NORTON ROSE FULBRIGHT

The Big Read Book Series Volume 22

Norton Rose Fulbright South Africa's review of South African insurance judgments in 2024

February 2025

Introduction

Dearest Reader

Welcome to Norton Rose Fulbright South Africa's The Big Read Book Series. This is volume 22 of the series – A review of South African insurance judgments in 2024. An online version of this publication is available through our Financial Institutions Legal Snapshot blog at https://www.financialinstitutionslegalsnapshot.com/.

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. You can access the other volumes here .

Norton Rose Fulbright South Africa Inc
February 2025

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Administrative action

Zondi v Registrar of Financial Services Providers and Another

(2023/067825) [2024] ZAGPJHC 410
(29 April 2024)

Keywords debarment / FAIS / administrative action

A non-life insurer accused an insurance salesperson of dishonestly claiming commission on fictitious sales and for claiming commission on genuine sales that were due to other salespeople, in 2016. After a disciplinary hearing the employee was dismissed and she was also debarred under the FAIS Act. She challenged the fairness of her dismissal with the Commission on Conciliation, Mediation and Arbitration (the CCMA). The proceedings at the CCMA were settled. The CCMA settlement recorded that the parties had agreed that the insurer would pay the applicant around R58 000 in full and final settlement of any monetary claims she may have against it. The insurer also undertook to "make application" to the Financial Services Board "for the upliftment of" her debarment, due to "insufficient evidence of wrongdoing on the part of [Ms. Zondi] at the CCMA".

The insurer did not make good on its undertaking to communicate with the FSB regarding the debarment. The applicant contacted the FSB directly to request that it implement the CCMA award by uplifting her debarment. The FSB informed the applicant that it could not uplift her debarment and that the only recourse was to apply to court to review the insurer's decision. The insurer took the same view.

The court confirmed that once administrative action is taken, it stands until it is set aside, and cannot unilaterally be reversed by the person who took it, unless the legislation governing the action itself says so (which it does not, in this case).

However, the court noted that there was no evidence that the insurer communicated this reasoning to the applicant until 2023. Therefore the applicant persisted for a number of years with the erroneous views that the settlement agreement concluded during the CCMA proceedings required the insurer to reverse the debarment.

The court therefore allowed the late application to review the insurer's decision, since the applicant was reasonably unaware of the fact that the decision could not be reversed by the insurer.

On the evidence, the court found that the decision to debar the applicant was procedurally unfair (since the applicant was not given notice of the debarment nor was she allowed to make representations in this regard). However, the court did not go into the merits of the applicant's debarment, and instead referred the decision back to the insurer for proper consideration of the issue, in a procedurally fair manner. The court did not allow the applicant's claim for compensation from the insurer. The court noted that there is clear evidence on the papers that the applicant may in fact be guilty of dishonesty and that a decision to debar her may have been justified. She studiously avoided dealing with the allegations of dishonesty made against her at the disciplinary hearing. She argued that she did not have to, because the CCMA award confirms that there was insufficient evidence of wrongdoing. The court noted that the rules governing debarment and dismissal are different, and that the one does not necessarily follow on from the other. Even if there was insufficient evidence to dismiss the applicant, the evidence may have been sufficient to debar her, under the conditions of the FAIS Act.

The court therefore directed the regulator to expunge its record of the 2016 debarment and remitted the decision back to the insurer.

Graduate Institute of Financial Sciences Pty Ltd v Insurance Sector Education and Training Authority

(134433/2023) [2024] ZAGPJHC 40
(22 January 2024)

Keywords accreditation / insurance sector training / administrative action / right to hearing

The applicant is a skills development provider in the insurance sector. The respondent, the Insurance Sector Education and Training Authority, provided accreditation to the applicant.

In 2021 the respondent de-accredited the applicant, following an investigation that arose from a complaint from a former employee of the applicant. The applicant was not furnished with the complaint and the investigation report and was not given an opportunity to be heard before it was de-accredited. It therefore applied to court to have that decision reviewed, since denial of a hearing resulted in the de-accreditation process being procedurally unfair.

The respondent alleged that it was only required to hear a party it was intending to suspend and not a party it intended to de-accredit. This was not accepted by the court. Further, during the various appeal and review proceedings launched by the applicant, the respondent renewed the accreditation of the applicant until June 2024. However, the respondent then made the decision (again) to de-accredit the applicant without informing the applicant of the basis of the change or the reasons for the decision.

The court was satisfied that the applicant had established its right to conduct training as an accredited skills trainer and its right to fair administrative action. Those rights were infringed. The loss of accreditation affected the applicant's ability to provide services to its clients, which it had already contracted to provided. The process was also unfair since the applicant's right to be heard was not fulfilled, and the change in decision (without providing reasons) impacted on the applicant's right to fair administrative action.

Regarding the balance of convenience, the court noted that the applicant was negatively impacted whereas the respondent had advanced no allegation that the applicant provided improper services; it was happy to let the applicant continue being an accredited trainer for over two years from the date of the investigation report being received. The respondent could therefore not claim any prejudice arising from a delay of the de-accreditation.

The court allowed the interim interdict against the respondent pending a final order, which stopped it from implementing the de-accreditation of the applicant pending finalisation of the various hearings related to the matter (the matter is still entangled in an appeal process).

Brokers

Kunver and Others v Mistry and Another

(22/007836) [2024] ZAGPJHC 974
(30 September 2024)

Keywords mandate / FAIS Act

The plaintiff entered into a mandate agreement with the first defendant, who carried out business as a representative and broker of the second defendant (a brokerage).
The plaintiff alleged that the first defendant was in breach of the mandate agreement and therefore claimed damages, arguing that the first and second defendants are liable jointly and severally for the plaintiff's damages.

The brokerage argued that the FAIS Act imposes no liability on a financial service provider for the actions of the representative provider. The court interpreted section 13 of the FAIS Act to mean that the section does not impose any liability on the service provider unless the representative, before rendering a financial service, provides confirmation certified by the services provider to clients that the following exists: a service contract that states that the financial service provider accepts responsibility for those activities of the representative delivered within the course and scope of implementing any such contract.

This written confirmation was absent in this case, and therefore, there was no cause of action against the second defendant. The claim against this second defendant was dismissed.

Augustyn v TWK Agri Insurance (Pty) Ltd

(9470/2023P) [2024] ZAKZPHC 19 (18 March 2024)

Keywords broker commission / set-off

The high court held that an insurer cannot set off the claim amount it paid to an insured from the commission due to a broker allegedly responsible for the insurers loss.

A broker had failed to include five soyabean fields in a policy brokered on behalf of a farmer. The fields were damaged in a hailstorm. Upon discovering the error committed by the broker, the insurer proceeded to compensate the farmer for the loss without consulting the broker and set that amount off against amounts owing to the broker as commission.

The broker sued the insurer for the offset commission.

The insurer's primary defence was rooted in the principle of common law set-off. The insurer argued that although they initially owed commission to the broker, he was indebted to them due to his error in obtaining inadequate insurance coverage for the farmer. The insurer contended that this mutual indebtedness allowed for an automatic set-off, negating their obligation to pay the commission.

The court examined the principles of set-off and clarified that for set-off to be applicable, there must be an existing mutual indebtedness between the parties. The court found that the insurer failed to establish the broker's indebtedness, as he did not admit to causing the loss and suggested that the farmer might have contributed to his own misfortune. An undetermined claim for damages cannot be set off against a determined claim for commission.

The insurer was ordered to pay the commission due to the broker, as there was no valid set-off to negate the debt.

Business interruption

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

(640/2023) [2024] ZASCA 97 (13 June 2024)

Keywords business interruption / Covid-19 / insured peril / interpretation / joint and composite policies

In this Covid-19 business interruption judgment, the Supreme Court of Appeal maintained its broad interpretation of the insured peril of an infectious disease extension, despite the contrary interpretation adopted by the UK Supreme Court.

The court ruled that the policy provided cover for business interruption losses even where the first confirmed infection in the specified radius was after the government had imposed restrictions in response to the wider national outbreak.

The policy included an extension which provided cover for interruption to the business of the insured caused by the outbreak of infectious or contagious disease within a radius of 25 km of the premises.

The insured operated a flight school from premises in Port Alfred. The business of the insured had been interrupted as a result of the national lockdown starting on 27 March 2020 arising from the Covid-19 pandemic. However, the Port Alfred area had only recorded its first confirmed Covid-19 infection on 26 April 2020, almost a month after the lockdown had started.

This judgment is the first South African court decision concerning a claim where the first Covid-19 infection was only identified after the start of lockdown.

The argument raised by the insurer was that the policy only covered business interruption losses where the infections of Covid-19 within the radius preceded the restrictions

imposed by the government. The argument relied upon the judgment of the United Kingdom Supreme Court in the *FCA v Arch Insurance (UK) Ltd and others* [2021] UKSC 1, more commonly known as the 'FCA Test Case'. In the FCA Test Case, the UK Supreme Court decided that the proper interpretation of similarly worded policies was that the insured peril was local infections of infectious disease within the specified radius.

The SCA held that foreign decisions such as the FCA Test Case are to be approached with caution as they were decided on a set of agreed facts on different policy wordings. The SCA did not follow the interpretation adopted in the FCA Test Case and instead followed its previous interpretation of a similar wording in *Guardrisk v Café Chameleon CC 2021 (2) SA 323 (SCA)* that the outbreak of infectious disease and the government response to it is part of the insured peril. It confirmed its interpretation that the outbreak of disease within the specified radius simply serves as a "trigger" to the cover becoming effective. The court ruled that there was no requirement for there to be a causal connection between the local outbreak of the disease and the government response to the wider outbreak. It was therefore not relevant that the first outbreak of the disease in Port Alfred did not contribute to the government's decision to enter lockdown. As no causal connection was required, it was also not necessary for the court to consider whether the local outbreak contributed to the maintaining or extending of the lockdown.

The court also clarified the distinction between joint and composite policies of insurance in relation to the multiple insureds of one insurer under one policy.

The definition of "insured" in the policy indicated that there were multiple insureds. Two insureds were identified by name, one of them being 43 Air School (Pty) Ltd. The policy also insured "subsidiary companies, managed, controlled, member companies, joint venture … and any other persons or entities for which they have the authority to insure, jointly or severally, each for their respective rights and interests" of the named insured.

43 Air School operated a flight school from premises in Port Alfred. Other companies in the same group of companies conducted related aviation training in Gqeberha and Lanseria.

43 Air School sought to claim business interruption losses from the earlier date of 27 March 2020. It relied on infections that had been confirmed within 25km of premises of other companies within the same group in Gqeberha and Lanseria prior to 27 March 2020 insured under the same policy.

The SCA distinguished between a joint policy and a composite policy. A joint policy is one where the "the interests of the several persons who are interested in the subject-matter are joint interests, so that they are exposed to the same risks and will suffer a joint loss by the occurrence of an insured peril". An example of a joint policy is where co-owners share a joint interest in a property. A composite policy is intended to insure each of the insureds separately in respect of its own interests.

The nature of the interest in the subject matter of the insurance is the decisive determinant. The subject matter of the business interruption insurance was the gross profit of the insured. The different insureds covered by the policy did not share a joint and common interest in each other's gross profits, so the policy was a composite policy and not a joint policy.

The outbreak of infections within 25 km of the premises of other insured companies insured under the composite policy did not trigger cover for the 43 Air School's business interruption claim for 27 March 2020.

The claim of 43 Air School was only successful for an interruption period starting on 26 April 2020.

Azrapart (Pty) Ltd and Another v AIG South Africa Limited and Others

(049359/2022) [2024] ZAGPJHC 423
(3 May 2024)

Keywords business interruption / Covid-19 / interpretation

The plaintiffs instituted a claim for over one billion rand against the five defendants, all insurance companies who had insured the plaintiffs in respect of various events. The plaintiffs each own 50% of a shopping mall (Fourways Mall). They earn income from letting out stores to tenants who trade from the mall.

In 2020, the plaintiffs suffered a major loss in rental income as a result of the business disruptions caused by the Covid-19 pandemic. They sued the insurers in 2022 for business interruption insurance. According to the plaintiffs the defendants had all agreed to indemnifying them (in various amounts) against business interruption which included loss caused by infectious and contagious diseases (ICD) for loss of rental income from their tenants. This case did not concern whether Covid-19 constitutes an ICD for which the plaintiffs could claim in terms of their policies. Rather the question was whether the plaintiffs were covered at all for ICD, something the defendants all contended that they were not.

Between the time that the first request for a quotation was made by the broker in July 2019, and the time a final policy was signed in March 2020, there had been 10 iterations of the contract, with the term ICD, variously in or out. These modifications were not noticed by the parties to whom the document was sent.

The court accepted that the explanation for this is that insurance contracts are filled with dense type, most of which is unchanging, and therefore the professionals keep a look out for the highlighted changes during negotiations, and the exclusions, the premiums, and the limits. Where a term is not highlighted and is buried in a long list of densely typed terms, infrequently modified, they "remain imperceptible".

The court had to decide whether the relevant contract was:

- The version that the plaintiffs' broker sent to all the insurers with ICD out (which the broker alleged was inadvertent), and which they all signed, after which he told them that they were now on risk; or
- The penultimate version called a placement slip, with ICD included, which the defendants had later all signed; or
- The policy, a still later and final version, which has ICD in, and which only the lead insurer had signed, apparently without the inclusion being noticed by that company's representative.

The court considered the parol evidence rule and the integration rule and on the evidence, found that the final policy was the relevant contract and therefore the contract did contain ICD cover. Since ICD was found to be included, the insurers then asked for rectification of the contract, to reflect the true common intention of the parties. On the evidence though, it could not be proved that the common intention of the parties was to exclude ICD cover.

The court therefore found for the insured on the issues heard at this trial (the issues were separated to deal with this contractual interpretation issue first). The insurers applied for leave to appeal. Leave to appeal to the Supreme Court of Appeal was granted. At the time of publication, the appeal decision has not been given.

Exclusions

Ngqeleni v Outsurance Insurance Company Limited

(EL933/2022) [2024] ZAECELLC 44 (14 November 2024)

Keywords defective workmanship / exclusions / stated case

This is a judgment which was given in peculiar circumstances. The insurer belatedly and out of time submitted its heads of argument and its counsel, due to an oversight, did not appear to argue the matter.

The parties had pre-agreed a stated case. The dispute related to comprehensive buildings cover.

The insured claimed for damage to its property when a wall above the ceiling of the insured property collapsed and fell through the ceiling. The parties agreed that the incident occurred due to defective or poor workmanship during alterations done before the insured had bought the property and of which the insured was unaware. The insured's expert opinion recorded that it would have been impossible for the insured to have been aware that a wall had been removed which made the relevant firewall brickwork unstable and that the insured would have had no knowledge of the impending collapse.

The court articulated the insurer's contention as being primarily that the insured could and should have foreseen the poor workmanship and for that reason the claim was rejected.

The relevant exclusion relied upon by the insurer read:

- "WHAT IS NOT COVERED under Comprehensive Buildings cover...
- ...Where any of the following cause or contribute to damage ...
  - defects in the design or construction of the building, or where the structure would not have been approved by the relevant local authority at the time of construction
  - construction, alteration or repairs, defective workmanship or materials..."

The court said that the exclusion had to be read in the context of the stated case which "raises pertinently the prior knowledge, or foreseeability, of the poor workmanship by the plaintiff". The stated case is not quoted.

The court held that the exclusions were only applicable to defective workmanship that the insured was "aware" of prior to entering into the policy. The court found that that was the consequence of the stated case and there were no other facts or documents which disputed the issue of a lack of knowledge.

Because it was clear that the insured, on the stated case, could not have known or foreseen that there was poor workmanship which he failed to disclose, the insurer was not entitled to reject the claim and the court found for the insured.

The judgment is the consequence of what appears to be a jumbled pleading and stated case and the absence of submissions and argument by the insurer. The exclusion relied upon by the insurer in rejecting the claim does not in its terms require knowledge by the insured in any form. On the terms, at least in part, of the stated case it is clear that the damage was contributed to by defective workmanship in the alterations.

Parties proceeding on the basis of a stated case must do so with caution.

Guarantees

Hollard Insurance Company Limited v Lynco Projects (Pty) Limited and Others

(1173/2023) [2024] ZAMPMBHC 86
(17 December 2024)

Keywords guarantee / supervening impossibility

The insurer issued a guarantee on the instructions of the respondents. The respondents issued counter indemnities and suretyships in favour of the insurer, agreeing to pay on demand any sums which the insurer was called upon to pay under the guarantee. The guarantee was issued in favour of the beneficiary, and the insurer received a written demand for payment, which it honoured. The respondents then failed to repay the amounts paid to the beneficiary, to the insurer. The insurer sued for payment.

The respondents raised the defense of impossibility of performance under the project contract between it and the beneficiary. The respondents were contracted to construct a water pipeline for the beneficiary, but the respondent was forced to abandon the project after members of the local community hampered their efforts. The respondents alleged that community members were unhappy at the contract being awarded to it, and at the respondent's failure to employ members of the local community, who they demanded should be hired for the project. The respondents' employees were intimidated, equipment was stolen, and the construction in progress was vandalized. The respondent brought this predicament to the attention of the beneficiary, who negotiated a truce with the local community, but then unrest erupted again. Security and police could not stop the unrest. It therefore became impossible for the respondent to perform its task, forcing it to terminate its contract with the beneficiary.

The court noted that the insurer's claim is based on a contract that is independent from the contract between the respondent and the beneficiary. The construction contract has no impact on the contract between the insurer and the respondent. If there is a claim in future for damages

based on non-performance of the contract between the respondent and the beneficiary, the respondent would be within its rights to raise the defense of supervening impossibility. The guarantee was to ensure that the beneficiary would be protected in case the respondent failed to fulfill its contractual obligations for whatever reason. The respondents did not allege any fraud on the part of the insurer. The validity of the contract between the respondent and the insurer was also not challenged.

The indemnity between the insurer and the respondents was therefore upheld, and the respondents were ordered to pay the insurer's claim.

Hollard Insurance Company Limited v Gaz Fuel (Pty) Ltd and Another

(2020/41361) [2024] ZAGPJHC 1278
(10 December 2024)

Keywords guarantee / oral variation not valid

The insurer issued a guarantee on the instructions of the respondents. The respondents issued counter indemnities and suretyships in favour of the insurer, agreeing to pay on demand any sums which the insurer was called upon to pay under the guarantee. The guarantee was issued in favour of the beneficiary, and the insurer received a written demand for payment, which it honoured. The respondents then failed to pay the insurer the amounts paid to the beneficiary. The insurer sued for payment.

The respondents argued that the agreement with the insurer was that if the beneficiary called for payment under the guarantee, the insurer would only make payment upon written confirmation by the respondent confirming its indebtedness to the beneficiary. The respondents alleged that it was not indebted to the beneficiary (and that in fact the beneficiary owed the respondents money). When the insurer notified the respondents that it had received a demand, the respondents called on the insurer not to honour the guarantee because the beneficiary was indebted to it. Despite this request, the insurer paid under the guarantee. The respondents accused the insurer of colluding with the beneficiary with the intention of defrauding or prejudicing the respondents. Alternatively, they accused the insurer of acting negligently in honoring the guarantee.

The insurer denied that it provided any assurance to the respondents to wait for confirmation from the respondents before payment could be made. The insurer argued that such an arrangement would be in direct conflict with the purpose of the guarantee and the terms of the indemnity and suretyship.

The court accepted that the insurer was not a party to any agreement between the respondents and the beneficiary. Any dispute between those parties has no consequence to the insurer, and must be resolved between them. The deed of surety and indemnity included a non-variation clause, and therefore any alleged oral agreement between the respondents and the insurer would be invalid and unenforceable. The terms of the alleged oral agreement conflicted with the terms of the guarantee and the suretyships, and are "far-fetched and against business efficacy". The allegation of collusion and fraud was neither properly pleaded nor proved.

The court therefore upheld the guarantee, and ordered the respondents to pay the insurer.

Niemand v Hollard Insurance Company Limited

(13691/2021) [2024] ZAGPPHC 1203
(22 November 2024)

Keywords guarantee / conditions

The applicant appealed a decision of the trial court which upheld payment under a guarantee by the insurer and the resulting liability of the applicant as surety for that payment.

The applicant executed a deed of indemnity and suretyship in favour of the insurer. The applicant bound himself as co-principal debtor of a contractor for any amounts which the insurer was called upon to pay under the guarantees issued on behalf of the contractor.

The applicant argued that the guarantees were subject to specific conditions that had to be fulfilled and since the insurer had not demonstrated compliance with those conditions (which required an authenticated signed demand with attached payment certificates), its payment under the guarantees was invalid.

The court stated that the formalities contained in the guarantee which require that the signature should be authenticated, and that all payment certificates together with all recovery statements should be attached to the demand, presumed that the contract would be carried to its finality which was not the case because the contractor went into liquidation.

The court held that the insurer acted appropriately by making payment under the guarantees in the circumstances. The applicant's claim therefore failed.

Joint Venture Comprising Gorogang Plant Razz Civils and Others v Infiniti Insurance Limited

(02252/2023) [2024] ZAGPJHC 1048
(15 October 2024)

Keywords demand guarantee / fraud

The Eastern Cape Department of Transport appointed the first respondent (the Joint Venture) to upgrade certain roads in the province. The Joint Venture was obliged to procure a guarantee in favour of the Department. The insurer issued the required guarantee.

A dispute arose during the works, and the Department cancelled the construction agreement with the Joint Venture. The Joint Venture contested the validity of the cancellation of the agreement, and the dispute was pending adjudication before the South African Institute of Civil Engineering.

The Department called on the guarantee. The Joint Venture contested the validity of the demand on a number of grounds, including that the Department falsely and knowingly misrepresented that it had defaulted on the contract. Ultimately, the Joint Venture argued that the demand on the guarantee was fraudulent and that payment under the demand should be interdicted. The Joint Venture defined the guarantee as a conditional guarantee, that is, conditional upon valid termination of the contract for the contractor's default, since there was a link created between the guarantee and the underlying contract due to the nature of the requirements for a call on the demand to be valid.

The Department asserted that the guarantee was a demand guarantee, independent of the underlying contract.

On considering the terms of the guarantee and precedent, the court held that the guarantee was a demand guarantee, independent of the underlying contract. Therefore, it had to turn to the question of fraud.

The court noted that it will only reach a conclusion on paper that a fraud has been committed in the clearest of cases. By arguing that the Department fraudulently cancelled the construction contract and fraudulently called on the demand, would in effect be seeking a judicial pronouncement on whether the Department was entitled to terminate the agreement. The court was not entitled, in this application, to determine the parties' right under the construction agreement (that was the subject of another court application). Further, the Joint Venture had not made out a sufficient case that the Department's call on the guarantee involved fraud or misrepresentation or even bad faith.

The court therefore found that the guarantee was a demand guarantee and that the call on the guarantee was valid.

Santam Limited v Shikita Trading (Pty) Ltd and Others

(35287/2017) [2024] ZAGPJHC 892
(5 September 2024)

Keywords guarantees / National Credit Act

This judgment dealt with an application based upon a deed of suretyship and indemnity executed by the respondents in favour of the insurer. The deed of suretyship and indemnity had its genesis in a guarantee issued by the insurer to an airline (FBC) in favour of Airports Company South Africa SOC Limited, the beneficiary.

The insurer, consequent upon the debtor's breach of its obligations under the agreement, made payment to the beneficiary under the guarantee as demanded.

FBC was placed into business rescue.

The respondents failed to make payment to the insurer under the suretyships and indemnities they had provided.

Default judgment was obtained against all the respondents except for the second respondent, who opposed the application.

One of the defences raised by that respondent was that the National Credit Act (NCA) applied to the transaction. The respondent contended that insofar as section 4(2)(c) of the NCA removes the protection for natural person consumers providing security for corporations under the NCA (the second respondent was a natural person) that was discriminatory and the relevant section fell to be declared invalid in terms of section 172 of the Constitution. In order to impugn the provisions of section 4(2)(c) of the NCA the court had to find that the deed of suretyship and indemnity should be regarded as a "credit guarantee" to which the NCA applies.

Having regard to Section 8 of the NCA, the court said that it could not find that the deed of suretyship and indemnity executed by that respondent should be regarded as a "credit guarantee" to which the NCA has application. In doing so the court had regard to the relationship between the insurer and FBC, it being common cause that the respondents executed a deed of suretyship and indemnity in favour of the insurer in terms of which they, as co-indemnifiers with FBC, indemnified the insurer against any loss it may sustain consequent upon the issuing of any guarantee by the insurer on behalf of FBC.

The Short-term Insurance Act defined a "guarantee policy" to mean "[a] contract in terms of which a person, other than a bank, in return for a premium, undertakes to provide policy benefits if an event, contemplated in the policy as a risk relating to the failure of a person to discharge an obligation, occurs and includes a reinsurance policy in respect of such a policy". FBC had applied to the insurer for the guarantee. The application stated that the insurer consented to issue a guarantee, in return for the premium paid for each guarantee issued.

The South African courts are clear that if the NCA does not apply to the principal debtor, it does not apply to the surety of the co-principal debtor.

The court accordingly held that there was no basis for the constitutional challenge.

Exxaro Coal Mpumalanga (Pty) Ltd v ABSA Bank Ltd and Another

(2023/028000) [2024] ZAGPJHC 540 (6 June 2024)

Keywords demand guarantee / autonomous contract / joinder

A guarantee was issued by the bank in favour of the applicant, on the instructions of TDS, a construction company contracted to the applicant. The applicant called on the guarantee, but payment was refused by the bank on grounds not dealt with in detail in the judgment. The applicant therefore sued the bank for payment under the guarantee.

TDS applied to intervene in the matter between the bank and the applicant. TDS allegedly wished to raise issues of fraud on the part of the applicant, and that the demands did not comply with the terms of the guarantee, in order to defeat the applicant's claim under the guarantee.

Even though TDS provided indemnities (and paid a deposit) under the guarantee to the insurer, the court stated that, by virtue of the autonomous nature of a demand guarantee, TDS has no legal interest in the outcome of the main application. This case was an independent dispute between the bank and the applicant. TDS retains its ordinary contractual remedy against the bank should it pay under the guarantee when it is not legally entitled to do so.

Since the nature of demand guarantees is accepted by the courts as providing a strong right to the guarantor which can only be interfered with in very limited circumstances, TDS raised the issue of fraud, since evidence of fraud is one of the few defences to payment under a demand guarantee. The court found the allegations of fraud in this case to be based on flimsy evidence.

Therefore, TDS's application to intervene in the matter was dismissed.

Bonifacio and Another v Lombard Insurance Company

(247/2023) [2024] ZASCA 86 (4 June 2024)

Keywords guarantor and beneficiary settlement / debtor's rights

The Supreme Court of Appeal held that a settlement agreement between a beneficiary and a guarantor does not give the principal debtor the right to challenge the guarantor's payment to the beneficiary.

Construction work was subcontracted to a contractor by the beneficiary. The contractor was required to provide an on-demand performance guarantee in favour of the beneficiary. A few years later, the beneficiary demanded the full guaranteed amount from the guarantor. The first demand was based on a higher and incorrect contract amount and the guarantor refused to pay.

The beneficiary sued for the amount. The guarantor's primary defence for not honouring the demand was that the demand was fraudulent because the guaranteed amount should have been reduced. Affidavits were exchanged and, based on the strength of the beneficiary's claim, and the indemnity executed in favour of the guarantor by the contractor, the guarantor decided to serve third party notices on ten third parties who gave indemnities for the debt. The third parties opposed the relief claimed against them and sought to prevent the guarantor paying.

The contractor was subsequently liquidated and would no longer actively pursue the claim against the beneficiary. The guarantor determined that it was in its best commercial interests to compromise and settle the beneficiary's claim because it could not advance a fraud defence that it had no personal knowledge of, and the party that did have personal knowledge, the contractor, was no longer opposing the main application.

The third-party indemnity providers had not taken any procedural steps to advance their defences against the claims against them to reimburse the guarantor when the settlement agreement was reached and made an order of court. The third parties contended that the settlement agreement deprived them of their right to defend the validity of the beneficiary's claim.

The court explained that fraud only affects a contract where the fraud is raised by one of the parties to the contract. The guarantor's claim against the third parties was based on the indemnity executed by the third parties who did not allege or prove fraud on the part of the guarantor in relation to the indemnities claims. The performance guarantee was a contract between the beneficiary and the guarantor and not with the contractor or the third parties.

The court held that the third parties were vested with certain procedural rights when they were joined as third parties, and they should have invoked those rights. One of those rights provided the third parties with the opportunity to contest the claim of the beneficiary; because the third parties failed to pursue this right there was no connection between the third parties and the beneficiary. As third parties, they had no right to contest the guarantor's agreement to pay the beneficiary.

Claims against the third parties to indemnify the guarantor were granted in favour of the guarantor.

The judgment demonstrates that a compromise between a beneficiary and guarantor will not prejudice the procedural rights of a third party to contest the right of the beneficiary to claim under the guarantee, if fraudulent. Third parties are vested with procedural rights when they are joined as third parties and they must make use of their right to challenge the beneficiary's right to the proceeds of the guarantee, timeously.

GMK Civils (Pty) Ltd v Bryte Insurance Company Ltd and Another

(2024-030334) [2024] ZAGPJHC 316 (27 March 2024)

Keywords demand guarantee / autonomous

The applicant applied to court to restrain the insurer (the first respondent) from paying an amount of around R17 million under a performance guarantee to the second respondent.

The insurer undertook in the guarantee to pay the second respondent the required sum upon receipt of documents outlined. The second respondent delivered the required documents, which included a payment certificate, and written demands to the applicant for the outstanding payment.

The court reiterated that demand guarantees are autonomous, and independent of the underlying agreement between the applicant and the second respondent. The insurer is obliged to make payment when presented with complying documents. The only question that the insurer needs to answer is whether or not it is presented with the correct documents, and if it is, then payment must be made. The insurer cannot exercise their discretion when making payment, and the guarantee must be paid according to its terms.

A demand guarantee can only be resisted on the basis of fraud. In this case, fraud was not alleged, but disputes arose between the applicant and the second respondent relating to the fulfillment of obligations in the underlying contract. These disputes do not affect the demand guarantee. The applicant and the second respondent were involved in arbitration proceedings to resolve their disputes. The insurer was not a party to the arbitration agreement nor to the disputes.

Therefore, the application to restrain payment of the guarantee failed.

Guardrisk Insurance Company Limited v Buck and Others

(2035/2020) [2024] ZAGPJHC 284
(7 March 2024)

Keywords guarantee / validity of demand for payment

Probuild executed a deed of indemnity in favour of the insurer. At the same time, the respondents executed deeds of suretyship in favour of the insurer. The deeds of indemnity and suretyship indemnified the insurer for any payments or expenses arising out of a guarantee issued by the insurer at the request of Probuild.

The insurer received a demand for payment under the guarantee in accordance with the terms of the guarantee. The insurer then sued the respondents for failing to pay the amount owing to the insurer under the suretyships.

The respondents defended the claim on the grounds that there was non-compliance with the performance guarantee. They alleged that the beneficiary under the guarantee was not entitled to issue its first written demand for payment on 6 June 2019, as it did. This is because payment under the construction agreement was due on 6 June 2019. Thus the written demand was sent prematurely and did not comply with the provisions of the guarantee. Therefore the insurer was allegedly under no obligation to make payment and should not have done so.

The insurer argued that the respondents' assertion that the demands were non-compliant with the terms of the guarantee, was evidence of the respondents' acceptance of the validity of the guarantee, because "non-compliance is a species of validity, and that the indemnities expressly provide that the respondents are liable to pay the amount whether or not they admit validity of the claims against the applicant under the guarantee".

The court agreed with the insurer. The respondents as sureties were obliged to pay the amount to the insurer whether or not they admit the validity of the claim under the guarantee. The guarantee and its related suretyships were independent from the underlying construction contract.

The respondents were therefore ordered to pay the insurer. The trial court heard this case in 2023. In 2024 the appeal court dismissed the respondents' application to appeal the judgment.

Innova Turnkey (Pty) Ltd and Others v Hollard Insurance Company Limited and Another

(2023-134395) [2024] ZAGPJHC 115
(9 February 2024)

Keywords on-demand guarantee / contractual dispute

The high court confirmed yet again that a contractor cannot rely on a prima facie right in a construction agreement to interdict the payment by the guarantor under an on-demand guarantee, in the absence of fraud.

A principal and a contractor entered into a written agreement for remedial works. The works were secured by two on-demand guarantees issued by an insurer on behalf of the contractor in favour of the principal. After various disputes arose, the beneficiary terminated the agreement and called up the guarantees. In response, the contractor brought an urgent application which sought to interdict the guarantor insurer from honouring its obligations under the guarantees.

The contractor contended that it had disputes with the principal and that its contract with the beneficiary provided that the parties must first attempt to resolve disputes between them by way of arbitration prior to the beneficiary seeking payment of guarantees. The court had to determine whether the contractor had established a prima facie right to secure an interim interdict preventing the insurer as guarantor from paying the beneficiary.

It is well established that a guarantor's obligations to pay a beneficiary in terms of an on-demand guarantee are separate from the rights and obligations of the underlying contract between a beneficiary and contractor as long as there is a complying demand for payment of the guarantee. Accordingly, any disputes relating to the underlying contract are irrelevant to a guarantor's liability to honour its obligations under an on-demand guarantee. Payment of an on-demand guarantee can only be interdicted where the demand made by the beneficiary is found to be fraudulent.

The court noted that the contractor did not allege fraud on the part of the beneficiary. The court refused to grant the interim interdict. The court further commented that the contractor would not suffer irreparable harm if it did not obtain the interdict. It had alternative remedies available to enforce its rights against the beneficiary. The application was dismissed.

Dr Fekeni and Others v Lombard Insurance Company Limited and Another

(43891/19) [2024] ZAGPJHC 84
(2 February 2024)

Keywords construction guarantee

The insurer issued a variable construction guarantee in 2013 in favour of Independent Development Trust (IDT) for the fulfilment of construction work undertaken by the second respondent (Group Five Construction). The applicants sued for an order directing the insurer to pay the guaranteed sum of R16 million because the second respondent committed acts which triggered the calling of the guarantee. The insurer refused to pay under the guarantee.

The applicants argued that the construction guarantee was validly called because the second respondent was placed under business rescue, and that IDT incurred expenses as a result of the appointment of another contractor to rectify some defects and complete the construction work which the second respondent failed to complete.

With regard to the final completion certificate, IDT asserted that the principal agent erroneously issued the certificate of final completion, because the certificate listed the defects which were identified before the certificate was issued and which should have been rectified first.

The court found that the demand under the guarantee, which related to the amount paid directly by IDT to a subcontractor who completed the works, was unsustainable since the demand under the guarantee was not accompanied or preceded by the recovery statement, as required. In any event the calculation of the final amount payable to the second respondent by the principal agent took into account the amount paid by IDT to the subcontractor.

The second respondent's counter application (for outstanding payment) also failed since the principal agent identified defects in the final completion certificate which existed as at final certificate (and not after the final certificate) which must be rectified by the second respondent. Since the defects were identified before the final certificate, the construction guarantee remains operational, though limited to those defects. The construction guarantee states that the guarantee would lapse on the date of payment of the amount in the final payment certificate.

Hollard Insurance Company Ltd v Force Fuel (Pty) Ltd and Another

(2020/34408) [2024] ZAGPJHC 41
(19 January 2024)

Keywords guarantee / surety / indemnity

The first respondent applied to the insurer for a guarantee, to be issued in favour of Engen, in the amount of R20 million. The second respondent executed a deed of suretyship and indemnity in favour of the insurer, binding itself as co-principal debtor with the first respondent for any amount paid under the guarantee.

The guarantee was called upon by Engen, and paid by the insurer.

The second respondent, when pursued for the debt, alleged that the conclusion of the deed of suretyship and indemnity was not authorised and that it was not bound by it. Further, the conclusion of the deed of suretyship and indemnity allegedly constituted the provision of financial assistance to the first respondent in terms of section 45 of the Companies Act – since there was no compliance with that section, the deed of suretyship and indemnity is void.

On the evidence, the court found that the resolution authorising the suretyship was valid, and that the provisions of the Companies Act had been complied with.

The respondents argued that guarantee was issued before the conclusion of the surety and therefore did not fall within the scope of indemnity. The court stated that there was no merit in this argument because the suretyship covered the amounts due and payable by the first respondents, even amounts which the insurer may not have paid out yet. The respondent also alleged that it only purchased fuel in the amount of about R4 million, and therefore could not be liable for more than that amount. There was no merit in this argument because the indemnity covers the respondents' liability for the amounts guaranteed and paid by the insurer. They agreed to pay any sum which the insurer may be called upon to pay under the deed of indemnity. In this case, that was R20 million.

The respondents were ordered to pay the insurer the guaranteed amount.

SMBT (Proprietary) Limited v Hollard Insurance Company Limited and Others

(2022-022086) [2024] ZAGPJHC 13
(12 January 2024)

Keywords guarantees / intention / punctuation / interpretation

The hight court held that an insurer's guarantee that ambiguously contained two incompatible expiry dates, namely the date of issue of the final completion certificate under the construction contract and the date on which the contractor had to pay under the consequent final payment certificate, should be interpreted in a businesslike fashion against the insurer. The insurance guarantee had not expired because the payment had not yet been made under the final payment certificate when performance was demanded from the insurer.

The insurer issued a variable construction guarantee creating a primary obligation on the insurer's behalf to pay money to the employer in the event of default by the contractor in the construction of a new dwelling. It was a true guarantee separate and independent from the construction contract. The guarantee had three possible expiry dates, namely the date of payment of the full amount under the final payment certificate, the date of payment in full of the guaranteed sum, and the date on which the final completion certificate was issued.

The final completion certificate was issued on 5 May 2020. A day later the final payment certificate was issued and the contractor defaulted and failed to make payment. On 9 June 2022 the employer demanded payment from the insurer under the guarantee which the insurer alleged had expired on the date of the issue of the final payment certificate. There was a clear conflict between the provision that the guarantee expired on the date of final completion certificate and the date on which the contractor defaulted under the final payment certificate.

The court relied on a number of principles of interpretation of contracts, namely the ordinary meaning of the words, the fact that provisions in a contract will not be seen as superfluous, greater weight is given to special conditions than general provisions, the contra proferentem rule, and the rule that policy limitations are interpretated restrictively and against the insurer.

On the insurer's interpretation, the insurer could never be called upon to pay because the completion certificate would be issued before the contractor was in default of payment under the payment certificate. This narrow peer at words ignored the relevant context within which the guarantee was provided under the construction contract. Such an unbusinesslike result could not be the intention of the guarantee.

The court referred to a clause in the contract which provided that "this construction guarantee shall expire in terms of either 1.1.4 or 2.1, or payment in full of the guaranteed sum or on the guarantee expiry date, whichever

is the earlier, where after no claims will be considered by the guarantor". The insurer contended that the issue of the final completion certificate as the earliest of those three dates applied. The court held that the first comma after "or 2.1" and no comma after the next word "or" meant that the phrase "whichever is the earlier" only referred to expiry on payment in full under the guarantee or an issue of a final completion certificate. Expiry after payment in full of the amount certified under the final payment certificate was a separate ground for termination of the guarantee. The presence of the comma after "or 2.1" was important to give meaning to the guarantee and the insurer's obligations. It meant that the unacceptable outcome that the insurer could never be called upon to pay was avoided.

The guarantee had not expired and payment was ordered.

Interpretation

Kramer Weihmann Incorporated v Joubert and Others

(3645/2022) [2024] ZAFSHC 374 (25 November 2024)

Keywords misappropriation of trust money / indemnity insurance

The plaintiff firm of attorneys sued a number of defendants including its professional indemnity insurers for money misappropriated from its trust fund. The insurer excepted to the claim, alleging that the particulars of claim did not set out a cause of action against it.

The court noted that a claim for indemnification insurance under a liability insurance contract can only arise when liability to the third party in a certain amount has been established. The debt, for purposes of the right to an indemnity, becomes due when the insured is under a legal liability to pay a determinate sum of money to a third party. Until then a claim for indemnification under the policy does not exist, it is only a contingent claim. In the present matter the plaintiff had suffered a trust deficit as a result of the misappropriation by a staff member for whom they were responsible and had already made good on R4 million to the trust depositors. The fact that the entire deficit was not yet made good was irrelevant: the moment the trust deficit was established, liability to pay arose.

Therefore, the exception to the particulars of claim was dismissed.

NJK Boerdery CC v Safire Insurance Company Ltd

(2279/2021) [2024] ZANCHC 73; [2024] 4 All SA 218 (NCK) (2 August 2024)

Keywords hail damage / wash away clause / Agri policy / pecan nut farm / assessment / interpretation

A pecan nut farmer in the Northern Cape sued his insurer for over R9.6 million after two hailstorms damaged his crops. The insured's crops were washed away by heavy rain before they could be assessed under the Agri policy. The first hailstorm took place in November 2020, shortly after the insurance policy was concluded in October 2020, and the second hailstorm followed not long thereafter in March 2021.

The farmer had taken out an Agri insurance policy which covered his pecan nut crop against the risk of hail damage. However, the policy did not specify how damage would be assessed in the event of a claim. The farmer claimed that the assessment procedure was explained to him by his broker and confirmed by the insurer's technical manager during a call, and that it included a "wash away clause". This clause provided that if the hail-damaged nuts were dislodged and washed away by rain, making it impossible to link them to specific trees, the assessment would be postponed to a week before harvesting, when the remaining nuts would be shaken and weighed.

The insurer disputed this allegation and relied on its own hail assessment procedure document, which post-dated the commencement of the policy and the first hailstorm. The insurer's document did not provide for a wash away clause, but rather required the assessor to count the hail-damaged nuts that fell from the trees over several weeks, and then calculate the percentage of damage based on the insured yield. According to this method, the farmer's damage was much lower than what he claimed, and the insurer offered to pay him R580 200.

The court had to decide which assessment procedure formed part of the insurance agreement. The judge found in favour of the farmer because, amongst other things:

- The insurance policy did not contain a definition of the assessment procedure, and therefore it was not the exclusive memorial of the policy. The judge was allowed to look at the surrounding circumstances and the negotiations of the parties to determine their intention.
- The farmer proved that the assessment procedure as explained by his broker and confirmed by the insurer's regional manager was an integral and material term of the agreement, and that he paid a higher premium and agreed to a 20% excess for this specific cover.
- The insurer's hail assessment procedure document did not form part of the policy and was not available when the policy commenced. The insurer's witnesses also conceded that previous versions of the document could have included a wash away clause.
- The insurer's employees did not correct or object to the use of the wash away clause when it was referred to in training on the product provided to brokers.
- The insurer had applied the wash away clause in other claims.
- The policy included a term that allowed the assessor to postpone the final assessment of any damaged fruit to such a time when the damage could be accurately determined, which supported the farmer's version.

The court therefore ordered the insurer to pay the farmer the full amount claimed, plus interest and costs.

This case illustrates the importance of clear and consistent policy terms, and of ensuring that any oral agreements or representations are properly recorded and incorporated into the written contract to avoid later disputes. Policies seldom include a 'whole agreement' clause. It also shows that the courts will look at the context and the conduct of the parties to interpret ambiguous or incomplete contracts, and that the insurer bears the risk of any uncertainty or inconsistency in its policy documents.

King Price Insurance CO v Joubert

(4083/2023) [2024] ZAFSHC 147
(24 May 2024)

Keywords payment of premium / summary judgment

The insurer sued the insured for payment of premium under three insurance policies, totalling around R1.4 million. Premiums were payable yearly, at the end of soyabean harvesting season, in this case 31 May 2023.

The defendant insured admitted that he concluded the insurance policies with the plaintiff insurer, and he admitted the premium per policy, the agreements, and that he refused to make payment. The defendant pleaded that the insurer repudiated the contract prior to 31 May 2023 through its omission to do a proper assessment after damages were reported timeously and by its unlawful insistence on payment prior to 31 May 2023.

The insurer applied for summary judgment, to which the defendant did not file an opposing affidavit (but instead filed heads of argument and raised a technical legal point). Summary judgment enables a plaintiff to obtain judgment against a defendant without resorting to trial when a defendant has no defence to a claim based on a liquid document, for a liquidated amount of money such as a premium.

The court stated that the insurer's affidavits verified its cause of action and quantum. The defendant did not raise a dispute on the assessment within the time frame allowed, failed to comply with terms of the agreement, while admitting entering into the insurance policy, and that the premiums were payable. By not submitting an affidavit as required by the court rules, in reply to the application for summary judgment, no viable defence was raised by the defendant.

Judgment was therefore given in favour of the insurer.

E.C.C obo J.V v MEC for Education, Gauteng Province

(36071/19) [2024] ZAGPPHC 261
(18 March 2024)

Keywords privity of contract / interpretation / public liability / joinder / costs

The plaintiff sued the MEC of Education for an injury that occurred to a minor child while at school. The MEC's insurer settled the claim, but refused to pay the litigation costs.

The plaintiff sued the MEC for costs. The MEC argued that had the plaintiff pursued the claim against the insurer properly, there would have been no need for costly litigation.

The court noted that it was not the plaintiff's obligation to follow up and pursue the insurance claim, since the contract of insurance was between the MEC and the insurer. The MEC tried argued that section 60 of the Schools Act confers rights on the plaintiff to pursue the claim against the insurer. The court rejected this argument, noting that the purpose of the legislation is to limit the liability of the State to compensation that it cannot obtain from the insurer. It does not alter the common law contractual relationship between insurer and insured. Regulations impose an obligation on the school to assist parents by claiming under the relevant insurance policies, but do not create a statutory third party benefit that can be pursued against an insurer directly.

On the question of joinder, the court noted that the MEC as insured should have joined the insurer to the proceedings if necessary (since it had the claim for indemnity against the insurer),and could not argue that it was the duty of the plaintiff to do so.

Costs were awarded to the plaintiff.

Joinder

Histerix (Pty) t/a Grand Shoe v Heartbeat Business Enterprises CC/ /ta Heartbeat Logistics (In Liquidation) and Another

(D359/2018) [2024] ZAKZDHC 44 (1 July 2024)

Keywords joinder/ liquidation

The applicant contracted with the respondent for road transport of a shipment of shoes. The first respondent subcontracted to the second respondent road carrier for the transport. The shoes were lost in transit. The applicant sued the two respondents, but the second respondent went into liquidation. The applicant therefore sought to join the second respondent's insurer to the proceedings, in this application.

The respondents objected to the joinder, arguing that there is no relationship between the applicants and the second respondent, nor between the applicant and the second respondent's insurer. However, briefly canvassing judgments relating to delictual and contractual relationships that could exist between the parties, the court allowed the joinder, noting that there may be a statutory claim under the Insolvency Act against the insurer if liability against the insolvent second respondent is proved at trial. The court stated that evidence which may be led at trial may justify the cause of action pleaded. However, whether the applicant succeeds in its claim is a matter for the trial court to determine after the hearing of the evidence.

Therefore the court allowed the joinder of the insurer to the matter.

Life insurance

S v Seyisi

(CC27/2024) [2024] ZAECMKHC 142
(18 November 2024)

Keywords funeral policy / murder

This is a criminal case dealing with murder and attempted murder. However, one paragraph of the judgment is noteworthy for insurers, since the victims were targeted in order for insurance benefits to be claimed from funeral policies:

> "We live in a country where the majority of the people live below the poverty line. The temptation to cover these people for funeral policies is rife for unscrupulous people. It is for that reason that a strong message must be sent to them that insurance companies created an industry where it is possible to give everyone a decent funeral. That industry has been highjacked by those who have no regard for human life and have turned it into an illicit money-making scheme. Those who participate in those criminal activities must face the full might of the law. The time has now come for the insurance companies to revisit their processes and introduce some safeguards to protect the unsuspecting public from those who are abusing these policies for financial gain."

Ntlokwana v Sanlam Life Insurance Limited

(2023-053497) [2024] ZAGPPHC 1092
(22 October 2024)

Keywords life insurance / cancellation of policy / legislation

The applicant retired in 2020 and arranged for his pension fund to transfer his retirement benefit to the respondent insurer, after withdrawing the tax free lump sum (one third of his pension benefits). The funds were invested in a number of annuities and life policies.

The applicant tried to cancel the policies a few months later, alleging that he had not agreed to the commission due to his financial advisor, that he had not seen the policy documents until after the funds were invested, and that he was not given proper advice. Further, it was not explained to him that he could not cancel or withdraw the investment. Evidence showed that the applicant had been made aware of the nature of the policies and that he had agreed to them.

The respondent argued that in terms of the relevant provisions of the Pension Funds Act and the Income Tax Act, the applicant was not entitled to be paid the commutation benefit. Legislation requires the imposition of the non-surrender clauses.

The court agreed with the respondent, that the court could not direct it to cancel the policies, since that would contravene legislation. The applicant's claim therefore failed.

Sanlam Life Insurance Limited v Chigombo

(A14/2024) [2024] ZAMPMBHC 71
(30 September 2024)

Keywords life insurance / section 54 of the LTIA / partial withdrawal / cancellation of policy

The high court found that the policy wording and section 54 of the Long-term Insurance Act of 1998 allowed the policyholder to either cancel her investment policy as a whole or make a partial withdrawal, but not both.

The policyholder invested her inheritance with the life insurer, with the policy to run for five years. Shortly after the conclusion of the contract, the policyholder requested and was paid a partial withdrawal from the investment.

Within a year, the policyholder requested a second partial withdrawal, which was declined by the insurer. Consequently, the policyholder demanded that the contract be cancelled and that the remaining funds be returned to her. This request was refused.

The policyholder instituted proceedings seeking an order that the contract be cancelled and that the balance of the funds be returned.

The crux of the policyholder's argument was that she had entered into a contract with the insurer in terms of which the insurer undertook to invest the funds for five years and to pay back the same with interest following the lapse of five years, or at any other time upon demand. By refusing to pay back the funds, the insurer had allegedly breached the contract and entitled the policyholder to cancel the contract.

The policy stated that "if you only partially cash in your policy before [the maturity date], you are not allowed to cash in again before this date". The insurer referred the court to s 54 of the Long-term Insurance Act and Long-term Insurance Regulation 4.2.

Section 54(1)(a) provides that a life insurer may not undertake to provide policy benefits under a life policy otherwise than in accordance with the requirements and limitations set out in the regulations. Regulation 4.2 provides that a long-term insurer must not undertake to provide, or provide, a benefit under the policy during an extended restriction period if the policy has previously been partially surrendered during the extended restriction period. In this case the restriction period was five years.

Accordingly, the court dismissed the policyholder's claim.

The court held that the policyholder had had an opportunity to either cancel the contract as a whole or request a partial withdrawal. The policyholder chose the latter. Had the insurer allowed the policyholder to make a second withdrawal or cancel the contract following a partial withdrawal it would break the law.

The Regulation prevents insured persons treating insurance companies as deposit-taking institutions.

C.M.M v Discovery Life

(2023-013519) [2024] ZAGPPHC 989
(26 September 2024)

Keywords group life policies / right to sue / eligibility for benefits

The high court dismissed an application to obtain benefits from a group life policy with a Global Education Protection benefit.

The applicant, acting in her representative capacity for her minor daughter, attempted to claim benefits under a group life policy issued by the insurer. The policy provided indemnity cover for education of children following the death of a member of the scheme.

The insurer submitted that the applicant did not have legal standing to claim because there was no contract between the applicant and the insurer. The group life policy was concluded between the insurer and the deceased's employer. Benefits under the policy were payable to the employer.

The policy clearly indicated that the deceased was a member of the employer's scheme and was not a party to the underlying agreement between the insurer and his employer.

The court held that the applicant could not claim directly from the insurer and she did not have the requisite right to sue.

Despite its finding on legal standing, the court dealt with the merits of the claim.

The policy placed the burden of proving eligibility for the Global Education Protector benefits on the employer. The employer, who was not party to the proceedings, relied on the applicant or the deceased's family members to secure and submit proof the deceased was the minor's biological father.

The insurer had the right to determine what information was considered proof of eligibility. The insurer required an unabridged birth certificate and proof of payment of the minor's school fees for 12 months prior to the deceased's death. The court emphasised that the insurer was entitled to stipulate its contractual preconditions for payment.

The court acknowledged the applicant's challenges in obtaining the required documentation. The affidavits by the deceased's siblings did not pass muster and there was no proof that the deceased paid for the minor's education or contributed to her maintenance.

The court dismissed the application.

Basdeo and Another v Discovery Life Limited

(056880/23) [2024] ZAGPPHC 884
(10 September 2024)

Keywords life policy / payment deferred / police investigation

An insurer assessing a life insurance claim may have valid reasons to defer its decision regarding payment to the beneficiaries until it obtains necessary information from third-party investigations, such as police officials. There is a rise in publicised cases of murder for insurance, and life insurers are right to defer payment in appropriate circumstances. However, the high court ordered payment to a beneficiary under a life insurance policy, because payment had been deferred for four years.

The claimants were the sons and beneficiaries of the deceased, who was murdered in November 2020. They submitted a claim for the death benefits under the policy, which amounted to R400 000, to be shared equally between them. However, the insurer was informed by the SAPS during December 2020 to stop all insurance payments concerning the deceased, as their investigation revealed that the first claimant's evidence during the police investigation did "not add up" in relation to whether the deceased was in or outside his vehicle when he was shot, and it was discovered that the first claimant had taken out policies on the life of his father.

In deferring payment, the insurer relied on a clause in the policy that reserved its right to investigate claims or await the outcome of third-party investigations and to defer its decision to admit or refuse a claim until such investigations are completed.

By the time that the summary judgment application was heard, the insurer had paid the capital amount to the claimants, and the second claimant's interests and costs, but it maintained reliance upon the deferment clause in relation to the first claimant's claim for interest from the date of demand in September 2022 and costs.

The court rejected reliance on the deferment clause. A balance of the factors of delay, prejudice and fairness to both parties is needed when assessing whether a deferment of payment is justified. The court found that the balance of fairness favoured the first claimant, who had been waiting for almost four years to receive payment, and that the delay was not reasonable especially since the insurer only followed up on the status of the police investigation after the application for summary judgment was made.

This judgment serves as a cautionary tale for insurers, even if their policies contain deferment clauses. While deferment may be valid in certain circumstances, payment should not be withheld indefinitely. Insurers have obligations to process claims within a reasonable time, such as in terms of policyholder protection rules, and should be proactive in following up on the outcome of any police investigations and conduct independent assessments of claims as far as possible. Reliance upon deferment clauses must be reasonable in the circumstances.

Ncube v Liberty Group Limited

(2021-23807) [2024] ZAGPJHC 298; [2024] 2 All SA 861 (GJ) (25 March 2024)

Keywords life insurance / deferment of payment / police investigation

The plaintiff took out a life policy with the insurer in 2013, over the life of Mr Mhlanzi. Mr Mhlanzi died in 2017, after which the policyholder plaintiff lodged a claim with the insurer. The insurer rejected the claim, because it alleged that the plaintiff is only entitled to payment if he is not a person of interest in the ongoing police investigation surrounding Mr Mhlanzi's murder. The insurer attached a letter from the South African Police Services from May 2021, confirming that they had not cleared the plaintiff as a person of interest in its ongoing investigations.

The insurer sought a stay of proceedings pending finalisation of the police investigation and inquest.

The court noted that a stay of proceedings is normally only granted in exceptional cases and the power is exercised sparingly. There is no rule of law which stays civil proceedings where a criminal prosecution is pending. Instead, a stay will be granted where there is an element of state compulsion impacting on the accused's right to silence.

The insurer was waiting for evidence which might constitute a defence in terms of the policy or the common law, to the plaintiff's claim. No policy terms were pleaded which might constitute a defence to the insured's claim. That is, no provision was raised that supported the allegation that the insurer is not obliged to pay in the face of an ongoing investigation in which the policyholder is a person of interest.

After almost seven years, a defence to the insured's claim was not pleaded by the insurer. The court therefore found that the balance of fairness favoured the insured.

The insurer was ordered to pay the insured's claim.

Misrepresentation and non-disclosure

Safire Crop Protection Co-Operative Ltd v Normandien Farms (Pty) Ltd

(AR246/2023) [2024] ZAKZPHC 115 (29 November 2024)

Keywords fire insurance / misrepresentation / non-disclosure / materiality

This is an appeal against a 2023 judgment, in favour of the insured.

The plaintiff insured instituted action against the defendant insurer, in relation to a claim arising from a fire on the insured farm (in May 2015) which the plaintiff alleged resulted in damage of around R14 million. The plaintiff's insurance claim was rejected on the grounds that the plaintiff had misrepresented which portion of the farm the fire originated from. The insurer alleged that the fire originated in a sawdust and timber waste area and that this waste area was not mentioned by the plaintiff in the insurance renewal form. The waste area required a fire break of at least 30 meters wide around the whole immediate exterior perimeter, and the plaintiff failed to maintain that fire break area. Both parties presented voluminous amounts of evidence and various witnesses were called.

Based on the evidence, the court concluded that the sawdust heap must have been the origin of the fire. It was common cause that the plaintiff had not ever informed the insurer of the sawdust heap. The evidence of the plaintiff was that it had been dumping at the site since 2003, in order to fill up the area to enable 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 which had increased the fire risk of the farm 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 did not therefore find the answer to that question on the proposal form to have been a misrepresentation or fraudulent.

It was never disputed by the plaintiff that the dumping had taken place at the sawdust dump area. The question that the court had to consider, therefore, was whether there was a duty to make disclosure of the dump site to the defendant. The court noted that there was no specific mention in the insurance certificate or in any other documents that stated that the dumping of sawdust waste is 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 plaintiff had been dumping at that site for approximately 12 years. It would be reasonable that a person in that position, in circumstances where fire had not occurred, would not regard it necessary to inform the insurer of the site.

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

The court stated that the insurer failed to prove that the disclosure or non-disclosure of the dump site would have affected its decision to insure the property. The insurer was ordered to pay the claim.

The insurer appealed this decision, and the court rejected the appeal on the merits.

M.D.L v Liberty Group Limited

(3387/2023) [2024] ZAECQBHC 70
(19 November 2024)

Keywords disability / salary replacement policy / misrepresentation / non-disclosure

The insured sued the insurer under a salary protection policy. The insured attempted to take out various policies with the respondent insurer between 2015 and 2020, but her applications were declined due to the disclosure of her medical conditions. Her 2020 attempt resulted in her being asked to undergo medical assessments, but she abandoned that application. In 2021 she found a policy online, underwritten by the same insurer, the respondent. She submitted an application for cover telephonically. During that telephone call she was asked a number of personal and health related questions. Her application was successful.

She was the victim of an attempted hijacking in 2021, and her right arm and hand were injured as a result. She alleged that her services were terminated by her employer due to the injury, and submitted a claim under the policy.

The insurer rejected the claim for non-disclosure of her previous medical conditions. The insured argued that the information was at the respondent's disposal due to the fact that she had disclosed it during her previous applications. She also pointed out that the respondent approved her application for insurance (the 2020 application) despite the medical conditions she had disclosed.

The insurer argued that the unsuccessful salary protection policy was intermediated and that the information provided on that policy was in a database that is not linked to its other database, therefore the information could not automatically be checked against her previous attempts to apply for a policy. The applicant was also informed, when she applied for the cover telephonically, that the salary cover was a new policy and that a new assessment was being done. Further, while the claim was provisionally accepted, the applicant refused to be examined by an

occupational therapist appointed by the insurer. It had also come to the attention of the insurer that she was still working, and therefore may not be disabled by her alleged injuries.

The court upheld the insurer's rejection and dismissed the insured's claim.

Discovery Life Limited v Pranpath

(07606/2021) [2024] ZAKZDHC 82
(1 November 2024)

Keywords disability cover / evidence / discovery

The insurer sought to recover R16 million paid to the insured pursuant to claims under two policies, which provided disability and income protection cover in the event the defendant became totally and permanently unable to perform his nominated occupation as an accountant. The insurer argued that the insured conducts business through various entities and that the income earned by those entities was probably generated through the insured's work activities. The issue was whether the defendant did become permanently unable to follow his nominated occupation as a result of suffering from depression from 2016 onwards.

This application by the insurer pursued a request for better discovery of documents by the insured. The insurer required documents which evidenced the insured's earnings. The insured resisted the claim on the grounds of relevance and that some of the documents requested do not exist.

Discovery affidavits listing relevant documents are usually conclusive and courts generally accept them unless there are reasonable grounds for believing that a party has relevant documents that have not been disclosed or that there are false assertions in the affidavit. The court assesses relevance in relation to whether the information may directly or indirectly enable a party requiring discovery to advance their case or damage their adversary's case.

The policy requires that the insured must have suffered, and continue to suffer, from permanent disablement. The claim is therefore reviewed annually, because an insured is no longer entitled to the benefit if they recover the ability to work. The insurers argued that, despite the insured's assertions, he had been able to and was working, at least during the period August 2019 to August 2020.

Regarding the relevance of the records of the various corporate entities, the defendant argued that these documents are irrelevant as the issue in the trial relates to his personal ability to earn an income. That line of resistance was ill-conceived because it was the insurer's case that the defendant generates income through those entities

The defendant submitted that the documents requested were all irrelevant because they are financial in nature and the central issue in the action was whether the defendant was unable to work, which is a medical question. The court did not accept this argument. The court stated that it is not possible to view the issues in the action through such a narrow lens. What will be decisive of the plaintiff's claim is not the defendant's diagnosis but whether, as a fact, he is and was able to work despite the diagnosis.

The need for documents before the claim was paid in 2016 was also accepted as relevant, to enable the insurer to establish a baseline of earnings against which subsequent earnings could be compared.

The insurer was therefore successful in its application to compel further and better discovery of the documents.

Swanepoel N.O. (Executor in the Estate Late Mignon Adelia Steyn) v Profmed Medical Scheme

(CCT 336/22) [2024] ZACC 23; 2025 (1) SA 33 (CC) (9 October 2024)

Keywords misrepresentation / non-disclosure

The Constitutional Court, although dealing with a medical schemes claim, pertinently confirmed that where an insurer avoids a policy on the grounds of misrepresentation or non-disclosure whether under the common law or the Short-term Insurance Act, the insurer has to prove that the

non-disclosure of material information induced it to enter into the contract. This is a subjective test. The question is: was the insurer induced by a failure to disclose a material fact to issue the policy? In making the enquiry, evidence that the insurer had a particular approach to risks of the kind in question would be relevant and could be cogent. The decision entails that the statutory test and the common law test are the same.

The court was reaffirming what was said in *Regent Insurance Company Limited v King's Property* in 2014.

The medical scheme in this matter did not produce any evidence to show that it was, in fact, induced to enter into the contract with the member by the non-disclosure and the claimant succeeded in reinstating the membership contract that had been avoided on the basis of alleged non-disclosure.

In the particular case the membership of the medical scheme of the claimant had been terminated. The medical scheme had to show what its membership acceptance practices were in relation to other applicants who made full disclosure and had similar medical histories to that of the member they wanted to terminate on the grounds of non-disclosure. Medical schemes provide a gateway for many South Africans to the right to have access to health care services and the court had granted leave to appeal for that reason, among others.

This finding will apply equally to misrepresentation as a ground of avoidance under the Long-term Insurance Act.

Nkosi v Sanlam Indie

(4925/2023) [2024] ZAMPMHC 45
(20 August 2024)

Keywords disability cover / summary judgment / evidence of disability over time / misrepresentation

The insured applied for summary judgment against the insurer, for his claim based on a disability policy. He alleged that he suffered an occupational disability which was covered by the policy. The insured was involved in construction work, but then began suffering from "crippling joint pains" and other ailments. He was diagnosed with hernias and osteoarthritis. He lodged a claim with the insurer for loss of income, which was rejected.

The insurer argued that it has a valid defence to the claim, and therefore summary judgment should not be awarded. Firstly, the applicant failed to establish a permanent and irreversible condition. Under the policy, the insurer is not required to cover clams if the disability can be substantially removed or improved by surgery or other medical treatment which the insurer can reasonably expect the insured to undergo, taking into account the risks involved and the chances of success of such surgery or treatment. The insurer argued that it had not rejected the claim but advised the insured that no permanent and irreversible disability condition can be accepted as being proven with the information furnished so far. He was informed that the insurer could only review his claim after a period of 6 to 12 months, once the insured had undergone maximum medical improvement, and that the review of the claim would only be considered with an updated medical report by a treating specialist with confirmation of diagnosis and treatment.

The court accepted that if the insurer established this defence on trial, it would constitute a complete defence to the cause of action because the applicant only has cover that is provided for in the policy. The insurer also raised valid questions around potential misrepresentations by the insured, which arose from the doctor's reports that suggested that the insured may have been suffering from some of his ailments before the policy commenced (but had not disclosed these conditions).

The court therefore dismissed the application for summary judgment.

Motor vehicle accidents

Jacobs v King Price Insurance Co Ltd

(A153/2024) [2024] ZAGPPHC 1296
(28 November 2024)

Keywords evidence / motor vehicle accident / expert witness / whoever alleges must prove

The plaintiff sued the insurer under a motor vehicle policy. The policy provided cover for repairs, or the retail value of the vehicle if the cost of repair was 65% or more of the retail value.

Merits and quantum were not separated, so the plaintiff had to prove both liability and quantum at the same trial. The plaintiff alleged that the cost of repair would be around R329 000 and that the retail value of the vehicle was R330 000. Therefore, he claimed R328 000 (the retail value, minus the excess of R2000).

The insurer asked the court for absolution from the instance, because the values alleged by the insured were not proved.

The plaintiff called an expert to testify on the reasonable cost of repair. The insurer objected to this expert's testimony because his assessment of the retail value came from one of the insurer's expert reports. This expert report of the insurer was never introduced into evidence – that is, that expert was not called to testify to confirm his report, and therefore the evidence was inadmissible. Further, the plaintiff's expert assessment of repairs was given on the basis of 2023 figures, whereas the damage and replacement values should have been assessed in relation to 2020 values. The expert worked as a panel beater and had no knowledge regarding engine damage and retail values.

The court accepted that the evidence introduced by the plaintiff was not competent to prove quantum, and therefore the court granted absolution from the instance.

Mthethwa v MiWay Insurance Limited

(84333/2017) [2024] ZAGPPHC 1095
(16 October 2024)

Keywords expert evidence / motor vehicle accident / reasonable care/ dishonesty

The high court examined the rejection of an insurance claim following a motor vehicle accident. The insurer rejected the claim on the grounds that the insured had provided dishonest information about the speed he was driving, how the accident occurred, and alleged a failure to take reasonable care to prevent the accident because he was driving at an excessive speed.

The insurer relied on the following section of the policy:

1. "MiWay will not pay me for a claim when I ... deliberately caused the loss, damage or injury; and
2. If I or anyone acting on my behalf submits a claim or any information or documentation relating to any claim that is in any way fraudulent, dishonest or inflated, all benefits under this policy in respect of such claim will not be paid;
3. In order to have continuous cover and a valid claim, I must ... use all reasonable care and take all reasonable steps, with the same degree of carefulness which can be expected from the reasonable man on the street, to prevent or minimise loss, damage, death, injury or liability."

The claimant testified that he was driving between 45-50 km/h when a dog suddenly entered his path, leaving him no time to react. To avoid hitting the dog, he swerved, lost control of the vehicle and collided with the wall.

The claimant's expert noted that the damage to the vehicle was consistent with an impact speed between 50 km/h and 60 km/h, although pinpointing an exact speed was difficult.

The insurer's expert argued that the claimant was driving at an excessive speed of 90-100 km/h and had applied full braking prior to the collision. His calculations were based on

these assumptions as well as that there had been no dog, and so the driver had not swerved the vehicle. However, under cross-examination, the expert:

- Agreed that the damage was possible from an impact speed as low as 50 km/h.
- Accepted that there were no physical markings indicating 100% braking on the road.
- Acknowledged that on the driver's version, calculations for the estimated speed would be substantially lower.

The court found the insurer's expert report flawed due to the assumptions made, stating that there was no basis for the expert's rejection of the driver's version. The judge remarked, "the process cannot … be complete without [the claimant's] version of how the accident occurred especially where the process of reconstruction is done after a lapse of a considerable period".

Some of the terms in the policy relied on by the insurer required intent or fraud, neither of which were proven. Regarding the allegation of deliberate causing of loss, the court noted that there was no evidence that the claimant was intentionally speeding, which could indicate recklessness or failure to take reasonable care. The claimant had the onus to demonstrate that he was not driving at an excessive speed and that he acted reasonably. Then, the onus was on the insurer to prove that the claimant's actions failed to meet the standard of care expected in the situation. The insurer failed to prove unreasonableness on the part of the insured, and also did not prove that he had provided information dishonestly.

The insurer was ordered to pay the claim.

Ngobeni v PSG Insure and Others

(14433/2022) [2024] ZAGPPHC 1158
(5 October 2024)

Keywords motor vehicle accident / reckless driving / decision of the short-term insurance ombud

The insured sued under a motor vehicle policy for the value of the vehicle (or the limit of indemnity) following a claim that was rejected by the insurer. The insured was involved in an accident in which the evidence showed that he was driving above the speed limit. The claim was therefore rejected by the insurer for reckless driving which contributed to the insured's loss.

The court accepted that the claim was validly rejected, and found in favour of the insurer.

The third respondent in the matter was the ombud for short-term insurance, who had also rejected the insured's claim. The court noted that the ombud renders a quasi-judicial function, and that its services are contractually regulated. Complainants such as the applicant are not bound by the ombud's rulings and may pursue complaints in court, irrespective of the stage of proceedings before the ombud. Therefore, it was wrong to join the ombud to the proceedings and request the decision of the ombud to be reviewed and set aside.

Old Mutual Insure vs Saider Towing Service CC

(2021/2023) [2024] ZAECMHC 36
(23 May 2024)

Keywords security for storage of motor vehicle / lien over insured property / towing company

The high court confirmed that a towing company's lien can be substituted by adequate security provided by an insurer.

The dispute between the parties related to the release of a motor vehicle which was insured by the applicant insurer. The motor vehicle was involved in an accident

and subsequently towed by the towing company, the respondent. Upon receipt of the invoice for towing and storage services from the respondent, the insurer challenged the charges, deeming them unreasonable. The key issue revolved around the respondent's right of lien and whether the security provided by the insurer was adequate to compel the release of the vehicle.

The court acknowledged the respondent's right of lien, allowing them to retain the vehicle until payment was secured. However, it emphasized that this right could be substituted by adequate security from the applicant. The insurer had offered to pay a reasonable amount based on industry norms and pay the balance into the applicant's attorney's trust account as security, with an undertaking to pay the balance on the success of the respondent's claim.

The court found the insurer's approach to be reasonable, highlighting the unnecessary nature of the litigation initiated by the respondent. The respondent's failure to suggest alternative security measures further weakened their stance.

The judgment reinforced that providing security in a trust account is an acceptable substitute for physical possession under lien.

The court ruled in favour of the insurer, ordering the release of the vehicle upon the security already provided.

Insurers are entitled to challenge unreasonable towing and storage charges by offering adequate security for any payment due on final resolution of any legal proceeding to determine the reasonable storage charges payable. This approach can also expedite the recovery of insured assets which are being unreasonably withheld by towing or storage companies.

King Price Insurance Company Limited v Muambadzi

(A236/2023) [2024] ZAGPPHC 336
(9 April 2024)

Keywords motor vehicle accident / expert evidence / quantum / cost of repair

A trial court awarded the insured's claim, arising out of a motor vehicle accident, against an insurer. There was no separation between merits and quantum. The insurer appealed the judgment, on the basis that the insured had not proved the quantum.

The insured claimed around R200 000, "being the reasonable and necessary repair cost of his motor vehicle to its pre-collision condition". However, the insured did not present any evidence to establish that the cost of repairs was reasonable and necessary. The insured admitted, in cross-examination, that the amount was what he paid for the repairs, and was not necessarily what was reasonable or necessary.

The court stated that an expert witness was necessary to enable the trial court to make a finding to sustain the material facts pleaded by the insured, relating to quantum. The court could not merely admit the hearsay evidence of the insured, that the amount was reasonable, based on his alleged "truthfulness" as a witness. The act of payment could not automatically constitute a reasonable amount as the evidential value of whether the amount is reasonable depends on, for example, the credibility of the panel beater.

Since no evidence was presented to establish quantum, the appeal court dismissed the insured's claim.

Restraint of trade

Simah Risk Advisors (Pty) Ltd v Van Niekerk and Others (Reasons)

(15110/24) [2024] ZAWCHC 369
(14 November 2024)

Keywords restraint of trade / solicitation

An insurance broker sought to enforce a restraint of trade clause against two ex-employees who had taken up employment with a competitor.

The respondents conceded that they had breached and would continue to breach the core restraints set out in the applicant's restraint of trade clause. They argued that the applicant's assertion that they were required to protect its confidential information "rings hollow because this is information which [they] carried and continue to 'carry with [them] in [their] head[s]'". They also argued that any information they may have been privy to does not assist them or the third respondent in carrying on the third respondent's business.

The court noted that it would be near impossible to demonstrate that confidential information had been imparted to a third party save in circumstances of direct evidence being tendered. The risk remains that the first and second respondents may give over the applicant's confidential information to the third respondent.

The court stated that "it does not matter whether or not the first and second respondents contacted the clients' of the applicant or whether such clients contacted the first and second respondent as both these forms of conduct amount to solicitation of the applicant's clients which is impermissible during the period of the restraint covenant." This is different to the correct reasoning of the court in the case of *Compendium Group Investment Holdings (Pty) Ltd and Another and Crofts and Others* (discussed below).

On the basis of the restraint clause and the evidence provided, the court upheld the restraint of trade clause.

Jones v Compendium Group Investment Holdings (Pty) Ltd

(DA20/2023; DA11/2024) [2024] ZALAC 49
(11 October 2024)

Keywords restraint of trade / privity of contract

The appellant was the CEO, founder and majority shareholder of Compendium Group. After remaining in the group for around 29 years, he sold his shareholding to Bidvest Insurance Group. He would continue as CEO. The sale agreement of 2015 contained a restraint of trade clause.

The appellant resigned from Compendium due to ill health in 2021. He negotiated to remain as a consultant, but insisted that the consultancy agreement be between Compendium and iRisk Underwiring Managers, for tax reasons. The agreements went through various drafts. The final version contained a restraint against competing with Compendium, but the appellant deleted that clause manually (by manuscript). He terminated the consultancy agreement in 2023. Compendium discovered that he was registered as the representative of a broking firm that was a direct competitor of Compendium.

Compendium sued to enforce the restraint. The appellant did not deny that he had developed strong customer relationships and had access to confidential information due to his time spent at Compendium. However, he argued that the consultancy agreement novated or superseded the 2015 restraint agreement.

The court did not accept this argument because it was at the appellant's insistence that the consultancy be between Compendium and iRisk. The restraint from 2015 bound him in his personal capacity whereas he removed himself as a party to the consultancy agreement in order to gain tax benefits. The consultancy agreement could not be read as a tripartite agreement with the appellant, in his personal capacity, as the third party to the contract.

The appellant responded that the consultancy agreement created some personal obligations and liabilities that referred to him as an individual. The court conceded this,

and accepted that the consultancy agreement was not entirely clear, but concluded that this was a result of the negotiation process and resulting amendments in various drafts that birthed the consultancy agreement. Even so, the court refused to read the contract in a manner that made the appellant a party to it.

The court therefore upheld the 2015 restraint of trade.

Compendium Group Investment Holdings (Pty) Ltd and Another and Crofts and Others

(D223/2024) [2024] ZALCD 18 (9 July 2024)

Keywords broker / restraint of trade / solicitation

The first and second respondents were employed by the applicant for over two decades, before they resigned and took up employment with one of the applicant's competitors. The applicant applied to court to enforce a restraint of trade agreement with the respondents. The applicant alleged that because of the respondents' employment with the competitor, some of the applicant's clients terminated their mandates and moved their business to the competitor. Further, the respondents engaged in solicitation of the applicant's clients, or at the very least accepted business from the applicant's clients, in contravention of the restraint of trade agreement.

In the previous judgment dealing with the same matter, the court prohibited the respondents from disclosing the applicant's confidential information and ordered them to destroy such information that was in their possession.

The court noted that there is no such thing as passive solicitation. That is a contradiction in terms. Solicitation by its nature is active and requires the employee to take some affirmative measures. The court stated that a customer contacting a restrained employee is not solicitation. While it was true that some clients terminated their portfolios with the applicant and moved to the competitor, there was no solicitation on the part of the respondents. The respondents did not notify any of the relevant clients that they were leaving the applicant's employ. The evidence also did not demonstrate that the clients who moved decided to follow either of the respondents when they left the applicant's employ. Those clients stayed with the applicant for a number of months after the respondents moved to the competitor.

The restraint clause does not contemplate hindering an employee from 'dealing with' a client who leaves the applicant for reasons unrelated to the employee's position in the competitor firm. The court also distinguished the non-competition clause, which operated for three months, from the non-solicitation clause. The non-solicitation clause had expired, and therefore mere competition (without solicitation) was allowed. The respondents were therefore allowed to accept business from previous clients of the applicant, if they did not solicit for that business. In the absence of any solicitation, the respondents were found not to be in breach of the restraint clause.

B Sure Insurance Advisors (Pty) Ltd v Schnepel and Another

(J29/24) [2024] ZALCJHB 142 (22 March 2024)

Keywords restraint of trade / brokerage / proof of competition

The applicant, an insurance brokerage, sought to enforce a restraint of trade clause against a former employee, the first respondent. The first respondent took up employment with the second respondent, a brokerage which the applicant defined as its "trade rival".

The applicant brokerage offers short-term motor vehicle insurance. It relies on referrals of customers by motor vehicle dealerships, the individual dealer from the motor vehicle dealership, or Financial and Intermediary Consultants (F&Is) employed by the motor vehicle dealership. These motor vehicle dealerships or individual dealers or F&Is do not provide customers exclusively to the applicant but are free to refer them to multiple brokerages. The motor dealership receives a fee if an insurance product is sold.

The respondent was employed by the applicant as a dealer sales consultant, and then a dealer sales manager, and was finally promoted to general manager. The applicant alleged that the respondent had been exposed to their inner workings for five years and had acquired the skills to start a successful short-term insurance brokerage in competition with the applicant. Further, the relationships and knowledge gained by working for the applicant would be "a treasure for any competitor of the applicant" which could negatively impact on the applicant's business. His role as a manager also put him in a position that would make it easy for him to poach employees.

The first respondent alleged that the second respondent is not a competitor of the applicant, and that his current position is as a personal lines sales consultant. He is not involved with motor vehicle dealerships at all, and he alleged that the second respondent is not involved in that marketplace either.

The applicant attached screenshots of the second respondent's website in an attempt to show that it is a competitor. Further, the applicant argued that the first respondent failed to prove that the second respondent is not a competitor of the applicant.

The court noted that the onus is on the applicant to prove breach of the restraint and, in that regard, that the second respondent is its competitor. Misconceiving this onus of proof was fatal to its case because the details provided about the second respondent's business was, according to the court, "non-existent". No details to substantiate how or where the second respondent competes with the applicant were provided.

Enforcement of the restraint of trade therefore failed.

Runis Capher Brokers v Danielle Uren

(J763-23) [2024] ZALCJHB 53
(20 February 2024)

Keywords broker / restraint of trade/ contempt of court order

The respondent worked as a call centre operator for the applicant, a brokerage firm for around two years. She resigned and took up employment with a competitor of the applicant. The applicant applied urgently to court to enforce a restraint of trade in the respondent's contract. The court granted the order, which stated that the respondent was not allowed to use the confidential information of the applicant to contact any clients that were clients of the applicant, at date of resignation and for a period of 12 months from date of order.

Two months later, the applicant filed a contempt of court application, alleging that the respondent refused to comply with the court order, in that she had contacted Mr Beukes, a client of the applicant, within the 12 month period.

A contempt application is a curious mix between civil and criminal law principles. It is a civil proceeding, but the applicant needs to prove beyond reasonable doubt that the respondent acted in bad faith and wilfully against the court order. Other civil remedies remain available (such as a declaratory order), on proof on a balance of probabilities.

The respondent alleged that Mr Beukes was a close friend and had been friends with her husband for over a decade. Mr Beukes had always deemed himself a client of the respondent and not the applicant and the only reason he supported the applicant was because the respondent was employed by the applicant. Mr Beukes' information did not form part of the applicant's confidential information and she did not contact Mr Beukes, but he initiated contact with her regarding his insurance premiums. Mr Beukes deposed to an affidavit, confirming the respondent's version.

The court found on the evidence that the respondent was not in wilful default of the court order, and the contempt application therefore failed.

Road accident fund

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

(2023/117206) [2024] ZAGPPHC 1303
(17 December 2024)

Keywords medical expenses / indemnification / subrogation / medical scheme

In August 2022, the Road Accident Fund 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. The court emphasised that the purpose of the Act is to provide maximum protection to persons who suffer loss or damage because of the negligent driving or unlawful conduct in the driving of a motor vehicle by the driver. The court found that the RAF was not entitled to unburden itself from its clear statutory obligation despite the fact that a medical aid scheme was claiming on behalf of its members.

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 on 18 October 2023.

The RAF claimed 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 12 April 2023 so as to only reject the payment of prescribed minimum benefits (PMBs) and emergency medical conditions (EMCs) claimed by medical schemes on behalf of its members who are victims of motor vehicle accidents. The RAF did not consider itself bound by the Constitutional Court's decision, claiming that its amended directive is a departure from the original August 2022 directive.

Finally, in this December 2024 judgment, Discovery applied to court arguing that the RAF was in breach of the 2022 order. The RAF argued that the Medical Schemes Act does not confer a right on medical schemes to seek reimbursement from its members upon meeting its statutory obligation to pay for PMBs and EMCs. The RAF also argued that s19 of the RAF Act disallows compensation when the third party has entered into an agreement with any person in accordance with which the third party has undertaken to pay such person a portion of its compensation from the RAF. Discovery argued that s19 seeks to exclude champertous agreements, and not medical schemes.

The RAF submitted that the principles of subrogation and collateral benefits, which find application in indemnity insurance contracts, do not apply to medical schemes. To make its case, the RAF distinguished itself from an insurer and distinguished medical schemes from insurers. Medical schemes operate on the basis of risk pooling and community rating and are limited in their ability to refuse to take on certain risks, whereas insurers have freedom to refuse to contract with anyone. Insurers and medical schemes are also governed by different legislation.

The court accepted the RAF's distinction between medical schemes and insurers. It also stated that medical scheme rules such as those requiring reimbursement cannot bind third parties, including the RAF.

Based on the above arguments relating to insurance and medical schemes and subrogation, as well as the court's view on policy considerations, fairness and reasonableness, the court held that the RAF is entitled to rely on its two subsequent directives.

The matter will be going on appeal.

Road Accident Fund v Sheriff of the High Court for the District of Centurion East and Another

(122825/2023) [2024] ZAGPPHC 149
(19 February 2024)

Keywords RAF / medical expenses / medical aid

The high court rejected the Road Accident Fund's argument that it is not liable for medical scheme members' past medical expenses paid by the injured person's medical scheme following a motor vehicle accident.

Section 19 of the Road Accident Fund Act 1996 excludes the RAF's liability in certain circumstances, and the RAF argued that section 19(d) of the Act meant that it is not liable to pay damages if a person has insurance for the damage.

Here, the court repeated the Supreme Court of Appeal's view that the purpose of Section 19(d) is to protect injured persons from entering into champertous (unlawful litigation funding) agreements.

Our courts have expressly approved the way section 19 functions. The supplier's (in this case, the medical scheme's) right to claim from the RAF is conditional on the validity and enforceability of the injured person's claim and does not to render the scheme's claim unenforceable against the RAF:

> "For if [an injured person's] claim is valid and enforceable and the supplier's is not, the Fund would still be liable to compensate the [injured person] who in turn remains contractually liable to the supplier".

The court reaffirmed that an agreement between a medical aid and an injured person is an insurance agreement and is not champertous. The court referred to and accepted that it was bound by various judgments that have held, as a matter of principle, that payment by a medical aid does not relieve the RAF "of its obligation to compensate the plaintiff for past medical expenses".

This is not the first time the RAF has made this argument. The RAF has consistently been unsuccessful in its argument before various courts and was unsuccessful once again.

The court discussed and reaffirmed the principles of double compensation and a new intervening cause (res inter alios acta) and the judgment will therefore be of interest to all insurers engaging in both recoveries and dispute resolution processes.

The general principle is that benefits received by a claimant from their own insurers and other paid-for indemnifiers are not to be taken into account in claiming or reducing damages claimed.

Settlement

Cloete v Van Zyl

(3384/2017) [2024] ZAECMKHC 48
(2 May 2024)

Keywords settlement / principal and agent

The plaintiff sued the defendants for damages, caused by a fire that originated on the defendants' property, a farm in the Eastern Cape. The parties settled the claim a day before the trial, with the defendant accepting 80% liability for the plaintiff's damages. The settlement agreement was reduced to writing and signed [?], in the form of a draft court order. Later that same day, the defendants purportedly withdrew their settlement proposal, because, they informed the plaintiff, their insurer had rejected their claim and they would have to pay out of their own pockets.

The court noted that the insurer was not a party to the proceedings, and therefore whether they later denied liability for the claim was irrelevant. The defendants were bound by the settlement agreement.

Subrogation

Maseko v Road Accident Fund

(84274/2016) [2024] ZAGPPHC 845
(27 August 2024)

Keywords subrogation / deceased insured / RAF

Subrogation is a common law doctrine that allows an insurer who has indemnified its insured to step into the shoes of the insured and recover the loss from the wrongdoer. It is a well-established principle of insurance law

In that light, the Road Accident Fund's (RAF) defence in this claim is astonishing. Damages were claimed for injuries the insured sustained during a 2015 motor vehicle collision. The insured received payment of his past hospital and medical expenses from Rand Mutual Assurance Company Limited (RMA) under a Commuting Journey Policy which covers accidents occurring while an employee of the "primary insured" (the employer) is commuting. RMA sought to recover these expenses from the RAF and the action was instituted in the name of the insured.

The RAF argued that the claim for past medical and hospital expenses should be dismissed, because it had been settled under the RMA policy. The RAF also contended that the insured, who had passed away during 2023, did not have legal standing to litigate, and that RMA, who was not a party to the action, did not have legal standing either.

The court dismissed the RAF's defences and held that the claim was a subrogated claim, meaning that RMA was entitled to claim payment of the compensation it paid to the insured in their insured's name. The court explained that subrogation is a doctrine that ensures that the insured receives no more and no less than a full indemnity, and that the loss falls on the wrongdoer. The court noted that it is a prevailing practice that insurance companies litigate in the name of the insured.

While it is undoubtedly correct that the RAF's first defence was baseless (because an insurance payout does not ordinarily limit the extent of a wrongdoer's liability), the court seems to have overlooked that procedurally, the correct course would have been to have the nominal insured substituted by the executor of his estate upon his passing in terms of Rule 15(3) of the Uniform Rules of Court.

Underwriters at Lloyd's of London v Minister of Safety and Security

(40975/2016) [2024] ZAGPPHC 198; (2024) 45 ILJ 1339 (GP) (4 March 2024)

Keywords subrogation / cession

SVB, a cash handling company, was robbed in 2014 by perpetrators that included at least two police officers. SVB indemnified its banking clients for the loss, and was indemnified by its insurer, Lloyd's. Lloyd's sued the Minister of Safety and Security (who is vicariously liable for actions of its employees, that is, the police officers who participated in the robbery) for damages. The Lloyd's claim against the Minister was based on written contracts of cessions concluded between them and SBV and its banking clients. In the alternative, having indemnified SBV, the claim against the Minister was by subrogation.

The Minister argued that there were no claims to cede because, by the time the banks ceded their claims to SBV, SBV had already indemnified them. The Minister relied on precedent to support this claim, but the precedent cited dealt with a judgment debt that had been satisfied – in this case, the banks ceded to the plaintiff their claims in delict against the Minister. These delictual claims had not been extinguished by either a settlement or a judgment, and therefore they were validly ceded. Further, the Minister cannot escape delictual liability on the basis of SBV indemnifying the banks based on its contractual obligations (the collateral source rule). The court also accepted that the insurer was entitled to sue via subrogation.

There was argument on vicarious liability and the court found, on the evidence, that the Minister was vicariously liable for the deviant acts of its employees.

Judgment was granted in favour of the insurer.

Time-bar clauses and delays in litigation

Sasria SOC v TUHF Limited

(2023/046891) [2024] ZAGPJHC 1296
(23 December 2024)

Keywords dismissal of claim due to unreasonable delay in prosecution

The high court discussed the requirements for a successful application to dismiss a claim due to want of prosecution.

The requirements for this type of dismissal is that there is an inexcusable delay that caused serious prejudice to the defendant. The court will consider reasons for the delay, and the effect of the delay. For example, a delay may be relatively slight but serious prejudice is caused to the defendant, or the delay may be excessive but prejudice to the defendant is slight.

The court first examined whether there was a delay in the prosecution of the action. The plaintiff initiated the main action against the defendant and others in March 2017, seeking indemnity for damages suffered during 2014 and 2015. The action against the other defendants was settled in 2019, leaving the applicant in this case (SASRIA) as the sole defendant. The court noted that the last meaningful step in the litigation was the withdrawal of the action against the other defendants in April 2019. Since then, the plaintiff had not taken any substantial steps to progress the case, such as delivering new expert summaries or undertaking pre-trial steps. This prolonged inactivity constituted a clear delay in the prosecution of the action.

Regarding inexcusable delay, the plaintiff argued that it needed time to "re-strategise" and consult with experts. However, the court found this explanation inadequate. Despite claiming to have consulted experts for over two years, no expert reports were produced. The court deemed it improbable that such consultations would take this long without any filed expert summaries, concluding that the explanation was vague and the delay inexcusable.

The final requirement was to assess whether the defendant was "seriously prejudiced" by the delay. The court emphasised that the passage of time from the events in question (2014/2015) to the anticipated trial date (potentially 2026) would make it nearly impossible for the defendant to secure a fair trial, highlighting three key points of prejudice:

- Witness availability: identifying and securing the presence of relevant witnesses would be highly unlikely after such a long period as most potential witnesses were third parties with whom the defendant had no relationship.
- Reliability of testimony: even if witnesses could be located, their ability to provide reliable accounts of the events would be significantly compromised due to the passage of time.
- Documentary evidence: there was no documentary evidence nor would there ever have been, available on the issues in contention, which served to exacerbate the prejudice suffered regarding the availability and reliability of witness testimony.

The court concluded that the delay had caused significant prejudice to the defendant, making a fair trial impossible. The prolonged delay meant that crucial evidence and reliable witness testimony would be unattainable, thereby undermining the fairness of the trial process. Therefore, the court granted the application to dismiss the claim due to want of prosecution.

This judgment underscores the potential consequences of prolonged inactivity. The interests of justice require that claims be pursued diligently and without unnecessary delay.

CCN Boerdery BK v ABSA Versekeringsmaatskappy BPK

(2622/2015) [2024] ZANCHC 98
(4 October 2024)

Keywords time-bar clause / broker / agent

The high court dismissed the claimant's claim against their insurer due to initiation of legal proceedings outside stipulated time limits in the time-bar clause.

The claimant operated a business centred around the purchase and resale of lucerne. To protect its stock, the claimant entered into an insurance agreement, negotiated through a broker appointed by the claimant, with the insurer, covering risks including spontaneous combustion.

On 29 December 2012 an incident of spontaneous combustion occurred and the claimant submitted a claim to its insurer. The insurer rejected the claim on 1 March 2013. The claimant thereafter appointed a new broker, who lodged a complaint with the insurance ombud on 11 December 2013. The matter could not be resolved, and the claimant issued and served summons on 18 December 2015.

The insurer argued that the insurance agreement contained a time-bar clause, which provided that the insurer would not be liable after the expiry of 24 months from the occurrence of the event. Additionally, if the insurer denied any claim and a summons was not served within six months from such denial, all benefits under the policy would be forfeited.

The claimant alleged that the time-bar clause did not form part of the insurance agreement.

In evidence, the insurer called the claimant's broker, who testified that he acted as the claimant's agent in brokering the insurance cover and that he was aware of the time-bar clause. The fact that the broker acted as the claimant's agent was also conceded by one of the claimant's witnesses.

The claimant's witness testified that the only written policy document received by the claimant was the schedule, which did not contain the time-bar clause. However, the schedule included a clause stating that it must be read together with the general terms and conditions that formed part of the agreement, which were either annexed to said schedule or could be obtained on request. The court found that this clause made it abundantly clear to the claimant that there was more to the agreement than just the schedule.

The court held that due to the broker acting as an agent of the claimant, which was conceded by both the broker and the claimant's witness, the claimant was accordingly bound to the terms of the insurance agreement, including the time-bar clause.

The claim was dismissed.

This case highlights the importance of not only adhering to policy timelines but also the importance of ensuring that policyholders are aware of important policy terms and requirements and the implications of non-compliance. Given the prevalent use of brokerage firms, policyholders must be aware that information that is within the knowledge of their appointed agent will probably be imputed to them as the principal.

Shezi v Santam Limited

(1109/2023) [2024] ZAFSHC 43
(16 February 2024)

Keywords motor vehicle claim / time-bar clause / pleadings

The insured sued the insurer under a motor vehicle policy.

The insurer excepted to the particulars of claim, alleging that the insured had not complied with the time periods set out in the policy and that he did not allege in the claim that he had complied with the time limit requirements, which is a necessary averment to sustain his cause of action.

The plaintiff argued that he had pleaded the necessary

facts that he intended to rely on at trial and that a copy of the policy was annexed to the pleadings, and that pleading the time frames was not necessary. Further, issuing the summons outside of the policy period did not equate to prescription. Evidence could be adduced in due course explaining why the late filing should be condoned.

The policy required that legal proceedings be instituted within 6 months from the date of rejection, and provided that the insurer would not be liable after 12 months from the date of the incident giving rise to the loss, unless the claim was the subject of pending court action for which the insured may be liable.

The relevant motor vehicle accident occurred in February 2022. The insured lodged a claim with the insurer in March 2022, and the claim was rejected on the basis of fraud in April 2022. The plaintiff lodged an internal appeal with the insurer, which was dismissed in May 2022. He then issued summons in March 2023, and service of the summons was effected in April 2023 (more than 6 months after the rejection, and more than a year after the accident).

The court noted that while courts may be reluctant to decide upon exception questions concerning the interpretation of a contract, this was only the case where the meaning of the contract is uncertain. The court stated that:

> "The terms of the contract in the present case are neither difficult to interpret nor ambiguous. The terms relating to the claim procedure to be followed and the exclusion of liability are not difficult to understand. The disagreement of the parties does not render the meaning uncertain."

Therefore the insurer's exception was upheld and the insured was given 20 days to amend his particulars of claim, failing which the insurer could apply to have the matter dismissed.

Legislation

D & O insurance: extended prescription for s 77 claims against directors

The Companies Second Amendment Act 2024 that came into force on 27 December 2024 permits the retrospective extension of the usual three year prescription period applicable to claims against directors under section 77 of the Companies Act, on good cause shown.

Those involved with D & O related insurance should be alert to their and their client's retrospective potentially long-term risk in placing and underwriting such cover.

This is part of an ongoing trend. Recently prescription was extended in professional negligence claims against attorneys.

Donald Dinnie
Director
Tel +27 83 450 6213
donald.dinnie@nortonrosefulbright.com

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