NORTON ROSE FULBRIGHT

The Big Read Book series Volume 9
Norton Rose Fulbright's review of South African insurance judgments of 2021

December 2022

Contents

Introduction

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

This is Volume 9 of the Series – A review of South African insurance judgments of 2021. Settle in for this bumper edition, which covers 32 cases.

2021 saw an increase in insurance cases heard by the courts, possibly a catch-up from the backlog caused by the 2020 pandemic lockdowns.

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

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

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

- Volume 3 is a guide to indemnity and reinstatement value conditions.
- Volume 4 collates South African insurance judgments of 2019.
- Volume 5 is the comic book edition for avoidance and cancellation of non-life insurance policies.
- Volume 6 is on drones.
- Volume 7 covers South African insurance judgments of 2020.
- Volume 8 is an overview of the South African law of marine insurance.

Norton Rose Fulbright South Africa Inc
December 2022

Competition law and insurers

Impac Underwriting Managers (Pty) Ltd and Another v Du Plooy and Others

[2021] ZAGPPHC 597 (14 September 2021)

Keywords: Proprietary information for crop insurance / unlawful competition / administrator

The applicant, Impac Underwriting Managers, applied to interdict and restrain the respondents from using its confidential information and from unlawfully competing with it. The confidential information cited included customer lists, correspondence with actual and potential customers, supplier lists, correspondence with suppliers, contracts regulating its relationships with customers and suppliers, costing and pricing information, financial and marketing information, and other strategic business information.

Impac provides underwriting services in non-life insurance of agricultural risk (known as crop insurance). It alleged that its revenue-based cover is the first revenue-based crop insurance in South Africa and unique. Revenue-based cover differs from yield cover, in that it does not insure the physical crop, but rather a portion of the revenue a farmer stands to lose in the event that the assumed risk matures into a loss which the farmer would otherwise have derived from harvesting the crop.

Impac's CEO stated that the revenue-based cover is modelled on the doctoral thesis of his co-founder, who spent six years researching and writing his thesis on revenue-based cover. The CEO personally drafted the necessary commercial instruments required to ultimately monetise and allow the commercialisation of the product.

As a result of employment with Impac, Du Plooy, his father and some of the other respondents gained unrestricted access to Impac's confidential information. Du Plooy and others resigned from Impac and started their own crop insurance business, Oopkop, aiming to enter the crop insurance market as an underwriting manager and not as an insurer.

Impac believed that Oopkop would use its confidential information to unlawfully compete with Impac. An Anton Pillar document-search order was obtained to access and confiscate the information in the possession of respondents. In executing the order, Impac's full financial results for the 2018/2019 crop season were found, along with other allegedly confidential information of Impac. Various emails indicating that Oopkop had been contacting Impac's clients with a view to provide crop insurance to them were attached to the founding affidavit as evidence that Oopkop had used Impac's policy documents.

Before dealing with the case against Du Plooy and others, the court looked at whether there was a case against the insurer (A) for which Oopkop acted as underwriting manager, cited as a respondent. Impac is not a registered insurance company and crop revenue policies are issued by its insurer (B) to clients. In insurer B's policy documents, Impac referred to itself interchangeably as "underwriter" or "administrator".

Client contact details and pricing structures contained in the bordereaux are that of the insurer and do not belong to Impac. In entering the crop insurance market, insurer A became a competitor of insurer B and therefore if insurer B was of the view that insurer A was competing unlawfully with it, the insurer could take the appropriate legal steps. The relief claimed by Impac against insurer A was dismissed because Impac as underwriting manager had no right of action against insurer A.

The only potential competitor was Oopkop, when it successfully registered as a financial provider with the Financial Services Conduct Authority (FSCA).

The next step was to determine whether Oopkop had used Impac's confidential information that would cause it to compete unlawfully with Impac.

Insofar as Impac claimed that "the wording of the insurance policies and their clients" had been appropriated by Oopkop, the allegations were dismissed for the same reasons that the claim against insurer A was unsustainable. That claim belonged to Insurer B.

The question then arose as to what exactly Impac wanted to protect. Having established that the wording of the policies and the clients did not belong to Impac, the only conceivable basis for a claim based on unlawful competition, was the protection of a trade secret.

In order to prove a right to a trade secret, Impact had to establish that the information pertaining to its revenue-based cover was in fact secret and confidential.

In answer to Impac's allegation that it introduced a unique product to the insurance market, Du Plooy explained that revenue-based cover is a well-established product that has existed for many years in the United States of America's crop industry. He provided evidence relating to the industry including some interesting history of the crop insurance market in South Africa.

Du Plooy emphasised that he gained this information in his 12 years of experience in the crop insurance industry and was complemented by his father's 39 years of experience and know-how in the field.

Based on this, the court was not able to find that the information relied upon by Impac was in fact "secret and confidential". Bearing in mind that the crop insurance business is a competitive market and that potential clients have the right to choose the best cover at a reasonable price, Impac's claim was dismissed. The court included a special costs order for unnecessarily joining the broker respondents.

Competition law: Mergers

There were a number of mergers taken to the Competition Commission for approval by insurers and their related companies. The Commission usually looks at whether a proposed merger will substantially prevent or lessen competition in each relevant market. The Financial Sector Conduct Authority also has to independently assess the potential impact of the transfer of policies to determine whether it will lead to any unfair outcomes for policyholders.

Dotsure Ltd v Hollard Holdings (Pty) Ltd

(LM156Nov20) [2021] ZACT 21 (10 March 2021)

Keywords: Competition law / merger

A large merger between Dotsure Ltd and Hollard Holdings (Pty) Ltd was approved, with conditions.

The proposed transaction presented both horizontal and vertical overlaps. The horizontal overlaps arose because both merging parties offered services in non-life and life insurance in South Africa. The vertical overlaps arise from reinsurance and brokerage arrangements within the groups of insurers involved.

It was found that the proposed transaction was unlikely to substantially prevent or lessen competition in any of the relevant life and non-life insurance markets due to the low levels of accretion in each market, and the fact that the merging parties would continue to face competition from various players in each market.

The vertical overlaps were also approved because Hollard had been the only firm that Dotsure had provided reinsurance to in the last three years and Dotsure's estimated market share in the reinsurance market was less than 0.1%.

The Commission noted that this transaction required the approval of the Financial Sector Conduct Authority, in relation to the potential impact of the transfer of policies from one insurer to the other, to ensure that it does not lead to any unfair outcomes for policyholders. At the time when the Commission filed its recommendation with the Tribunal, the FSCA had not yet commenced its assessment of the proposed transaction. Nevertheless, the Commission's consideration of the proposed transaction from a competition law point of view was not dependent on the commencement or outcome of the FSCA process.

K2020791073 (South Africa) Proprietary Limited ("New Holdco") v Adcorp Support Services Proprietary Limited

(LM175Dec20) [2021] ZACT 16 (24 March 2021)

Keywords: Competition law / merger

In this acquisition of Adcorp, one of the acquiring firms was ultimately controlled by The First Rand Group.

The Competition Commission identified a vertical overlap in the parties' activities and assessed the transaction in the national upstream market for the provision of life insurance related services and brokerage services, and the national downstream market for life insurance related services.

The Commission found that the proposed transaction was unlikely to result in anticompetitive input foreclosing other insurers from accessing Adcorp's life insurance and brokerage related services, because the First Rand Group does not use the life insurance related services provided by Adcorp, nor any brokerage services, as it sells its life insurance products directly to individuals. The Commission also found that Adcorp had a low market share for the provision of life insurance and brokerage services. The Commission contacted Adcorp's customers and none of these firms raised any concerns regarding the proposed merger.

The Commission found that the proposed transaction was unlikely to result in any customer foreclosure by, for example, denying Adcorp's rivals access to the First Rand Group as a customer to provide life insurance related services and brokerage services, as the First Rand Group has a low market share for the provision of life insurance and therefore does not have market power. The Commission also contacted Adcorp's rivals and none of them raised any concerns regarding the proposed merger.

The Commission received a concern from a competitor to the First Rand Group in the life insurance and related services market. This competitor was concerned that its commercially sensitive information would be accessible to the First Rand Group, its direct competitor. A subsequent submission from the competitor revealed that its fears were allayed by the fact that the proposed transaction was effectively a management buy-out.

The Commission concluded that the proposed transaction did not substantially prevent or lessen competition in any relevant market. The merger was also unlikely to have a negative effect on employment.

Transaction Capital Motor Holdco (Pty) Ltd v WBC Holdings (Pty) Ltd

(LM030Jun21) [2021] ZACT 50 (3 August 2021)

Keywords: merger / intermediary services

SA Taxi Holding was a division of the acquiring firm in this merger. SA Taxi provides a comprehensive financial, insurance and allied services offering to minibus taxi operators. SA Taxi also offers minibus taxis for sale through its dealerships. The acquired firm acted as an intermediary in the provision of insurance products, including motor insurance.

In the markets for the provision of insurance products and services, and stolen vehicle recovery services, the Commission found that the merging parties acted as intermediaries for a wide range of insurers, finance houses and stolen vehicle recovery service houses.

In light of this, the Commission did not assess these markets any further as all dealerships offer these services and customers are ultimately able to freely choose an insurer that best suits their individual requirements.

SPE Mid-Market Fund I Partnership (represented by the general partner, SPE Mid-Market Fund I General Partner (Pty) Ltd) v Q Link Holdings (Pty) Ltd

(LM107OCT21) [2021] ZACT 82 (10 December 2021)

Keywords: Competition law / merger

The acquiring group, a financial services group in South Africa, provided insurance and financial planning services. The acquired company provided financial technology that focused on the insurance industry. The acquired company had a sufficiently low market share for the provision of its type of services in South Africa and there are other providers of payment collection solutions in the market. The merger was approved.

COVID-19 Business interruption claims

Santam Limited v Ma-Afrika Hotels (Pty) Ltd & Another

[2021] ZASCA 141 (7 October 2021)

Keywords: Business interruption / non-damage extension / insurance indemnity periods / COVID-19

The respondents are hotel and restaurant operators whose businesses were severely affected by the national lockdown. The high court found that the insurer was liable to provide business interruption cover. This appeal focused on the period of indemnity. The indemnity period under the business interruption cover section is listed as 18 months, but the memorandum immediately after the extension schedule stated that extensions under the section were limited to an indemnity period of 3 months.

The judgment is fact-specific and turns on the policy wording and structure and does not establish new principles. The court applied the approach to interpreting insurance contracts as stated in *Centriq Insurance Company Limited v Oosthuizen and Another (SCA)*.

The court held that having regard to the text, the context, and the purpose of the policy and the schedule, the indemnity period in relation to claims for loss of revenue due to business interruption was 18 months. The court said that those conclusions made business sense.

The court held that given that the policies were admittedly difficult to navigate and assuming at best for the insurer that there was, according to the judgment, a meaningful degree of uncertainty concerning the indemnity periods, the conclusion "might be reached that on that aspect the policies are ambiguous." In that context the court said that the *contra proferentem* rule would be applied to interpret the policy against the insurer. It was therefore not necessary to engage in a debate as to whether the indemnity period was a limitation or not and should be restrictively interpreted.

Policies often evolve over time. Extensions and memoranda are added and removed. Insurers and intermediaries should regularly review their policy wordings as read with the schedules issued to ensure consistency in language and terminology used throughout the policy and structure.

The Trustees for the Time Being of the Bymyam Trust v The Butcher Shop and Grill

[2021] ZAWCHC 240; 2022 (2) SA 99 (WCC) (19 November 2021)

Keywords: Business interruption / rental remission / COVID-19

This judgment contains useful guidance for insurers in adjusting Covid-19 business interruption claims involving recovery or remission of rental.

The court confirmed that as a matter of general principle:

- A lessee is entitled to claim rental remission where there is a deprivation of or lack of beneficial use of occupation caused by *vis maior* (a superior force, power or agency that cannot be controlled or resisted by the ordinary individual).
- The lockdown regulations would constitute *vis maior* causing material impossibility of performance.
- The lessee's rental remission may be set off against the lessor's claim for rent if it is capable of speedy and prompt ascertainment.

The lease defined "beneficial occupation" as "the physical possession and control of the leased premises". On the particular facts of the case the lessee had sublet, and had itself not occupied, the leased premises for some time prior to the lockdown. Moreover, it was not in physical possession or control of the property. The lessee was therefore not entitled to claim rental remission.

In the circumstances the lockdown regulations had not resulted in the loss of beneficial occupation. The lessor was entitled to recover the full rental.

The context of the disaster regulations applicable at the time, the extent to which performance was not possible, the extent to which there is a loss of beneficial occupation, and the terms of the parties' lease agreement must be considered in each case.

The judgment finds application in business interruption claims:

- A lessor in the same position claiming business interruption would have no claim for the rental since it is entitled to recover the rental from the lessee.
- As the lessee had an obligation to the lessor to pay the rental, any business interruption claim by the lessee would include the rental as an expense and part of the loss calculation.
- If on the facts the lockdown had deprived the lessee of beneficial occupation entitling it to a remission of rental, that would constitute a loss by the lessor and a saving by the lessee. This should be taken into account in each party's business interruption claim.

FAIS Debarment

Motea v New Era Life Insurance SOC Ltd

(FSP39/2021) [2021] ZAFST 27 (6 November 2021)

Keywords: FAIS debarment / reconsideration

The applicant was a juristic representative for the life insurer, the respondent. He marketed and sold the financial products of the respondent.

In relation to his debarment, the applicant raised one procedural point, stating that the respondent had not provided him with its debarment policy at the commencement of their relationship. Based on the evidence, the Tribunal found that this ground had no merit because the policy had been provided to him.

He argued that the disputes between him and the respondent were contractual and that debarment proceedings could not be used to settle such issues. While this assertion is correct in general, it was found that neither the Financial Advisory and Intermediary Services Act (FAIS) nor the respondent's debarment policy say that contractual breaches cannot in themselves be demonstrative of a failure to comply with fit and proper requirements nor constitute a material breach of FAIS. If a charge is based on a contractual breach, it must also result in a failure to meet the fit and proper requirements or constitute a material breach of FAIS.

The applicant charged an administration fee for premiums received before paying the money to the respondent. It was disconcerting to the Tribunal that he did not appreciate that his conduct was wrongful and illegal, because he is not a financial services provider authorised to perform administrative functions, and was not authorised to charge a fee for performing such functions. He was a juristic representative with a mandate to perform only those functions stipulated in the mandate on behalf of the respondent and for which only commission was payable. His conduct breached the Policyholder Protection Rules and FAIS, because he carried out intermediary functions without being authorised as a Financial Services Provider (FSP).

The breaches were found to be sufficiently material to give rise to debarment. The application for reconsideration was therefore dismissed.

Arendse v Financial Sector Conduct Authority; West-Pro Holdings (Pty) Ltd v Financial Sector Conduct Authority

(A12/2020; A46/2020) [2021] ZAFST 5 (1 December 2021)

Keywords: FAIS debarment / reconsideration / fit and proper / dishonesty

Following a complaint and an investigation by the FSCA, the FSP West-Pro Holdings' licence was suspended and its key individual Arendse was prohibited from providing financial services for a period of 8 years.

This application was for reconsideration of the debarment.

The complaint was initially brought by Sebomai, a juristic representative of an FSP Administrator that administers funeral policies and places them with a life insurer for underwriting. Sebomai was approached by a representative of West-Pro, to place their business with them. After some negotiations, Sebomai moved the business to West-Pro on the understanding that the policies would be underwritten by Old Mutual. However, the Old Mutual agreement with West-Pro had already been terminated before Sebomai moved its business to West-Pro and this was only discovered after claims were unpaid.

Arendse was debarred and West-pro's licence was suspended for not having an approved key individual, for collecting premiums into its own bank account without a mandate from an insurer, and for failing to insurer the clients with and pay over the premiums to an underwriter.

Arendse lodged an application for reconsideration of the matter based on procedural irregularities. However, the Tribunal found that the basic ground of debarment, that is that Arendse no longer satisfied the fit and proper requirements due to misrepresentations and dishonesty surrounding the conclusion of the Sebomai agreement, were sufficiently foreshadowed in the notice of intention to debar. West-Pro and Arendse's actions in relation to the Sebomai agreement evidenced an unwillingness to comply with the financial sector laws.

Arendse argued that his conduct did not warrant debarment because his transgression was a once-off incident, and that the FSCA had to establish that the incidents occurred over a long period of time and that there were numerous repeated similar incidences. In other words, he submitted that the incidences complained of must create a pattern and there was no evidence of this.

The tribunal held that the FSCA does not have to demonstrate that Arendse is not of good character. The FSCA only has to show that Arendse contravened a financial sector law.

This was also not a once-off incident of dishonesty. While the various instances of dishonesty may have stemmed from one transaction, namely the transaction with Sebomai, there was more than one act of dishonesty. The different versions put up by Arendse in the documents were found to be dishonest in themselves. Even if not fraudulent, Arendse's conduct at the very least was found to be neither frank nor sincere. His version of events was not supported by the objective evidence available.

The applications for reconsideration were dismissed.

Financial services tribunal: Lapsed policies

Amanda Niemiec v Constantia Insurance Company Limited

Financial Services Tribunal: Case no. PA1/2021: 27 October 2021

Keywords: non-life policies / life policies / transitional arrangements / lapsed policies

Prior to conversion of its short-term licence to a non-life licence under the Insurance Act 2017, the insurer underwrote accident and health policies with what are now both life and non-life risk components. Under the Insurance Act, non-life insurers are only permitted to conduct accident and health policies insuring costs or loss of income on the happening of a disability or death event caused by an accident (not illness or non-accidental death).

The Prudential Authority (PA) dealt with the issue under Item 6(5) of the Transitional Arrangements because the licence was converted to a non-life licence under which the policies could not be written. The PA chose to "ensure the orderly resolution of that insurance business of the insurer".

The PA pointed out that the accident and health policies could not be legally underwritten under the non-life licence. It directed the insurer to offer each policyholder a replacement policy with a personal accident death policy and discounted individual funeral products.

The insurer could not be directed to continue to extend or provide each policyholder with death and disability benefits because that would be illegal. The policies were not cancelled but instead lapsed because the insurer was no longer permitted to conduct that business.

Running off the policies was not legally possible. The policies would then endure until the death of the last surviving policyholder, some of whom were younger than 40. This would not "resolve the issue". The PA's decision was upheld by the Financial Services Tribunal.

Funeral insurance

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

[2021] ZAECQBHC 2780/2021

Keywords: funeral insurance / group policy /master policy / intermediary / change in underwriter

A court ordered a life company to transfer a portfolio of funeral business to the new life underwriter when the independent intermediary terminated its relationship with the company and moved the business to another life insurer. The court held that once the intermediary agreement between life insurer and intermediary was terminated, the parties were restored to the position they were prior to the conclusion of the agreement between them in 2015. On the evidence it was a necessary implication that there was a tacit term that the intermediary had the right to move the business after termination of the agreement.

The existing underwriter alleged that it had the relationship with the policyholders which could not be terminated until each policyholder entered into a new agreement with the new underwriter. It also alleged that the master policy was no longer a group policy because of the change of the definition of "group" under the Insurance Act, 2017. Neither of these arguments was upheld. It was found that the intermediary had lawfully moved all the business to the new underwriter and had notified the policyholders properly by data message. An SMS to each of the policyholders was found to be sufficient communication of the change.

The previous underwriter was ordered to effect the transfer and to pay all the premiums, that it had received from the date of termination of the agreement, to the new underwriter within 24 hours, and to pay the costs.

These issues have arisen frequently in the funeral space. If the intermediary has moved the business in the past or placed the business in the past without consulting each individual policyholder as to the identity of the underwriter, it is correct to deal with the matter as subject to a tacit mandate from the policyholders for the intermediary to choose the suitable underwriter. Expecting the intermediary to get thousands of policyholders to sign up to the new underwriter is unworkable and not in the interests of policyholders.

Fraud and forfeiture clauses

Discovery Insure Limited v Masindi

[2021] ZAGPPHC 145 (8 September 2021)

Keywords: fraud clause / penalty / proportionality

The court had to consider whether a claim "tainted with fraud" lodged by a policyholder had the effect of rendering the whole claim voidable, even the parts not tainted by fraud and the claims preceding the fraud.

The policyholder sustained damages in December 2016 to his insured residential property due to a storm and flooding. The policyholder lodged a claim with the insurer under the building section of the policy claiming a total amount of R972 592.67 for repairs and damage to household contents. The policyholder also provided a number of tax invoices in respect of his emergency accommodation during the period 20 November 2016 to 16 May 2017. These invoices amounted to R675 000.

The insurer alleged that the policyholder had not made use of the emergency accommodation as the invoices were made out to a third party. As a result of the policyholder's alleged fraud and misrepresentation, the insurer alleged that it was, in addition to recovering the money paid to the policyholder, entitled to cancel the contract with the policyholder with retrospective effect to the date of the incident.

Although the parties did not dispute the facts regarding the fraud and misrepresentation on the part of the policyholder, the dispute between the parties was on the basis that there was no express provision in the insurance policy that entitled the insurer to claim repayment of all benefits paid before termination, including benefits received by the policyholder not tainted by fraud.

The court considered the following:

- What was the extent of the policyholder's liability?
- Whether the policyholder's fraud in respect of part of an otherwise valid claim, resulted in the forfeiture of the entire claim retrospectively from the date of the cancellation of the policy
- Whether the insurer was entitled to cancel the policy as well as reclaim repayment of all the amounts paid to the policyholder irrespective of whether those payments were made in response to the policyholder's fraud.

In order to prevent policyholders benefitting from fraudulent deeds, insurance companies include forfeiture clauses in their policies. Although penalty clauses are enforceable under the Conventional Penalties Act, the penalty must not be out of proportion to the prejudice suffered.

The court referred to the judgment of *Schoeman v Constantia Insurance Company Limited (SCA)* where the court found that if a policy does not have an express forfeiture clause, fraud will be confined to only the fraudulent part of the claim and will not result in the policyholder's claim being forfeited.

The insurer's policy contained an express forfeiture clause. The clause stated that the consequence of fraud is that "all benefits in terms of this policy in respect of any claim will be lost and this policy may be voided or cancelled at our discretion".

The policyholder only committed the fraud after the first payment was made by the insurer and the insurer could therefore only avoid the contract from that date onwards for the false accommodation claim.

If the policyholder were ordered to repay the amount paid by the insurer for benefits that rightly accrued to the policyholder and were both due and payable, the penalty imposed on the policyholder would be disproportionate to the breach by the policyholder.

The court concluded that there was no justification for the enforcement of the penalty clause in the policy and the insurer was only entitled to recover the amounts paid in response to the fraud and misrepresentation on the part of the policyholder and not the entire amount.

King Price Insurance Company Limited v Concise Consulting Services (Pty) Limited

[2021] ZASCA 42 (13 April 2021)

Keywords: fraud clause / false or misleading information from a third party

The Supreme Court of Appeal dealt with the interpretation and application of a fraud clause found in the policy.

The clause read:

> "If you, or anyone acting on your behalf submits a claim, or any information or documentation relating to a claim, that is in any way fraudulent, dishonest or inflated, we will reject the entire claim and cancel your policy retrospectively, from the date on which the incident has been reported, or from the actual incident date, whichever date is earliest."

An employee of the insured had submitted false, untrue and misleading information regarding the claim.

The evidence was provided during an investigation process initiated by the insurer well after the claim had been lodged by the insured. There was no suggestion that the employee was asked by the insured employer to fabricate anything that was not true. The insured was not even aware what the employee was going to say to the insurer.

While the information provided was untrue, the court found that there was no examination of the employee directed to the question of whether he was supplying information on the insured's behalf. Any ambiguity regarding the meaning of that phrase in the fraud clause should be resolved against the insurer.

Ordinarily "acting on behalf of" denotes agency, and the employee was not acting as an agent for the employer. So there was no reason why the employee, who was clearly just a witness as to how the incident occurred, should be elevated to an agent for or acting on behalf of the insured in providing a version of the event.

To interpret the phrase more broadly as being acting for the benefit or in the interests of another would not, said the court, be in keeping with the drastic consequences of the insured being penalised for fraudulent or dishonest information emanating from a third party.

Even if the broader meaning was applied, the evidence did not show that the employee had perceived himself to be acting for the benefit of or in the interests of the insured. His purpose in providing dishonest information was to shield himself from adverse consequences whether at the hands of the insurer or the insured.

The judgment is correct, but it again highlights the need for insurers to review and carefully consider the wording of fraud clauses used in a policy in the light of this and other judgments. The courts have and will restrictively interpret the meaning of words and phrases used.

The acts of an employee should only be attributed to the insured if the employee is expressly or impliedly mandated to perform the act on behalf of the insured, for example to complete the claim form.

Naicker v S

(A388/2019) [2021] ZAGPPHC 136 (22 February 2021)

Keywords: fraud / motor vehicle claim

This criminal case, brought by the state against the accused insured, related to a fraudulent insurance claim.

The accused informed his insurer that he had been robbed of his motor vehicle and he was paid out as a result of the loss of the vehicle.

The state alleged that the insured pretended that he had been robbed of his motor vehicle when he had actually caused his motor vehicle to be set alight, in order to claim from his insurer.

In order for the accused to be found guilty of a crime, guilt must be proved beyond a reasonable doubt. This is a higher standard of proof than in civil matters (which is proof on a balance of probabilities). If the accused's version is reasonably possibly true, even though improbable, they should be acquitted.

There were material contradictions in the evidence presented by the witnesses for the state, and the appeal court therefore overturned the conviction of the accused.

In a civil action where the insurer denies liability under the policy by reason of fraud, fraud needs to be proved by the insurer on a balance of probabilities

Jurisdiction on insurance dispute where both parties are foreigners

Ingosstrakh v Global Aviation Investments (Pty) Limited Investments (Pty) Ltd and Others

[2021] ZASCA 69 (4 June 2021)

Keywords: jurisdiction / foreign insurer / foreign insured

Both the insured and insurer were foreign peregrini, that is, neither was resident nor domiciled in the Republic of South Africa. The insured and insurer were residents of the Virgin British Islands and Russia respectively.

The policy provided that it was governed by the laws of the insured's country of domicile, that is the Virgin British Islands, and that the parties submitted to the exclusive jurisdiction of the courts of the insured's country of domicile for any dispute arising from the policy.

The insurer submitted that in the circumstances the Gauteng High Court did not have jurisdiction to determine the dispute.

The court said that if a foreign peregrinus defendant submits to the jurisdiction of the court and a ground of jurisdiction is established that links the court to the subject matter of the litigation that will suffice to assume jurisdiction. There is then no need to attach the property of the defendant as well. The insurer had submitted to the court's jurisdiction by providing a domicilium address for service of legal process in South Africa – on its representatives in Durban.

Apart from the issue of submission, there was a ground of jurisdiction that linked the subject matter of the litigation to the high court. The insurance policy was concluded in Johannesburg within the area of the court's jurisdiction.

The insurer had also been involved in at least three substantive applications in the litigation in respect of the policy issue. In none of those applications did the insurer object to jurisdiction of the court.

The court also considered of importance the business relationship between the parties and the convenience of a South African court hearing and determining the matter. The insured's associated companies, who were the first and third respondents in the application, are domiciled in South

Africa. Convenience and common sense are, among other things, valid considerations in determining whether a court has jurisdiction to hear a case.

In the circumstances the Supreme Court of Appeal confirmed that the court had jurisdiction to determine the disputes. The insurer had failed to deliver its plea in time, without sufficient cause and was therefore barred from doing so. The insured's claim for cover in respect of an aircraft damaged beyond economical repair was upheld. Default judgment was granted against the insurer in the amount of US$2.5 million.

Foreign parties to any contract need to carefully consider the provisions of their contract regarding dispute resolution and submission to the South African's court's jurisdiction, as well as their subsequent conduct once any dispute arises lest that constitute submission to jurisdiction.

Legal expense insurance

There were a number of condonation applications related to legal expense insurance, in which the party seeking condonation for late filing of papers alleged that they were waiting on funds from their insurers, in order to proceed with litigation.

Nair v Telkom SOC Ltd and Others

(JR59/2020) [2021] ZALCJHB 449 (7 December 2021)

Keywords: condonation application / litigation funding / legal expense insurance

The lateness of the applicant's papers in this condonation application was based partially on the allegation that he had to procure approval from his legal expense insurer.

The court was not satisfied with this explanation because no correspondence between the applicant and his legal representatives or any insurer was attached to the application for condonation. There were no details included relating to his attempt to procure approval from the insurer.

The court needs full reasons explaining the reasons for delay that cover the entire period of delay. Merely listing reasons is not sufficient.

SA Post Office Ltd v Chetty and Others

(D935/18) [2021] ZALCD 52 (4 August 2021)

Keywords: condonation application / litigation funding / legal expense insurance

The respondent applied for condonation for the delay in dealing with the matter. One of the grounds of delay was that he was waiting for his legal expense insurers to effect necessary payments to service provides (including the transcribers of the record).

However, the application for condonation was dismissed because sufficient reasons for the full delay were not provided.

Bayat v MEC, Department of Health - Kwazu-lu-Natal Public Health and Social Development and Others

(D 2278/18) [2021] ZALCD 54 (4 August 2021)

Keywords: condonation application / litigation funding / legal expense insurance

Part of the explanation for delay in this condonation application related to legal expense insurance. The applicant said that the time taken by the insurer to assess the balance of funds available to her after they had paid a portion of her expenses caused some delay.

The court found that allegations related to communications with the insurer lacked sufficient detail. Other periods of delay (unrelated to the legal expenses issue) were also not sufficiently explained. The application for condonation was dismissed.

Life insurance

Discovery Life Limited v Hogan and Another

[2021] ZASCA 79; 2021 (5) SA 466 (SCA) (11 June 2021)

Keywords: grace period / non-payment of premium / repudiation / life insurance

The Supreme Court of Appeal held that the 30-day grace period for an unpaid premium in a life policy did not apply where the cancellation of the policy was a result of a repudiation by the insured herself. The grace period only applies where the non-payment of the premium is not due to a repudiation of the policy.

The insurer, in responding to the policyholder's request to cancel the policy, advised the insured that a notice period of 30 calendar days applied to cancellations.

Despite that requirement, the insured instructed her bank to stop payment of the debit order in respect of the premium due for the last month of the policy. When the insurer submitted the monthly debit order to the bank for payment, the order was returned unpaid with the remark "payment stopped by account holder". In consequence of the non-payment, the insured was informed that the policy had been cancelled from the beginning of the month of default being 1 September 2018.

The insured died on 22 September 2018 in rather unfortunate circumstances by gas poisoning at a tourist resort.

Subsequent to the death, on 27 September 2018 on the advice of the insured's erstwhile broker, the month's premium was paid for September by the executor of the insured's estate without mentioning the death. The insurer communicated with the claimant in respect of their reinstatement requirements requiring a fully completed signed declaration of heath by all lives insured. There was no response.

A claim was subsequently submitted under the policy to the insurer. The claim was rejected because the premium for the month in which the death had occurred had not been paid and the insured had been notified, in a number of ways (including an SMS to her cell phone number) that the policy had been cancelled with effect from 1 September 2018.

The executor argued that the insurer was required to meet the claim because the insurer failed to notify the insured of the unpaid premium and before cancelling the policy should have afforded the insured a 30-day grace period to make the payment, and that the premium was paid within the 30-day grace period.

The insurer argued that the grace period provisions did not serve to extend the policy against the wishes of the insured after the policy had been cancelled and did not preclude the insurer from cancelling the policy immediately in the event of a repudiation. When the bank message was received that the payment had been stopped it was clear to the insurer that the insured did not intend to comply with her contractual obligations under the policy. In the light of the insured's repudiation of the contract, the insurer had elected to cancel it and had communicated its decision to the insured.

The appeal court found that the insured's conduct in instructing the bank not to pay the premium could be interpreted in no other way than that she no longer wished to remain bound by the terms of the policy and that she had no intention of honouring the terms of the policy which required her to give a month's notice. The court accepted that the insured had deliberately repudiated the policy.

The test for repudiation is objective and not subjective: what would someone in the position of an innocent party think the insured intended to do? Repudiation is not a matter of intention but of perception of the reasonable person placed in the position of the aggrieved party.

The insured had been informed by the insurer at least twice that she was contractually bound to give 30 days' notice to cancel the policy. She was a professional woman assisted by a financial broker. In those circumstances the court had no doubt that the insured knew of the terms of her policy. Further, she must have known what the consequences of instructing her bank to stop payment of the premium would be.

The insured had made it clear that she wanted to move her policy to another insurer as they had offered her something better.

She clearly had no intention of paying two insurance premiums in September. Accordingly the insurer was perfectly entitled to accept the repudiation and cancel the policy immediately. This situation does not arise where there are insufficient funds in the insured's account or if the bank makes an error in respect of non-payment of a debit order. In the circumstances there was no obligation on the insurer to advise the insured of the unpaid debit order nor to afford her 30 days within which to pay the arrear premium.

Grace period provisions cannot exclude reliance on repudiation resulting in cancellation or even a mutual agreement by the parties to cancel the policy. The Policyholder Protection Rules do not assist an insured in these circumstances. The same principles will apply to non-life policies.

Phillip Siphiwe Ngwenya N.O. v Ombudsman for Long-Term Insurance and Others

(17326/2018) [2021] ZAGPJHC 172 (30 August 2021)

Keywords: life insurance / review / ombudsman

The insurer rejected the life policy claim of the executor of the deceased estate relying on an exclusion in the policy that liability would not arise where death resulted from a condition that pre-existed the existence of the policy, if that death occurred before the expiration of twelve months from the date of commencement of the policy.

The Ombudsman dismissed the claim and refused leave to appeal to the Appeal Tribunal. The executor sought to review that refusal.

The court held that the rules of the relevant Ombudsman provides that a determination made by the Ombudsman is binding on the subscribing member so that the applicant could not disregard the final determination and seek payment from the court without first seeking for that to be reviewed, set aside and substituted.

The executor could also not rely on the Promotion of Administrative Justice Act to review the refusal because the Ombudsman's decision did not constitute administrative action as defined under that legislation and nor was the Ombudsman an organ of state.

The court did hold however that the decision was reviewable at common law and granted leave to appeal to the Appeal Tribunal because the applicant had prospects of success on appeal.

Malcolm Wentzel v Discovery Life Limited and Others

[2020] ZASCA 121 (2 October 2020)

Keywords: trustees / life policy / unrehabilitated insolvent

An unrehabilitated insolvent, who is a nominated beneficiary in terms of a life insurance policy, is not entitled to the proceeds of the policy to the exclusion of the trustees of their insolvent estate.

The claimant was married in community of property to the deceased, his wife. A contract of insurance was concluded with the insurer, in terms of which their lives were insured and the survivor was appointed beneficiary of the proceeds payable upon the death of the first-dying.

Prior to the death of the claimant's wife's, the joint estate was provisionally sequestrated by order of court.

Shortly after his wife's death the claimant accepted the policy benefits and sought payment of the proceeds of the insurance to him. The insurer informed the claimant that the proceeds would be paid over to the trustees of the insolvent joint estate.

The claimant argued that as the nominated beneficiary in terms of the insurance policy, the proceeds were due and payable to him exclusively because his wife's death had terminated the joint estate.

The question was whether the death of the claimant's wife's altered the ordinary consequences of insolvency and modified the application of the Insolvency Act to allow an insolvent to receive and own property beyond the reach of the trustees of his insolvent estate.

Pursuant to the sequestration of the joint estate, the claimant and the deceased both became insolvent debtors for the purposes of the Insolvency Act. The effect was that all property acquired by the claimant as "the insolvent" before the sequestration as well as property acquired or that may have accrued to him during the sequestration, including the proceeds of the contract of insurance payable to the claimant after his wife's death, vested in the trustees to be used to meet the claims of creditors.

On the claimant's acceptance of the benefit, the proceeds become an asset in his hands as an insolvent debtor which proceeds cannot belong to a separate estate of the claimant. Such separate estate is not legally recognised.

The court confirmed that the trustees were entitled to the proceeds of the policy.

Litigation funding

Anglo American South Africa Limited v Kabwe and 12 Others in re: Kabwe and 12 Others v Anglo American South Africa Limited

[2021] ZAGPJHC 892 (26 October 2021)

Keywords: Litigation funding / privilege of communications with insurer / common interest privilege / legal advice privilege / premium privilege

This application for discovery of information was brought in relation to an application to certify a class action against the applicant. The respondents intended to claim damages from the applicant on behalf of children and women of child-bearing age who reside in the Kabwe district of Zambia, due to alleged pollution from the Kabwe mine, which operated between 1906 and 1994.

The estimated costs and funding of the litigation were described by the court as a "novelty in the South African jurisprudential landscape".

Kabwe Finance is a company established solely for the funding of the litigation. Kabwe Finance is funded through investment vehicles and has also taken after-the-event (ATE) insurance to meet an adverse costs order if the litigation is unsuccessful.

The applicant sought further detail on the funding arrangement in order to determine whether the respondent could meet an adverse costs order. Among the documents that they wanted to see was the full unredacted ATE insurance policy.

The SCA has already confirmed that third-party litigation funding can promote access to justice and is consistent with the Constitution.

The respondents argued that the disclosures demanded would not only deprive the respondents of the protections of legal privilege, but would also have a chilling effect on litigants' ability to obtain litigation funding and insurance in order to have their disputes resolved in court.

The effect, they submitted, would be that parties like the respondents, who are unable to afford the costs of litigation out of their own pocket, and are reliant on others to fund the litigation or to provide insurance, will forfeit the protection of legal professional privilege when they communicate with funders and insurers.

Forcing disclosure would allegedly also mean that litigants who are reliant on third-party funders or insurers would be stripped of protection in respect of their confidential communications, whereas self-sufficient litigants would be protected by privilege.

After discussing the nature of legal privilege generally, the court went on to note that legal professional privilege extends to common interest privilege. This type of privilege preserves legal professional privilege where the third party, recipient or creator of a communication has a common interest in the subject of the privilege with the primary holder of the right to privilege. The key principle is that privilege is not lost where there is limited disclosure for a particular purpose or to parties with a common interest.

The court agreed with the respondents that the sharing of privileged communications with a third-party funder or insurer falls within common interest privilege. All have a shared interest in the outcome of the litigation and all have a common interest in ensuring the confidentiality of their communications. A litigant does not waive their right to privilege by disclosing privileged documents and advice to a third-party funder or insurer on a confidential basis

A redacted version of the ATE Insurance Policy was shared with the applicant. The applicant sought the full policy. The only clauses removed from the policy sent to the applicant related to the premium and contingent premium to be paid. The applicant argued that the premium was important in assessing the extent to which it would be insulated from loss in the event of an adverse costs order, and the premium would not reveal the substance of any legal advice.

The respondents argued that the premium reflects legal advice on the prospects of success, based on opinions and advice provided by the respondents' legal team in contemplation of the litigation. The premium is reflective of risk, which is determined by the prospects of success, and disclosing this would allow the applicant to infer the legal advice received by the respondents, which was shared with Kabwe Finance and the insurer on a confidential basis. This again falls under the broad protection of legal advice privilege, which covers documents that evidence the content of legal advice, in that they provide a clue to the advice given by the legal representative.

The court agreed that the premium contains material information that would allow the reader to work out what legal advice had been given.

This court was satisfied that, in the circumstances of this case, the premium is privileged as it evidences legal advice provided by the respondents' legal team on the prospects of success. The fact that the insurance policy was concluded between Kabwe Finance and its insurer is of no consequence. Once it is accepted that the premium reflects legal advice given to the respondents and shared by the respondents' legal team, that brings it firmly within the protection of privilege.

Sharing this legal advice with the insurer does not impliedly waive privilege on the part of the respondent.

Further, the amount of the premium has no bearing on any debates as to whether the amount of the insurance is sufficient. The respondents had disclosed that the total amount of liability covered under the policy is GBP 2 million.

The fact that the respondents provided a full copy of the ATE Insurance Policy, with only a single clause redacted, demonstrates that they did not adopt an unthinking "blanket" approach to privilege.

Therefore, the court refused discovery of the unredacted ATE Insurance Policy.

Motor vehicle accident claims

Monametsi v Miway Insurance

[2021] ZAGPPHC 478 (22 July 2021)

Keywords: motor vehicle insurance / rejection of claim / speeding / breach of policy conditions / recklessness / reasonable precautions

The insurer undertook to indemnify the plaintiff for third-party liability arising from motor vehicle collisions, subject to the terms and conditions of the policy.

The insured collided with cattle, lost control of his vehicle and then collided with a stationary vehicle, while driving through a rural village. He alleged that he was driving at 90 km per hour at the time of the accident, which is below the speed limit of 120 km per hour.

The insurer appointed an assessor to investigate the matter, and then rejected the claim based on the assessor's evidence that the insured was speeding at the time of the accident. The insured was driving between 95 to 105 km per hour, but the speed limit at the point of collision was 60 km per hour.

The court assessed the evidence and found that the insured was reckless. It considered the surrounding circumstances of the area, the conditions of the road, the speed limit of 60 km per hour (which the court said the insured was aware of), and that the place was dark. Based on these factors the court found that the plaintiff should have taken all reasonable care and reasonable steps to prevent or minimise loss, damage, death, injury or loss.

The plaintiff should have foreseen that driving during the night, in an area with those circumstances, he might cause himself to be involved in an accident. The plaintiff drove recklessly and failed to comply with the terms and conditions of the insurance agreement.

The court held that the insurer was not contractually obliged to perform in terms of the agreement entered into with the plaintiff and had correctly rejected the plaintiff's claim.

Non-disclosure of refusal to quote

Advocate Bokang Mpho Motshwane v iWyze Valuables Insurance

(87941/2016) [2021] ZAGPPHC 111 (26 January 2021)

Keywords: material misrepresentation / refusal to quote

The insured took out insurance on his new car in December 2015. The car was damaged beyond economic repair in February 2016. The insurer rejected the claim due to alleged material non-disclosure by the insured of a refusal by another insurer to insure him.

The court had to determine whether the non-disclosure was material.

In proposing for the insurance, the insured had been asked four questions which the court categorised as referring to the insurance cover in existence at the time. They were whether an insurance broker or insurance company informed the insured:

- that his insurance was cancelled;
- that he should seek alternative insurance;
- that they refused to renew his insurance;
- whether any policy had been cancelled due to fraud or dishonesty.

The express questions asked did not relate to a refusal in respect of new cover or insurance for a new item. The other insurer had declined to furnish a quotation for his new car.

The court said that the questions asked were so ambiguous that the insured could not have been faulted for failing to disclose a refusal by an insurer to furnish him with a quotation.

On the facts, the court said that the insurer should have sought the answer to the question along the lines of "has any insurance company, whether a company which had previously provided cover for you or not, ever refused to furnish a quotation to you for this vehicle?". Had the insured then answered "no" to such a question, that would have amounted to a non-disclosure.

There was no obligation on the insured to disclose that an insurer declined to quote on insurance cover unless such a question was clearly and unambiguously asked. It had not been. The insurer was ordered to pay the insured's claim.

Principal's liability for third-party service provider

Melamu v Legal Expenses Insurance Southern Africa Limited t/a Legalwise and Another

[2021] ZAGPPHC 533 (19 August 2021)

Keywords: liability / third-party service provider / principal / independent contractor

The court confirmed that as a "general rule an employer is not liable for the wrongdoing of an independent contractor unless the employer is personally at fault."

The plaintiff sued a legal expenses insurer for damages resulting from the alleged negligence of the attorneys appointed to act for the insured.

A principal is only liable for the negligence of their independent contractor if it can be shown that there was a legal duty on the part of the principal to take steps to prevent harm to others at the hands of the independent contractor and the principal failed to take those steps or the principal is otherwise personally negligent.

If an insured wishes to bring a claim against an insurer for vicarious liability due to the wrongdoing of the attorneys appointed as third-party service providers, the insured must establish that there was a legal duty upon the insurer to take steps, and that it had not taken such steps, to prevent the harm that occurred.

This judgment confirms that when a third-party service provider provides work for which costs the insurer gives an indemnity, such as the legal expenses in this case, the relationship is between the insured and the third-party service provider. That remains the case even if the insurer recommends an apparently competent third-party service provider and the insured has a choice of appointing a provider of their own choice, while bearing any cost consequences.

No breach of any duty of the insurer had been alleged and therefore the summons was set aside with leave to amend.

Subrogation, cession and privity of contract

The Minister of Police v Underwriters at Lloyd's of London

(Case no 1212/19) [2021] ZASCA 72 (8 June 2021)

Keywords: vicarious liability / subrogation / cession

In this case the defendant was the insurer of a security company liable in contract to its clients, a number of banks, for loss of money in it its custody. The robbery was perpetrated by an employee of the security company acting in concert with employees of the Minister of Police (a number of police officers).

Since their cause of action rested on both a cession of claims and subrogation, Lloyd's sued in their own name and not in the name of the insured. The underwriter subrogated the security company's claim and took cession of the banks' delictual claims against the Minister of Police, for breach of the legal duty to prevent crime and safeguard the public against crime.

The Minster of Police alleged that the security company was vicariously liable for the robbery, at least partially, because one of its employees also participated in the robbery. The court said that a party cannot be both the person robbed and at the same time liable in delict for the actions of the robber. The security employee's involvement is only relevant to the question of whether her conduct can be taken into account in reducing or expunging the liability of the Minister, but not in attributing liability to the security company.

The security company's liability to the banks was contractual and not delictual. The Minister of Police was potentially liable to the banks in delict. Given the different legal bases for the claims by the banks against the security company and the Minster of Police, they cannot be joint wrongdoers in the common law as alleged by the Minister of Police.

Smada Security Services (Pty) Ltd v Tshwane University of Technology

(11587/2019) [2021] ZAGPPHC 301 (16 March 2021)

Keywords: subrogation

A security company claimed against Tshwane University of Technology for over R5 million which it alleged was due and payable for services rendered. The university counterclaimed for around R500 000 for the theft of goods by the security company's employees.

The security company raised an exception to this claim, one of the grounds being that the university had agreed to accept, from its insurers, the sum of R576 903.93 in full and final settlement and satisfaction of all claims against the insurer in relation to the stolen goods. An annexure detailing the loss and the insurer's offer was attached to the pleadings.

The security company alleged that the annexure showed that the university had not suffered any damages in relation to the theft because its insurer compensated it for the loss.

The university argued that generally, insurance payments are res inter alios acta, meaning that the contract between an insured and its insurer does not affect claims against third parties. There are exceptions to this general principle, but these exceptions must be argued at trial and cannot be determined using the exception process.

The court agreed that indemnification by its insurer did not necessarily mean that the university had no cause of action against the security company. The argument of the security company, on exception, failed. The matter will go to trial.

Metal Technics (Pty) Ltd v RNS Trucking CC and Another

[2021] ZAGPPHC 487 (21 July 2021)

Keywords: privity of contract / res inter alios acta

The plaintiff is a company that upgrades ATMs for banks. The defendant, a transport company, was meant to transport the ATMs for the plaintiff. The defendant's truck driver caused an accident, and the ATMs were damaged beyond economical repair. The plaintiff paid the bank the value of the machines and claimed against the defendant for the loss.

The defendant questioned why the plaintiff had not chosen to pursue a claim against the defendant's insurer. The insurer had not taken over the defendant's defence by way of subrogation but had initially paid half of the defendant's legal costs.

The court stated that the issue of the defendant's insurance is, as far as the plaintiff is concerned, legally *res inter alios acta* (it is a matter between the insurer and the insured). The plaintiff cannot itself claim from the defendant's insurance company (where the insured is not insolvent).

The defendant had the option to pursue its indemnity against the insurer.

Leopard Line Haul (Pty) Ltd t/a Elite Line v New Clicks South Africa (Pty) Ltd; In re: New Clicks South Africa (Pty) Ltd v Leopard Line Haul (Pty) Ltd t/a Elite Line

[2021] ZAGPJHC 89 (16 July 2021)

Keywords: insurer defending matter on behalf of insured / miscommunication / rescission / default judgment

Elite Line, the insured, is a conveyor of goods. After some months during which Elite Line had conveyed New Clicks' stock, New Clicks realised through an investigation that its employees had stolen stock from its warehouses and had caused that stock to be conveyed on Elite Line's trucks while Elite Line was performing in terms of the agreement.

The stolen stock had been offloaded from Elite Line's trucks between its warehouses in Germiston and Centurion. New Clicks alleged that Elite Line was liable to compensate it for the stolen stock.

Elite Line wrote to its insurer enquiring whether its policy would cover the loss. The insurer stated that the policy covered the insured's legal liabilities that arose whilst the insured was operating as a transporter. In this instance however, the insurer said that because the actual time of the theft of the goods must have been at the time they were illegally loaded out of the New Clicks warehouse, the loss did not occur whilst the goods were in the insured's custody and control, but rather while still under the custody and control of New Clicks. Elite Line adopted a similar stance that it was not liable for the thefts.

New Clicks sued Elite Line and Elite Line sent the summons to its insurer via its broker. The insurer informed the broker that it had instructed attorneys to act in the matter on its behalf. The broker and the insured assumed this meant that the insurer was defending the matter on the insured's behalf.

New Clicks obtained default judgment against Elite Line because no appearance to defend was lodged. After enquiring the insured realised that the insurer had appointed attorneys to act on the insurer's behalf to advise whether they were implicated in the matter, and not to act on behalf of the insured. After looking at the evidence, the court accepted this as a reasonable mistake, based on the correspondence between the parties. The broker and the insured were found to be mostly reasonable in their actions, except for one period of time in which the broker should have followed up with the insurer and failed to do so. This was reflected in a costs order against the insured, but the default judgment was rescinded.

Tax

IEA Taxpayer v The Commissioner for the South African Revenue Service

(VAT 1908) [2021] ZATC 7 (21 June 2021)

Keywords: Tax / VAT / intermediary

The appellant conducted the business of administering funeral policies on behalf of a long-term insurer. It was both a registered VAT vendor and an FSP. Its business involved negotiating policies on behalf of the insurer, collecting the premiums and paying them over to the insurer, submitting detailed monthly collection reports, and processing claims by beneficiaries.

For these services the appellant was paid an administration fee calculated in accordance with the written administration agreement concluded with the insurer.

The appellant applied to SARS to be deregistered as a VAT vendor.

SARS refused, stating that the company was not providing insurance under a long-term insurance contract but only acted as an administrator for the insurance company. For these services the company charged an administrative fee that was subject to VAT in terms of the VAT Act. The company's turnover also exceeded the minimum threshold for compulsory VAT registration.

Counsel for both parties accepted that the administration services provided were an intermediary service as defined in FAIS. However, they agreed for purposes of determining the core issue, no regard should be had to FAIS but only to the deeming provisions of what constitutes a "financial service" in the VAT Act. For the purposes of the VAT Act, provision, or transfer of ownership, of a long-term insurance policy is deemed to be a financial service unless the consideration payable in respect thereof is any fee, commission, merchant's discount or similar charge, excluding any discounting cost.

The appellant argued that the agreement made it clear that the services performed were purely administrative ones for which the appellant was paid a fee. The appellant did not provide long-term insurance policies. Rather the insurer does that. Accordingly, the activities of the appellant could not be deemed to be "financial services" for purposes of the VAT Act.

The evidence of the appellant was that the fees that the appellant was paid by the insurer for performing its administration services formed part of the premium and were determined on a sliding scale, depending on the number of policyholders in any given group. The premiums themselves had no built-in VAT component.

The insurer is VAT exempt in terms of the VAT Act as a supplier of a deemed financial service as defined.

It was common cause during argument that the appellant did not charge the insurer VAT on its fees, although there was nothing in the agreement to preclude it from doing so and, in any event, given its VAT registration, the appellant had an obligation to charge VAT.

It was accepted on behalf of the appellant that it incurred expenditure in the operation of its administration business (the fees paid by the insurer in terms of the agreement were its sole source of income) and that at least some of this expenditure resulted in it incurring input tax.

There was no dispute that if the appellant were to charge the insurer output tax it would be able to claim the difference between its input and output tax from SARS. This fell outside the premium itself, since the premium did not accrue to the appellant but only to the insurer. Put differently, the appellant merely administered the premium and was paid a fee for this service

In terms of the agreement between the insurer and the appellant, the appellant was entitled to negotiate its own fee plus VAT (if applicable). This was then intended to be recorded in the particular policy document.

The appellant's application to deregister as a VAT vendor was dismissed.

Time bar clauses in insurance policies

Qhibi v MiWay Insurance Ltd

[2021] ZAMPMBHC 12

Keywords: time bar clause / reasonableness / fairness

The court upheld the insurer's reliance on the time bar clause in the policy.

It was common cause that the insured issued and served summons commencing action well outside the time bar period. The clause stated that the plaintiff must institute action within 270 days from the date on which the insurer rejected its claim.

There was an implicit agreement that proceedings challenging the rejection of the claim were to be initiated by summons and that a letter of demand was inadequate to interrupt the time bar.

The insured admitted that the action was instituted outside of the time bar period but challenged the validity of the clause on the ground that observance in the circumstances would be unfair and unreasonable to the insured.

The insured bore the onus of proving that enforcement would be unfair and unreasonable in the circumstances.

The only intimation of the alleged unfairness or unreasonableness was the allegation by the insured that he had been paying his premiums and was up to date when the insured peril occurred. The court said that those are not factors to be considered when determining unfairness or unreasonableness.

There was no dispute that the documents comprising the policy were sent to the insured and that he had perused the terms and conditions which he found acceptable. That was evidenced by the fact that the insured knew that he had to pay monthly premiums and did so.

The court said that the insured's court papers were "stridently silent" on how enforcement would be unfair and unreasonable.

The contract was clear on the claims process to be followed. The insured lodged the claim punctually which in turn was rejected with reasons by the insurer. The insurer, in communicating its rejection, complied with the Policyholder Protection Rules. The various time bar and contractual prescription periods were clearly set out in the letter of rejection.

The insured was furnished with reasons for the rejection and his rights fully explained. There was no allegation of illiteracy, and he was legally represented at a relatively early stage.

The court reaffirmed that parties who freely and voluntarily enter into a contract are bound by the terms and conditions except where enforcement thereof would be unfair or unreasonable. The insured had provided no facts to establish unfairness or unreasonableness.

The judgment is clearly correct. It is surprising on the facts reported that the insured persisted in the litigation where he was plainly dilatory in pursuing his rights. The consequence was a cost order in favour of the insurer.

Unconditional performance guarantees

SA National Roads Agency SOC Limited v Fountain Civil Engineering (Pty) Ltd

[2021] ZASCA 118 (20 September 2021)

Keywords: performance guarantee / interdict of payment / unconditional guarantees

The Supreme Court of Appeal emphasised that a performance guarantee in terms of which the guarantor undertakes to pay an amount if the contractor fails to perform the required work is unconditional. The beneficiary of the guarantee is not obliged to prove an entitlement under the principal contract before it can make a demand on the guarantee. A claim on the guarantee is permissible regardless of disputes under the main contract.

The guarantor undertook to pay the beneficiary on receipt of a written demand, if the contractor failed or neglected to commence or proceed with work as prescribed in the contract. The demand could be made based on the opinion and sole discretion of the beneficiary.

The contractor sought to interdict payment under the guarantee alleging that it had lawfully terminated the main contract because of impossibility to perform its obligations. This allegation was disputed but it was irrelevant for the purposes of enforcement of the guarantee. An order by the lower court requiring the parties to go to arbitration was also impermissible because it would re-write the contract for the parties.

These attempts to convert unconditional guarantees into conditional guarantees almost invariably fail in the courts.

Donald Dinnie
December 2022

NORTON ROSE FULBRIGHT

Norton Rose Fulbright is a global law firm. We provide the world's preeminent corporations and financial institutions with a full business law service. We have more than 3700 lawyers and other legal staff based in Europe, the United States, Canada, Latin America, Asia, Australia, Africa and the Middle East.

Law around the world

nortonrosefulbright.com

47796_SA – 12/22