NORTON ROSE FULBRIGHT

The Big Read Book Series Volume 24

Norton Rose Fulbright South Africa's review of insurance judgments of Namibia (2012-2024)

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Introduction

Dearest Reader

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

This is Volume 24 of the series – A review of insurance judgments of Uganda (2002-2023).

Like our Zimbabwe, Kenya, Uganda and Botswana editions, which you can access here, the cases discussed in this edition are binding in Namibia but not in South Africa. However, Namibia applies many similar principles of insurance law to South Africa and readers will find useful comparisons.

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 the previous volumes in the series, here.

Norton Rose Fulbright South Africa Inc with Shonubi Musoke & Co.
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Namibian Insurance Law

Currently, insurance law in Namibia is primarily governed by the Long-Term Insurance Act of 1998 and the Short-Term Insurance Act of 1998. These acts regulate long-term insurance (life, health, disability) and short-term insurance (property, vehicle, liability), respectively.

The Namibia Financial Institutions Supervisory Authority (NAMFISA), an independent entity established under the Namibia Financial Institutions Supervisory Authority Act of 2001, is responsible for regulating and supervising both the long and short term insurance industry.

Contracts of insurance are subject to general principles of contract law, including the necessity for mutual consent, lawful purpose, and consideration.

The Namibia National Reinsurance Corporation Act of 1998 regulates the reinsurance industry in Namibia. English law applies to marine insurance.

Evidence

Diamonds v Alexander Forbes Insurance Company, Namibia Limited (2021)

(HC-MD-CIV-ACT-CON- 1274 of 2018) [2021] NAHCMD 382 (30 August 2021)

Keywords
motor vehicle accident / absolution from the instance / no evidence of damage

The plaintiff sued the insurer for indemnification under a motor vehicle policy. The insurer had rejected the plaintiff's claim as the accident had been caused by the insured driving under the influence of alcohol. Damages and loss were in issue.

The insurer applied for absolution from the instance on the basis that the plaintiff had failed to lead any evidence regarding its damages and the quantum of its claim.

The court noted that, for a claim to survive an application for absolution from the instance, a plaintiff must prove every element of that claim and lead evidence where necessary.

The plaintiff accepted that he did not lead evidence relating to his damages and the quantum of the claim. He however argued that the policy set out the insured value of the vehicle, remedying any defects in the case.

The insurer submitted that the insured value set out in a policy does not reflect the actual value of the vehicle at the time of the loss, nor of the damages suffered.

The court agreed, noting that even if it the contract set out the vehicle's insured value, the plaintiff failed to adduce any evidence that the plaintiff suffered damages to the value equal to the insured value.

The plaintiff's failure to provide evidence of damages was conclusive and the court granted the insurer absolution from the instance. It is not clear why the insurer did not close its case and get the claim dismissed once and for all.

Western Insurance and Another v Swartbooi (2019)

(HC-MD-CIV-ACT-DEL 3118 of 2017) [2019] NAHCMD 544 (6 December 2019)

Keywords
motor vehicle accident / evidence

The insurer and the insured sued the defendant for damage to the insured's truck following a motor vehicle accident. The insurer had indemnified the insured for the reasonable cost of repairs as well as an assessor's fee, and sought to recover these amounts from the defendant. The insured sued for the excess, and the defendant counterclaimed for damage to his vehicle.

The plaintiffs' and defendant's versions of the accident were mutually destructive, each alleging that the other was solely responsible for the accident on the alleged facts. The court found the plaintiffs' version to be more probable and the plaintiffs' witness to be more credible than the defendant's. The court found the defendant solely liable for the accident.

The plaintiffs' claims succeeded.

Ribs Logistics cc v Santam Namibia Limited (2017)

(551 of 2016) [2017] NAHCMD 100 (20 June 2017)

Keywords
breach of contract / exclusion / evidence / motor vehicle accident / interpretation

The plaintiff claimed specific performance and payment of general and special damages based on the alleged breach of an insurance agreement. In terms of the policy, the insurer undertook to provide cover for all loss or damage the plaintiff sustained in respect of a heavy load motor vehicle and two trailers. The insurer had rejected the plaintiff's claim for damage to the vehicles on the basis that the vehicles were not roadworthy, and therefore that cover was excluded. The plaintiff alleged that the accident occurred when the driver swerved to avoid a stationary truck, and was not due to the vehicle's roadworthiness.

The defendant insurer did not appear at trial and the court proceeded in terms of Rule 98(1). This Rule provides that if a defendant does not appear at trial, judgment must be given in favour of the plaintiff if that plaintiff discharges the burden of proof on them.

The court found that the truck and trailers were insured, and that the policy also included a standard extension for wreckage removal. The plaintiff provided expert and documentary evidence to prove the vehicles' roadworthiness, proving that the policy was in force and that the plaintiff was entitled to indemnification.

The plaintiff also sought special and general damages flowing from the breach of contract. The claim for general damages included storage fees, towing fees, and expenses relating to expert witnesses.

The court incorrectly noted that the policy provided for towing fees, but that those costs should be dealt with as part of the plaintiff's special damages claim. The plaintiff's claim for expert witness costs also did not constitute general damages, but would form part of a legal costs award.

As its special damages claim, the plaintiff claimed for loss of profit following the accident. The court noted that the policy only covered damage to the truck and trailers, and so any consequential loss of income caused by the loss of the vehicles had to be specifically included in the policy in order to be covered. Because the policy did not contain a loss of profit extension, this part of the claim could not succeed.

The court accordingly ordered the insurer to pay the claim for damages to the vehicle and storage fees only.

Fraud

Mikiti v S (2024)

(CC 10/2019) [2024] NAHCMD 597 (22 October 2024)

Keywords
insurance fraud / proof

The accused was arrested on charges of insurance fraud and forgery.

A car accident occurred in June 2014. The police officer on duty when the accident report was prepared testified that the report submitted to the insurance broker was different to the report that he prepared. The photos submitted to the broker also did not correspond with the vehicle damage he had observed at the scene of the accident. The handwriting on the accident report was not his.

It was revealed that the accused's vehicle was in another accident after the initial accident report had been completed. After the first accident, the vehicle was slightly damaged, but was severely damaged and written off after the second.

The court held that there was no evidence that the accused had changed the date of the accident and the vehicle model on the copy of the accident report that was handed in to the broker. There was also no evidence proving that the accused had any knowledge that the document had been changed.

He was therefore acquitted.

Interpretation

Red Trading Restaurant v Momentum Insurance Limited (2023)

(HC-MD-CIV-ACT-CON-2021/03278) [2023] NAHCMD 35 (6 February 2023)

Keywords
business interruption / Covid-19 / interpretation / occurrence / risk / uncertain event

On 1 April 2020, the parties concluded an insurance agreement including business interruption cover following the occurrence of a notifiable disease.

The policy defined "notifiable disease" as an "illness sustained by any person resulting from human infectious or human contagious disease, an outbreak of which the competent authority has stipulated shall be notified to them." Covid-19 fell within this definition.

A state of emergency was declared in Namibia on 18 March 2020. Regulations and further proclamations were issued on 28 March 2020.

The plaintiff conducts business in the tourism sector, running restaurants and providing luxury accommodation. The Covid-19 pandemic affected its business, and the plaintiff claimed under the policy for business interruption due to the occurrence of Covid-19 within a 50km radius of its premises for the period commencing 1 April 2020.

The insurer rejected the claim and excepted to the particulars of claim on the basis of they did not contain a cause of action. The insurer argued that the insurance agreement was invalid and could not have been validly concluded, because the formation of an insurance contract depends on the happening of a specified *uncertain* event, and at the time of conclusion of the agreement on 1 April 2020, the event was already certain. They argued that the Covid-19 pandemic had already "occurred" and a notification from government had been issued before the agreement was concluded.

The plaintiff did not disagree with the insurer's interpretation of the word "uncertain" but argued that the interpretation of the word "occurrence" was also important. It argued that the outbreak of the pandemic was not the peril, but rather the notifiable disease manifesting per reported case; to the extent that each reported case of Covid-19 caused or contributed to its business interruption, each relevant reported case would give rise to a claim under the policy.

The plaintiff relied on the UK case of *The Financial Conduct Authority v Arch Insurance (UK) and Others*. In that case, interpreting a policy nearly identical to the one under consideration, the House of Lords held that what was covered was not a notifiable disease, but an "occurrence" of a notifiable disease. While an occurrence happens on a specific date, the spread of disease occurs "at a multiplicity of different times and places" and each case of illness was to be treated as a separate occurrence. A similar approach was adopted by the South African courts.

The court accepted that insurance contracts are risk-based and that if there is a certainty of harm, there is no risk to insure. Nevertheless, the court stated that:

> "The clause clearly speaks to an 'illness sustained' as a result of the outbreak and not the outbreak itself. Thus the occurrence of the illness, is to my mind, the insured peril or insurable interest. The outbreak may well have manifested, coupled with the relevant notification requirements, but it remained uncertain as to when, if, and how many occurrences of Covid-19 would still take place."

The court held that, on a contextual and businesslike interpretation of the policy, an insured peril could "occur and reoccur, and on each occasion give rise to a claim". The courts adopt sensible businesslike interpretations of contracts, based on the context of the provisions within the document as a whole. The court continued that:

> "The word 'occurrence', makes it apparent that the uncertain and insured peril cannot be the outbreak, or notification related to the Covid-19 disease, but to the actual occurrence of the disease. These are separate, isolated and uncertain events."

The court noted that the insurer's interpretation of the clause would mean that no one in the country would be able to insure against the possibility of someone becoming infected by Covid-19 after 18 March 2020, and that this was an unbusinesslike interpretation.

The insurer's exception to the plaintiff's particulars of claim therefore failed.

Standard Bank Namibia Limited v Ngashikuao (2018)

(HC-MD-CIV-ACT-CON 2264 of 2016) [2018] NAHCMD 282 (4 September 2018)

Keywords
bank / instalment sale agreement / parties to the contract / interpretation

The plaintiff, a bank, sued the defendant under a car finance agreement. The bank financed the car, and the defendant was obliged to pay monthly instalments. When the defendant defaulted on payment, the bank repossessed the vehicle, sold the vehicle at auction at less than the amount owed, and sued the defendant for the balance.

The defendant opposed the action on the basis that there was an insurance agreement in place between the parties. The vehicle was insured under a Motorite insurance policy, and the defendant paid the premiums to the bank together with the monthly instalments. The defendant alleged that the bank did not pay out his insurance claim relating to severe mechanical problems.

The bank argued that the contract of insurance was between the defendant and the insurer, which was not a party to the proceedings. The defendant therefore did not have the right to stop paying the monthly instalments if there were disputes under the insurance policy.

The court accepted that the instalment sale agreement and the Motorite plan were two separate agreements. The sum due in respect of the insurance plan was paid over to the insurer in a lump sum, and was then recovered by the bank through monthly instalments payable by the client. But the plaintiff bank is not an insurance company and the instalment sale agreement was not conditional on the conclusion of the Motorite plan. Therefore, the defendant was not entitled to withhold payment under the instalment sale agreement because of the insurance policy dispute.

The plaintiff's claim accordingly succeeded.

Van Der Merwe v Nedplan Insurance Brokers (Pty) Ltd and Others (2014)

(APPEAL 402 of 2013) [2014] NAHCMD 34
(5 February 2014)

Keywords
broker / contract / interpretation

The applicant, a financial adviser, signed a form on behalf of a client to finalise a life policy without the authorisation to do so. When the respondent insurer found out about the unauthorised signature, it cancelled its agency agreement with the applicant.

The applicant applied to court to interdict the cancellation of the agreement with the respondent.

The court noted that the applicant had breached his agency agreement by falsifying documents, and this was not in dispute. The cancellation of the contract was a logical consequence of his dishonest conduct.

The applicant's claim failed.

Life insurance

CEO of Namibia Financial Institutions Supervisory Authority v Fis Life Assurance Company Ltd and Others (2012)

(234 of 2012) [2012] NAHC 296 (7 November 2012)

Keywords
life insurer / curatorship / corporate governance / administrative law

The registrar of long term insurers applied to court under section 6(1) of the Financial Institutions (Investments of Funds) Act to appoint a curator to take control of and manage the business of the respondent, a long-term insurer.

The application followed investigations revealing irregularities with the insurer's operations, including unsatisfactory corporate governance. The insurer had also failed to comply with the applicant's instructions following the investigations.

The court noted that to establish the need for a curatorship, it must determine that the registrar's opinion on the necessity of curatorship was reasonably and rationally held, backed by evidence from the preceding inspections. If those two facts are established, the court would ordinarily grant an application of this nature unless exceptional circumstances existed which, in the court's discretion, would justify a refusal of the application. The court has limited bases on which to refuse this type of application if the jurisdictional facts exist.

The inspections spanned seven years, beginning with the first inspection in 2005 and culminating with the final inspection in 2011. During the course of these inspections, a number of letters and directives were addressed to the insurer, requesting information and requiring remedial action. The court noted that a number of these directives were met with hostile and obstructive responses.

It was not disputed that the inspections had been conducted. The court found that the opinion of the registrar, arising from the inspection report as well as the insurer's continued failure to address non-compliance with statutory provisions and directives on good corporate governance, was reasonably and rationally held. Despite making some progress to rectify its operations, the insurer had not done enough to justify the exercise of the court's discretion to refuse the application for curatorship.

Therefore, the insurer was placed under interim curatorship. On the return date, the court will consider whether it (and not just the registrar) is satisfied that it is desirable to place the insurer under curatorship.

Misrepresentation and non-disclosure

Jacobs v Hollard Insurance Company of Namibia Limited (2024)

(HC-MD-CIV-ACT-CON-2023/01234) [2024] NAHCMD 635 (25 October 2024)

Keywords
motor vehicle policy / non-disclosure / misrepresentation / prior damage and repairs

The plaintiff sued his insurer after it rejected his claim under a motor vehicle policy.

The plaintiff bought the vehicle 2016. The vehicle had been written off and was damaged at the time of purchase. The plaintiff repaired the vehicle over time, registered it in his name in 2017, and took out insurance on the vehicle in 2020.

The plaintiff claimed for damage caused by an accident in April 2022. After a few months, the insurer rejected the claim on the basis of a non-disclosure by the plaintiff regarding the vehicle's condition.

The policy required the insured to inform the insurer of material modifications to the vehicle and if the vehicle had been structurally altered from the manufacturer's specifications. The plaintiff had not disclosed the fact that he had purchased the vehicle at auction and that he had rebuilt it after it had been written off. He had represented that the vehicle was used but in good condition, and that he had purchased it in December 2020.

The court held that the insured's non-disclosure and misrepresentations were material to the risk insured. The insurer would not have provided the insurance (or if it would have, the terms would have been less favourable to the insured) had it known the true state of the vehicle. Therefore, the plaintiff's claim failed.

The policy provided that the insured would be liable for the costs of a rental car if the insurer did not pay the claim. Therefore, the court allowed the insurer's counterclaim for repayment of the amount spent on providing the plaintiff with a replacement vehicle before the claim was rejected.

Huseb v Old Mutual Short-Term Insurance Company (Namibia) Ltd (2023)

(HC-MD-CIV-ACT-CON-2019/03452) [2023] NAHCMD 466 (4 August 2023)

Keywords
motor vehicle accident / misrepresentation

The plaintiff claimed payment under an insurance policy, following damage to his vehicle.

The insurer rejected the claim on the basis of a misrepresentation of the circumstances surrounding the accident, and alleged that the plaintiff had deliberately caused the accident. The plaintiff's version was that he had hit a cow and then swerved and collided with a tree.

The insurer's loss adjuster told the court that the number of claims relating to accidents where no other cars were involved had risen steeply for all insurers, and were therefore investigated more carefully. A forensic reconstruction of the scene indicated that the vehicle had not collided with the tree the plaintiff alleged he hit. The police who attended at the scene also noted that the vehicle was not in contact with the tree. Data retrieved from the vehicle showed that there was only one moment of impact. The vehicle had also accelerated (and not braked) a few seconds prior to impact.

The court found that the plaintiff's witness, a tow truck driver, was not independent. It however found that the numerous witnesses called for the insurer independently corroborated the inference that the plaintiff's account of events was false.

On the evidence, the court found that the insurer was entitled to reject the claim.

Mutumbulwa v Alexander Forbes Insurance Company Namibia Limited (2023)

(HC-MD-CIV-ACT-CON- 1686 of 2021) [2023] NAHCMD 66 (17 February 2023)

Keywords
motor vehicle accident / absolution from the instance / breach of policy / evidence / non-disclosure

The plaintiff claimed from her insurer when an accident damaged the insured vehicle beyond repair. The insurer rejected the claim on the basis that the driver had refused to allow the police to draw blood to perform an alcohol or drug test. Three months later, the insurer informed the plaintiff that her policy would be cancelled with effect from the following month, due to the excessive loss ratio.

The plaintiff sued for payment under the policy and for reinstatement of the policy.

The insurer referred the court to a clause in the policy stating that the insured will have no cover if the driver of the insured vehicle refuses to submit to alcohol or drug testing, when reasonably requested to do so by the authorities. The plaintiff had included the signed accident report in her claim form, which indicated that the driver had refused the blood test. The plaintiff alleged that although she knew the driver had not refused the test, she signed the police accident report because she was confident that the truth would be revealed at the conclusion of the then-pending criminal case.

The court noted that the evidence at trial included only the claim in which the plaintiff declared that the information she provided was true in every respect. No other claim was submitted by the plaintiff, correcting the information contained in the original claim to the insurer. Therefore, from the evidence, the plaintiff had breached the term of the policy, and the insurer was justified in rejecting the claim. The quantum of damages claimed was also not supported by any evidence.

Regarding the cancellation of the policy, the court noted that the plaintiff did not allege any term of the contract upon which she founded her claim. She did not provide evidence to the effect that, in cancelling the cover, the defendant acted in breach of any term of the policy.

The plaintiff's claim failed.

Nampolo v Hollard Insurance Company of Namibia Ltd (2023)

(HC-MD-CIV-ACT-CON-2021/00287) [2023] NAHCMD 2 (20 January 2023)

Keywords
motor vehicle accident / misrepresentation

The plaintiff claimed under a motor vehicle policy. The insurer rejected the claim on the basis of an alleged misrepresentation.

The plaintiff alleged that he swerved to avoid hitting an animal in the road, and then collided with a tree. He left the scene of the accident before the police arrived.

The policy excluded cover if there had been a material misrepresentation or if the insured left the scene before the police arrived. Based on an expert reconstruction of the accident, the insurer alleged that the plaintiff brought his vehicle to a standstill near the tree, then accelerated towards the tree and intentionally collided with it. The insurer's version of where the accident occurred (which differed from the plaintiff's) was corroborated by a tow-truck driver. Therefore, the insurer alleged that the claim was fraudulent, with the plaintiff having intentionally caused the accident.

The insurer counterclaimed for repayment of the amounts already paid to the plaintiff, including a replacement vehicle, storage fees, and the costs of an assessor.

The parties' versions were mutually destructive. The plaintiff had to convince the court that, on a preponderance of probabilities, his version was true. Based on the evidence presented and the credibility of the witnesses, the court found that the plaintiff's version could not be accepted.

The court noted that insurance contracts are classed as contracts of utmost good faith. Misrepresentation of the facts on the event on the part of the insured entitles the insurer to reject claims made.

The plaintiff's claim failed.

Don v Hollard Insurance Company of Namibia Ltd (2020)

(HC-MD-CIV-ACT-OTH-2019/02372) [2020] NAHCMD 217 (10 June 2020)

Keywords
motor vehicle accident / exclusions / misrepresentation and non-disclosure / utmost good faith

The plaintiff claimed for damage to his vehicle following a car accident. The insurer rejected the claim on the basis that the plaintiff had left the scene of the accident before the ambulance or police arrived, in contravention of the policy. He also misrepresented information regarding the circumstances of the accident and failed to cooperate with the insurer in providing information to substantiate his claim. The plaintiff then sued for payment.

The plaintiff alleged that the insurer had breached the agreement by wrongfully rejecting the claim, despite having partially honoured the agreement by providing an alternative vehicle. The insurer alleged that despite having partially honoured the contract, and despite renewing the agreement after the accident, it was entitled to reject the claim on the basis that the plaintiff had breached the terms of the agreement.

The court found that there were discrepancies in the plaintiff's version of events (related to the date, time, and location of the accident) which the plaintiff failed to reconcile or clarify. The plaintiff left the scene, without a sufficiently good reason. While he alleged that he had to accompany an injured passenger to the hospital, the court noted that there were two uninjured passengers who could have left instead.

The court noted that because the insurer depends on the insured to provide accurate information in order to assess risk and any subsequent claims, the principle of utmost good faith (*uberrima fides*) and not the usual standard of good faith (*bona fides*) applies to insurance contracts.

The insurer's rejection of the claim was upheld and the plaintiff's claim failed.

Malakia v Alexander Forbes Insurance Company (2018)

(HC-MD-CIV-ACT-OTH 3868 of 2017) [2018] NAHCMD 365 (16 November 2018)

Keywords
motor vehicle accident / exclusions / non-disclosure / misrepresentation / materiality / interpretation

The plaintiff sued the insurer following the rejection of his claim under a motor vehicle policy. The insurer had rejected the claim on the basis of exclusions or general exceptions contained in the policy.

The insurer had objected to the information the plaintiff provided regarding when the accident occurred. The court however noted that the differences in time were not in hours, but in minutes, and that the plaintiff had indicated that he could not place the exact minute of the accident. The insurer did not provide any reason for the significance of the time of the accident. The court noted that most people involved in a motor vehicle accident would not note the exact time the accident occurred, and found that it was unreasonable of the insurer to expect this of an insured.

The plaintiff's inability to give exact times did not amount to a failure to give full and complete information and these discrepancies could not be used as the basis of rejection.

The insurer also argued that the plaintiff was driving at an excessive speed at the time of the accident. However, the court found no credible evidence to support this allegation. The plaintiff's version was that he drove at a speed of between 60 and 65 kilometres per hour at the time of the accident, which the insurer noted was in excess of the general speed limit. The court accepted that driving above 60 kilometres per hour contravened the law. However, there was no explicit clause or exclusion stating that there would be no cover in situations when an accident occurred as a result of the insured having driven in excess of the speed limit. In the absence of an explicit stipulation, the court stated that it would be unfair to penalise insured drivers for every traffic infraction.

Finally, the insurer argued that the plaintiff had left the scene of the accident, in contravention of the policy. It was not in dispute that the plaintiff left the scene. However, in interpreting the policy, the court held that cover was excluded only if the plaintiff left the scene of an accident "unlawfully". There was no unlawful conduct on the plaintiff's part in leaving the scene of the accident, and so the inclusion of the word *unlawfully* was fatal to the insurer's argument.

The court accordingly found in the plaintiff's favour.

Subrogation

Clayton v Williams (2023)

(HC-MD-CIV-ACT-DEL-2021/01779) [2023] NAHCMD 510 (18 August 2023)

Keywords
subrogation / motor vehicle accident / pleadings / capacity to sue

The defendant applied for permission to amend his plea to include the plaintiff's failure to plead that he had been fully indemnified by his insurer, and to allege that the insurer should have been joined as an interested party in the proceedings. The defendant argued that because the plaintiff had been indemnified, he lacked capacity to sue.

The court quoted the case of *Sheehama* (discussed below) with approval and held that subrogation concerns only the parties to the insurance contract. Subrogation is not relevant between the insured and third parties and there is no duty on the insurer to allege or prove subrogation when it sues in the name of the insured.

The court therefore dismissed the defendant's application to amend its plea.

Iglo Portugal, Comercializacao E Producao De Produtos Alimentares Sociedade Unipessoal LDA v Hangana Seafood (Pty) Ltd (2022)

[2022] NAHCMD 599 (2 November 2022)

Keywords
subrogation / marine law / cession / insurable interest

Namibian marine insurance law is governed by the English Marine Insurance Act of 1906. That Act specifically allows insurers to step into the insured's shoes to recover losses from third parties following indemnification of an insured under a marine insurance policy.

I&J sold consignments of fish under the CIF Incoterms (for Lisbon and Genoa). The consignments were loaded at Walvis Bay for carriage to and discharge in Lisbon and Genoa. In terms of the sales contracts, risk for the fish passed to the plaintiffs on shipment. On discharge of the consignments at Lisbon and Genoa, the fish was found to be rotten. The plaintiffs were indemnified for the loss suffered by the marine insurers. The plaintiffs concluded subrogation forms, and the marine insurers instituted proceedings against the suppliers pursuant to the principles of subrogation in the name of their insured.

The defendants raised a special plea alleging that the insurers of the first plaintiff (Iglo), Zurich Insurance Company Limited, lacked legal standing to institute proceedings in Iglo's name, as it was not a named party to the marine insurance policy. Iglo's conclusion of a subrogation form could not correct that defect.

The second plaintiff, Atlas, although named in a policy with Mutual & Federal Insurance Company, did not bear risk of loss of the cargo at the time the damage arose, which was agreed to have occurred prior to shipment. As a result, Atlas was not entitled to claim under the insurance policy and Mutual & Federal Insurance Company accordingly should not have indemnified them and, as a result, held a hollow right of subrogation.

In examining the rights of the two insurers to pursue subrogated claims, the court considered the wording of the policies and sales contracts and examined the principles of subrogation. The court held that a valid insurance agreement is the foundation of the right to subrogation. If a valid insurance agreement is not in existence between the parties, then the insurer has no right of subrogation. This means that the authority to use the name of the insured in recovery actions against third parties does not exist and accordingly, the insurer has no legal standing to advance the claim.

The court confirmed that the plaintiff bears the onus of establishing its legal standing. This concerns not only establishing the sufficiency and directness of interest, but also that it has legally acquired the rights of the named plaintiffs to pursue the claim.

Because Iglo was not a party to the insurance agreement with Zurich, Zurich enjoyed no rights of subrogation and accordingly that claim was dismissed.

Insofar as Atlas was concerned, the court was satisfied that it had an insurable interest in the consignment of fish notwithstanding that the damage took place before loading. As a result, indemnification under the policy had been properly made and accordingly Mutual & Federal were subrogated to the rights of Atlas.

This case is a reminder of the importance of ensuring that a party seeking indemnification under an insurance policy is entitled to do so, both in terms of being a named party or identified beneficiary under the policy and they bear an interest in the subject matter insured. If the party is not entitled to indemnification for these reasons, that defect cannot be cured by a subrogation form. Subrogation takes place by operation of law once proper indemnification under a policy has been paid. That right either exists or not and a subrogation form cannot change the legal position. It would need a cession of the claim to the insurer who would then sue in its own name.

Sheehama v Nehunga (2021)

(SA 13 of 2019) [2021] NASC 1 (7 April 2021)

Keywords
motor vehicle accident / subrogation

The parties are cousins, who were involved in a motor vehicle accident. The appellant was following behind the respondent, on their way to a social event. At a T-junction, the appellant attempted to overtake the respondent while the respondent was turning right, and the cars collided. Both cars were damaged.

The appellant sued the respondent for damage to the car, and the respondent counterclaimed. There were differing versions of the accident and each party claimed that he was not at fault.

The trial court criticised the appellant for failure to disclose that it was his insurer (using his name via subrogation) who was suing the respondent. The trial court found the fact that the appellant had already been compensated by his insurer to be "vital information". Due to this perceived dishonesty to disclose the subrogated nature of the claim, the trial court dismissed most of the appellant's evidence. The respondent cited a South African precedent to the effect that subrogation must be pleaded when it is relied upon.

The appeal court stated that the trial court's approach to the issue of subrogation was a "serious misdirection." The fact that the appellant's insurer had indemnified him for his loss was a non-issue and was irrelevant to the proceedings. The court stated that:

> "Subrogation concerns solely the parties to the insurance contract, i.e. the insurer and the insured. It confers no rights or liabilities on third parties who are strangers to the insurance contract. A third party retains all the rights and obligations he has against the insured irrespective of whether subrogation took place or not."

The insurer's right of subrogation involves the right to take charge of proceedings against third parties. The insurer should give notice of its intention to sue in the insured's name to the insured but not the third party. The insured is obliged to assist the insurer in the resulting litigation. The South African authority relied on by the respondent was not accepted by the appeal court. The court noted that the South African case has not been met with unanimous approval in South Africa.

There is no duty on the insurer, when it sues in the name of the insured, to allege or prove subrogation.

The fact that the appellant had been paid by the insurer did not affect the claim against the respondent and, in fact, subrogation is used to avoid double payments to the insured.

The appeal court therefore concluded that the matter should be considered afresh, due to the erroneous credibility findings regarding the appellant.

Eventually, on the evidence, the appellant was awarded 50 per cent of his proven damages.

Western National Insurance Company Ltd & Another v Mweulinale & Others (2021)

(HC-MD-CIV-ACT-DEL-2019/02849) [2021] NAHCMD 82 (11 February 2021)

Keywords
subrogation / cession / suing in insurer's name

The first plaintiff insurer indemnified its insured, the second plaintiff, in relation to a motor vehicle accident. The plaintiffs then sued the defendant third parties for the loss, which they alleged was caused by the defendants.

The defendants excepted to the insurer's claim, arguing that the insurer has no right to sue in its own name, and has no legal standing in the matter. The defendants argued that the doctrine of subrogation requires that an insurer to litigate in the name of the insured. The insurer can only litigate in its own name if it has taken cession of the insured's claim against third parties, and this cession must be pleaded.

The insurer referred to the South African Supreme Court of Appeal case of *Rand Mutual Assurance Co Ltd v Road Accident Fund* (2008), in which that court developed the common law to allow insurers to sue in their own names, via subrogation. This is a departure from the English law position.

The Namibian High Court noted its reluctance to interfere with settled legal principles. It however held that the English rule (in its stark form) cannot be justified and that, unless the wrongdoer will be prejudiced in a procedural sense, courts may permit the insurer to proceed in its own name. Nevertheless, the court distinguished the facts from the *Rand Mutual* case, because, in this case, the insured was liable for the excess (which it claimed, as second plaintiff, from the defendants) and had incurred other damages not covered by the insurance.

The court noted that providing a blanket allowance may prejudice insureds, as they may not have a right of recourse to claim any excess, unlike in the *Rand Mutual* case where the insured was fully indemnified). Even though this was not an issue in this case because the insured was cited as the second plaintiff and was able to pursue his outstanding damages against the defendants, the court upheld the defendant's exception.

The court stated that the second plaintiff insured was best suited to pursue his delictual claim for damages caused by the defendants' negligence. The insurer, in terms of the doctrine of subrogation, was entitled to litigate in the insured's name after indemnifying him under the policy.

The common law applied in Namibian courts grants the insurer the right to sue in the name of the insured but does not extend an entitlement to sue in its own name. The exception was consequently upheld.

In an action in delict there should be only one claimant.

Nafuka v Alexander Forbes Insurance Company Namibia Limited and Another (2018)

(2380 of 2015) [2018] NAHCMD 298 (24 September 2018)

Keywords
subrogation / legal standing

The insured sued the insurer under a motor vehicle policy, for damage to his car caused in a motor vehicle accident. The parties settled the claim during mediation, and the settlement agreement was made an order of the court. What remained was the dispute between the insurer and the third party who caused the accident.

The third party raised the issue of legal standing, alleging that the insurer had no right to sue her because it did not allege subrogation or cession of the plaintiff's claim.

The court noted that after the defendant insurer settled its insured's claim, cession fell away, but subrogation was still an option. The settlement agreement made it clear that the third party was not released from liability through the settlement. By indemnifying the insured, the insurer met the requirements of subrogation. Therefore, the insurer's legal standing to sue the third party was established.

On the evidence, the court found that the third party was negligent in causing the accident and was liable for the damage caused.

Therefore, judgment for the insurer against the third party, in the amount of the settlement paid to the insured, was granted.

Shivute v Redemptus (2017)

(HC-MD-CIV-ACT-CON 234 of 2016) [2017] NAHCMD 354 (6 December 2017)

Keywords
indemnification / unjustified enrichment / subrogation

The defendant caused an accident, which damaged the plaintiff's car. The plaintiff was indemnified for the damage, in full, by his insurer. This case is the result of the insurer's subrogated claim.

The defendant argued that the plaintiff did not suffer any loss as he had been indemnified by his insurer.

The court noted that this is not a valid defence. The insurer has the right to recover from the defendant damages for any wrong done to the plaintiff, through subrogation, even though the plaintiff has been compensated by the insurer.

Time-bar clauses

New Creations Printing and Design CC v Quanta Insurance Limited (2021)

(HC-MD-CIV-ACT-CON-2018/02486) [2020] NAHCMD 27 (05 February 2021)

Keywords
time-bar / prescription / agency

The plaintiff sued the insurer for damage to an insured printer as well as for loss of income as a result of the printer being damaged.

The insurer filed a special plea of prescription, based on a time-bar clause requiring the insured to sue the insurer within 12 months of a claim being rejected. The plaintiff objected to the insurer's reliance on the time-bar clause, on the basis that it was never brought to its attention by its broker.

The court held that the principles of agency law provide that the knowledge of an agent acquired while acting within the scope of employment, is imputed to the principal.

Therefore, the claim had prescribed. The plaintiff's claim failed.

Mushindi v Hollard Insurance Company of Namibia (2014)

(1362 of 2013) [2014] NAHCMD 228 (31 July 2014)

Keywords
time-bar clause / prescription / absolution from the instance

The plaintiff sued the insurer under an insurance policy, which required summons to be served within 90 days of rejection of a claim.

The plaintiff accepted that the time-bar clause was valid but argued that 'days' meant business days. The court considered the Interpretation of Law Proclamation and noted that when a particular number of days is prescribed for doing something, it must be reckoned exclusively of the first and inclusively of the last day, unless the last day falls on a Sunday or a public holiday, in which case it must be reckoned exclusively of the first day and exclusively also of the last day (not business day).

Therefore, by this calculation, the plaintiff's claim was time-barred. The court granted the insurer absolution from the instance. Dismissal of the claim was the more appropriate order.

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