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The Big Read Book series

Volume 1

A collection of South African insurance judgments of 2018

Dear reader

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

This is Volume 1 of the series – A collection of South African insurance judgments of 2018.

You may be surprised by the sparsity of judgments in an industry where there are millions of insurance transactions every year and hundreds of thousands of claims.

There are happily only a few judgments reported showing that an industry that pays out billions each year is seldom involved in major disputes.

Credit is also due to the various alternative dispute resolution mechanisms provided by the insurance industry to their clients, the insured. That includes the internal ombuds system offered by many insurers and resolution by the FAIS Ombud, and the Insurance Ombuds.

For more about avoidance and cancellation of non-life insurance policies see Volume 2 of The big read book series.

An online version of this publication is also 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.

A Norton Rose Fulbright guide
October 2019

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South African insurance cases 2018

B v Hollard Life Insurance

South Gauteng High Court [2018] 4 All SA 77 (GJ) (April 16, 2018)

Policy avoided for non-disclosure of medical and insurance information

Keywords
- life policy
- misrepresentation
- non-disclosure
- avoidance of policy

The surviving spouse of the deceased insured instituted action against the life insurer for payment under a life policy for the amount of R1.16 million. The plaintiff surviving spouse was the beneficiary under the policy.

Avoidance by insurer

The insurer avoided the policy on the basis of the deceased's misrepresentation and non-disclosure at the time of applying for the policy. The deceased failed to disclose that he had a heart ailment, that he had a lung ailment, that he had suffered from depression and that previous applications for life policies had been declined by other insurers.

The insurer affirmed that they would not have offered cover based on the combination of the cardiac failure, chronic obstructive pulmonary disease (COPD) and undiagnosed lung tumour. Doctors' reports confirming these conditions only came to the insurer at claims stage and not at the underwriting stage because this insurer usually requests the deceased's personal doctors' reports if they receive a claim within three years of date of inception of the policy. The insured had signed a declaration at application stage warranting that all information provided in the application was true, correct and complete and agreed that material non-disclosures would result in forfeiture of benefits. The insurer therefore avoided the policy and refunded the premiums.

The insurer argued that the misrepresentation and non-disclosures were material to the assessment of the risk and induced them to enter into the contract, and that the insured had breached his warranty.

Insured reliance on waiver

The defendant insurer did pay out the insured's related funeral policy due to the fact that when that payment was made they did not yet have the medical reports referred to above. This insurer's practice is that if they decide to reject the claim or avoid the policy, the funeral payment is usually considered an ex gratia payment and is not claimed back. The plaintiff tried to argue that the funeral policy was inextricably linked to the life benefit and the fact that it was paid out meant that the insurer elected to be bound by the policy because a forfeiture of benefits would relate to all benefits. However, the evidence was that the funeral cover was paid one hour prior to receipt of the medical reports which ultimately evidenced the non-disclosures and misrepresentations.

Waiver not proved

The court found that waiving repayment of the funeral costs did not affect the avoidance of the main policy and its benefit. The law on waiver is clear that there must be appreciation of the right to avoid and abandonment of that right. The insurer had paid the funeral benefit part of the claim when they had no information entitling them to avoid the policy.

Insured relied on ambiguous application form

The insured's main argument was that the broker had completed the form for the insured (while they went through the form together) and that the broker had incorrectly understood and conveyed the relevant questions to the insured. The plaintiff admitted the non-disclosure of certain facts but argued that the manner in which the questions were phrased was confusing and that the insured acted in good faith in answering the questions. The insurer had the resources to ask for further information in regard to the questions that had been answered that may have raised some red flags and failed to do so.

Form unambiguous

The court found that the application form was clearly worded and unambiguous. For example, the form asked "do you, or have you ever" suffered from any of the conditions listed on the proposal form. The broker testified that when they were completing the form, he asked the insured whether he "currently" suffered from the conditions listed. This was therefore not an unclear form, but a mistake on the part of the broker. Further, if a person employs a broker to obtain insurance, the broker is the agent of the insured and the relationship is governed by the law of agency – the deceased was therefore bound by the statements of the broker.

Warranty breached

It was found that the failure to answer the relevant questions truthfully breached the warranty signed by the deceased and the representations and non-disclosures were likely to have materially affected the assessment of the risk by the defendant under the policy. The defendant was therefore entitled and justified in avoiding the policy. The insurer had repaid the premiums after avoiding the policy, 15 months prior to the institution of legal action by the plaintiff, and there was no evidence led that the repaid premiums were not accepted. Therefore, the plaintiff's claim was dismissed with costs.

Discussion

While the court used the term "rejected the claim", this was in fact a case of avoiding a policy on the basis of misrepresentation and non-disclosure.

Even if the disclosure obligations are framed as warranties, the insurer must prove the materiality of the non-disclosure or misrepresentation in the sense of materially affecting the assessment and must prove they induced the insurer to issue the policy at all or on terms (including premium). That they did (section 59 of LTIA).

Whip Fire Projects (Pty) Ltd v Competition Commission of South Africa and Another

Western Cape High Court [2018] ZAWCHC 28 (February 28, 2018)

Imposed inspection bureau standard may be anticompetitive

Keywords
- insurance
- anticompetitive conduct
- competition law

Search and seizure warrant

The court reconsidered the application of a warrant obtained by the Competition Commission (the Commission) to carry out a search and seizure operation at the premises of the Applicant, Whip Fire Projects (Pty) Ltd without notice to the company being searched.

Alleged anticompetitive behaviour

The Automatic Sprinkler Inspection Bureau (ASIB) which was an organisation formed by a group of short-term insurance companies to conduct inspections of fixed automatic fire installations, test alarm apparatus and issue clearance certificates for installations that complied with its standards, and its members'. The Insurers had engaged in contraventions of the Competition Act, 1998 by requiring a single set of fire prevention standards as a basis for building insurance. Prior to obtaining the warrant to carry out the raid on Whip Fire, the Commission had investigated ASIB and its Gauteng based members for the same conduct. Several of the entities implicated entered into settlement agreements with the Commission. By obtaining the warrant, the Commission sought to obtain evidence of the same alleged conduct in other regions in South Africa.

As a basis for obtaining the warrant, the Commission alleged that ASIB standards are widely recognised and enforced by many insurers as a prerequisite for underwriting building insurance. The requirement by insurers for ASIB certification to be used allegedly led to the redundancy of South African Bureau of Standards (SABS) in this sphere. Only members of ASIB are allowed to conduct inspections and non-registered members are excluded from the market. In essence, "in order for installers to do any meaningful work, capable of being insured in South Africa, such installers must all be members of ASIB, notwithstanding the existence of alternatives."

Challenge of warrant

Whip Fire approached the court for a reconsideration of the warrant on various grounds. These included challenging the chain of custody, the lack of an initiation document by the Commission, the speculative nature of the allegations in support of the application for the warrant, and the nature of the application without any warning.

Whip Fire also alleged that the basis on which the warrant was obtained was incorrect because the Commission sought and received search and seizure warrants for various fire control and protection companies, on the basis of horizontal anticompetitive relationships between those companies. However, Whip Fire alleged that ASIB's rules are imposed on the market by insurers and therefore any alleged anticompetitive behaviour to be investigated was not among the fire control and protection companies (horizontal) but rather related to supply relationships (vertical practices). These practices fall under different sections of the Competition Act. Therefore, it argued that the Commission's case that Whip Fire and other market players are engaged in horizontal restrictive practices is problematic because it is the insurance companies that insist that installers and providers of fire protection equipment be accredited to ASIB.

The Commission argued that its suspicion that Whip Fire, as a member of ASIB, is likely to have documents pertaining to the ASIB Rules and Whip Fire's implementation of those rules was reasonable and therefore Whip Fire's membership of ASIB was sufficient for the Commission to commence an investigation.

Court finding

The court found that this stage of the Commission's inquiry (the initiation of the complaint and search and seizure stage) triggers an investigation and that investigation may reveal whether the relationship between the parties is vertical or horizontal. If necessary, the Commission may then initiate other investigations to incorporate other horizontal or vertical anticompetitive practices and may refer further parties to the Competition Tribunal. Whether the conduct complained of is incorrectly classified as horizontal or vertical anticompetitive conduct does not justify setting aside the search and seizure warrant at the investigation stage. The court noted that "It is always open to the Commission to initiate a further complaint against the insurers at a later stage should it wish to tackle any difficulties at the vertical level as well as the difficulties at the horizontal level."

All the grounds for reconsideration were dismissed by the court and the warrant upheld.

Discussion

This is another case that demonstrates that the Commission has broad discretion to investigate potentially anticompetitive conduct and to use the mechanisms available to it in the Competition Act. The point of a search and seizure operation is to obtain evidence. It cannot be argued that the Commission should be in complete possession of all the relevant facts at the time of seeking to use its powers to obtain evidence to support its investigation.

Although this case relates to the Commission's powers of search and seizure operations, it does illustrate the potential competition issues that could possibly arise as a result of standard-setting or conditions imposed by insurance companies. The Commission is suspicious of industry bodies. Industry bodies need to take care that there are rules and mechanisms in place to protect members from competition law risk – even if all the members are not competitors or potential competitors.

Whip Fire argued that whilst it is true that most insurance companies insist as a condition of insurance that fire-protection systems be installed and maintained by ASIB-accredited installers, some do not, and are satisfied if the installer complies with the standards imposed by the SABS.

Insurers should therefore take care that they do not agree among themselves on exclusive standards or conditions of cover and should also carefully assess whether standards may have an exclusionary or other anticompetitive effect. This needs to be carefully assessed individually by each insurer. This is particularly relevant in light of the recent amendments to the Competition Act. All contraventions of the Competition Act will now carry a penalty for a first time contravention and firms operating in South Africa should also be mindful of the impact of any practices not only on competition but on the ability of small and medium firms and firms owned by historically disadvantaged people to participate in relevant markets.

Naidoo v Discovery Life Limited and others

Supreme Court of Appeal [2018] ZASCA 88 (May 31, 2018)

Life risk policy beneficiary damages

Keywords
- life policy
- beneficiary nomination
- change of beneficiary
- marriage in community of property

Implications of risk policy for in community of property spouses

The case dealt with two questions: Whether a risk-only life insurance policy with a beneficiary nomination clause is an asset of the policyholder during his or her lifetime; and whether the change of a beneficiary by a policyholder married in community of property, constitutes an alienation of that policy as contemplated in section 15(2)(c) of the Matrimonial Property Act. The answer to both questions is "no".

A risk-only life policy allows for payment of benefits only upon the death of the policyholder and proceeds can never be paid to the policyholder or beneficiary during the policyholder's lifetime. The contractual rights of the policyholder to nominate or change beneficiaries, or terminate or cede the policy, continue as long as the policyholder is alive. However there is no corresponding claim that can be made during the policyholder's lifetime and therefore the policy itself is not an asset in the policyholder's estate. Unlike a pension benefit, for example, there is no surrender value or investment portion.

Spouse alleged change in beneficiaries not valid

Mr Naidoo took out such a life insurance policy around 2002 and nominated his wife, Mrs Naidoo, as the beneficiary of the proceeds on his death. They were married in community of property.

In 2011 Mr Naidoo changed the beneficiaries to his parents and siblings, without his wife's knowledge. He died in 2012 and the benefits (around R3million) were paid out by the insurer to the nominated beneficiaries. Mrs Naidoo sued the insurer alleging that the change in beneficiaries was not valid and that she was entitled to the benefits.

Her claim rested on section 15(2) of the Matrimonial Property Act, which says that a spouse in a marriage in community of property cannot alienate any asset (including insurance policies) forming part of the joint estate without the other spouse's consent. The court looked at the purpose of section 15 of the Act, which aims to give both spouses the ability to enter into legal transactions without the consent of the other spouse, except for the limited exceptions of section 15(2), in which a spouse's consent is required in order to alienate assets forming part of the joint estate. The intention of these provisions is to balance the power previously held solely by the husband in a marriage in community of property and to allow wives the ability to contract without consent, except for the limited exceptions. In order to determine whether consent is required for alienating the life policy, the court looked at whether the policy formed part of the assets of joint estate. If it did, consent would have been required.

Are pure risk policies not pure assets?

In deciding whether "insurance policies" mentioned in section 15(2) included pure life policies, the court looked at section 15 as a whole to compare "insurance policies" to the other types of assets listed. The court found that, in the context, it only includes policies "having a current value, such as endowment policies or retirement annuities that can be surrendered or made paid up. Pure risk policies such as life, motor, fire and theft or household goods policies are of a different character." The court also employed a definition of "asset: that relates to something that can be "applied to the payment of debts."

Right to change beneficiaries

The court noted that life insurance beneficiary clauses are widely used in their current form to allow the proceeds to be made immediately available to the beneficiary upon death of the policyholder, without the benefit having to go through the deceased estate. The deceased estate is therefore bypassed. This is a useful and tried-and-tested estate planning mechanism that provides the beneficiary with an often-needed immediate cash flow.

The right to change a beneficiary is a right retained by the policyholder until death – by changing the beneficiary, the husband had not disposed of anything. The court also concluded that the life policy was not an asset in the deceased's estate, and also that it did not form part of the joint estate. The appellant's claim failed.

Discussion

Any attempt to change beneficiaries must always take into account the requirements in the policy. Life insurers usually require that there must be proof that the insurer has received (and sometimes acknowledge) the beneficiary change.

Shuping v Nom & Magg Funeral Services (Pty) Ltd and Another and *Maseng v Nom & Magg Funeral Services (Pty) Ltd* and Another

North West Consumer Affairs Court [2018] ZANWCAC 5 and [2018] ZANWCAC 14 (July 2, 2018)

Keywords

- funeral policy
- unpaid benefits

Funeral policy benefits not paid

A number of plaintiffs launched proceedings against Nom & Magg Funeral Services and Dovelink Funeral Services. The plaintiffs had taken out funeral policies, apparently issued by the funeral parlours themselves, and had been paying premiums since 2014. In 2017, the nominated persons under the policies passed away and claims made in respect of funeral expenses were not paid.

The plaintiffs launched proceedings against the defendants. The defendants did not appear at court and therefore no evidence was presented on their behalf.

When benefits due

The court noted that if it is satisfied that a policy for the insured event existed, that the insured event took place when the policy was active and that all the requirements for lodging a claim have been met, but the insurer has failed, refused or neglected to pay out the claim amount, relief will be granted to the plaintiff.

The court was satisfied that all of the requirements of establishing a claim had been met. Therefore the defendants were liable to pay the amounts claimed under policies as well as the costs that may be incurred by the plaintiff in the process of enforcing the judgment.

Discussion

Funeral policies are a massive industry in South Africa. This multi-billion rand industry provides some of the most popular insurance on the market. It is relatively rare for disputes to arise in the circumstances so these judgments are unusual. This may be in part due to services being provided by the ombud for long-term insurance.

The ombudsman for long-term insurance has written that a characteristic of the market is a large number of insurers, and while there are some who are unscrupulous, it is also "burdensome for the smaller insurers to muster the means to comply with the not inconsiderable regulatory requirements of the Act, including the Policyholder Protection Rules." Another feature is that insureds are often from less affluent parts of society and therefore are particularly vulnerable to deceitful practices by non-insurers.

The growth in the industry lies in the provision of much needed cover for funeral costs which provides a prompt response to claims.

AON South Africa v Gordon and Others

South Gauteng High Court [2018] ZAGPJHC 448 (June 7, 2018)

Wrongful sharing of broker's confidential documents

Keywords

- confidential documents
- broker
- Anton Piller order

Facts

An ex-employee of AON attempted to share confidential documents with his new employer, a competing insurance broker. Most of the case focused on the Anton Piller order (an order allowing the applicant to search and seize or preserve evidence of alleged wrongdoing) sought by AON. In order to succeed AON had to show that the respondent broker and new employer had in their possession documents belonging to AON which were confidential.

Confidential nature of premium and forecast documents

A premium summary spreadsheet was found to be confidential because it showed the workings of percentages for discounts and a table consolidating those workings to propose what a final premium sum could be. It is a working document of interest to an insurance broker such as the ex-employee's new employer. In determining that the document is confidential, the court said that a "working document whose function is to massage the insurers' quoted prices with possibilities to put to a client is indeed confidential. An argument was advanced that the data is in effect accessible to all, but this is simply incorrect."

A forecast document prepared by the ex-employee was also found to be confidential because it was prepared based on data he had from AON's sources. It included a list of all of his clients, and an account of which clients would be going to tender and their prospects. There was also disclosure of historical income (drawn from AON's financial information) and an extrapolation based on the applicant's familiarity with the historical data.

Another email was sought as part of the application, but no evidence could be found that this "plunder" email which supposedly contained a raft of attachments had ever been properly sent or received.

Therefore the Anton Piller seizure order was justified in relation to the forecast document and the premium summary spreadsheet.

Discussion

This judgment is not surprising (except the respondent's denial of confidentiality). There is well established case law protecting confidential information of an employer.

What is confidential is determined by a factual enquiry in the context of each case. Marking a document as "confidential" or suchlike is not necessarily definitive of the question.

An employment contract will often include confidentiality undertakings and appropriate definitions as to what is considered confidential in the context of the employment. That is also not necessarily definitive where it can be established that information and documents not originally contemplated in that contract of employment are nevertheless confidential to the employer.

The fact that the employee generated the documents or information during the course of their employment does not usually destroy its confidentiality.

Altrisk v Barker

South Gauteng High Court [2018] ZAGPJHC 458 (June 15, 2018)

Lapsing for non-payment of premiums

Keywords
- life policy
- payment of premiums
- lapsing of policy

This case illustrates what needs to be considered by both the insurer and the insured in dealing with premium payments and default notices.

Facts

The insured took out a life policy in 2009 and made payments, which were due on the first of every month, via debit order from a business Nedbank account. There was a 30 day grace period for payment of premiums.

The August 2012 debit order was rejected by the bank and not paid. The September payment was then misallocated to a similar policy, being paid for under the same bank account, for another member of the insured's business. When the mistake was realised, the September premium was allocated to the August overdue premium. It was not clear whether the insured had been made aware of these defaults.

The October debit order was also rejected. Therefore premiums due for September and October were unpaid.

The insurer notified the insured on October 24 and he immediately made payment of the overdue amount. The insured then checked his Nedbank business account and assumed that the debit order would proceed correctly. However, on December 3, 2012 the insured decided to switch his debit order to be paid from his FNB account (presumably to make payment from January 2013 because he paid the December premium in cash on December 4, 2012).

The insurer did not present the November debit order for payment to Nedbank and the November premium went unpaid. The insured alleged that he was unaware of the non-payment for November.

On December 20, 2012 the insurer wrote to the insured, notifying him that he was in arrears and that the policy would lapse by January 18, 2013.

It seems that proof of payment for December could not be found. Later, on investigation, it was found that the December payment was misallocated to the other policy that was linked to the insured's Nedbank account. The amount was then refunded by the insurer to the insured's FNB account. The Insured and his broker attempted unsuccessfully to make a payment to rectify the confusion, but as the court noted, the "degree of carelessness which has attended these several actions by, or on behalf of, Barker loom large" and the confusion continued.

The insurer's procedure to notify policyholders only after a default had occurred twice was criticised by the court because the policy would have lapsed by the date of second default. Notice must be given timeously and clearly, to allow the policyholder to rectify the situation.

Notice of default for November was given, albeit belatedly, so the insured was at fault for non-payment in November.

Conduct criticised and findings

However the court found that it was clear that the insured intended to pay the December premium and took steps to do so before the lapsing on January 18, 2013. Even though he was careless in his efforts, incorrectly describing the policy, for example, the insurer's conduct was reproachable too. The policy description used by the insured was related to a policy no longer in existence and therefore there could be no confusion about a sum being due for such a policy. The insurer recognised that the payment was misdirected and then refunded the premium. And even though the insured paid the amount from his FNB account, the insurer refunded the amount to his Nedbank account, which may have masked the fact that the policy had not been credited with his payment. The fact that the insurer chose to pay the amount into a different account also evidenced that the insurer knew the identity of the payer.

Importantly, when a similar mix-up had happened in September, the insurer transferred the sum to the correct policy account. No explanation is offered why that practice was not followed again. The insurer also did not alert the insured to the fact that his efforts to make payment for December had failed. The insurer's conduct created a wrong impression, which was only cleared up by 18 January. By failing to take proper steps to either notify the insured of the failed attempt to pay or by correctly allocating the payment, the insurer was in breach of its contractual obligations to accept payment tendered or to notify correctly of a default. The court noted that "in the particular circumstances when an insurer knows that its debtor policyholder has made an attempt to pay the premium due, and knows that the payment has been misdescribed, it is not permissible to turn a blind eye to the facts and allow the debtor to remain ignorant of what the insurer knows to be the true state of affairs."

As for January's premium, the insurer failed to present the FNB debit order for payment. The court found that there was no justification for doing this especially because the insurer had represented to the insured that the new debit order instruction had been accepted. Had the insurer accepted payment, payment up until December 2012 would have been up to date (because the December payment would have had to be allocated to November, and the January payment allocated to December since one payment was still outstanding). The grace period would have still been running until the end of January.

The insurer's notice that the policy would lapse on January 18 was met with the insured trying to make further payments on January 18 and 21 to bring the policy payments up to date.

Insurer liable for not accepting tendered payment

It was found that if the insurer had complied with its contractual obligation to accept the tender of payment in December and in January, only the sum due for January would have been outstanding, and the grace period of one month calculated from January 1 would still have had to run out. When the payments on January 18 and January 21 were made, the insured would not only have been up to date but would have paid in advance.

Therefore the insurer wrongly regarded the policy as lapsed on January 18, 2013. The court ordered that the policy be reinstated with retrospective effect.

Discussion

The Policyholder Protection Rules now contain specific requirements for the termination (including lapsing, cancellation and non-renewal) of policies.

Ponderosa Pine Trading 31 CC v Santam Limited

Eastern Cape High Court [2018] ZAECGHC 30 (April 26, 2018)

Unlicensed driver exclusion

Keywords

- vehicle insurance
- exclusions
- unlicensed driver
- rejection of claim

The insured carries on business as a wholesaler and distributor of board and timber.

The insured sued the defendant insurer for compensation relating to the plaintiff's modified truck which was damaged beyond economic repair when the driver attempted to avoid a collision with an animal on the road.

The insurer rejected the claim on the basis that the driver was not licenced to drive a truck of this nature, and therefore an exclusion relating to unlicensed drivers applied. The insurer was successful in its defence of the claim.

Facts

The plaintiff owned two ten ton trucks and sought a bigger truck to carry heavier loads (of at least fifteen tons). He discussed various options with a truck retailer and decided that a bigger truck would be too expensive. The plaintiff then suggested modifying a ten ton truck by adding a tag axle onto the rear of the truck to increase its load capacity.

The evidence relating to the Gross Vehicle Mass (GVM) and the weight of the vehicle itself (known as the TARE) was relevant to the matter. The GVM is the maximum weight of the truck plus its load permissible in order for the road use of the truck to remain legal. The GVM and TARE are usually recorded on a data disc or plate affixed to the truck and in the official licensing authority's records. Alterations are also recorded.

The weight that a truck may carry is calculated by deducting the weight of the truck (the TARE) from the GVM. A ten ton truck's GVM is actually fifteen tons, and the truck itself weighs around six tons, making it able to carry around nine tons. Adding the modification via a tag axle to a ten ton truck would have doubled the payload of the vehicle, allowing it to carry in excess of fifteen tons.

The registration papers of the plaintiff's modified truck incorrectly reflected the GVM of the new truck as fifteen tons. The TARE was also wrong because it reflected the weight of the truck before the modification was made. The data plates underneath the truck reflected the correct figures, with a GVM of twenty four tons.

A truck driver may only drive a truck with a particular GVM if they hold a driver's licence which demonstrates that the driver is qualified to drive a truck with that particular GVM. If a truck driver drives a truck with a GVM which exceeds that for which they are licensed, effectively the driver is unlicensed.

The driver employed by the plaintiff to drive the modified truck was the holder of a valid code 10 C1 driver's licence, qualifying him to drive lawfully a truck with a GVM of less than 16000 kg, or sixteen tons.

Policy exclusion

The insurer's policy contained an exclusion for damage that occurred while the vehicle was being driven by someone who, to the insured's knowledge, is not licensed to drive such vehicle. Since the driver was licensed for a truck with a GVM of 16 tons and the modified truck in question had a GVM of 24 tons, the insurer argued that the driver was not licensed to drive the truck.

The insured plaintiff relied on a sub-section of the exclusion which contained a qualification, saying that the exclusion would not apply "if the insured was unaware that the driver was unlicensed and that the insured can prove to the satisfaction of the Company that, in the normal course of his business, procedures are in operation to ensure that only licensed drivers are permitted to drive insured vehicles." He alleged that he only saw the tags of the vehicle, which indicated the true load capacity of the truck, after the collision.

Furthermore, even if the insured was unaware of the unlicensed state of the driver (which the court found he was not), he would also have had to demonstrate that "in the normal course of his business, procedures are in operation to ensure that only licensed drivers are permitted to drive insured vehicles" (the second part of the qualification to the exclusion) which was not shown.

Intention of clause

The court said that the clear intention of the clause is to limit potential exposure of the insurer as much as possible by ensuring that where a driver is unlicensed, this situation has not occurred due to lack of diligence on the part of the insured. Procedures to check the licensing requirement must surely include the physical checking of data tags or plates of the vehicle, the vehicle licence documents and the driver's licence. No evidence was provided to show that such procedures were in place.

Therefore the plaintiff's claim was dismissed.

Discussion

There are good public policy and public safety reasons for ensuring that properly licensed drivers are on the road and that insured risks are properly insured. Unlicensed driver exclusions must be included, drafted and interpreted with this in mind.

Propell Specialised Finance (Pty) Ltd v Attorneys Insurance Indemnity Fund NPC

Supreme Court of Appeal [2018] ZASCA 142 (September 28, 2018)

Attorneys own indemnity insurance not transferable

Keywords
- cession of insurance
- professional indemnity insurance
- attorneys insurance

Facts

Propell, a private company moneylending business, provided bridging finance for clients of Buurman Stemela Lubbe Incorporated (BSL), a law firm. Propell paid the loan amounts into BSL's trust account. BSL undertook to repay Propell from the proceeds of their clients' property transactions. BSL failed to make payment because a partner or employee of BSL misappropriated the proceeds of the property transactions.

BSL was insured under the professional indemnity insurance contract issued by the respondent, the Attorneys Insurance Indemnity Fund. Propell demanded payment and BSL notified the respondent of Propell's claims and sought indemnification under the policy. The Attorneys Insurance Indemnity Fund denied liability on the ground that the loss suffered was excluded in terms of the policy.

Insured attorneys purported to cede policy specific to lawyers

Instead of suing the Attorneys Insurance Indemnity Fund for specific performance, BSL instead purportedly ceded to Propell its indemnification rights against the insurer under the policy. The cession agreement was entered into without the Attorneys Insurance Indemnity Fund's consent. Propell then sued the Attorney's Insurance Indemnity Fund, who countered that the cession was invalid.

The court held that the professional indemnity policy issued by the Attorneys Insurance Indemnity Fund is incapable of cession to a third party. Contracts can be ceded to third parties if there is no agreement between the parties prohibiting cession (hence the common non-cession clause in contracts) but not if the parties have specifically chosen each other as contracting parties because of a specific relationship between them that would not be shared by a third party (known as a *delectus personae*).

The Attorneys Insurance Company is specifically established to insure attorneys and provides an indemnity for their "legal liability to any third party arising out of the conduct of the profession by the insured". The insurer can only insure attorneys.

The policy covers claims for theft by any principal, partner, director, candidate attorney, employees or in-house consultants of an attorney. Therefore a specific group or class of people for whose benefit the insurance is established is defined in the policy.

Every individual practitioner who, on the date of a claim being made, is practising in South Africa is indemnified by the policy automatically. The contract gives no right of indemnity to anyone except a legal practitioner.

Cession not valid

An attorney may not, without the insurer's consent, cede their right to obtain indemnification under the attorneys PI policy to a client who has lost the funds because of the personal, restricted and statutorily regulated nature of the insurer's obligation to its attorney insured.

The purported out-and-out cession would make the client the person making the claim as well as the insured seeking an indemnity under the policy. The client, a victim of the fraudulent conduct, would step into the shoes of the fraudster. That is an untenable situation having regard to the nature of the legal relationship between the attorney's insurer and attorney insured.

In addition, a contract cannot be ceded without the debtor's consent if the cession will impose a greater burden on the other party. In this case the cession would allow an entity which is not a practising attorney to become an insured which would place an entirely different burden on the insurer.

On both grounds, the purported agreement of cession was declared invalid and incapable of giving the appellant legal standing to sue the insurers.

Discussion

It is possible, and commonly done as security, to transfer the rights to the proceeds of a policy to a third party by cession or a loss payee provision on notice to the insurer if the policy does not prohibit it. In that case the cessionary does not become the insured so the above principles are not violated.

SA Taxi Securitisation (Pty) Ltd v National Credit Regulator

National Consumer Tribunal [2018] ZANCT 1 (January 3, 2018)

Keywords
- National Credit Act
- Credit Insurance premiums
- Section 105 of NCA

This matter against SA Taxi was ultimately dismissed on the basis that the claim had prescribed, but the facts are worth noting.

Premium payment under National Credit Act

The National Credit Regulator (NCR) received a complaint against SA Taxi Securitisation (Pty) Ltd (SA Taxi) in 2011 regarding their credit agreements and related insurance. The complainants had entered into credit agreements with SA Taxi to finance the purchase of minibus taxis, with the requirement that the vehicles be insured via SA Taxi. SA Taxi took out insurance and paid the premiums to the insurer annually. However, even though they debited the accounts of the complainants annually, the complainants were liable for payment of premiums on a monthly basis. In exchange for paying the premiums upfront, SA Taxi received a 15 per cent discount/rebate from the insurer.

They did not disclose or pass this discount on to the complainants.

This process of premium payment occurred between October 2007 and October 2010, after which SA Taxi began paying premiums monthly and the discount agreement ceased. The rebate received by SA Taxi during the three year period was around R110 million.

It was alleged that this was a contravention of section 106(5) of the NCA which prohibits a credit provider from adding any surcharge, fee or additional premium above the actual cost of the insurance. The credit provider is further obliged to disclose any fee, commission, remuneration or benefit receivable by the credit provider.

The NCR issued a compliance notice to SA Taxi in October 2013, ordering SA Taxi to refund all the excess amounts charged for insurance to its clients. After objecting to the compliance notice and after further correspondence between the parties, the NCR intended to continue to investigate the matter on receipt of further documents from SA taxi.

The NCR ultimately decided to regard the discount agreement as a contravention of the National Credit Act and issued a further compliance notice, ordering SA Taxi to refund the discount to the complainants and refund the interest amounts charged to the complainants on account of the full credit insurance premiums having been included in the principal debt deferred under their credit agreements.

The alleged contraventions relied on sections 100, 101, 102 and 106 of the NCA and mainly related to unlawfully concluding credit agreements with consumers which required the consumers to pay amounts in excess of the actual cost of credit insurance, or adding a surcharge, fee or premium to the cost of insurance and failing to disclose the true cost of insurance to the complainants. SA Taxi failed to disclose to consumers that the insurance premiums would be payable monthly but debited annually and that the annual premium so debited would be included in the deferred amount under the credit agreement on which interest would accrue.

SA Taxi objected to the compliance notice on three grounds: that the process followed by the NCR was incorrect; that the process contravened principles of administrative law; and that the matter was time-barred. They failed on the first two points but succeeded on prescription, and therefore the matter was ultimately decided in favour of SA Taxi.

Prescription (time-bar)

Section 166 of the National Credit Act does not allow the NCR to refer any complaint to the tribunal which is older than three years. The three years is calculated from the act or omission that is the cause of the complaint or in the case of a course of conduct or continuing practice, the date that the conduct or practice ceased.

The allegedly unlawful actions of SA Taxi ended in October 2010, therefore any action against SA Taxi in regard to that conduct should have commenced by October 2013. The NCR only issued its first compliance notice in November 2013, outside the legislated three year period.

The NCR argued that the conduct was ongoing because the complainants had not been repaid for the overcharged insurance premiums. This was not accepted by the court because the National Credit Act does not make any reference to refunding consumers in section 166. The court said that having to "refund consumers may be a possible consequence of non-compliance but cannot itself be an act or omission constituting non-compliance with the NCA and a basis for arguing that the conduct is continuing. If this were the case no claim could ever prescribe until the responsible party actually admits guilt and refunds the amount owed."

Therefore the claim was unenforceable and the compliance notice against SA Taxi was set aside.

Discussion

The facts were not discussed in detail because the prescription issue disposed of the entire matter.

However, it is interesting to note that SA Taxi objected to the compliance notice mainly on the basis that the agreement between the insurer and SA taxi "is of an entirely separate nature" to the agreement between the insurer and the insured clients. SA taxi also argued that they did not receive the benefit of the discount on the premiums because they had to borrow money in order to pay the premiums annually upfront, and therefore incurred finance charges. It was alleged that the 15 per cent rebate was a reimbursement of these expenses and therefore constituted "premium finance charges" and not a discount. The merits of these submissions were not decided by the court.

Four Wheel Drive Accessory Distributors CC v Rattan NO

Supreme Court of Appeal [2018] ZASCA 124 (September 26, 2018)

Keywords

- risk in courtesy vehicle
- obligation to insure
- public policy

Facts

This case dealt with the question of who bore the risk of damage to a courtesy vehicle damaged when the user was fatally shot by assailants. The car was recovered riddled with bullet holes.

Most of the case involved a discussion on the right to sue (locus standi) but the court did mention, in relation to the contested agreement, that requiring someone to take out insurance on a vehicle is not contrary to public policy. The court said "a requirement obliging a contracting party to obtain insurance, a failure to explain why an owner does not sue, non-disclosure as to whether an insurer paid damages and convoluted business arrangements between entities, are neither indicative of bad faith, nor contrary to public policy."

Discussion

The driver should check that the driver's own comprehensive motor policy covers them when driving another vehicle.

FAIS Ombud determinations and enforcement actions by the registrar of financial services providers

FAIS Ombud determinations

Many insurance related determinations related to brokers who made mistakes with their client's insurance. Brokers are often ordered to compensate their clients for their losses when insurers are not liable for claims as a result of these broker mistakes. Brokers must insure themselves adequately against errors, omissions and professional liability.

The other frequent type of claim dealt with persons who were not registered financial services providers unlawfully selling insurance. These types of claims generally result in the unregistered party having to pay the insured's claim.

We have included some of the relevant rulings, with brief summaries of the outcomes. Here is the link to all of the FAIS ombud's determinations: https://faisombud.co.za/determinations/

Diandra Laura Adams v Thiersen Brokers (Pty) Ltd t/a HCT Konsult, Jacques Carstens and Hendrik Thiersen

Case No FAIS 06649/11-12/ WC 1

The complainant's vehicle, valued around R100 000, was incorrectly insured via the brokers for around R30 000. The brokers were ordered to pay R65 100 to the complainant.

Karen Mandie van der Merwe obo Brother Roadside Assist v Forum SA Trading 325 (Pty) Ltd and Christo Jonker

Case No FAIS 00450/15-16/ MP 3

The complainant had not been advised that her vehicle tracker did not comply with the insurer's minimum security requirements and her insurance claim was therefore rejected. The complaint was against the broker. The broker was ordered to compensate the complainant for the loss in the amount of R355 785.

Kloof Plant Hire CC and Krish Moodliar v CDK Event Solutions t/a CDK Brokers and Naidoo

Case No FAIS 00753/17-18/ KZN 3

The complainant had not been advised of the required vehicle tracker for his insurance. His insurance claim was therefore rejected. The complaint was against the broker. The broker was ordered to compensate the complainant for the loss in the amount of R310 227.

Nxumalo v Central Financial Advisors (Pty) Ltd t/a Coler Financial Services Providers

Case No FAIS 03440/16-17/KZN 3

The complainant's broker did not place the appropriate type of insurance cover for his vehicle (it was insured under a personal lines policy, but the vehicle was used in the insured's courier business, which the insured specifically disclosed to the broker).His insurance claim was rejected. The complaint was against the broker. The broker was ordered to compensate the complainant for the loss in the amount of R144 590.

Wessels v UMC Brokers (Pty) Ltd and Freswick

Case No FAIS 01699/17-18/ LP 3

A wildlife policy was incorrectly cancelled by broker. The broker was ordered to compensate the client's loss in the amount of R456 000.

Unregistered financial services providers

Martha Bitterbos v Miriam Maketlo t/a Jo-Meri Funeral Services

Case No FSOS 00246/15-16/ FS 1

The respondent who sold funeral insurance was not a registered financial services provider, nor was there an insurer. The respondent was ordered to pay the complainant's claim in relation to a funeral policy of R10 000.

David Jackson Mbetse v Pieter de Wet t/a Model Insurance Company

Case No FSOS 00132/13-14/ GP 3

An unregistered insurer sold policies to the public without a licence. They were liable to pay R172 145 under a motor vehicle policy sold to the complainant.

Govender v Pieter de Wet t/a Model Insurance Company

Case No FAIS 01933/13-14/ KZN 3

An unregistered insurer sold policies to the public without a licence. They were liable to pay R97 776 under a motor vehicle policy sold to the complainant.

Maarman v Buys Burial Society and Buys

Case No FSOS 00002/18-19/ NC 2

The respondent who was not a registered financial services provider (and there was no insurer for the insurance sold) was ordered to pay the complainant's claim under a funeral policy of R13 462.

Sidinana v Eyodidi Funeral Undertakers and Chris Stali

Case No FSOS 00129/17-18/ WC 2

The respondent who was not a registered financial services provider (and there was no insurer for the insurance sold) was ordered to pay the complainant's claim under a funeral policy of R3000.

Gert Goeiman v Rekathusa Funeral Parlour and Job Dada

Case No FSOS 00340/14-15/ NW 2

The respondent who was not a registered financial services provider (and there was no insurer for the insurance sold) was ordered to pay the complainant's claim under a funeral policy of R15 000.

Enforcement actions by the Registrar of Financial Services Providers

The two insurance related cases also dealt with lack of licences to sell the relevant product

The Registrar of Financial Services Providers and the Financial Services Board v Aegis Outsourcing (Pty) Ltd

Case No 1/2018

Aegis removed long-term insurance from its licence but continued to sell long-term policies for a year after this removal. This was in contravention of its licence and therefore Aegis was fined R250 000 for the infraction.

The Registrar of Financial Services Providers and the Financial Services Board v Dell Computer (Pty) Ltd

Case No 3/2018

Dell collected insurance premiums for insurance products that covered accidental damage to Dell devices sold to customers. Dell was not an authorised financial services provider and therefore not permitted to collect premiums and sell financial products. A settlement was reached in which Dell agreed to a fine of R 100 000.

Long-term insurance ombudsman final determinations

The ombud for long-term insurance received almost 6000 complaints in 2018. Most of the cases were decided wholly or partially in favour of the insurer. This indicates that perhaps there is a lack of understanding by insureds in relation to their policies and cover. An education drive may help in lessening the number of complaints.

The ombud does not make a determination in all cases. In some matters, the complaint is referred back to the insurer, for the insurer to deal with internally. If the complainant is still not satisfied, the ombud will then deal with the matter.

Seven final determinations and settlements were published on the ombud's website, indicating that most complaints are resolved efficiently, without the need to get to an advanced stage of adjudication within the ombud's office.

The final determinations and settlements, along with a brief summary of their subject matter, are listed below. The full text of the determinations can be accessed here: https://www.ombud.co.za/useful-information/final-determinations.

Case 28 Funeral insurance

Whether a customary law adoption was valid and therefore the insured was entitled to the funeral benefit of a child adopted in terms of customary law. Matter settled, by insurer paying R10 000 ex gratia.

Case 29 Funeral benefit

An increased funeral benefit was claimed, insurer said the benefit was subject to a waiting period but that period was incorrectly recorded on the participation form (the insurer's error). Around half the increased benefit was paid to the insured as compensation.

Case 30 Dread disease claim

The insurer rejected a dread disease claim, arguing that the benefit had been paid under the policy by the previous insurer. This argument was rejected because when they took over the group policy, a new policy incepted. Further, the insured's recurrence of cancer is not the same claim as had been paid under the previous policy. The insurer was ordered to pay the benefit.

Case 31 Poor service in claims handling

The insurer was ordered to pay compensation to complainant for poor claims handling, for terminating the benefit incorrectly and for a delay in reinstating the benefit.

Case 32 Disability – Temporary benefit

A disagreement over the waiting period for payment of disability benefit and whether insured's depression was linked to the injury which triggered the disability benefit was resolved by the insurer being ordered to and agreeing to pay the benefit in response to a preliminary order.

Case 33 Funeral benefit

A dispute over a funeral benefit and whether the beneficiary was entitled to reinstate the policy and fund the payment of premiums resulted in the insurer being ordered to and paying the benefit.

Case 34 Funeral benefit – Definition of wider family member

Invoking its equity jurisdiction, the ombud ordered the insurer to pay a funeral claim to the insured's second cousin, even though "cousins" insured under the policy referred to first cousins only.

Short-term insurance ombudsman case studies

The ombud for short-term insurers does not publish final determinations or rulings. However, the quarterly "ombudsman's briefcase" includes some case studies. The case studies are published for guidance and do not create precedent. We briefly mention some of these case studies below. If you are interested in any particular case study, you can find the ombud's briefcase here: https://www.osti.co.za/news-room/#briefcase

Edition 1

Case study 1

A motor vehicle accident claim was rejected by insurer. The ombud ordered payment of the claim because the insurer failed to discharge the onus of establishing that the insured was under the influence of alcohol (he was below the legal limit and the insurer presented no further circumstantial evidence, which would have been considered, relating to their claim that the insured was under the influence of alcohol).

Case study 2

In a dispute regarding the breakdown of a car, the insured brought the claim within the policy. Therefore the onus was on the insurer to prove that an exclusion applied. The insurer failed to prove that the exclusion (mechanical failure) was the most probable cause of the damage and was therefore ordered to pay the claim.

Edition 2

Case study 1

The ombud upheld an insurer's rejection of a motor vehicle claim. The insured failed to exercise due care after driving over a rock on a gravel road. The warning light was displayed on the dashboard but the insured continued to drive 500m to a garage to assess the damage. According to the insurer, the insured failed to exercise due care and precaution in preventing loss or damage. The insured argued that he had only driven an additional 500m after the warning light went on, but the ombud looked at the vehicle manufacturer's manual which states that the vehicle must be immediately stopped and not driven any further once the oil warning light is displayed.

Case study 2

The difference between a claims made and claims occurring (losses occurring) policy was discussed. With a loss occurring policy, the policy does not have to be in force when claiming, as long as the loss occurred during the subsistence of the policy or period of insurance. If it was a claims made policy, the policy would have had to be in force at the time that the claim was registered.

Edition 3

Case study 1

At the time of an accident, the insured vehicle was driven by the insured's friend. The insurer argued that the driver was driving over the speed limit and therefore the insured did not take all reasonable steps and precautions to prevent accidents or losses. However the ombud looked at the general definition of insured (because it was not defined in this particular policy) and found that the driver was not a party to the policy and was not the insured. The insured owner of the car had suffered the loss. Further, there was no exclusion in the policy, for claims where the vehicle is driven by another party, who is not the insured on the policy. The insurer had therefore not proved that the insured, had failed to take all reasonable steps and precautions to prevent the accident or loss and was ordered to pay the claim.

Case study 2

The insured submitted a claim for fire damage to his home. He contacted his broker on the day after the fire to notify the damage and indicated that he would need to pay his premium manually because he had changed banks and had not set up a stop order for the premium. The insurer's view was that the policy had been cancelled a month prior to the loss for non-payment of two months' premiums. There was no notice of change in bank details by the insured and no indication that the insured intended to pay the premium until after the loss occurred. The ombud agreed with the

insurer that the policy had been cancelled prior to the loss and the insured had no cover.

Case study 3

A settlement had been reached between the insured and insurer relating to a household theft claim. The insured then approached the ombud because he was dissatisfied with the outcome. The ombud confirmed that it will rarely set aside a full and final settlement agreement (it is in the public interest that disputes, once settled, remain so). The insured should have approached the ombud before agreeing to settle. There was no evidence of fraud on the part of the insurer in concluding the settlement agreement. Therefore the settlement agreement stood.

However, the ombud did note that "Many insurers labour under the incorrect impression that where the insured accepts an offer in full and final settlement, it removes any dispute from the jurisdiction of the ombud. Although the ombud may not always be willing to set aside a full and final settlement, [the ombud] can still consider such a dispute and explore the circumstances under which the settlement was reached."

Edition 4

Case study 1

The insurer avoided a motor vehicle policy due to the insured's non-disclosure of previous policies that had been cancelled by previous insurers. The insured argued that the specific car insurance had never been cancelled. However this argument was rejected because the question about previous insurance related to the types of risks for which the insured was applying for cover. The insured should have disclosed the previous cancellations and the matter was decided in favour of the insurer.

Case study 2

An insurer rejected a motor vehicle claim because it alleged that the insured had been under the influence of alcohol while driving. The insured alleged that he had blacked out due to medication that he was taking for a severe sinus infection. The ombud looked at evidence from various witnesses and concluded, on a balance of probabilities, that the insured had been driving under the influence of alcohol and therefore decided in favour of the insurer. The ombud noted that "confusion as to the standard of proof often leads to an insured concluding that it is sufficient to poke holes in the versions of the insurer's witnesses to create doubt or offer other possibilities without presenting an alternative probable version of his/her own". However, the insured's version must be, *on the whole*, more probable than the insurers in order to succeed.

Case study 3

The ombud generally upholds exclusions in cell phone policies stating that the device must be used with the sim card noted on the policy in order for damage to be covered. However, in this case the ombud recommended that the insurer extend cover to the insured based on the ombud's equity jurisdiction, stating that it would be unfair to exclude cover in this case where the insured could show that the sim card belonged to him and the phone was in his possession. Further, the insurer could not show that it had been prejudiced by the use of a different sim card. The insurer abided by the ombud's decision.

Case study 4

An insurer decided to write off a vehicle after it assessed the damage at around R96 000. The insured obtained a quotation for repairs in the amount of R54 000 and proceeded to have the vehicle repaired. The insurer argued that the SAIA Code of Motor Salvage placed a moral duty on insurers to ensure that they safeguard insureds from unscrupulous operators who put unfit and unsafe vehicles back into use. Further, they had the option to pay cash or repair or replace the vehicle. However, the ombud found, on the evidence, that the vehicle was out of its warranty period and therefore it was acceptable for the insured to have it repaired with second hand parts. The insured had also provided sufficient proof that the vehicle repairs were of an acceptable standard. He had also received a guarantee on the repairs. The ombud noted that if the insurer wrote the vehicle off and sold it to a salvage contractor, it would inevitably be repaired and sold again to another consumer. The decision to write off the vehicle was found to be unfair and unreasonable and it was recommended that the insurer indemnify the insured for the cost of the repairs.

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