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The Big Read Book series

Volume 2

Avoidance and cancellation of non-life insurance policies

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A Norton Rose Fulbright guide
October 2019

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There are fundamental misunderstandings relating to an insurer's right to avoid or cancel a policy or reject a claim under a policy. This can affect the reputation of the insurer as well as the relationship between an insurer and the insured.

Word usage

"Void"

Refers to a policy that never existed as a lawful contract so that no rights and obligations came into being.

"Voidable"

Refers to a policy that either party may elect on good grounds to declare to be of no effect from its inception or from renewal or variation.

"Cancellation"

Is a term appropriately used for policies cancelled for breach of a material term or in terms of a cancellation clause in the policy.

"Repudiation" and "Rejection"

Are interchangeably used for a claim not paid in full or in part. The decision to avoid, cancel or reject

It need hardly be said that the steps referred to below are very serious steps with potentially far reaching consequences. A bad decision can cause major reputational damage and unnecessary litigation.

In most cases the insurer has to justify taking the step and if the court or ombud can find in favour of the right to an indemnity, it will. An avoidance or a cancellation of a policy or the rejection of a claim should therefore be based on facts that the insurer is able to prove in court. Hearsay evidence or an unsigned statement by the insured, or simply a claim investigator's view is not usually sufficient proof. The question is not only "Are there legal grounds for avoidance/cancellation/rejection?", but, "Do we have evidence to prove the factual grounds for avoidance/cancellation/rejection on those legal grounds?" Because the onus is usually on the insurer, ask the question: "Who will be the witnesses to establish our case on a balance of probabilities?"

The decision to avoid/cancel/reject is so important that it should be discussed with management within the company on every occasion that it is contemplated. No decision should be taken without full consideration of the claims information and the underwriting terms.

If there are co insurers, ensure that where necessary every co insurer agrees to, or has agreed to follow the avoidance/cancellation/rejection decision. The extent to which co insurer's consent is necessary and the extent to which it is bound by the decision of the lead insurer depends on the terms of the policy.

Bear in mind at all times the obligation to treat policyholders fairly, especially the requirement that they do not face unreasonable barriers to submit a claim and are given clear information regarding the process of claims, including the requirements of the insurance standards, regulations and policyholder protection rules.

Void policy

When is a policy void?

A policy is void (i.e. it never gave rise to rights and obligations) if, for instance, the object is illegal (e.g. the insured knowingly insures stolen goods); or if there was no real agreement (consensus) reached (e.g. where the insured and insurer are each contemplating an entirely different risk or insured property); or where the subject matter of the contract does not exist, or is destroyed before the insurance commences. These are just a few of the possible examples.

Policies that are void because of non-compliance with the insurance laws under which they are purportedly written may still be enforced despite non-compliance with the law. This situation is not dealt with here.

Method of declaring contract void

A void agreement gives rise to no contract at all and no formal act is required to declare the "contract" void. The insurer who contends that the policy is void bears the onus of proving that assertion.

The fact that the "contract" is void should be communicated to the insured as soon as possible when all the facts are known.

Save in the case of illegal policies where special rules may apply, the insurer must repay any premium received and the insured must repay any claims paid. The one amount may be set off against the other.

An act by the insurer inconsistent with treating the contract as void after the facts come to its knowledge may prevent the insurer from relying on the policy being void. Therefore the policy must be treated as void without delay so as not to waive your rights.

Letter to inform that policy void

The following is the suggested wording of a letter to advise the insured that the policy is void (adapted to the circumstances):

"We record that by reason of (here briefly and clearly state the reason for the "contract" being void) ABC policy no 123 is void.

In the circumstances, no rights and obligations arose between us and you and repayment of the amount paid to us as premiums will be made in due course.

In the circumstances your claim will not be dealt with and no admissions whatsoever are made in that regard or in regard to your alleged loss.

[Add if a claim has been paid]: We require from you repayment to us within XX days of the sum of R... paid in terms of the claim(s) made by you under the policy under Claim(s) no XYX dated ... less the premiums paid, namely the amount of R[INSERT]]."

Voidable policy

When may an insurer avoid a policy?

The insurer may decide to declare a policy to be of no effect (avoided) from its inception if a material misrepresentation (i.e. giving of false material information) or material non disclosure (i.e. withholding of material information) induced the insurer to enter into or renew the contract. Until the policy is declared void it remains valid and enforceable.

The insurer bears the onus of proving that:

- The insured or someone for whose act the insured is responsible (for example the insured's broker) made the misrepresentation/non-disclosure;
- The misrepresentation/non disclosure related to material facts;
- The misrepresentation/non disclosure actually induced the insurer to enter into the contract or induced it to do so on terms or for a premium it would not otherwise have agreed to.

The test for materiality of the misrepresentation or the non disclosure will be described in the insurance laws. Generally:

- Whether a misrepresented or non-disclosed fact is material is judged objectively from the point of view of the reasonable, prudent person. The fact is material where that person would consider that the particular information should have been disclosed to the insurer so that the insurer could form its own view as to the effect of the information on the assessment of the relevant risk.
- The test is applied in relation to the insurer's decision whether to accept the risk, or on what conditions to accept the insurance, or as to the amount of the premium required.
- Examples of material information include adverse insurance history such as a past cancellation or refusal of cover; bad risk experience; the adverse character of the proposer for instance in relation to insolvency or criminal convictions; a materially incorrect value of the property at risk; pre-existing damage; unusual factors increasing the risks of loss, and many more possible adverse circumstances.
- Materiality is a question of fact in each case. This is a separate subject and is not dealt with in this document. For some examples of how South African courts deal with the issue of material misrepresentation or non-disclosure see Regent Insurance Co Ltd v King's Property Development (Pty) Ltd T/A King's Prop 2015 (3) SA 85 (SCA) (http://www.saflii.org/za/cases/ZASCA/2014/176.pdf); and Jerrier v Outsurance Insurance Co Ltd 2015 (5) SA 433 (KZP) (http://www.saflii.org/za/cases/ZAKZPHC/2015/34.pdf).

The fact that the insured warrants the correctness of the information provided does not in itself render the misrepresentation or non disclosure material.

Method of avoidance

The insurer who elects to declare the policy void:

- Must decide finally and irrevocably to avoid the contract within a reasonable time of the misrepresentation/non disclosure coming to its knowledge;
- Must avoid the policy from the inception date, or from the variation date to which the misrepresentation/non disclosure relates or from the last renewal date, depending on the date of the misrepresentation/non disclosure;

- Must give clear notice of avoidance of the policy to the insured;
- Must repay the premium received for the period after the avoidance date. If it is necessary to repay the premium to the insured this need not necessarily be done simultaneously with the notice of avoidance or of cancellation of the policy, but a tender to refund the premium should be included in the notice. Avoidance or cancellation should not be held back whilst the refund is calculated. Refund should be made within a reasonable time, unless the policy says otherwise;
- May claim repayment (or set off against any premium refund due) of claims previously paid under the policy for events that occurred after the date from which the policy is declared void;
- May claim damages for fraudulent and possibly for negligent misrepresentation (this remedy is very seldom used or appropriate).

Important note

The insurer must give notice of avoidance of the policy within a reasonable time of the misrepresentation/non disclosure coming to the insurer's knowledge. If the insurer does not do so and performs any act inconsistent with its decision to avoid the policy (such as delaying the decision to avoid, accepting further premiums, giving notice of cancellation of the policy, rejecting the claim itself without avoiding the policy, or otherwise acting as if the insurance policy is in force) the right to rely on the nondisclosure/misrepresentation may be lost forever.

The factual grounds may allow for either the avoidance of the policy, or for cancellation of the policy, or for rejection of the claim. In those circumstances great care must be taken in communicating with the insured to make it clear that the policy is avoided and that as an alternative cancellation or rejection of the claim may be asserted if a court decides that there was no basis for avoidance of the policy. Legal advice should be sought when communicating that dual message to the insured.

If a policy is avoided because of a breach of a policy term entitling the insurer, to avoid the policy, the premium need not be refunded.

Letter of avoidance

The following is a suggested wording of a letter of avoidance for adaptation in every case to the particular circumstances. The grounds for avoidance should be clearly stated. It is usually not advisable nor necessary to give details of grounds of avoidance unless some adverse inference can be drawn from a failure to give detailed grounds.

The proposed wording of the avoidance letter adapted to the circumstances is:

"We hereby give you notice of avoidance of the ABC policy number 123 from the date of commencement [variation] [renewal] namely from the Xth of Month 20... by reason of misrepresentation or non disclosure of the following material information, namely [INSERT]: [or give other grounds of avoidance]"

In the circumstances the claim notified will not be dealt with and no admissions whatsoever are made in that regard or in regard to your alleged loss.

Your premiums, less all amounts due by you, will be [have been] refunded [or have been set off against the claims refund due].

[Add if claims have been paid: We demand restitution of all past performance by us after the avoidance date by repayment of R... comprising (here give brief details of past claims paid) payable at our offices within X days of the date of this letter].

We reserve our rights to claim any damages suffered by reason of the misrepresentation/ non disclosure."

If the misrepresentation or non-disclosure goes back to a previous policy period, all policies renewed since the misrepresentation or non-disclosure may have to be avoided. Usually only the latest policy is avoided on the grounds of a misrepresentation or non-disclosure carried forward to renewed or replaced policies.

If more than one policy is avoided it is necessary to reflect all policy numbers of policies being avoided.

Cancellation of policy for breach

When may an insurer cancel a policy for breach?
An insurer may cancel a policy for breach of a term of the policy where the provision breached is so material or essential that the breach entitles the insurer to cancel the contract (sometimes referred to as a "warranty" or if the policy wording entitles the insurer to do so), for instance:

- If it relates to a matter that fundamentally affects the contract (for example, an affirmative warranty that the premises are burglar-barred or the vehicle has a tracking device);
- If the insurer contracted on the basis that a breach of the term in question would entitle it to cancel (for example, a continuing warranty in a fire policy that a complete set of books will be kept and backed up);
- Where the policy expressly stipulates that the term (for example, a duty not to act recklessly) is a material term the breach of which creates a right of cancellation.

In deciding whether there has been a material breach a distinction must be drawn between a general warranty and a specific warranty:

- A general warranty is a warranty in broad terms and requires only substantial compliance (for example, an undertaking to take all reasonable steps to keep a vehicle in an efficient condition requires the insured to take the steps that a reasonable person will regard as sufficient and necessary);
- A specific warranty is a warranty in specific terms and must be strictly complied with (for example, an undertaking that the vehicle will only be driven by a duly licensed driver).

Note that the courts and the ombud will usually require that the breach caused or materially contributed to the loss, for example smooth tyres will not normally be accepted as a reason to reject an otherwise valid vehicle theft claim.

Method of cancellation

The insurer bears the onus of proving the breach and:

- Must decide, within a reasonable time after the breach comes to its knowledge, whether to cancel the policy;
- Must not do anything in the meantime which amounts to a waiver of the right to cancel (for example, accept further premiums, continue to deal with the claim unconditionally, give notice of termination of the policy, or perform other acts demonstrating an intention to regard the policy as in force);
- Must cancel the policy to take effect retrospectively from the moment that the breach occurred (which may in some cases even be the inception date or renewal date);
- Must give clear notice of cancellation to the insured;
- Must repay all premiums collected after the date of cancellation;
- Must pay all claims arising prior to the cancellation date;
- May claim repayment of any claims paid for events that occurred after the retrospective cancellation date.

It is possible to cancel only a portion of a policy which is divisible from the rest (for instance in the case of a divisible multiperil policy where only one section is breached). The letter must make plain what is being cancelled.

A material misrepresentation may, subject to the specific terms of the policy, amount to both a non disclosure inducing the contract and a breach of a material term under the contract at the same time (for example, a false statement that the insured had no prior accidents). In this situation it is common practice to rely upon a breach of contract because the contractual claim is usually easier to prove.

Letter of cancellation

The following is the suggested wording of a letter of cancellation to be adapted in every case to the particular circumstances.

"We hereby give you notice that the ABC policy No 123 [section z of the policy] is cancelled by reason of your breach of a material term (namely...). Cancellation is effective from the date of the breach, namely [INSERT].

In the circumstances your claim will not be dealt with and no admissions whatsoever are made in that regard or in regard to your alleged loss.

Any premiums paid for the period after the date of cancellation, less all amounts due by you, will be refunded in due course or set off against any claims refunds due.

[We demand restitution of past performance by us for claims paid that arose after the date of the breach in the sum of R... comprising (here give details of past claims paid arising after the cancellation date) at our offices within X days of the date of this letter].

We reserve our rights to claim any damages suffered by reason of the breach.”

The policyholder protection rules provide that where a personal lines policy is cancelled for breach (which includes cancellation) by an insurer, the insurer must give the Policy at least 31 days’ notice of the intended termination. The insurer will remain liable under the policy for the shorter of:

- A period of 31 days after the date on which the insurer receives proof that the policyholder has been made aware of the intended termination of the policy; or
- The period until the insurer receives proof that the policyholder has entered into another policy in respect of similar risks to those covered under the policy that the insurer intends to terminate.

Use a means of delivering the notice so you know the delivery date. In the event that the insurer is unable to obtain the proof referred to above, the insurer must be able to prove that:

- A period of 31 days had passed since notification was sent to the last known address of the policyholder; and
- The insurer took all reasonable steps to ensure the contact information of the policyholder is correct and to contact the policyholder.

Under the policyholder protection rules an insurer may terminate immediately (without giving 31 days’ notice) in limited circumstances: non-payment of premium, material changes in the risk covered, or where required by law.

Bear in mind however that, the policyholder protection rules only apply to: (i) personal lines policies, where the policyholder is a natural person and commercial policies where the policyholder is juristic person, whose asset value or annual turnover is less than R2 million (or such other value as may be determined form time to time).

Rejection/Repudiation of claims

When may the insurer reject a claim?

Subject to the terms of the policy, the following are examples of situations when the insurer may reject/ repudiate the claim:

- Where the loss does not fall within the terms of the indemnity provided under the policy (for instance, there is no theft by violent and forcible entry) – the insured bears the onus;
- Where an exception excludes cover (for example, where a building is not covered for damage caused by wear and tear, depreciation or gradual deterioration over time) – the insurer bears the onus;
- Where the insured fails to perform a duty that is a condition of the insurer’s liability (for example, failure to report the loss timeously) - the insured bears the onus of proving compliance;
- Where the insured fails to perform a material obligation which is not a warranty under the contract (for example, failure to comply with the condition requiring the insured not to act recklessly in taking reasonable care of the insured property) – the insurer bears the onus of proving the breach (see as referenced below)

In many reported cases the insurer’s defence has failed because of inexact policy wording or an inability to prove the facts necessary to establish a defence. For instance, the defence often resorted to, namely that the insured “failed to take reasonable precautions against loss” has limited application – the insurer has to establish recklessness on the part of the insured. General conditions such as this should be relied on with care and in clear cases only.

- Where in a claim under a liability policy there is no legal liability to the third party (for instance, a third party’s goods are in the custody of an insured and liability is contractually excluded) – the insured bears the onus of proving legal liability to the third party;
- Where the insured lacks an insurable interest in the property damaged or destroyed, at the time of the loss – the insured bears the onus to prove their insurable interest;
- Where the insured has not claimed or instituted action within the required time period.

Note: The above are only some of the many possible examples.

Policies may contain exceptions which reverse the onus of proof but these must be reasonably imposed.

In many reported cases the insurer’s defence has failed because of inexact policy wording or an inability to prove the facts necessary to establish a defence. For instance, the defence often resorted to, namely that the insured “failed to take reasonable precautions against loss” has limited application – the insurer has to establish recklessness on the part of the insured. General conditions such as this should be relied on with care and in clear cases only.

Method of rejection

A notice rejecting the insured's right to an indemnity must be given to the insured in clear terms.

As the rejection of the claim does not affect the validity of the policy, no repayment of premiums is required.

Letter of claim rejection

In terms of personal lines policyholder protection rules (besides the detailed requirements for claims/ management):

- An insurer must accept, reject or dispute a claim or the quantum of a claim under a policy within a reasonable period after receiving the claim;
- The insurer must notify the policyholder of its decision in writing within 10 days of the decision being taken;
- If the insurer repudiates the claim, the policyholder must be informed in writing and in plain language:
  - Of the reasons for the decision;

Note: The grounds of rejection must be adequately recorded to enable the claimant to dispute the reasons.

  - That the policyholder may within a period of not less than 90 days after receiving the notice of rejection make representations to the insurer in respect of the decision;
  - Of the details of the insurer's internal claims escalation and review process;
  - Of the right to lodge a complaint with the relevant ombud with contact details and time limits;
  - Of any time limitation provisions in the policy for the institution of legal action and the implications of that provision in a manner which the policyholder can easily understand;
  - If the policy does not provide for a time bar period, the policyholder must be informed of the prescription period (usually 3 years from the event) that will apply in terms of the Prescription Act, 1969 and the implications of that limitation, in a manner which the policyholder can easily understand.
- If the claim is repudiated on behalf of an insurer by a person other than the insurer (for example, an intermediary or loss adjuster), then that person rejecting the claim on behalf of the insurer must also record the name and contact details of the insurer and state that any recourse or enquiries must be directed to that insurer;
- If a policyholder makes representations, the insurer must notify the policyholder of its reconsidered decision in writing within 45 days of receiving the representation. If the insurer confirms the rejection of the Claim, despite the policyholder's representations, the notice must:
  - Inform the policyholder of the reasons for the decision;
  - Include a summary of the facts that informed the decision sufficient to enable the insured to challenge them; and
  - Include the information as referenced below.

Of the reasons for the decision;

Note: The grounds of rejection must be adequately recorded to enable the claimant to dispute the reasons.

That the policyholder may within a period of not less than 90 days after receiving the notice of rejection make representations to the insurer in respect of the decision;

Of the details of the insurer's internal claims escalation and review process;

Of the right to lodge a complaint with the relevant ombud with contact details and time limits;

Of any time limitation provisions in the policy for the institution of legal action and the implications of that provision in a manner which the policyholder can easily understand;

If the policy does not provide for a time bar period, the policyholder must be informed of the prescription period (usually 3 years from the event) that will apply in terms of the Prescription Act, 1969 and the implications of that limitation, in a manner which the policyholder can easily understand.

- The 90 day representation period should not be included when calculating any time limitation period for the institution of legal action;
- Any time limitation period must allow for a period of not less than 6 months after the expiry of the 90 day representation period;

- A court may, upon request by the policyholder, condone the policyholder's noncompliance with the time limitation provision for the failure to institute legal proceedings if good cause exists or if the provision is unfair to the policyholder, so consider carefully whether the strict terms should be relied on; and
- Prescription (under the Prescription Act) will be interrupted during the 90 days representation period.

The following rejection wording is suggestion when rejecting a claim under a policy to which the policyholder protection rules apply (subject to adaptation to the particular circumstances):

"We refer to your above claim under the policy number mentioned.

We advise that your claim is rejected for the reason that [give clear, brief details of the facts at hand, for example, the facts which indicate non compliance with a particular condition of the policy; or, if a fraud clause is being relied on, the false information provided in respect of the claim; or the fact that there was no insurable interest of the property lost or damaged at the date of the loss or damage; or the facts that indicate that a claim has not been lodged timeously under the conditions of the policy; or the reasons why the loss is not covered by the policy, etc.].

If you dispute this rejection you are entitled to make representations to us in respect of our decision within a period of 90 days after the date of receipt of this letter. If you decide to take legal action by way of service of a summons (whether or not you make representations regarding the rejection of the claim), you must serve that summons within the time limitation period contained in your policy of [INSERT] for an institution of legal action. The 90 days referred to will not be included in the time limitation period. [State the applicable time-limitation period].

Our policy requires you to institute legal action within X months of the final rejection. If you do not institute legal proceedings within that time you will no longer be entitled to claim the benefit under the policy. If we persist in our rejection or dispute your claim after you have made representations you should consult a lawyer who must approach the relevant ombud or institute the action for you within that time limit to avoid you losing your right to claim.

Should you wish to lodge a complaint with the ombud, you may do so by filling out the appropriate complaint form which may be obtained from the website for the ombud at [insert]; or by contacting the ombud on [insert]; or Fax. [Insert]; or by email at [insert]. The completed complaint form together with supporting documentation can be sent to the ombud by post, fax or email.

No admissions are made in regard to your claim and all our rights are reserved, including the right to rely on any other ground of rejection of the claim at any stage before or after the institution of legal proceedings."

The official receipt of a complaint by an ombud suspends any applicable time-limitation terms, whether in terms of the policy or any law, or the usual running of prescription, from the time that the complaint is officially received until it is withdrawn by the complainant or the ombud delivers a determination.

If the policyholder protection rules do not apply, the following wording is suggested (subject to adaptation to the particular circumstances):

"We refer to your claim under the policy number mentioned.

We advise that your claim is rejected for the reason that [give clear, brief details of the reasons for repudiation at hand, for example, the facts which indicate non compliance with a particular condition of the policy; or, if a fraud clause is being relied on, the false information provided in respect of the claim; or the fact that there was no insurable interest of the property lost or damaged at the date of the loss or damage; or facts that indicate that a claim has not been lodged timeously under the conditions of the policy; or the reasons why the loss is not covered by the policy, etc.]

If you dispute this rejection of your claim you are entitled to approach any relevant ombud or take legal action by way of service of a summons, you must serve that summons within X days [insert the time limitation period contained in policy for an institution of legal action].

No admissions are made in regard to your claim and all rights are reserved, including the right to rely on any other ground of rejection of the claim at any stage before or after the institution of legal proceedings."

Agents and underwriting managers

Where an intermediary or loss adjuster or other agent, acting as the agent of the insurer, rejects the claim, the communication should clearly record that the intermediary acts on behalf of the underwriter. The underwriter should be properly described. In those circumstances, for example, a rejection letter must be written "on behalf of your insurer X".

Terms and conditions of policy are paramount

In every case the specific wording of the policy under which action is taken may override the general principles set out above and the terms and conditions of the policy must be carefully read before any step is taken.

You must refer to the policy to determine whether breach of the particular term, condition or section entitles the insurer to avoid the policy or a section of the policy, cancel the policy or reject a claim.

Some policies specify the method for cancellation in which case the procedure as set out in the policy must be strictly followed, subject to the policyholder protection rules.

If a policy contains a clause which entitles the insurer to reject a claim where there has been a material misrepresentation and/or non-disclosure, the insurer has the right not only to avoid the policy, but to rely on this clause to reject the claim (see below reference). Such a letter must set out the alternative grounds upon which the insurer relies bearing in mind that notice must first be given in respect of the avoidance or, in the alternative, notice of cancellation or breach.

> *The factual grounds may allow for either the avoidance of the policy, or for cancellation of the policy, or for rejection of the claim. In those circumstances great care must be taken in communicating with the insured to make it clear that the policy is avoided and that as an alternative cancellation or rejection of the claim may be asserted if a court decides that there was no basis for avoidance of the policy. Legal advice should be sought when communicating that dual message to the insured.*

The following additional wording is suggested if giving notice in the alternative:

"[Set out notice of avoidance as suggested below]."

> *"We hereby give you notice of avoidance of the ABC policy number 123 from the date of commencement [variation] [renewal] namely from the Xth of Month 20... by reason of misrepresentation or non disclosure of the following material information, namely [INSERT]: [or give other grounds of avoidance]"*
>
> *In the circumstances the claim notified will not be dealt with and no admissions whatsoever are made in that regard or in regard to your alleged loss.*
>
> *Your premiums, less all amounts due by you, will be [have been] refunded [or have been set off against the claims refund due].*
>
> *[Add if claims have been paid: We demand restitution of all past performance by us after the avoidance date by repayment of R... comprising (here give brief details of past claims paid) payable at our offices within X days of the date of this letter].*
>
> *We reserve our rights to claim any damages suffered by reason of the misrepresentation/ non disclosure."*

"Even if the policy were not avoided, your claim would not have been payable for the reason that [set out notice of rejection as suggested below."

> *Any time limitation period must allow for a period of not less than 6 months after the expiry of the 90 day representation period;*

If a policy contains a clause which entitles the insurer to only avoid certain sections of the policy due to a material misrepresentation and/or non-disclosure, the insurer cannot reject the claim but can only avoid the relevant section in accordance with the specific wording of the clause.

Giving of notice

Notice of avoidance or cancellation of a policy or repudiation of a claim should always be in writing. This includes giving notice electronically.

If the policy or policyholder protection rules stipulate the manner in which notices must be given or the address to which notices must be sent or delivered these provisions must be complied with.

The onus is on the insurer to prove if and when the notice was received by the insured or the insured's authorised agent. Thus notice should be given by email or other electronic means, or, if delivered by hand, a receipt should be obtained or other proof of delivery kept on file. The policy should have an address chosen by the insured for notices sent to the insured.

Where a broker is acting for the insured, notice should be given to the broker and the broker should be asked to confirm authority to accept the notice on behalf of the insured and that the notice has been passed on to the insured. In the absence of immediate confirmation, a copy of the notice should be sent to the insured as well.

For the purposes of the policyholder protection rules or if litigation ensues following the avoidance or cancellation of a policy or rejection of a claim, the precise date on which the fact of the avoidance, cancellation or rejection was communicated to the insured and the fact of that communication may be of significance. That is so, for example, where the insurer relies on a contractual time-limitation requiring commencement of litigation by the insured within a specified time following rejection of the claim. Appropriate evidence should accordingly be retained to establish what was communicated to the insured, when and by whom.

When giving any notice to the insured bear in mind the requirements relating to the general format of policies and principles of disclosure in the policyholder protection rules:

- Use plain language so as to promote easy comprehension and to avoid uncertainty or confusion;
- The layout, font and spacing used in the notice should be set out in an easily readable manner;
- Adequate information/reasons should be provided and the information provided should not be misleading;
- The nature and extent of any monetary obligations on the insurer and the policyholder should be clearly set out;
- Ensure that the relevant notice periods are complied with;
- Time limitation provisions and the consequences of non-compliance must be clearly set out;
- The insurer’s and intermediary’s contact details should be used;
- Details of any alternative dispute resolution procedures should be provided; and
- Details of the manner of lodging complaints and particulars of the relevant ombudsman should be provided.

Return of Premium

If it is necessary to repay the premium to the insured this need not necessarily be done simultaneously with the notice of avoidance or notice of cancellation of the policy, but a tender to refund the premium should be included in the notice. Avoidance or cancellation should not be held back whilst the refund is calculated. Refund should be made within a reasonable time.

The amount of the premium that must be refunded may be set off against any amount due by the insured in repayment of claims paid under a void, avoided or retrospectively cancelled policy.

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Revised 2019 by Patrick Bracher

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Reg. No. 1984/003385/21

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