NORTON ROSE FULBRIGHT

The Big Read Book series Volume 18

Norton Rose Fulbright's review of Zimbabwe's insurance judgments (2003-2023)

April 2024

Introduction

Dearest Reader

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

Note that these cases are binding in Zimbabwe but not in South Africa. The findings in some of the judgments do not match South African law and the case law should not be relied on in South Africa. This makes interesting reading nonetheless.

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.

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The Zimbabwean Insurance Law

Zimbabwean insurance law is derived from three sources, namely common law, statutory law and judicial precedent. Section 192 of the Constitution of Zimbabwe (2013) as read with section 89 of the now repealed Constitution of Zimbabwe (1980), recognise that Roman-Dutch law is the applicable common law of insurance.

The main insurance legislation in Zimbabwe is the Insurance Act (Chapter 24:07) and the Pensions and Provident Funds Act (Chapter 24:09). The Insurance Act provides for the registration and prudential regulation of insurers and insurance brokers. Section 89 of the Insurance Act empowers the Minister of Finance, who is responsible for its administration, to make Regulations relating to the Act to give effect to its provisions.

The decisions of the superior courts of Zimbabwe and other Roman-Dutch jurisdictions are another source of Zimbabwean insurance law. Considering the role that English insurance law played in the development of Zimbabwean insurance law, decisions of the English courts carry great persuasive value in the determination of insurance law matters in Zimbabwe.

Insurance business in Zimbabwe is regulated by the Insurance and Pensions Commission (IPEC). Being a creation of the Insurance and Pensions Commission Act (Chapter 24:21) (IPEC Act), IPEC can only exercise those functions and powers that are conferred on it under the IPEC Act. In addition to registering insurers, mutual insurance societies and insurance brokers, IPEC is empowered to monitor the insurance sector and to provide the public with information relating to insurance and pensions and provident funds. IPEC issues circulars from time to time which prescribe matters that in its opinion are necessary in the discharge of its statutory duties.

Norton Rose Fulbright South Africa Inc
In association with Gill Godlonton & Gerrans
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Brokers

Arenel Sweets and Biscuits (Pvt) Ltd v Alexander Forbes Risks Services Zimbabwe (2016)

HB 94/16 / HC 2098/15

Keywords: broker / premiums / prescription

In 2011, the plaintiff, a sweet manufacturer, requested the defendant broker to procure credit insurance for its exports. The broker approached Credit Insurance Zimbabwe Limited (Credsure) for an insurance policy. A policy document was negotiated and prepared, but would come into operation once a valid credit limit form in the name of the foreign buyer had been approved by the insurer.

The plaintiff, through its broker, submitted the relevant forms and paid the premiums but, despite the plaintiff continuing to pay premiums through the broker, the insurer never approved the credit cover.

Because the broker failed to inform the plaintiff that the credit cover had not come into operation, the plaintiff proceeded to export and supply goods to its foreign customer.

When the customer defaulted on payment, the plaintiff turned to its insurer for cover, but was informed that the cover was not in place. The insurer made an *ex gratia* payment of around US$1 000 to the plaintiff, and the plaintiff sued the broker for the outstanding amount of roughly US$78 000.

Credsure had informed the plaintiff that it was not insured on April 12, 2012, and the plaintiff served summons on the defendant on August 17, 2015, more than three years after the alleged cause of action arose. The defendant therefore alleged that the plaintiff's claim had prescribed.

The plaintiff argued that after the insurer rejected the claim, the broker had informed the plaintiff that it was engaging with the insurer in an attempt to resolve the dispute, going as far as attempting to arbitrate. The plaintiff therefore alleged that it only became aware of its cause of action against the broker after receiving a letter from the broker in April 2015 indicating that the matter was not resolved.

The court confirmed that prescription begins running as soon as a debt is due. A debt is not deemed to be due until the creditor becomes aware of the debtor's identity and of the facts from which the debt arises. However, the creditor will be deemed to be aware of the debtor's identity and the necessary facts if they could have acquired that knowledge by exercising reasonable care.

It was common cause that the insurer had refused to indemnify the plaintiff in its letter of April 12, 2012, in which it gave reasons for its rejection. While parties often engage each other despite pending court proceedings, the court stated that attempts to resolve a matter out of court do not interrupt the running of prescription.

The plaintiff was not prevented from instituting legal action against the broker within the prescribed timeframe, and simultaneously attempting to resolve the matter out of court. The broker did not acknowledge liability for the debt, and the court was therefore satisfied that the plaintiff's claim had prescribed.

Midlands State University v Zimbabwe Insurance Brokers Ltd (2016)

HH 367-16 / HC 8358/14

Keywords: broker / fraud / acknowledgement of debt

The respondent insurance broker provided brokerage services to the applicant policyholder. By inflating debit notes for premiums due, and collecting some premiums in cash and failing to pay those over to the insurer, one of the broker's employees misappropriated funds that were meant to be paid over to the insurer as premiums.

The broker signed an acknowledgment of debt for US$143 596 and agreed to pay the debt off in instalments. When the broker failed to make payment timeously, the applicant sued for default judgment.

In its defence against the application for default judgment, the broker alleged that prejudice was yet to be proved as the relevant employee had yet to be found guilty of criminal charges, there was connivance between that employee and the applicant's employees, the applicant contributed to the loss by paying in cash, and that the debt had not been proved.

The court rejected the broker's arguments, noting that it had signed a clear and unconditional acknowledgment of debt, for a specific amount. How the debt arose was clear and did not depend on any further investigations, and the defences were therefore found to be spurious.
The applicant's claim succeeded.

Insurable interest

KDV Foam Manufacturers (Pvt) Ltd v Zimnat Lion Insurance Company Ltd (2017)

HH 233-17 / HC 6083/14

Keywords: fire insurance / immovable property / leased premises / insurable interest

The plaintiff, a mattress manufacturer, insured its assets with the defendant insurer. A fire occurred on the insured's premises, and the insurer paid out the claim for machinery, stock, and loss of profit. However, a dispute arose regarding the insured's claim for damage to immovable property.

The plaintiff had leased the premises. In terms of its lease, the insured, as tenant, had to return the property to the lessor in the state in which it was received, as well as make good any damage caused to the property. The insured argued that these clauses captured the risk relating to the immovable property, and that the insurer was therefore liable for damage to the immovable property under the policy.

The insurer argued that the plaintiff had no insurable interest in the property and that the lease in fact stated that the lessor should insure the full value of the premises with a reputable insurance company, under a comprehensive policy of insurance.

The court interpreted the insurance contract as it related to the plaintiff's lease agreement, and specifically considered the wording of the clause contained in the contract of insurance that covered "all tangible property in Zimbabwe owned, leased, held in trust or on commission for which the insured are legally responsible". Whether the insured was "legally responsible" for the destruction of the premises was integral to whether it had an insurable interest in the property.

The court found that the clause obliging the insured to restore the building to its previous state was a standard maintenance clause contained in lease agreements. The clause creates an expectation that a tenant will use the property with the same care as they would their own property, and a breach of that duty affords the lessor certain contractual remedies, including cancelling the agreement of lease. But the court noted that a lessor cannot use this clause when the leased property is destroyed. Because the clause was headed "interior", it suggested that it could only be applied in respect of damages to the premises' interior.

The tenant's obligations should also be read together with the lessor's obligation to secure comprehensive insurance. The inclusion of the lessor's insurance obligation indicated that if the leased premises were damaged or destroyed, the lessor's insurance would cover that loss.

If the parties to the lease had intended for the insured to cover the premises' destruction, then it would have been unnecessary to include the clause obliging the lessor to insure the property. The fact that the lease agreement contained two separate and distinct clauses supported the insurer's argument that, in terms of that agreement, the insured was not legally responsible to pay for the destruction caused by the fire.

The court held that the insured did not stand to suffer any loss due to damage to the building and accordingly had no insurable interest in the immovable property. The insured's claim was therefore dismissed.

Interpretation of contract

Alliance Insurance v Imperial Plastics (Pty) Limited and another (2017)

Civil Appeal No. SC 504/16 / Judgment No SC 30/17

Keywords: arbitration award / assets all risk / quantum / auditor's report / interpretation

Imperial Plastics owned a plastic processing plant that was insured by the appellant insurer under an assets all risk policy. A fire destroyed the building in 2013 and the insured claimed for replacement of the building, stock and other movables covered under the policy.

The insurer requested a list of information to allow its auditors to assess the loss and made a payment, below the sum insured, on the basis of its auditors' report. The insured did not have access to the insurer's audit report, and instead engaged its own auditors to determine the amount of the loss.

Disputes arose regarding the value of the stock, whether a crane was a fixture of the building, and whether electrical connections were covered under the policy.

In terms of the policy, any dispute arising in respect of a claim had to be referred to arbitration. The arbitrator upheld the insured's claim for the crane but dismissed its claim for electrical connections. The arbitrator favoured the insured's auditors' report, and ordered that the insurer pay roughly US$180 000 as the balance of the amount owing on the destroyed stock. The insurer applied to the High Court to set aside the arbitrator's award.

Zimbabwe's Arbitration Act limits the grounds upon which an arbitral award can be challenged. The insurer alleged that the arbitral award went outside the scope of the issues arbitrated, and that it violated public policy. The court was however unable to find any instance of the arbitrator exceeding the terms of reference, and said that the award was not "so unreasonable" as to offend public policy.

The court found that the fact that the arbitrator had relied on the insured's auditor's report to determine the value of the award did not mean the arbitrator had made an award beyond the scope of the arbitration. This was because the insured claimed the amount set out in that report and the arbitrator had found that report to be credible evidence.

A court will not set aside an arbitral award lightly – even if the court considers the arbitrator's decision to be wrong in fact or in law. The court will only intervene if the award goes beyond mere faultiness and "constitutes a palpable inequity", where the arbitrator has totally misunderstood the issue, or has not applied their mind to the case.

In this case however, the arbitrator's decision was reasonable in light of the evidence placed before him and the insurer's appeal was dismissed.

Wedzera Petroleum (Pvt) Ltd v Zimnat Life Assurance Company of Zimbabwe (2004)

HH 14/2004 / HC 5947/02

Keywords: policy document / interpretation

The plaintiff took out two investment policies with the defendant, which specifically prohibited cession. The parties negotiated and agreed that the benefits of the policies could be ceded. They also negotiated various fees relating to the policy, including the fee payable when cashing out a portion of the policy.

The plaintiff attempted to cede the benefits of the policies as security for loans, but the defendant declared that the plaintiff could not cede the benefits of the policies. The defendant stated that the plaintiff's executive agent had misconstrued the terms of the policies.

The plaintiff argued that the written representations made during the negotiations formed part of the contract, and that the defendant's employees' representations regarding cession amounted to novation of the policy documents. The defendant's employees had acted within the course and scope of their employment when negotiating the terms of the policies, and they were senior members of the defendant's management team.

On the evidence, the court found that the parties did not intend the policy documents to constitute the entire agreement between them. While the documents specifically prohibited cession, the parties had, through letters, negotiated the cession in writing and the defendant's employee specifically stated in a letter that the correspondence would form part of the agreement between the parties.

The court accordingly held that the agreement allowed the plaintiff to cede the benefits of its policies, and the defendant's application for absolution from the instance was dismissed. The plaintiff's case was allowed to proceed.

Motor Vehicle Accidents

Dengezi v Nyamaruru and others (2022)

ZWHHC 693

Keywords: Road Traffic Act / insurance liability to third parties

In this case, the court considered whether the sections of the Road Traffic Act limiting the liability of third party insurers could be referred to Zimbabwe's Constitutional Court.

The applicant, a street vendor, was injured and her infant son killed when a commuter bus veered off the road and crashed into them. It was common cause that the vehicle's driver had acted negligently and that the vehicle was insured by the third defendant, Champions Insurance Company Limited, under a third party insurance policy.

The insurer tendered payment of the amount provided for by section 23(3)(b) of the Act, Zimbabwean US$2 000. The applicant argued that the sections limiting an insurer's liability was unconstitutional and should be referred to the Constitutional Court for consideration.

The Act provides for statutory insurance policies insuring death, injury and destruction of property arising out of the use of a motor vehicle on a road. Subsection 23(3)(b) provides a monetary limit of liability (between USD 1000 and USD 10 000) for injuries sustained by passengers or people getting in or out of the vehicle.

The court noted that the provisions apply strictly and do not account for important factors like the extent of the injuries, or factors usually taken into account when assessing damages like the loss of amenities of life. The limitation of liability also seemed to be "arbitrarily imposed by Parliament" and could be seen as irrational on the face of it.

On the facts of this case, however, the court could not refer the section to the Constitutional Court. The court interpreted the limitation as applying only to the vehicle's passengers and noted that the applicant and her son were not passengers in the vehicle involved in the accident.

The insurer's obligation to compensate pedestrians injured by an accident does not arise from, and is not limited by, the Act.

The court accordingly held that the applicant was not restricted from claiming whatever damages were payable by any of the defendants, including the insurer.

The provision was therefore not referred to the Constitutional Court, but the action was stayed pending the resolution of unrelated constitutional issues.

Tigere and another v Nicoz Diamond Insurance Company Ltd and another (2017)

HH 66-17 / HC 2938/09

Keywords: motor vehicle accident / currency fluctuations / Zimbabwean dollar / US dollar / demonetisation

The plaintiffs claimed damages arising out of a motor vehicle accident allegedly caused by the second defendant. The first defendant was the second defendant's insurer.

The insurer did not attend the initial trial because of an error by its attorneys. The second defendant withdrew its defence, and judgment was granted in the plaintiffs' favour against the defendants in the amounts of roughly US$39 000 and US$85 000 respectively.

The insurer applied for and was granted rescission of the default judgment against it.

The court had to decide whether the insurer was liable to compensate the plaintiffs for claims under the second defendant's insurance policy.

The insurer argued that it was only liable for what was specified in the policy. The policy was taken out in Zimbabwean dollars and the insurer argued that it could not cover a claim for US dollars.

The policy was a statutory policy under the Road Traffic Act and, in terms of the Act, a third party can sue the insurer directly. The Act also provides for compulsory statutory insurance cover for third parties harmed by an insured's conduct, and requires all drivers to be insured against third party claims.

Section 23 of the Act states that statutory policies must insure against "any liability" arising from death, bodily injury and destruction of property relating to a motor vehicle accident. The plaintiffs argued that the phrase "any liability" meant that foreign currency claims were included. The court however interpreted the phrase to mean any type of injury or damage, and not any amount payable because of an injury. Section 25 of the Act also states that a claim cannot exceed the amount covered in the statutory policy and so the amount not covered by the insurer can be claimed directly from the insured.

The Act initially included some limits of liability in Zimbabwean dollars. This was amended to US dollars in 2009, but without retrospective effect.

The court noted that the principle of currency nominalism means that a debt sounding in money must be paid in terms of its nominal value, irrespective of any fluctuations in the currency's purchasing power.

When the policy was in force, the Act limited claims to 75 million Zimbabwean dollars. Due to the devaluation (or "demonetization") of the Zimbabwean dollar, "holders of one hundred and seventy five quadrillion dollars were paid US$5". This meant that the plaintiffs' claims could not exceed US$1, and the court found that the plaintiffs could not bring a claim against the defendant in any meaningful amount, and so their claim against the insurer failed.

The court noted the unfortunate circumstances in which this left many claimants, but were constrained by the applicable law and called for a policy decision to be made to address the situation.

The judgment does however mention that default judgment was only rescinded against the insurer. The insured driver may therefore still be bound by the original judgment.

Sibanda v Chikumba and Altfin Insurance Company (2017)

HH 56-17 / HC 10435/12

Keywords: motor vehicle accident

The plaintiff sued the first defendant and her insurer for damage to his vehicle arising from a motor vehicle accident caused by the first defendant. The plaintiff claimed for the cost of repairs and the cost of hiring a replacement vehicle while his car was repaired.

The defendants accepted liability., The first defendant had referred the plaintiff to her insurer, who alleged that it attended to the repairs. The insurer argued that the plaintiff had signed a release form, releasing it from any further claims arising from the accident.

The plaintiff told the first defendant's insurer that the repairs were not done properly, and the insurer offered him US$3 500 in exchange for the vehicle, but this offer was rejected. At the time of the trial, the insurer was in liquidation, and was no longer a party to the action.

The court found that the plaintiff could proceed against the first defendant. In the court's view, the fact that the first defendant was comprehensively insured did not provide immunity to a suit, as the insurer had not fully or satisfactorily covered the loss.

Nevertheless, the plaintiff's claim failed as he failed to show sufficient evidence of the loss suffered.

Manduna v Alliance Insurance (Pvt) Ltd (2016)

HH 147-16 / HC 1257/14

Keywords: arbitration clause / motor vehicle accident

The insured had a comprehensive motor policy with the insurer. The motor vehicle was damaged beyond repair in an accident. The plaintiff alleged that he reported the accident at the relevant police station, which resulted in an investigation. The police concluded that the plaintiff was responsible for the accident and caused the plaintiff to pay a deposit fine of US$200.

The plaintiff then lodged a claim with the defendant insurance company, claiming payment in the amount of US$11 000. A dispute arose between the insurer and the insured, with regard to liability. The plaintiff therefore instituted legal proceedings against the insurer, in court.

The defendant argued that in terms of the policy document the plaintiff had no right of action against it. That is because the policy provided that any differences arising between the insurer and the insured regarding the amount of any claim under the policy must be referred to arbitration, and this is a condition precedent to any right of action against the insurer. The plaintiff had therefore allegedly approached the court prematurely.

The court noted that in exceptional cases it could exercise its judicial discretion in favour of continuing a matter in court without reference to an arbitration clause. However, exceptional circumstances did not exist in this case. Furthermore, the arbitration clause did not unlawfully bind or restrict the court (as alleged by the plaintiff); rather, it was the parties who bound themselves to arbitration in their agreement.

The insurer asked the court to dismiss the plaintiff's claim and refer the matter to arbitration. The court was hesitant to dismiss the action altogether, because that would potentially raise the issue of res judicata (a defence that the matter has already been adjudicated on), and the court did not want to imply in its judgment that its ruling related to the merits of the matter, which it did not.

The court therefore upheld the arbitration clause and referred the matter to arbitration and stayed the court proceedings.

Murozvi v Sign and others (2015)

HH 481-15 / HC 10446/14

Keywords: consequential loss / motor vehicle accident

The plaintiff alleged that his tractor had been damaged by a motor collision caused by the first defendant. He sued the first defendant as driver of the vehicle, the second defendant as employer of the driver, and the second defendant's insurer for consequential loss arising from damage to his tractor.

The insurer objected to being sued as it had already paid for the tractor's repair and alleged that it had no further liability. As a statutory insurer, its liability was limited to damage to property, bodily injury, and death – consequential damage was not covered.

The court agreed and dismissed the plaintiff's claim for consequential damage against the insurer.

Masunga v Mutema and Sigudu (2004)

HH 110-2004 / HC 10899/02

Keywords: motor vehicle accident / insurer as agent of insured / acceptance of liability

The plaintiff claimed damages, caused in a motor vehicle accident, from the defendant. The defendant's insurer had accepted liability and paid the plaintiff US$250 000. The defendant authorised the payment, and in doing so, ratified the insurer's acceptance of liability on her behalf.

However, the insurer could not pay the claim in full because the defendant was underinsured.

The court noted that the insurer, acting as agent of the insured, accepted liability on her behalf. By authorising her insurer to accept liability and to effect payment on her behalf, the defendant was in fact accepting liability.

Having accepted that liability, the defendant could not then deny liability for the remainder of the amount owed.

The court therefore ordered the defendant to pay the outstanding amount to the plaintiff.

Muzeya NO v Marais and AIG Zimbabwe Ltd (2004)

HH 80-2004 / HC 555/01

Keywords: motor vehicle accident / bodily injury

The plaintiff sued on behalf of his daughter for personal injury and consequent damages arising from a motor vehicle accident. The defendants admitted liability but disputed the quantum.

The first defendant caused the accident and was prosecuted and convicted in terms of the Road Traffic Act. The vehicle was comprehensively insured by the second defendant.

As the plaintiff's daughter had suffered severe injuries, causing her to be almost completely disabled for the rest of her life, the court awarded the plaintiff 60 million Zimbabwean US$60 million and US$20 000, and held the defendants jointly and severally liable.

CGU Insurance Zimbabwe Ltd v Kirby (2003)

HH 180-03 / HC 4647/01

Keywords: motor vehicle accident / negligence

The plaintiff insurance company sought damages of roughly US$620 000 arising out of a motor vehicle accident between its insured and the defendant.

The evidence showed that the defendant had attempted to overtake two long fuel tankers with trailers on a curve. This caused the defendant to be on the wrong side of the road when the insured driver entered the curve.

The insured driver attempted to go left onto a gravel shoulder, but the defendant also moved towards the gravel. This caused the insured driver to swerve back onto the road, and collide with one of the tankers. The defendant's vehicle was unharmed.

The court found the insured's actions to be reasonable in the circumstances and found the defendant to have been driving negligently. The plaintiff's claim succeeded.

Prescription

Kanjere v Old Mutual Life Assurance Company Limited (2023)

HH 280-23 / HC 3983/16

Keywords: prescription

The insured sued the insurer under a life policy that matured on July 1, 2013.

The defendant raised the defence of prescription because summons was served on July 18, 2016, more than three years after the claim arose.

The court accepted the maturity date of the policy as the date from which prescription began to run. The plaintiff did not raise any evidence to demonstrate that the running of prescription had been interrupted.

The court noted that "the law assists the vigilant and not the sluggard", and held that the plaintiff's claim had prescribed.

Premiums

Delta Beverages (Pvt) Limited v Zimbabwe Revenue Authority (2022)

ZWSC 3

Keywords: tax / allowable deductions / prepayment of insurance premium

This matter concerned a tax dispute between a beverage company and Zimbabwe's revenue authority. The court had to consider whether a statutory prepayment of an expense can be deducted from tax liability in the year of payment.

The insured's premium payments straddled current and subsequent tax years.

The court held that the date on which the insured was required by law to pay the premium would be the date on which it had an unconditional obligation to discharge that liability. The trial court held that:

> "The premature discharge of a contingent liability in the preceding tax year simply meant that the appellant was discharging a liability that had not yet been incurred. In those circumstances, the Commissioner correctly disallowed the payments in question."

The appeal court upheld this reasoning and did not allow the insured to deduct the prepayment of premiums from the calculation of its tax liability.

Rollex (Pvt) Ltd v Delta Beverages (Pvt) Ltd (2015)

HH 66-15 / HC 3814/13

Keywords: farming stop order / insurance premium / agency

The parties entered into an agreement in terms of which the defendant advanced the plaintiff, a farmer, money to grow barley, and the plaintiff would sell its harvest to the defendant at US$450 per tonne. The value advanced to the plaintiff was to be set off against the purchase price, which the defendant would pay to the plaintiff when the barley was delivered.

The defendant facilitated insurance for its contract farmers and the plaintiff took out a policy under the arrangement. In terms of the policy, the plaintiff would pay the premium from the proceeds of its winter crop. The premium would be collected by the defendant and paid into the insurer's account.

Rain damaged a portion of the plaintiff's crop, and the defendant rejected that portion. The plaintiff sold that portion to a third party at a discounted price of US$250 per tonne, at a loss of roughly US$53 000.

The proceeds could not cover both the input provided by the defendant as well as the premiums due to the insurer. No funds were paid to the insurer as premium, and the insurer therefore refused to indemnify the plaintiff for the loss. Further, in terms of the policy, any losses or potential losses should have been notified within 24 hours but this claim was submitted only five months after the loss.

The plaintiff did not sue the insurer but claimed from the defendant, arguing that the defendant's actions resulted in the plaintiff being unable to claim from the insurer.

The court had to interpret the insurance policy to determine who was responsible for payment of the premium.

The court found that the defendant was required to make the premium payment, but that this in no way implied that the defendant was required to pay the premium from its own funds. The policy stated that the defendant was required to collect the premium first and then paid the amount collected into the insurer's account. The premium was to be paid from the proceeds of the crop, and the defendant, acting as the insurer's agent, merely facilitated the insurance contract between the plaintiff and the insurer.

In terms of the agreement between the plaintiff and the defendant, the defendant was not required to insure the plaintiff's crop. The defendant was also not a party to the insurance contract. The court found it reasonable to expect that the defendant would not pay the premium when the crop was not delivered and the sale of the crop was not made. The plaintiff was paying its own premiums, and as a result, the court found that there was no cause of action against the defendant.

Regarding notification, the policy was clear that the insured was required to lodge the claim itself. There was no suggestion that the defendant was required to lodge the claim on behalf of the plaintiff.

The plaintiff's claim therefore failed.

Forestry Commission v Cell Insurance Company (Pvt) Ltd and Premier Insurance Brokers (Pvt) Ltd (2013)

HC 1130/10 / HH 116-2013

Keywords: payment of premium / condition precedent / claim within a reasonable time / motor vehicle policy

The plaintiff's motor vehicle was involved in an accident. The plaintiff claimed for damages under a policy, which the plaintiff alleged was effective from January 1, 2009.

The court had to determine whether a contract of insurance existed between the parties at the time of the loss, whether payment of premium for the period of insurance was a condition precedent for cover, as well as whether the plaintiff's claim was submitted within a reasonable time.

In 2008, the plaintiff and the insurer entered into a contract brokered by the second defendant. The policy was due to end on December 31, 2008 but the plaintiff wrote to the insurer through the broker on December 24, 2008 to extend the policy for a further two months, from January 1 to February 28, 2009. The extension was confirmed in a letter from the broker to the plaintiff of January 6, 2009.

The motor vehicle accident occurred on January 14, 2009. The plaintiff informed the broker of the accident on January 15 and followed up in a letter of January 16, giving formal notice of the accident. The plaintiff then received an endorsement to the policy covering the renewal, signed on behalf of the insurer on January 30, 2009. The premium for the renewal was paid on February 6, 2009. The relevant claim documents, including quotations for repairs, were submitted on March 4, 2009.

The broker wrote to the plaintiff on March 19, 2009, rejecting the claim on the basis that the premium was paid after the loss had occurred and that the claim papers had been submitted after the permissible period of 30 days.

The court stated that there was a policy of insurance between the parties at the time of the loss. The renewal was confirmed before the accident, and the insurer and the broker would have been aware of the claim at the time that the endorsement was signed by the insurer on January 30, 2009. The dispute was therefore whether the insurer's obligations were subject to prior payment of the premium by the insured.

The court noted that "neither the issue of a policy nor the payment of a premium is essential to the conclusion of the contract, unless the parties have expressly or impliedly agreed to the contrary". In this case, the policy explicitly stated that cover was conditional on the premium being paid. The relevant wording stated:

> "In consideration of the Insured having actually paid the premium for the period of insurance … the Insurers agree to indemnify the Insured in respect of accident loss or damage occurring during the period of insurance".

An insurance contract subject to a condition precedent cannot be enforced before the fulfilment of that condition. After that condition is fulfilled, the contract operates prospectively.

The parties therefore agreed on a contract of insurance subject to the payment of premium. The insurer's obligation only arose once the premium had been paid and then only in relation to any loss that occurred after payment.

While this was the end of the matter, the court went on to consider whether the claim was submitted within a reasonable time.

The broker testified that when a claim is submitted, the claim form, three repair quotations, a copy of the driver's license and a police report are required. Under normal circumstances, accidents can be notified within seven days and claim documents submitted within 30 days. This was in line with usual practice in the industry at the time.

While it may take longer to submit the claim in exceptional circumstances, the broker was of the view that the delay of 48 days after the accident and 26 days after the claim form was completed was unreasonable. The court accepted that in this case, documents could have been submitted within two weeks.

The court noted that the time-bar clause obliging the insured to submit any claim for litigation or arbitration within 12 months could not assist the insured with respect to the timeframe within which it had to submit its claim. The court accepted that the plaintiff's delay in submitting the required forms was unreasonable. The court dismissed the plaintiff's claim.

Mabvuramiti v Altfin Insurance Company (2013)

HH 63/2013 / HC 12713/2011

Keywords: payment of premium / cancellation of contract / specific performance

The plaintiff claimed under a motor policy, following the destruction of his motor vehicle in an accident. The defendant insurer rejected the claim because the last premium had not been paid.

The plaintiff admitted to failing to make the last payment and asked the court to deduct the last premium from the claimed amount. He argued that the insurer had condoned the nonpayment through "quasi mutual assent" as it had sent an assessor to assess the damage and had continued to send him statements.

The court rejected the plaintiff's arguments, noting that the payment of premiums is central to indemnity. While the plaintiff failed to attach the policy document to his pleadings, he did himself state that he was entitled to indemnity "upon payment of premiums".

If a party claims specific performance of a contract, that party must have properly performed under that contract and cannot be in breach at the time of their claim. The time for payment had been agreed and the plaintiff was aware of his obligations regarding timeous payment of the premium. The insurer was therefore not required to demand payment to confirm that the insured was in default of his obligations.

The plaintiff argued that the contract was in force because the insurer had not cancelled the policy. The court stated that if a party has committed a major breach, the aggrieved party is not required to turn to the law for relief but is entitled to disregard the contract. The court added that if the defaulting party then sues the aggrieved party, the aggrieved party is entitled to raise the default as a defence.

The plaintiff's claim was therefore dismissed.

Homeplus Investments (Pvt) Ltd v Kantharia Insurance Brokers (Pvt) Ltd and Global Insurance Company (2008)

HH 15-2008 / HC 10633/04

Keywords: payment of premium in instalments / motor vehicle policy

The insured sued its broker and insurer for payment of US$60 000, the sum assured, under a motor vehicle policy it held with the insurer. Before the trial, the insured amended its claim to include a claim for US$100 000, which it alleged was the replacement value of the vehicle.

The policy period was from February 1, 2004 to January 31, 2005, and the insured paid a portion of the premium on February 10, 2004.

The insured vehicle was involved in an accident on March 23, 2004. At the time of the accident, the full premium had not yet been paid. The insured paid the balance of the premium to the broker on April 7, 2004.

The insured alleged that it had agreed to a payment plan with the broker, which allowed it to pay the full premium over the course three months. The policy document did not envisage such a payment arrangement, but the insurer's pleadings indicated that it condoned the payment of the premium in instalments. The fact that the insurer accepted part payment of the premium was also an indication that it had accepted the arrangement. In the court's view, if the insurer was dissatisfied with the arrangement, it should have cancelled the contract. The insurer instead merely warned the broker of the risk to the insured of nonpayment of the full premium. The court accordingly held that the insurer could not rely on the payment of premiums in instalments as the basis on which to reject the claim.

The court found that in the circumstances, the broker had acted both as agent for insured in procuring the insurance, as well as for the insurer in collecting the premium.

As the broker received the balance of the premium from the insured on April 7, 2004, but transmitted the money to the insurer on a later date, the court found that the question of when the balance of the premium was paid to the insurer was a matter between the broker and the insurer. The insurer had granted the broker a credit period of at least 60 days, and the court said that this arrangement should not prejudice the insured.

The sum insured was US$60 000 and the insurer had the option to pay the lesser of either the value of the vehicle specified in the schedule or the reasonable market value at the time of the loss. The insurer also had the option to pay for the loss in cash or to have the vehicle repaired. The insured had claimed an amount of US$100 000, which it alleged was the replacement value of the vehicle.

The insured also argued that the insurer should pay consequential damages due to its breach of the insurance contract. Had payment been made in 2004, the insured would have been indemnified in the amount of US$60 000, but due to the volatile nature of Zimbabwe's economy, US$60 0000 was only a fraction of the actual market or replacement value of the vehicle at the time of the trial. The insured alleged that the insurer's refusal to pay the replacement value was "grossly unreasonable".

The court held that the insurer's rejection of the claim was not grossly unreasonable because the full premium had not yet been paid at the time of the loss. The court also noted that property insurance operates on the principle of indemnity and an insurer's liability was limited to the real and actual value of the loss. This liability cannot exceed the amount insured or the amount of the insurable interest and if it does, the claim must be reduced to correspond with whichever is lower. In a limited value policy, the parties are bound to the value agreed on and barring evidence of fraud or mistake, the value stated in the policy stands.

The court held in favour of the insured in the amount of US$39 600, being the sum insured of US$60 000 less deductions for the salvage value and the excess payable.

Boenor Trading (Pvt) Ltd T/A Swankers Menswear v Total Insurance Company Ltd and Momentum Insurance Brokers (Pvt) Ltd (2007)

Judgment No. HB 29/07

Keywords: payment of premium / condition precedent / credit facility

The applicant, a retailer of men's clothing, approached the second respondent, an insurance broker, to insure his stock. The first respondent, the insurer, issued a policy covering US$60 million worth of risk, in exchange for a premium of roughly US$1 million.

The applicant then informed the broker that the cover was inadequate because of the value of the machines in his factory, and proposed that adequate cover would amount to US$180 million. An endorsement schedule was drawn up, to form part of the original policy. The sum insured was increased to US$180 million (with the sum insured for burglary being US$90 million). The total premium rose from around US$1 million to around US$3.7 million. The document was signed and dated December 3, 2003, but backdated to November 18, 2003. The policy covered the period from October 1, 2003 to September 30, 2004.

The applicant told the broker that the new premium was too high and unaffordable. The broker informed him that he could pay the US$1 million premium first and pay the balance within 60 days. The broker wrote to the applicant on December 8, 2003, noting the increased policy limits, effective from November 18, 2003, and attaching the insurance endorsement to this effect as well as the broker's debit note in the amount of US$3.7 million. The letter stated that "as per agreement, this additional premium is payable within 60 days at no interest".

The applicant believed that a credit facility had been granted as promised and asked the broker whether he could draw a postdated cheque. The broker confirmed that he could, and the applicant wrote a cheque for US$1 million, postdating it to December 10, 2003. The applicant's bank honoured the cheque.

On December 5, 2003, the applicant's factory was burglarised, and machinery and stock were stolen, resulting in a loss of around US$23 million. The applicant reported the burglary and claimed from the insurer. The insurer stated that it would pay US$12.5 million, which would be a payment under the original policy in the amount of US$60 million. The applicant rejected the offer, arguing that the original cover had been increased on December 3, 2003 and backdated to November 18, 2003.

The broker wrote to the applicant in January 2004, indicating that the insurer had not accepted the revised policy and had also refused to accept the US$1 million paid as premium and returned that payment. The broker explained that when the loss occurred, no premium had been paid by the applicant.

The applicant argued that no specific condition required the premium to be paid on any specific date, and that payment of a premium was not a condition precedent to the existence of the contract of insurance. He asserted that should a loss occur before the full premium was paid, the insurer was bound to indemnify him, although he noted that as a precondition to payment, the balance of the premium had to be paid. He confirmed that he was given a credit facility and had paid US$1 million already. The 60 days had not yet expired and he was prepared to pay the balance of the premium or suggested that the insurer deduct the outstanding amount from the payment due to him.

The insurer argued that the principle of "no premium, no cover" applied. The court was however of the view that applying the principle would ignore the agreement on the alleged credit facility.

The court noted that payment of the premium was not a condition precedent to indemnity under the policy. Further, the applicant had alleged that the question of the policy having lapsed due to non-payment of the premium never arose during a number of meetings between himself, the broker and the insurer between December 2003 and January 2004. The applicant added that it would have been nonsensical to appoint an assessor or seek to make an *ex gratia* payment, as the insurer had done, on a lapsed policy. In the applicant's view then, the insurer raised the lapsing of the policy due to non-payment of the premium as an afterthought.

The broker did not file an affidavit disputing the applicant's assertions. The court therefore accepted these assertions as unchallenged and found that the broker had granted the applicant a credit facility. Further, the parties' conduct pointed to the policy being in existence at the time of the break-in, and the court accordingly granted judgment in the applicant's favour.

Tenders

Tel-One (Pvt) Ltd v Capitol Insurance Brokers (Pvt) Ltd (2016)

HH 26-16 / HC 3651/13

Keywords: brokers / tenders

The plaintiff invited insurance brokers to tender to provide it with brokerage services. The defendant's bid won.

The tender required the plaintiff and the successful bidder to conclude a binding contract within 14 days of its bid being accepted. The parties discussed drafts of this contract, but it was never signed.

Meanwhile, the defendant broker approached Zimnat Life Insurance and negotiations commenced. However, the cover did not materialise because the parties could not agree on terms and Zimnat withdrew from taking on the risk. The broker then approached Altfin Life Assurance, who assessed the risk. The plaintiff refused to pay the premium Altfin had calculated, or to accept reduced benefits in line with the premium it was willing to pay. Therefore, no contract of insurance was concluded.

The plaintiff's risk was therefore left unsecured such that it was not indemnified against losses related to the deaths of its staff in the amount of US$458 000. The plaintiff then sued the broker for this amount, which is characterises as "consequential losses" arising from the deaths of staff members.

The broker denied that it was liable and argued that if the matter were to proceed, it should be by way of arbitration. The plaintiff said that, since the contract between the parties had not been signed, the arbitration clause could not be enforced. The court agreed with the broker, but nevertheless discussed the merits of the plaintiff's claim.

The plaintiff argued that a brokerage agreement between the parties did exist as it was contained in the tender documents. The court rejected this argument because the plaintiff had relied on the lack of an agreement when arguing that the arbitration clause could not be enforced. Further, the tender documents themselves envisaged that the parties conclude a separate, signed brokerage agreement.

The plaintiff did not allege that an insurer was willing to cover the risk on its terms. Instead, the plaintiff seemed to suggest that the broker was obliged to find an insurer willing to meet the risk on the plaintiff's terms as outlined in the tender documents and that the failure to do so amounted to a breach of duty, rendering the broker liable to indemnify the plaintiff for the insurance exposure. The court rejected this argument.

The court reiterated that a broker's role is to facilitate the agreement between the insured and insurer. A broker is not the insurer and cannot force an insurer to cover a risk. An insured and insurer must agree on the premium and the risk. The broker in this case did attempt to find coverage for the risk, but the plaintiff was inflexible. The plaintiff refused to agree to the premiums or risk profiles the insurers had proposed.

Ultimately, the court found that the broker had not failed to find a policy. Instead, the plaintiff's refusal to pay a premium commensurate to the risk prevented the parties from concluding an insurance contract. Had a contract been concluded between the plaintiff and the broker, it may have included terms providing recourse to the plaintiff should the broker fail to find an insurer willing to assume the risk. As this was not the case, the court found that the plaintiff's claim did not contain a proper cause of action.

The matter was referred to arbitration due to a technicality.

Registration of insurers and brokers

KMFS Insurance Company of Zimbabwe (Pvt) Ltd v The Insurance Council of Zimbabwe and others (2016)

HH 992-15 / HC 12430/15

Keywords: registration of insurer / suspended licence

The applicant is an insurance company registered in terms of the Insurance Act. The applicant is a member of the first respondent, the Insurance Council, an association of insurance companies. The second respondent is the regulator, the Insurance and Pensions Commission. The third respondent is the Zimbabwe National Road Administration (ZINARA), a corporate body constituted in terms of the Roads Act.

In 2015, the applicant issued insurance cover to its client, Great Rivers Transport, which had been contracted by a church to ferry its members on a trip to Botswana. The church contacted the Insurance Council to confirm the applicant's good standing. The Insurance Council informed the church that the applicant had been deregistered and that the insurance cover issued was invalid. This meant that the insurance certificates would not be validated through ZINARA's new computer system, and the church cancelled its trip and demanded a refund from the applicant.

The applicant then approached the court to compel the respondents to withdraw certain damaging reports, and to compel the Insurance Council and ZINARA to validate its insurance certificates.

ZINARA argued that it was incorrectly joined because it merely acted on advice of the Insurance Council regarding insurance companies that are duly registered and therefore had no interest in the matter. The court agreed and dismissed the claim against ZINARA.

The regulator stated that the applicant had failed to disclose that a standing suspension was in place, which prevented them from writing business. When the suspension was imposed, the applicant had been afforded 30 days to challenge the suspension with the Minister, but had not done so.

The applicant argued that the suspension had expired, but the court rejected this argument and found that the applicant's papers showed flagrant violations of the law. The applicant had clearly written new policies while its license was suspended.

The court chastised the applicant and dismissed its claim.

Tour Operators Business Association of Zimbabwe v Motor Insurance Pool and others (2015)

CCZ 5/15 / CCZ 23/14

Keywords: (un)licenced brokers / motor vehicle insurance / foreign vehicles

The applicant, known as TOBAZ, is an association of registered tour operators that buys and arranges insurance services for tourists, including motor vehicle insurance for foreign vehicles entering Zimbabwe. The first respondent is an association of insurers, the Motor Insurance Pool (MIP). The second and third respondents are the Zimbabwe Revenue Authority (ZIMRA) and the Insurance and Pensions Commission.

TOBAZ alleged that prior to February 2010, they were allowed to arrange temporary insurance cover for tourist motor vehicles. However, MIP and ZIMRA later concluded an agency agreement, with the regulator's tacit approval, allowing only MIP and ZIMRA to issue such cover. TOBAZ alleged that MIP, as an association of insurers, could not issue cover nor authorise ZIMRA to do so as its agent, as neither are registered insurers. Further, TOBAZ argued that the arrangement created a monopoly violating the Competition Act and foreign motorists' ability to contract freely. TOBAZ therefore sought an order declaring the agency agreement between MIP and ZIMRA void and compelling ZIMRA to accept insurance cover obtained from any registered insurer.

MIP submitted that it had an agreement with the Minister of Roads and Road Traffic authorising it and in turn MIP's members to issue temporary policies for foreign motor vehicles. As these policies form a very small part of the total insurance market, the agreement did not offend the Competition Act. Further, members of TOBAZ are not insurers or brokers, and so the agency agreement did not restrict its right to carry on its trade or profession.

The court found that TOBAZ's members' business is confined to the tourism industry. TOBAZ failed to provide any evidence that it represents the interests of the motoring public. TOBAZ's members are also not registered insurers or brokers or licenced insurance agents and have no legal interest in issuing insurance, insurance brokering, or any other form of insurance activity.

The court therefore found that TOBAZ had no legal standing to pursue the matter because "insurance is none of their business".

The court nevertheless considered whether the relief TOBAZ sought was appropriate under the Insurance Act. The respondents alleged that TOBAZ's members had been operating as unregistered insurance brokers, in contravention of the Insurance Act. TOBAZ's own evidence and the very nature of the relief it sought confirmed this allegation. As it is a statutory offence to carry on the business of insurance broking without being registered to do so, the court found that the relief sought was aimed at allowing its members to persist in criminal conduct.

TOBAZ's application was therefore dismissed.

Trust Insurance Broker (Pvt) Ltd v The Minister of Finance and The Commissioner of Insurance (2007)

HB 13/07 / HC 1712/05

Keywords: challenge to regulations / registration of broker

The applicant, an insurance broker, challenged the Minister of Finance's Insurance Amendment Regulations.

In terms of the Insurance Act, the Minister is empowered to make regulations prescribing anything which, under the Insurance Act, is to be prescribed or which, in the Minister's opinion, is necessary or convenient to be prescribed to give effect to its provisions. In the Insurance Amendment Regulations, the Minister laid down minimum equity capital requirements for insurers and brokers. Additional requirements, relating to shareholders and applications for registrations, were included.

To ensure that all insurers and brokers complied with the new requirements, every insurer and broker was required to re-register if it had already been registered, or be deemed not to be registered.

The broker challenged the Minister's powers to make these regulations, in particular the requirement that all entities apply for registration or re-registration. The broker noted that this was not an acceptable reason for an entity to be deregistered.

The court noted that the Minister's aim was to "bring an end to a host of problems bedevilling the insurance industry" and agreed that it is in the public interest to ensure that all players in the insurance industry comply with the regulations that govern them. Section 89 of the Insurance Act gave the Minister very wide powers, and while substantial new requirements were promulgated, every player had to comply with them. It was necessary and convenient for all insurers and brokers to re-register to ensure compliance with these new requirements.

As the Minister acted within his powers, the court dismissed the application.

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