's motor vehicle was written off in a collision. The issue was whether the insured had produced evidence that supported his pleaded case on quantum.

The insured confirmed that he claimed, as damages, the market-related value of his vehicle. Yet he had presented no evidence on the market value of the vehicle, and conceded under cross-examination that he had no knowledge of its market value.

The only evidence presented by the insured to establish the damages was a written settlement quotation supposedly provided by the bank that had financed the purchase of the vehicle, which stated the settlement amount due to the bank under the finance agreement. The court pointed out that the insured had not pleaded damages based on the settlement amount. Nor had he proved that amount adequately.

The court said that it is trite that it is for a plaintiff to prove its damages. Where the insured had elected to frame his damages as the market-related value of the vehicle, the insurer was entitled to defend the action on the basis that the insured had not discharged his onus. There was no duty on the insurer to plead or present evidence to prove an alternative quantum of damages.

The court found that the insured had failed to prove his pleaded damages. The insured's claim was therefore dismissed.

Claimants can lose sight of first principles in the fog of a claim and litigation. An insured bears the onus of establishing its claim – including the quantum – on a balance of probabilities. The dispute can only be decided on the pleaded and proven case.

Payment of premium

Clientele Life Assurance Company Ltd and Another v Payment Association of South Africa

(2021/42435) [2023] ZAGPJHC 987
(September 4, 2023)

Keywords: payment of premiums / bank reversals / debit orders

Clientele Life (a life insurer) and Clientele General (a non-life insurer) applied to court for an order against the Payment Association of South Africa (PASA). PASA is the only body recognised by the South African Reserve Bank as a payment management system under the National Payment System Act. It has many banks as its members.

Clientele's contracts usually include a debit order for premiums. PASA's rules grant insured persons the ability to reverse payments, and Clientele became concerned at the increasing rate of debit orders going through but then being reversed.

Clientele has no means of contesting the reversals. Clientele sought a rule change to allow it an opportunity to provide proof of a valid mandate before reversal takes place. The main cause of action is that the money reversed from its account with its bank is its property, under section 25 of the Constitution, of which it may not be deprived of. Alternatively, Clientele sought judicial review of PASA's decision to make the reversal rule.

PASA raised a preliminary objection: that the Reserve Bank and PASA's member-banks should have been joined in the application. The court found that the Reserve Bank and the other banks have a significant interest in the outcome of the application and postponed the matter. The court ordered the plaintiff to serve joinder papers on the relevant parties.

This is a matter to watch.

Hollard Insurance Company Ltd and Others v Insure Group Management Ltd (in liquidation) and Others

(21/43014) [2023] ZAGPJHC 371
(April 25, 2023)

Keywords: intermediary in liquidation / duty of auditor to insurers / duty of compliance officer to insurers

Various insurers issued summons against an intermediary (the first defendant), its auditor (the second defendant) and its compliance officer (the third defendant) in relation to the collection of premiums.

The intermediary collected premiums on behalf of the insurers. The insurers alleged that the intermediary unlawfully appropriated the value of approximately two months' worth of premiums and invested those premiums in illiquid assets. The intermediary failed to maintain an adequate balance sheet for the purposes of maintaining its guarantees and failed to pay the amounts due to the plaintiffs in terms of its mandates. The intermediary collapsed and went into liquidation.

The issue in this case related to the second and third defendants only (the auditor and the compliance officer). The main argument was that there was no cause of action against either of them because their obligations were to the company itself (the intermediary) and at times to the regulators. They argued that they owed no legal duty to creditors and clients of the intermediary, either to protect their interests or for the benefit of their commercial decisions.

The insurers alleged that the breach of the auditor and compliance officer's statutory duties was prima facie proof of wrongfulness. The court did not agree and upheld the second and third defendant's exceptions: to hold auditors and compliance officers liable in cases such as these would open them up to numerous plaintiffs and indeterminate liability.

Proximate cause and suicide

L M and Others v Road Accident Fund

(A30/2023) [2023] ZAWCHC 249
(October 11, 2023)

Keywords: RAF / proximate cause / new intervening cause / suicide

The claimants claimed in delict for loss of support arising from the death by suicide of their claimants' husband and father.

The deceased had been involved in a motorcycle accident involving a driver insured in terms of the Road Accident Fund Act. As a result of the collision, he sustained multiple orthopaedic injuries to his body. Liability was admitted.

Before his Road Accident Fund claim was finalised, he committed suicide. The appellants had to prove that, on the probabilities, the deceased's suicide was a direct or proximate result of the accident (that is, that the accident was sufficiently causally related to the suicide). Our courts apply the common law test for causation flexibly, recognising that common sense may have to prevail over strict logic.

The enquiry into legal causation follows factual causation. It asks whether a sufficiently close relationship exists between the factual cause and the consequent loss to give rise to legal liability. In other words, is the loss too remote for the factual cause to be the legal cause too?

It was common cause that the deceased suffered severe bodily injuries due to the collision, which significantly impaired him physically. The uncontested evidence was that the injuries the deceased sustained in the accident had a profound physical, emotional, and psychological effect on him.

The court said that the claimants did not need to prove that the deceased suffered from a psychiatric condition at the time of the suicide. All they had to prove was a sufficient causal link between the injuries' consequences of the injuries, and the deceased's suicide.

The court said that the evidence was clear. The deceased was depressed because of the serious injuries he sustained in the accident. He experienced unending, excruciating pain, and could not think clearly. His ability to form clear judgement was diminished, and he committed suicide as a result.

The court found that there was a clear causal connection between the injuries and the suicide.

No evidence was presented to support a finding that a cause unrelated to the accident prompted the deceased to commit suicide. The court held that, but for the accident, the deceased would not have committed suicide.

While the deceased's act may have been deliberate, the court was of the view that the weight of the evidence proved on the probabilities that the deceased's ability to make an informed judgement was impaired. His judgment was impaired to a material degree by the unending excruciating pain, stress-related issues, and depression, caused by the consequences of the accident. Although the suicide was deliberate, it did not amount to a new intervening cause.

Applying the flexible approach in determining legal causation, the court held that it was reasonable and just to hold that the evidence presented at the trial established the requirements for causation. The appeal succeeded and the defendant was liable to compensate the claimants for their proven damages.

Reasonable precautions and recklessness

Govender v Guardrisk Insurance Company Limited

Case No. 64633/2019

Keywords: reasonable precautions / motor vehicle accident / recklessness

The insurer rejected liability under the policy on the basis that the insured had failed to take all reasonable precautions to prevent loss, damage, or accidents, as required by the relevant clause in the policy. The defence failed because the insurer failed to prove that the insured drove recklessly.

The insured vehicle was damaged beyond repair in an accident. The insurer rejected the claim on the basis that the insured had been travelling at a speed that was so excessive that the insured was regarded as having been reckless.

The parties agreed that only a finding of recklessness would absolve the insured from liability under the policy.

The court referred to *Santam Ltd v CC Designing CC* for the test as to what is reasonable as between insured and insurer. The court must consider whether the insured recognised the dangers to which he was exposed and, if so, whether he deliberately courted them by taking measures that he knew were inadequate to avoid them.

The court found that there was no evidence to establish that the insured knew or foresaw that the road conditions could cause him to lose control of the vehicle.

The evidence was that the road surface was good and, with a camber to the right, would have caused water to flow across it from left to right, towards the stormwater drain. The plaintiff did not see sufficient water on the road's surface to cause aquaplaning.

The insured's evidence that he was travelling at 80km per hour could not be excluded. His evidence of aquaplaning, although less likely at that speed, could not be excluded.

Insurers who seek to decline a claim for reason of breach of the reasonable precautions clause need to be satisfied that the evidence is sufficient to discharge what the courts see as a heavy onus on insurers to prove recklessness as the probable inference on the facts.

Road accident fund

Note: we do not provide a comprehensive overview of all or even most of the Road Accident Fund cases heard in 2023 – these cases usually do not materially impact on insurance jurisprudence. However, this year we have included a few RAF cases that are of wider application and general interest.

Road Accident Fund v Discovery Health (Pty) Ltd and Minister of Transport

(CCT 106/23) [2023]

Keywords: medical expenses / indemnification / subrogation / medical scheme

In August 2022, the Road Accident Fund, possibly in a bid to escape its ever-expanding pothole of debt, issued a directive instructing its staff to reject any claims made for past medical expenses if a medical aid scheme had already paid for them. This meant that where a claimant was a medical aid scheme claiming on behalf of its members, the claim would be rejected by the Fund. The reasoning for this directive was that "the claimant has not sustained any loss or incurred any expense in respect of the past medical expenses claimed and there is therefore no duty on the RAF to reimburse the claimant."

In October 2022, the Pretoria High Court found this directive to be unlawful, following an urgent application brought by Discovery Health (Pty) Ltd. Pivotal in the court's ruling was Section 17 of the Road Accident Fund Act of 1996, the legislation within which the RAF operates. This section states that the Fund:

> *"[S]hall be obliged to compensate any person (the third party) for any loss or damage which the third party has suffered as a result of any bodily injury to himself or herself or the death of or any bodily injury or death is due to the negligence or other wrongful act of the driver or of the owner of the motor vehicle..."*

The court emphasised that the Act aims to provide maximum protection to people who suffer loss or damage because of the negligent driving or unlawful conduct in the driving of a motor vehicle. The court found that the RAF was not entitled to unburden itself from its clear statutory obligation to pay full compensation to victims of motor vehicle accidents, even if a medical aid scheme claimed on behalf of its members. A medical aid scheme claiming from the RAF through its members via subrogation is therefore an irrelevant consideration for the RAF.

What followed was an unsuccessful spate of appeals by the RAF against the court's decision, culminating in its application for leave to appeal to the Constitutional Court, which was refused with costs on October 18, 2023. The Constitutional Court found that the RAF's appeal did not fall within its jurisdiction.

The RAF claims that the Constitutional Court did not engage with the merits of the case, and instead came to their decision on a mere technicality. The RAF then communicated that it amended its directive on April 12, 2023 to reject only the payment of prescribed minimum benefits and emergency medical conditions claimed by medical schemes on behalf of members who are victims of motor vehicle accidents. The RAF does not consider itself bound by the Constitutional Court's decision, claiming that its amended directive is a departure from the original August 2022 directive. As it stands, this supposedly updated directive continues, in the eyes of the RAF, to be applicable because it has yet to be challenged or set aside.

This stance is likely to be challenged.

Van Tonder v Road Accident Fund

(1736/2020; 9773/2021) [2023] ZAWCHC 305 (December 1, 2023)

Keywords: medical schemes / past medical expenses / subrogation

The court consolidated two matters against the Road Accident Fund for payment of each plaintiff's past medical and hospital expenses. Both claims, were rejected by the RAF because both plaintiffs were members of private medical aid schemes, which covered those medical expenses.

The court canvassed the RAF's attitude to medical aid payments, including the Discovery case discussed immediately above, and the RAF's failed application for leave to appeal to the Constitutional Court.

The RAF tried to reclassify the plaintiff's medical costs as related to emergency medical conditions, in an attempt to fit them under the Prescribed Minimum Benefits as defined in the Medical Schemes Act – and in this way to fit them under an exclusion in the RAF Act. The RAF reasoned that because the medical scheme is bound to pay certain minimum benefits without any deduction (including for emergency medical conditions) that precludes the scheme from relying on the doctrine of subrogation. Since the scheme could not claim repayment by virtue of subrogation, then the scheme could not claim against the RAF for past medical expenses.

The court stated that the RAF's argument was contrived and was an attempt to avoid the consequences of the Constitutional Court's refusal of leave to appeal. The court was informed that despite the Constitutional Court refusal, the RAF nonetheless persisted in refusing to pay claims for past medical expenses. The court expressed its disapproval of the RAF's actions and ordered the RAF to pay the claims.

Nemangwela v Road Accident Fund

(437/2022) [2023] ZASCA 90 (June 8, 2023)

Keywords: RAF / motor vehicle accident / definition of vehicle / forklift

The Supreme Court of Appeal held that a forklift is not a motor vehicle as defined in the Road Accident Fund Act which defines a "motor vehicle" as

> *"any vehicle designed or adopted for propulsion or haulage on a road by means of fuel, gas or electricity …".*

The three requirements to be met to qualify as a motor vehicle are that the vehicle must (a) be propelled by fuel, gas, or electricity; and (b) be designed for propulsion; (c) on a road.

The accident happened in the receiving area of a supermarket store, where the plaintiff worked. The forklift was propelled by a battery and diesel fuel, and was used to transport goods in and out of the store, particularly at the premises' receiving area. A "road" under the RAF Act is not limited to a public road. The question is whether the forklift was designed or adapted for propulsion or haulage on a road. The ordinary meaning of a road was taken from the dictionary as "a wide way leading from one place to another, especially one with a specially prepared surface which vehicles can use". The court found that the forklift was not used on a road but was used in and out of the warehouse in the yard. The receiving area was a private area and not a road. It was only used to receive and load goods and not used by the general public. Therefore, the forklift did not qualify as a motor vehicle for the purposes of the RAF.

This judgment is not particularly helpful because it does not discuss the distinction between a road and a public road, or what happens if a forklift is used for purposes on a road as described. Over and above its implications for the RAF Act, it is nevertheless a reminder that insurers who insure motor vehicles must be clear in their definitions as to what vehicles will be covered.

Storage lien

Santam Limited v Selby Panel & Paint Proprietary Limited

(005540/2022) [2023] ZAGPJHC 776 (June 15, 2023)

Keywords: motor vehicle insurance / motor storage costs / security / lien

The High Court allowed a motor insurer to put up security for the disputed balance of motor vehicle storage costs to enable the insurer to get release of the vehicle and to stop storage charges being incurred.

The insurer paid the full value of the seriously damaged vehicle and, now as owner, sought to retrieve the vehicle from the panel beaters. The panel beaters initially claimed storage costs of R95 220 at the daily rate of R600. A subsequent invoice claimed R43 700 at R250 per day for a five month period. The insurer disputed the reduced amount and offered R26 220. The disputed amount eventually came down to just R5 244, which the insurers offered to put up as security by paying that amount into trust to the panel beater's attorneys pending resolution of the dispute. The offer was refused, and the insurer went to court.

The court found that where a lien (a right of retention of possession) is exercised, the court has a discretion to substitute security for payment as a temporary measure while considering any objection to an offer. The court will assess the good faith of the person holding the asset. It was not disputed that a salvage lien, such as the panel beater asserted, allows a party to claim repayment of necessary and reasonable expenses incurred by it in preventing property from perishing.

The court found that if it dismissed the application, it would leave the insurer with an election either to pay the panel beater's disputed claim or reconcile itself to an ever-escalating claim for storage charges, coupled with litigation burdens, while its vehicle remained in the panel beater's possession in perpetuity or until the end of litigation. The court exercised its discretion in favour of the insurer and found that the tender of security of the balance of the panel beater's claim and further storage charges up to the date of the court's order was not a trivial offer. The tendered security was adequate. The panel beater would have to

decide whether to pursue an action in respect of their alleged claim.

The court gave an order of attorney and client costs against the panel beater, noting that the panel beater's conduct was consistent with an unreasonable attempt to bring about a grudge payment of the disputed storage costs.

The action was clearly and usefully pursued by the insurer to create a precedent that prevents towing companies or repairers from impounding vehicles until their disputed claim for storage charges is paid.

Financial services tribunal

Wilmic Trust v Riebeeckstad Makelaar CC and Others

(A31/2023) [2023] ZAFST 149 (October 31, 2023)

Keywords: broker / debarment

The applicant Trust sued a broker in relation to a life policy that the Trust claimed had been ceded to it. The policyholder had nominated his wife as beneficiary, and she was paid out on his death. However, the Trust alleged that the nomination of beneficiary was void because a change in nomination had to be done by the Trustees, who had to act in terms of the Trust deed.

The Trust wrote to the Financial Sector Conduct Authority, alleging that the broker had failed to provide the trustees with documents relating to the change of beneficiaries, had failed in his duties by proceeding with filing a claim with the insurance company (because the trustees disputed the correctness of the change in the beneficiaries), and that the result was that the incorrect beneficiary received the proceeds of the insurance policy. The Trust's letter did not indicate what substantive relief it sought.

The FSCA found that the Trust was not a beneficiary of the policy. The deceased policyholder was the broker's client. Even though the policyholder may have acted without the Trust's proper authorisation, the internal arrangement relating to the operation of the Trust does not fall within the scope of financial services. The broker had therefore discharged his duties to his client. The policy payment was paid in accordance with the policyholder's instructions.

The Trust applied for a reconsideration of the FSCA's findings. The Financial Services Tribunal agreed with the FSCA's finding, stating that if it accepted the facts in favour of the Trust (which it did not) the only relief it (or the FSCA) could grant would be to debar the broker or impose an administrative penalty, neither of which would have been helpful to the Trust. The Trust should have approached a court if it sought an award for damages. The application was dismissed.

Abacus Insurance Limited v Prudential Authority

(PA4/2022) [2023] ZAFST 69 (May 30, 2023)

Keywords: non-life insurer / first party risks / third party risks / insurance licence

The Financial Services Tribunal found that there is no implied prohibition in the Insurance Act on traditional (not cell) insurers underwriting risks for both its own first party risks and third party risks.

Abacus Insurance Limited (***Abacus***), a traditional insurer, holds a non-life insurance licence, permitting it to underwrite third party risks. The Pepkor Group did not hold an insurance licence and wanted Abacus to underwrite the Pepkor policy. Abacus applied to the Prudential Authority to vary the Abacus insurance licence to add further classes and sub-classes to the licence conditions for third party policyholder benefits.

The Prudential Authority declined the application on the grounds that the Insurance Act implicitly prohibits traditional insurers (not captive or cell captive insurers) from underwriting both first party and third party risks. The Authority also argued that a traditional insurer should not be allowed to conduct both first party and third party business under the same licence, because of potential conflicts of interest.

The Tribunal disagreed with the Prudential Authority's interpretation of the Insurance Act. It noted that there is no provision in the Act that expressly prohibits a traditional insurer from underwriting first party risks. The Tribunal stated that "it is relevant that the legislature has not expressly prohibited 'traditional' insurers from underwriting first party risks, nor from underwriting first party and third party risks under the same licence".

The Tribunal also disagreed with the Authority's reliance on the definition of "first party risks" in section 1 of the Insurance Act to contend for an implied prohibition. The Tribunal stated:

> "The definition section makes plain that the words would only bear the meaning ascribed to it by the legislature if the context so requires… The Authority elevates the definition of "first party risks" to a substantive statutory provision. The definition imposes neither obligations nor does it confer rights."

The interpretation that the FSCA advanced would result in unbusinesslike results. For example, if only cell captive insurers could insure third party risks, traditional insurers would not be allowed to insure either first party nor third party risks, because they fall under neither definition.

Finally, the Tribunal noted that the FSCA has powers under the Insurance Act to mitigate any perceived risks in respect of a traditional insurer underwriting first party and third party risks. If the FSCA has concerns in respect of a licence variation application, it may impose suitable conditions.

Caple v Scott-Kohler CC t/a Risk Sure Insurance Brokers and Another

(FSP1/2023) [2023] ZAFST 46 (April 24, 2023)

Keywords: debarment / honesty / integrity / confidential information

The applicant applied to the Financial Services Tribunal reconsider the first respondent's decision to debar her. She was employed by the first respondent, brokers, as a personal lines representative. She resigned from her position on August 26, 2022. The brokers informed her that it was not necessary to work during her notice period and asked that she return her laptop the same day.

A few days later, the employer served a notice of intention to debar the applicant in terms of the Financial Advisory and Intermediary Services Act, alleging that she acted without honesty or integrity in sharing client information with a competitor broker during her employment, without authority from those clients. She was still employed by the brokers until September 23, 2022 despite not being required to work during the resignation period.

The applicant challenged the decision to debar her on the basis that her employment was terminated with immediate effect, by mutual consent, on August 26, 2022. This would mean that whatever happened or was discovered by the employer thereafter did not constitute grounds for debarment in terms of their Debarment Policy and the FAIS Act. She claimed to have contacted the clients and received consent to share their information with the competitor broker after August 26, 2022 (between August 29 and September 7).

The Tribunal found that the employer had carried out the debarment process in a procedurally fair manner. The applicant was invited to various meetings to explain her actions, but she did not attend.

On a plain reading of the resignation letter and the reply, the Tribunal said that it was evident that the parties had agreed that the applicant would continue being employed by Risk Sure until September 23, 2022, the date nominated by the applicant. The brokers accepted this in its tender to pay commission for the month of September.

Once it was accepted that the applicant was employed until September 23, 2022, the argument that she was entitled to disclose information to the prospective new employer before that date was unsustainable. She breached the express written terms of the contract of employment, and materially breached her obligations under the FAIS Act. Her actions were evidence of a lack of honesty and integrity and her application for reconsideration was dismissed.

Singh v Marsh Proprietary Limited and Another

(FSP57/2022) [2023] ZAFST 39 (April 12, 2023)

Keywords: debarment / fit and proper / FAIS Act

An application was made to the Financial Services Tribunal for reconsideration of the FSCA's decision to debar a natural person.

In the context of the FAIS Act, a fit and proper person is someone who is considered to have the necessary integrity, competence and financial soundness to operate as a financial service provider. That Act does not provide a specific definition as to what constitutes a fit and proper person but sets out various factors to be taken into account when assessing a person's fitness and propriety.

These factors include the person's honesty, integrity, reputation, their financial soundness and solvency, their competence and qualifications, and whether they have been convicted of any criminal offences or have been found guilty of any misconduct in relation to their business activities. A fit and proper person is an honest person who has integrity and is of good standing.

On the facts, the Tribunal held that the employer's information found on its erstwhile employee's e-mails, constituted confidential intellectual information and trade secrets. That information was very sensitive and should not have been transferred to any third party without the employer's authority. The harm that the employer could suffer if its confidential and intellectual property ended up in the wrong hands could not be disputed.

The Tribunal reminded us that debarment is not aimed at punishing the relevant financial services provider but rather to ensure and maintain the honesty and integrity required from a financial services provider. A financial services provider who is not fit and proper should not be unleashed on the unsuspecting public.

Escap Soc Limited v Prudential Authority

(PA3/2022) [2023] ZAFST 36 (April 4, 2023)

Keywords: penalty / dividends / financial reports

Eskom's non-life captive insurer applied to the Financial Services Tribunal to reconsider a R5 million penalty imposed by the Prudential Authority. The insurer was fined for contravening the Insurance Act and two of the Prudential Authority Standards issued in terms of the Act. The contravention the Prudential Authority had identified related to the declaration of a R600 million dividend by the insurer to its shareholder (Eskom) in July 2021.

In 2021, Eskom had serious liquidity problems and asked the insurer to invest R600 million in it. The insurer decided instead to declare and pay a dividend of that amount. Before payment was made, the insurer's board met, and their actuarial head prepared an opinion based on a hypothetical R600 million dividend payment. The board also relied on a report related to the interim financial position based on the quarterly quantitative reporting template. The board decided that the R600 million pay-out would not drop its solvency ratio below solvency requirements. However, the actuarial report was incorrect, and the dividend adversely affected solvency ratios and should not have been paid.

The insurer set out four reasons why the penalty should be reconsidered. First, the insurer cooperated with the Prudential Authority at all times. Second, it put measures in place to prevent such an event from occurring in the future. Third, the industry generally relies on quarterly reports for its important decisions. And finally, in taking the decision, the board was not reckless in following the commonly accepted approach.

The Tribunal found that the penalty amount was fair and even lenient. There was no evidence that industry practice is to declare dividends based on quarterly reports. The board did not in fact rely on the quarterly reports but relied instead on the actuarial head's report. The board did not take sufficient heed of the report's qualifications and conclusion, which the actuarial head had "carefully drafted in negative terms".

He stated: "as far as the duties of the Head of Finance is concerned, that there are no obvious reasons for me to advise the board against the hypothetical payment of a R600m dividend at this time".

The Tribunal held that the board took "a calculated risk" by taking a decision based on the Head of Finance's report, which had the potential to put policyholders at risk. The ultimate responsibility for the dividend declaration, as the report stated, was that of the board. The Tribunal therefore declined to reconsider the penalty.

National consumer tribunal

Mokgoke v Momentum Insure Company Limited

(NCT/279251/75(1)(b) - Rule 34) [2023] ZANCT 35 (September 20, 2023)

Keywords: consumer tribunal / insurance services not under CPA

The applicant submitted a claim to his insurer for water leakage of his motor vehicle, in June 2020. Two days later, the insurer referred the vehicle to various service providers. In August 2020, the insurer informed the applicant that his claim was rejected as it was not covered by the policy.

On the date scheduled to collect the vehicle, the applicant found the vehicle in a state of disrepair. The front lights system and the tracker had been removed, the bumper was broken, and engine parts were either missing or scattered inside the vehicle. Because of the vehicle's condition, the applicant refused to take possession.

According to the applicant, the insurer was liable for the appointed service providers' actions, and they had failed to exercise the required care.

The applicant did not dispute the rejection of the insurance claim but claimed damages for the loss. In March 2022, the National Consumer Commission recommended that the applicant refer his complaint to the Financial Sector Conduct Authority. The FSCA referred him to the Motor Industry Ombudsman. The applicant applied, in June 2023, for leave to refer the matter directly to the National Consumer Tribunal.

The application was filed late, and the applicant had to apply for condonation. In determining the issue of condonation, the Tribunal had to consider the applicant's prospects of success.

On the papers, the Tribunal found that the applicant did not have a reasonable prospect of success, because the Tribunal does not have the statutory jurisdiction to consider the complaint because the insurer is not a supplier as defined in the Consumer Protection Act. It was also common cause that third parties had provided the services led to the damage, and the applicant did not claim against those suppliers as respondents in the matter. The Tribunal stated that the dispute revolved around the contractual obligation of an insurer in terms of its insurance contract.

The services of insurers are governed by the Insurance Acts, and not by the CPA. The Tribunal the applicant that he should approach a court for relief as required by the insurance contract.

Section 10(1) A of the Financial Sector Conduct Authority expressly provides that the Consumer Protection Act does not apply to or in relation to a function, act, transaction, financial product or financial service which is subject to a financial sector law which is regulated by the Financial Sector Conduct Authority.

Subrogation

See the discussion on the *Road Accident Fund v Discovery Health (Pty) Ltd and Minister of Transport and Van Tonder v Road Accident Fund* judgments under the section related to the Road Accident Fund.

Donald Dinnie
Johannesburg
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