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The Big Read Book series

Volume 4

Norton Rose Fulbright's collection of South African insurance judgments of 2019

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This is Volume 4 of the Series – A collection of South African insurance judgments of 2019.

The year 2019 saw a limited number of insurance disputes determined by way of litigation. The various alternative dispute resolution mechanisms used by the insurance industry are functioning well and delivering a tremendous service to insured and insurer alike.

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

You can access Volume 1, which covers South African Insurance Judgments of 2018, here.

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Volume 3 is a guide to indemnity and reinstatement value conditions.

A Norton Rose Fulbright guide
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South African insurance cases 2019

Centriq Insurance Company Limited v Oosthuizen & another
(237/2018) [2019] ZASCA 11 (March 14, 2019)

Interpretation of a professional indemnity insurance contract

Keywords
- interpretation of contract
- professional indemnity insurance
- exclusions
- depreciation in value
- negligence
- commercial efficacy

A widow, Mrs Oosthuizen, received over R3million from her deceased husband's life insurance policy. She invested R2million of these proceeds with her trusted broker, who was registered as a financial services provider and broker. He advised her to invest in Sharemax, a property development for a shopping complex. The broker did not advise her that the development was yet to be completed.

The development failed and Sharemax was found to be taking deposits illegally in contravention of the Banks Act.

There was no prospect of recovery from Sharemax, so Mrs Oosthuizen sued the broker for failing to act honestly and fairly in her interests in recommending the investment; failing to provide objective financial advice appropriate to her needs; and failing to exercise the degree of skill, care and diligence expected of an authorised financial services provider.

The broker joined his insurer in the case, claiming that he was entitled to an indemnification under a professional indemnity policy.

The policy was sold specifically to members of the Financial Intermediaries Association. However, it contained the following exclusion:

"[I]n respect of any third party claim arising from or contributed to by depreciation (or failure to appreciate) in value of any investments, including securities, commodities, currencies, options and futures transactions, or as a result of any actual or alleged representation, guarantee or warranty provided by or on behalf of the Insured as to the performance of any such investments. It is agreed however that this Exclusion shall not apply to any loss due solely to negligence on the part of the Insured ... in failing to effect a specific investment transaction in accordance with the specific prior instructions of a client of the Insured."

The broker and the insurer did not dispute that the broker was liable to Mrs Oosthuizen for her loss. But the insurer maintained that their liability was excluded. They alleged that the exclusion was triggered by two distinct provisions. Firstly, the claim arose from depreciation or failure of the investment to appreciate in value. Second, the investment was undertaken pursuant to a representation, guarantee or warranty by the broker as to the performance of the investment.

Background to the investment

The court looked at the factual background leading up to the investments. Mrs Oosthuizen was in a vulnerable position and explicitly informed her broker that she required maximum monthly income with very low risk. She required a "safe" investment. She accepted that even though her investment or returns could not be guaranteed in the short term, her broker would direct his best endeavours to making a safe investment. The broker specifically drew Mrs Oosthuizen's attention to news articles warning about the risks of Sharemax, but he showed her the articles only to assure her that there was no substance to these criticisms. In his words, he explained that "property cannot disappear". He did not tell her that she was not investing directly in fixed property and that the development was not completed, and therefore he created a false impression. In fact, Mrs Oosthuizen would only own a small number of shares in a company that would hold 60 per cent of the company that owned the property. The whole scheme collapsed before the share transfer could even come to fruition. Even if the scheme had worked, investors were required to transfer their money into the investment, and would receive interest on this money, without the underlying investment (the property development) having earned anything, and where it was unlikely to do so for years. Only on completion of the constructing would rental income be realised. The prospectus did not explain this situation accurately and in fact amounted to a Ponzi scheme. On an objective analysis, the scheme was not viable.

The lower court was amazed that the broker could think that the investment would yield lawful returns. The court surmised that the broker himself did not understand the investment. He failed to check whether there was any substance in the media criticisms of the scheme, and he failed to warn Mrs Oosthuizen of the risks to enable her to make an informed decision. He was in breach of his fiduciary duty towards her. This was not denied by the insurer.

Interpreting the policy

The court restated that an insurance contract is a contract like any other and must be construed by having regard to its language, context and purpose in what is a unitary exercise. A commercially sensible meaning in line with the purpose of the contract is to be adopted. The analysis is objective and is aimed at establishing what the parties must be taken to have intended, having regard to the document as a whole and the factual matrix within which they concluded the contract.

Insurance contracts have a risk-transferring purpose. Therefore any clause that limits the obligation to indemnify (that is, any exclusion) is usually interpreted narrowly. The insurer must be clear in the exclusion – any ambiguity will most likely be interpreted in favour of the insured (as long as a commercially sensible result follows). Despite the general tendency to favour the insured in cases of ambiguity, the court noted that "courts are not entitled, simply because the policy appears to drive a hard bargain, to lean to a construction more favourable to an insured than the language of the contract, properly construed, permits."

The depreciation exclusion

The insurer argued that it was not established that the investment was not "hopeless from the onset" or worthless. The fact that Mrs Oosthuizen was paid an amount of R1400 a few days after making the investment was used to support this argument. However, the court noted that the R1400 payment was part of the scheme's attempt to dupe investors into thinking the deal was lucrative. There was no rationale for how this amount was generated or that it represented any intrinsic value of the investment. The evidence, instead, strongly suggested that no reasonable investor would have invested in the scheme. Depreciation relates to diminishing value over time, and not to an investment not capable of generating any value from the beginning. The word "depreciation" therefore cannot apply to any or every reduction in value. The onus was on the insurer to prove that the investment initially had value which then declined or depreciated, in order for the depreciation exclusion to apply. They did not do this and therefore reliance on this exclusion failed.

The warranty and guarantee exclusion

The second exclusion related to the broker's representations to Mrs Oosthuizen about the investment. The insurer argued that the broker represented that the investment would be profitable (that is, he made a representation relating to the performance of the investment). However, the court found that the broker's representations to Mrs Oosthuizen related to the safety of the investment, and not its performance. The insurer accepted that their interpretation meant that the purpose of the exclusion is to exclude any investment advice. The insurer argued that the broker was still covered for his other work apart from investment broking (such as placing long- and short-term insurance and medical aid) and therefore the policy did indemnify the broker for some aspects of negligent advice. However, the court found that the policy was offered mainly to all members of the Financial Intermediaries Association and their main business is to offer financial advice – it would be difficult to accept that these members would buy a policy that excluded all coverage for their investment business. Secondly, if the insurer sought to achieve this type of exclusion, it should have done so with clear language. The insurer bore the onus of bringing itself within this exclusion and failed to do so.

The court held that the broker must be indemnified under the PI policy.

Raubex Construction (Pty) Ltd v Bryte Insurance Company Ltd (337/2018) [2019] ZASCA 14 (March 20, 2019)

Fraud as a defence to payment under a guarantee

Keywords

- guarantee
- construction
- good faith
- error

The insured construction company Raubex had a retention money guarantee with Bryte Insurance Company. The retention money was retained for building work which remained outstanding on the date of the taking-over certificate and for defects and damage which existed after that date. Upon the issue of the completion certificate the main contractor was entitled to require the subcontractor to complete any work which was outstanding on the date stated in the certificate of completion and was entitled to incur the cost of completing the work itself if the work was not done.

When the subcontractor failed to complete the work properly, and failed or refused to perform remedial work, Raubex called on the retention guarantee in the amount of around R1,4million. The insurer refused to pay because it alleged that the demand for payment in terms of the guarantee did not comply with the provisions of the guarantee because it contained fraudulent misrepresentations. The insurer alleged that, to Raubex's knowledge, the subcontractor was not in breach of its contract and therefore no money was due and payable. The insurer also alleged that even if the subcontractor had breached its contract, the cost to remedy the breach could not amount to the sum claimed. This alleged fraud by Raubex was the crux of the dispute.

Raubex and the subcontractor had a dispute with regard to the quality of the work. The insurer relied on the allegations of the subcontractor that the work had been adequately completed, but his mere say-so was insufficient to prove fraud on the part of Raubex. The guarantee was unconditional and was intended to be a separate contract, and not an accessory obligation. It would not be affected or diminished by any disputes between Raubex and the subcontractor. The only condition was compliance with the demand provisions. If Raubex complied with the terms of the guarantee, the insurer could not escape liability unless fraud was proved. The party alleging fraud has the onus to prove it. The assertion that the amount demanded was inflated and fraudulent was also inadequate to prove fraud, because it was a bald assertion, not backed up by any facts. In reply, Raubex provided a detailed explanation of its estimation of costs to demonstrate how it had arrived at its estimation in good faith.

A mere error, misunderstanding or oversight, however unreasonable, does not amount to fraud and is insufficient to show that the contentions of the beneficiary are deliberately incorrect. The guarantor has to go further and show that Raubex advanced the contentions in bad faith knowing them to be incorrect. Factual allegations have to be proved that lead to a conclusion of fraud.

The loss was therefore found to be the amount guaranteed (though without a detailed analysis of the evidence) and the insurer was ordered to pay that sum in terms of the guarantee.

Discussion

The court suggested that "fraud is not easily inferred" implying that there is some additional onus to establish fraud. This is not good law. All civil disputes are decided on the balance of probabilities.

Parktown High School for Girls v Hishaam & another (93/2018) [2019] ZASCA 10 (March 14, 2019)

Public liability of a school

Keywords

- limitation of liability
- public liability insurance
- school liability

A member of the public was injured while attending a fashion show at a school. He sued the school for damages.

The South African Schools Act governs the liability of public schools. Generally, the State will be liable when a public school is sued (via the principle of vicarious liability).

The aspect relevant to insurers is that legislation also says that "where a public school has taken out insurance and the school activity is an eventuality covered by the insurance policy, the liability of the State is limited to the extent that the damage or loss has not been compensated in terms of the policy."

The school did have public liability insurance. The school claimed an indemnity from its insurance broker (not the insurer, because the broker had allegedly failed to timeously notify the claim to the insurer, which resulted in the insurer justifiably rejecting the claim).

The court did not have to determine whether the broker was liable because the insurer rejected the school's claim and therefore the school had not been compensated in terms of the policy – this meant that the State's liability was not limited by the insurance policy. If the school was held liable, the State was the party who had to pay the claim. If the school's insurers had compensated the injured party, the state's liability may have been decreased, depending on the circumstances of the insurance payout.

Discussion

Insurers of public schools should be alert to the effects of section 60(1)(b) of the South African Schools Act.

Octofin (Pty) Ltd v Hugenote College (17084/2010) [2019] ZAWCHC 162 (June 27, 2019)

Broker liability for under-insurance

Keywords
- under-insurance
- broker liability

Hugenote College sued its broker for breach of contractual obligations due to under-insurance of one of the College's insured buildings. The trial court awarded the College the full extent of its alleged loss, around R17 million. However, the appeal court reversed this finding and awarded a lesser amount of around R380 000.

The College alleged that the broker undertook to renew comprehensive cover for its buildings, that the broker could and would recommend replacement building cost values and value the buildings and that the difference between the replacement cost and the value of the buildings would be minimal (so that under-insurance would not be an issue). They alleged that the broker was able to give recommendation on the valuation (upon which the College could rely) due to their experience, expertise and research.

However, the facts showed that the College knew that they were under-insured and chose not to increase their premiums to match the true value of the buildings. When the policy was taken out in 2003, the College did not insure the buildings at the replacement cost values recommended by the broker due to "budget constraints. The College alleged that on renewal in 2006, they requested insurance at the full replacement value cost. This allegation was not supported by the documents: the renewal summary presented to the College by the broker in 2007 included a warning of the danger of under-insurance, which included an example, it also showed that an amount of between R5200 and R6400 per metre squared was the replacement value for the building. The College's building was insured at R4200 per metre squared, between 20 to 45% less than it should have been. The court found that the summary clearly reflected that the building was significantly under-insured. A copy of the agenda of a meeting between the parties in August 2007 also showed that the replacement value was not representative of the true replacement value. The agreement was that the values would be adjusted over time until they were sufficient. These undisputed facts were irreconcilable with the College's allegations that had they been informed of the actual replacement values, they would have insured the building at the correct value.

The College's main claimed therefore failed.

The broker was held liable for around R390 000 in relation to the College's alternative claim, which was that the broker had incorrectly entered the amount of R4200m2 instead of R4500m2. The shortfall for this error was around R390 000, which the broker was ordered to pay.

In summary, the broker was not liable for the loss due to under-insurance (the loss of R17 million), firstly because the College knew they were under-insured and secondly because it was unlikely they would have insured the buildings at the actual replacement value because that would have involved an increase of more than 300 per cent in premiums.

National Credit Regulator v Mortgage Secured Finance (Pty) Ltd and Others (NCT 84832/2017/140(1)) [2019] ZANCT 41 (April 5, 2019)

Disclosures relating to credit insurance

Keywords
- credit insurance
- reckless credit
- disclosure of fees

This case related to whether a credit provider had contravened the National Credit Act (NCA) by providing reckless credit. The credit provider provided loan consolidation services, secured by the consumers' immovable property.

Various types of credit insurance was provided and charged for as part of the fees included under the credit agreement. This included an income protection fee for the possibility of the consumer being retrenched, home insurance over the secured property, and credit life insurance for the possibility of the consumer's death before repayment.

Section 106 of the NCA requires a credit provider to disclose the cost, fees and commission relating to credit insurance arranged for the consumer. The terms of the policy must be explained and a copy of the policy must be given to the consumer.

The evidence showed that the credit provider did provide credit life, income protection and home owner insurance but did not provide policy documents or other information disclosing the cost of insurance. The credit provider did not dispute that the consumers had been provided with the insurance but argued that it was not the insurer and therefore could not explain the terms and conditions of the policy to consumers, and that it is not for the credit provider to provide copies of the policy to consumers.

The court stated that this argument does not help the credit provider in any way and therefore found them to have contravened section 106 of the NCA for failing to provide policy documents and information relating to costs, fees and commission of the insurance. The credit agreement was set aside as reckless and the credit provider was ordered to repay to consumers all fees or charges to which it was not entitled (to be determined by an independent auditor). This would include fees relating to credit insurance.

Wentzel v Discovery Life Limited and Others (30934/2018) 2019 (6) SA 472 (GP) (May 6, 2019)

Payment of a life policy to an insolvent estate

Keywords

- life insurance
- insolvent
- joint estate
- beneficiaries' right to claim

The insured took out an insurance policy on the life of his wife in 2007. They were married in community of property. He was the beneficiary under the policy. The joint estate of the insured and his late wife was sequestrated in 2012 and trustees were appointed to manage the insolvent estate. The Liquidation and Distribution (L&D) Account was finalised in 2014.

The applicant's wife died in 2017 and he claimed payment of the policy's proceeds, amounting to around R5,2 million. The insurer responded that the proceeds would be paid to the trustees of the insolvent estate and the insured objected to this. The insurer chose to abide by the order of the court, so the dispute was argued between the insured and the trustees.

The insured alleged that because the L&D Account had been confirmed, the administration of the insolvent estate had been finalised.

The trustees countered that there were three claims lodged and proved by creditors, as reflected in the L&D Account. After realisation of the assets in the estate, there was still a shortfall of around R3,4 million. The insured had never successfully applied for rehabilitation and therefore the estate remained vested with the trustees.

The insured then alleged that the joint estate was dissolved by the death of his wife and therefore the estate to which the trustees were appointed had also dissolved by mere operation of the law (that is, he did not have to apply for rehabilitation).

The court noted that for an insurance policy, "where a beneficiary has been appointed the insurance policy would be paid to such beneficiary and where none is appointed the proceeds would be paid into the estate."

While the joint estate is dissolved by death, the status of the applicant and his late wife (as insolvent) was not changed by her death, until they are released from insolvency by rehabilitation. The surviving spouse or the deceased estate may both acquire assets after sequestration – in terms of insolvency law, any assets acquired after the trustees are vested with the estate must be handed over to the trustees, apart from some exclusions.

If the trustees are not able to pay the creditors in full, any assets acquired while the estate is still under sequestration may be realised and distributed by the trustees, and this is applicable also to a deceased estate. The filing of the first and final L&D account does not necessarily mean that the trustees have completed their duties in administering the estate. The trustees are not barred from filing further accounts with regard to assets acquired later.

The court distinguished this case from the case of *Pieterse v Shrosbree N.O. and Others, Shrosbree N.O. Love and Others* 2005 (1) SA 309 (SCA). In the *Pieterse* case, the estate only became insolvent after death. The Pieterse case was helpful to the court though, in confirming the nature of a life insurance policy as a contract for the benefit of a third party (stipulatio alteri). The court held, according to the rules of stipulation alteri, that only the appointed beneficiary of the policy may demand and accept or refuse payment of the benefit, and the trustee therefore cannot directly demand payment from the insurer. Nevertheless, when the benefit is paid by the insurer to the insured/beneficiary (and the insurer is obliged to pay the beneficiary), the proceeds represent an asset in the hands of the insured which is not protected or exempted from the reach of the law of insolvency. Therefore, the proceeds must be paid by the insured to the trustees of the insolvent estate (or the trustees have a right to claim the proceeds from the insured) because this asset was acquired before rehabilitation of the estate.

The insured was not incapacitated from contracting (due to his insolvent status) and could claim and accept the benefit from the insurer. He was however obliged to pay the proceeds to the trustees to be administered for the benefit of the creditors. The trustees' claim does not arise from the stipulatio alteri contract but from the insolvency.

Discussion

Neither party gained anything from this litigation. Although the insolvent beneficiary had to be paid by the insurer, the money received had to be handed to the trustees.

Magic Eye Trading 77 CC v Santam Limited (775/2018) [2019] ZASCA 188 (December 10, 2019)

Contingent right to an indemnity

Keywords

- contingent rights
- liability insurance
- prescription

The insured had been sued by a third party for damage to his vehicle allegedly as a result of the negligent conduct of the insured's employee. The vehicle accident happened around April 2011. The insured joined the insurer to the proceedings as a third party in 2016, based on their insurance policy which included indemnity insurance against loss suffered by the insured by way of liability to third parties. The insurer alleged that the claim for indemnity had prescribed, alleging that upon the occurrence of the defined event (the vehicle accident), or when the insured and its employee became aware of the event, or when the insurer rejected the claim, the right to indemnity against the contingent future monetary consequences of the accident (a third party loss payable) became vested in the insured. And because the insured hadn't instituted proceedings within three years of any of those events the claim had allegedly prescribed.

The court stressed the distinction between a claim and a contingent claim. An insured is only entitled to indemnity against loss or damage when they become legally liable to a third party. An insured can only become legally liable to pay once that sum due by them to the third party is fixed by a court or by agreement. Until then no claim for indemnification can arise.

A claim for indemnification under a liability insurance contract only arises when liability to a third party for a certain amount has been established. For purposes of prescription, the debt becomes due when the insured is under legal liability to pay a fixed and determined sum of money to the third party. Until then a "claim" for indemnification under the policy doesn't exist and cannot prescribe.

The corollary also applies. If a rejection of liability by the insurer requires the insured to institute action within a certain period after the rejection, that condition doesn't permit the general rejection of future liability claims at a stage when a precise claim in a fixed amount is not and cannot be made by the insured.

In the circumstances the insurer could not rely on the statutory prescription period, nor any time bar provisions in the policy. The insured's liability to the third party had not yet been established (it was still to be determined by the court) and therefore prescription in relation to the liability insurance had not even begun to run yet.

Discussion

The position is different where first party insurance is concerned. In the normal course of events, whether it be a life or non-life insurance policy, the debt owed by the insurer becomes due as soon as the event insured against has taken place. In the case of life insurance for example the debt is due on the death of the life insured. Prescription (or a time-bar after rejection) commences to run against the beneficiary if at that stage the existence of the policy, the identity of the insurer, their nomination as beneficiary and the death of the deceased are known to the beneficiary. Subject to the Policyholder Protection Rules, the beneficiary doesn't have to wait for the insurer's decision whether to pay or not and any delay by the insurer in making a decision doesn't delay the commencement of prescription. See for example *Danielz NO v De Wet and Van der Westhuizen v Hollard Life*. The same principle applies where for example the insured claims for theft of a motor vehicle or damage or destruction of the insured property by fire. Prescription and time-bar provisions start running when the loss event occurs.

Prescription can be interrupted by service on the insurer of a summons or by an express or tacit acknowledgement of liability on the part of the insurer.

Also bear in mind that in terms of the Ombud Rules and the Policyholder Protection Rules the running of prescription or time bar provisions will be interrupted or suspended in certain circumstances.

The principles of this case are not new but the judgment contains a useful review and discussion of the law.

Salligram and Others v Salligram and Others (AR 292/2018, 13560/2014) [2019] ZAKZPHC 63 (September 20, 2019)

Rights attaching to an insurance policy are debts capable of becoming prescribed

Keywords

- life policy
- cession
- incorporeal rights
- debt
- prescription

This was an application to amend particulars of claim, but one aspect of the claim is relevant to insurance law.

The appellant and respondent entered into an agreement in which it was agreed that a particular life policy would be ceded to the respondent, who would hold it in trust for the family trust (the nominated beneficiary), and return the benefits under the policy to the family trust when called upon to do so. The respondent would pay the premiums.

The court had to decide whether the appellant's claim for re-cession of the policy constitutes a debt for the purposes of the Prescription Act 1969.

It was argued that even though the word "debt" is not defined in the Prescription Act, based on case law it has to be interpreted to mean "...that which is owed or due, anything (as money, goods or services) which one person is under an obligation to pay or render to another." The appellant argued that the transfer of incorporeal rights attaching to an insurance policy does not amount to "money, goods or services" and therefore the claim was not a "debt" under the Prescription Act. However, the court did not accept this argument (based on the judgment of *eThekwini Municipality v Mounthaven (Pty) Ltd* 2018 (1) SA 384 (SCA)) which held that a contractual claim for the retransfer of land is a "debt" under the Prescription Act). Therefore the court held that this type of claim is a debt capable of becoming prescribed.

Discussion

These facts should not be confused with the *Magic Eye Trading* judgment (discussed above) dealing with prescription of a right to claim under a professional indemnity policy for third party liability. This case dealt with the narrow question of interpretation of the word "debt" under the Prescription Act.

De Bruyn & De Kock Inc and Another v Theunissen (68433/2016) [2019] ZAGPPHC 467 (September 13, 2019)

Proper instruction to insurer to defend a claim

Keywords

- prescription
- rescission of judgment
- request to insurer to defend claim

An attorney was sued by his client for failing to lodge a claim with the Road Accident Fund (RAF) timeously. The client's claim prescribed and he was therefore unable to claim from the RAF. Default judgment was taken against the attorney when he failed to defend the matter. The attorney sought to rescind the default judgment.

In order to get a rescission of default judgment, the following factors must be proved: there is a reasonable explanation for the default in defending the matter; the application for rescission must be made in good faith and not with the intention of merely delaying the plaintiff's claim; and the defendant has a bona fide defence to the claim.

The attorney alleged that he had a genuine believed that the Attorneys Indemnity Insurance Fund (AIIF) would defend the matter on his behalf. To support this belief, he claimed that he forwarded the Notice of Bar to the AIIF when he received it. He also said that he forwarded the plaintiff's file to the AIIF on 12 December 2016. He alleges that he only became aware of the judgment when he was served with a notice to tax the bill of costs against him on April 19, 2018.

The attorney laid blame on the AIIF for failing to file a plea of for failing to instruct the defendant to file the plea.

This explanation was not accepted by the court. The defendant was unable to provide any evidence such as correspondence to show that he had communicated with the AIIF at the earliest reasonable opportunity when he became aware of the possible claim. The first letter of demand was served on him In October 2015. The final demand was served in May 2016. But the only proof of correspondence with the AIIF is from December 2016, more than a year after he first became aware of the potential claim. It was unreasonable to assume that the AIIF would defend the claim on his behalf, especially because he could also not provide evidence that the AIIF acknowledged receipt and confirmed their handling of the case. This explanation was therefore found to be wholly unsatisfactory and the claim for rescission failed.

Discussion

The insurer's obligation to defend the claim is not automatic. The insurer must elect to do so unless the policy states differently.

Direct Channel Holdings (Pty) Limited and Another v Shaik Investment Holdings (Pty) Limited and Others (9062/18) [2019] ZAGPJHC 232 (July 24, 2019)

Keywords

- Anton Piller order
- insurance call centres
- access to documents
- confidential information

The applicant successfully applied for an Anton Piller order (for search and seizure of documents) against the respondents. It was alleged that the respondents stole several of the applicant's servers which contained confidential information, and used that information unlawfully to compete with the applicant. This case was about whether the Anton Piller order was correctly ordered and executed.

The applicant (DCH) is a call centre working in the insurance industry. DCH sold insurance products to prospective customers over the telephone for insurers, and provided leads to insurers. DCH did not deal with incoming telephone calls from prospective clients and did not sell insurance policies by means of face-to-face marketing.

The respondent Direct Rewards contracts with suppliers to obtain discounts on products and services from those suppliers. Members are recruited via cold calling and direct face-to-face canvassing. Some of the suppliers that Direct Rewards contacted were also clients of DCH. DCH provided some of these cold calling marketing services to Direct Rewards until February 2017. DCH and Direct Rewards shared some servers and software related to some aspects of the business such as payroll and some other financial information. Direct Rewards argued that it does not compete with DCH. Based on Direct Reward's business model, the court concluded that Direct Rewards does not compete with DCH.

The respondent, Affordable Benefits, provides field marketing services to one insurer, in the form of pop-up kiosks and face-to-face selling (cold canvassing of potential customers). Affordable Benefits' operations are housed within the offices of the insurer for which it provides marketing services. The court also accepted that Affordable Benefits does not compete with DCH.

The final relevant respondent, Activation Agency, sets up and operates branch offices for one insurer throughout South Africa. It provides customer services to the insureds and concludes long-term policies with insureds on behalf of the insurer. It stores some of its payroll information and financial information on DCH's servers and shared various IT systems with DCH. The court also accepted that this respondent does not complete with DCH. All of these respondents have a common shareholder, Mr Shaik, also a respondent. Mr Shaik was a shareholder of DCH before he sold his interest in DCH to the second applicant. He remained as CEO of DCH, with a restraint of trade in place, prohibiting him from competing with the applicants. Mr Shaik's shareholding and interests in the other respondents were specifically carved out of the restraint.

The relationship between Mr Shaik and DCH soured. Mr Shaik ordered copies of the information on the servers relating to the various respondents' business to be made and transferred to other offices. This led to the applicants applying for an Anton Piller order. However, the court found in this case that the Anton Piller order was not properly granted or executed. Based on the nature of the relationships, none of the respondents were competing with the applicants. The information they took was not confidential, since the servers had already been operating as shared servers. The Anton Piller order was set aside.

Discussion

While the judgment does not deal with an insurance principle it will be of interest to those in the insurance industry dealing with call centres.

Chard v Old Mutual Insure Limited (A66/2017) [2019] ZAKZDHC 23 (September 30, 2019)

Privilege for expert reports

Keywords

- privilege
- expert report
- contemplation of litigation

This dispute relates to the insured Mr Chard's insured vessel which partially sank in the Durban Marina. Sinking was an insured peril covered by the policy. The engines of the vessel were partially submerged in salt water. The parties disputed whether the vessel was a total loss or whether the reasonable cost of repair or market value should be paid. Mr Chard alleged that the insurer's assessor and technician negligently caused the damaged engine to be started and operated without following proper procedure for doing so after the engines had been damaged by salt water immersion, causing a total loss.

Various experts were appointed by the parties to investigate the cause of the sinking. The court had to decide first whether the Mr Chard was entitled to access to the full expert reports from the insurer. The insurer claimed its expert reports were legally privileged and therefore they did not have to hand them over. In the circumstances, the court found that privilege did not attach to these reports and ordered them to be made available to the insured.

Loss Adjusters' reports are only privileged where the reports are prepared in contemplation of litigation and for the purpose of seeking legal advice. But it is not every insurance claim where litigation is likely or reasonably anticipated at investigation stage.

The sole or dominant purpose of the creation of the report need not be for the purposes of the pending or contemplated proceedings. It is sufficient if that is one of the purposes. The intention of the party (for example the insurer) requesting the document is decisive and not the intention of the party (the loss adjuster) creating the document. It is sufficient if there is duality of purpose, for example if the report is intended to be used both to ascertain the cause of the insured event and to quantify the loss, as well as to obtain legal advice regarding the pending or contemplated litigation.

The privilege claim fails if at the time of requesting the report, there was (or objectively was) no pending or contemplated litigation. It doesn't matter that litigation arose or was contemplated after the report was requested.

On the evidence, at the outset of the claim when the reports were requested, the insurer's approach was a willingness to co-operate in trying to resolve the claim. The communications and negotiations at the time were not done with the purpose of litigation in mind but to obtain the best deal possible. Timing is important in evidencing contemplation of litigation. The pleadings, said the court, never really addressed the matter of when and why litigation was contemplated nor what areas of advice were sought for comment on by the legal advisors.

Discussion

Privilege over documents created by any loss adjuster or any expert report is easily established, by the insurer instructing their attorneys to consider coverage, who will in turn instruct the loss adjusters and experts, provided litigation is reasonably anticipated.

Watson and Another v Renasa Insurance Company Limited
2019 (3) SA 593 (WCC) (February 14, 2019)

Reinstatement value clause

Keywords

- reinstatement value
- replacement value
- interpretation
- ability to reinstate
- intention to reinstate

The insured, Mr Watson, instituted a claim in 2011 for payment under a policy relating to his business machinery, which was damaged by a fire. The insurer initially rejected the claim because they suspected that the claim was fraudulent (alleging that Mr Watson was responsible for the fire). That matter was determined by the Supreme Court of Appeal and on the facts the court found that Mr Watson was not responsible for the fire, and held that the insurer must pay the claim.

The insurer then refused to negotiate and settle the quantum of the claim, despite the order of the SCA requiring them to pay the claim (and they did not make any interim payments). The insured therefore had to approach the High Court to determine quantum.

The plaintiff claimed as damages the cost of replacing or reinstating the machinery under the reinstatement provisions of the policy, as read with the alternative replacement conditions. The claim was quantified at the date of the loss (in 2011) at around R17,9 million. The alternative claim was for around R32 million, which was the valuation at May 31, 2017 (the more recent date agreed by the parties' experts)

The replacement value clause provided that: the work of replacement or reinstatement must be commenced reasonably quickly otherwise no payment beyond the indemnity payment would be paid; the insurer would not pay replacement or reinstatement costs exceeding the maximum sum insured; the replacement value clause would be without force and effect if the plaintiff failed to intimate to the defendant within six months of the damage of his intention to replace or reinstate the property; the clause would also be without force and effect if the plaintiff is unable or unwilling to replace or reinstate the property.

The court noted that this type of clause may give rise to difficulties for an insured who is not in the financial position to reinstate the property themselves – the insured would be required to evidence a sincere intention to replace or reinstate the property, and would also be required to actually do so, without any firm commitment from the insurer that it accepts liability for the costs. The court quoted, with approval, the case of *Grand Central Airport (Pty) Ltd v AIG South Africa Ltd* which held, on a similar clause:

"The construction contended for by the [insurer] is an improbable one and in conflict with a businesslike construction of the policy. Where the insurer repudiates liability the insured is obliged to institute action in order to enforce its claim. If the [insurer's] construction of the clause is correct, the insured would have the additional burden of commencing and completing the work of replacing or reinstating the damaged property at its own cost without any certainty that it would be indemnified in respect thereof. This is the very eventuality that an insured would seek to avoid by procuring a policy of insurance, that is the risk of itself having to fund the replacement or reinstatement."

The insurer insisted that the insured was not entitled to reinstatement under policy because he did not carry out reinstatement work reasonably quickly after the fire; he failed to do so after the SCA judgment; he did not incur expenditure in reinstating the property and "forfeited" the right to rely on the reinstatement clause; he was unable and unwilling to reinstate the property and therefore the clause was "of no force and effect". Alternatively, if the court finds the reinstatement provision enforceable, the insurer argued that the insured would not be indemnified until the reinstatement was actually carried out by him.

On the facts, the court found that the insured commenced reinstatement and showed a continuing intention to reinstate in the period between the fire and the SCA judgment. The insurer's attorneys also wrote to the insured (after the SCA judgment) stating that if the insured "did not have the financial wherewithal (to reinstate), then our client will not rely on the plaintiff's failure to have commenced the process of reinstatement of the property and the business despite the lapse of time." However, the insurer changed their stance

and required the insured to testify about the steps taken to reinstate. It was eventually accepted the insured did have an intention to reinstate the property. The remaining issue was whether he had the ability to do so. The question was whether the insured's inability to reinstate rendered the reinstatement provisions void.

The facts showed that the insured incurred expenditure in trying to keep his business going, obtaining quotes for repair and generating income by trying to run the business and service clients while the factory was not fully operational. The insured also incurred costs in trying to repair the machine in order to generate income while waiting for a decision from the inure. The insured requested an interim payment from the insurer during this time, which was rejected. He then sold some of his assets to tried to take out loans. The insured eventually had to close down the business because he ran out of capital. However he still had an intention to revive the business because he again obtained quotes for repair shortly after the SCA judgment was delivered.

The court held that the proviso to the reinstatement value conditions that they are 'without force or effect if the insured is unable or unwilling to replace or reinstate the property on the same or another site' does not refer to an inability to replace or reinstate if money is not available because the insurer withholds the indemnity payment.

The court granted judgment for the insured of the replacement value fixed by the experts in evidence. The court also awarded interest on the amount at the legal rate of 15.5 per cent from September 2011 when the costs of reinstatement had been established. The court awarded the 2011 valuation amount because it said that the interest on the awarded amount, when added to the 2011 valuation, would bring the total award close to the amount of the 2017 valuation.

Discussion

Where an insurance policy includes reinstatement value conditions and the insured had taken immediate steps to comply with the reinstatement conditions, the insured can rely on the clause as long as the insured is genuinely desirous of reinstating the property but is unable to do so because of the insurer's unjustifiable decision not to indemnify under the policy. For more on reinstatement conditions, see our Big Read Book Volume 3.

Technogistics (Pty) Ltd v ABSA Insurance Risk Management Services t/a AIRMS

(A5029/2018) [2019] ZAGPJHC 349 (September 19, 2019)

Insurer to prove exclusion applies

Keywords

- theft
- proof of theft
- exclusion
- onus of proof
- fidelity cover

The insured, a logistics company, claimed under the fidelity insurance portion of the policy from the insurer. The policy covered the insured for loss of money or property belonging to the insured or for which the insured is responsible, stolen by employees of the insured.

The insured discovered that stock was missing when a customer, which it provided warehousing and distribution services to, requested delivery of certain items in November 2013. The insured conducted an investigation to establish that the items were missing and that there were no administrative or inventory mistakes. To address the problem, the insured also hired a guard to patrol the warehouse. The guard caught an employee stealing goods a few months later (in January 2014). The employee implicated other employees in various thefts of stock and one other employee admitted to theft. These employees were then dismissed.

The customer held the insured liable for the stolen stock and invoiced the insured for the products to the value of R1,3million. The customer recovered the amount through a set-off. The insured claimed under its policy for thefts of stock they allege occurred between September and November 2013. The claim was rejected.

The insurer alleged that it was not proved that the stock had actually been stolen because the theft in January 2014 was not enough to conclude that there could be no other reason for the missing stock of November 2013. There was also another tenant on the premises, and the insured did not investigate the possibility that employees of this other occupant could have stolen the stock. They also said they were absolved from indemnifying the insured because they did not give written consent to the insured to accept liability and reimburse the customer for the stock.

The court reiterated the usual contractual principles: the insured must bring its claim within the policy and the insurer has to prove any defence to justify its rejection. Limitations or restrictions on cover are narrowly interpreted.

On the evidence it was shown that no one had access to the insured's premises and stock other than the insured's employees, who accessed the site with a fingerprint system. The other tenant and other security guards could not gain access to the premises.

With regard to breaching the policy, the insured alleged that they received specific permission from the broker to go ahead with reimbursement to the customer. The insured did reimburse the customer a few months later, so there was time for the insurer to raise any issues, but the insurer did not do so. The onus was on the insurer to prove this breach but the insurer did not lead any evidence at all in this regard and therefore failed to demonstrate that no consent was given.

The insurer was ordered to indemnify the insured.

Discussion

The onus was on the insured to prove theft and on the insurer to prove breach of the admission-of-liability clause on the balance of probabilities. An onus requires evidence if it is to be discharged.

Concise Consulting Services (Pty) Ltd v King Price Insurance Company Limited (A88/2018) [2019] ZAGPPHC 275 (May 9, 2019)

Materiality of a misrepresentation or non-disclosure at claim stage

Keywords

- Motor vehicle insurance
- misrepresentation
- non-disclosure
- materiality

Concise Consulting Service (CCS) had comprehensive motor insurance with King Price Insurance Company for a company vehicle. The car was damaged in a collision with a wall. The driver at the time was an employee of CCS and was also registered as the regular driver of the car.

The insurer rejected the claim because it alleged that during the validation of the claim, the employee driver provided false information to the insurer about his whereabouts before and after the incident. The insurer alleged that this material misrepresentation was made on behalf of CCS and therefore the insurer was entitled to avoid the policy.

The court canvassed the law on materiality as it related to insurance contracts and also analysed the relevant policy terms. The policy states that the insured and "anyone else" who acts on their behalf must "always" provide true and complete information. Providing incorrect or untrue information will prejudice the validity of the claim.

The court found the wording of the warranty to provide correct information to be very wide, and taken literally would mean that even irrelevant information which is incorrect or false could be a ground for repudiation. This would lead to an unbusinesslike result, especially in the context of this insurance contract. The court also reiterated principles related to the interpretation of an insurance policy that any limitation on the obligation to indemnify should be restrictively interpreted and that exclusions must be clear. A misrepresentation must be material in order to justify avoidance of the policy. The truth clause was not an absolute warranty and had to be weighed against the requirement for materiality to found an avoidance of the policy. Courts will also "incline towards upholding the policy against producing a forfeiture."

It was common cause that the insurance contract was validly entered into and was valid at the time of the accident. The damage to the vehicle was assessed to be R75 000 and CCS did not claim an amount higher than the assessed figure. CCS did not have any intention to deceive or defraud the insurer by getting a benefit they were not entitled to. When providing the dishonest information, the employee was not acting on behalf of CCS – he was providing information at the request of the insurer and CCS itself did not know what the true facts were. The employee's false statements were also insignificant and in no way materially affected the assessment of the indemnity. His statements were made after the valid claim had been lodged. No evidence was adduced to prove the materiality of his statements to the validity of the claim. An untrue statement which is not material cannot be relied on to limit or exclude liability simply on the fact of its untruthfulness.

The insured's claim was upheld.

Discussion

Our law has moved away from the concept of an absolute consequence of a breach as with a warranty and requires cause and effect or materiality for successful reliance on a provision.

Shaman Filling Station CC t/a Total Orangesig and Another v Garagesure Consultants and Acceptances (Pty) Ltd
(A268/2018) [2019] ZAFSHC 60 (May 30, 2019)

Fuel insurance guarantee

Keywords
- guarantee
- surety
- legal standing of agent of insurer

Garagesure Consultants and Acceptances (Pty) Ltd described itself as acting as the duly authorised agent of the insurer, Compass Insurance Company Limited. Garagesure issued a fuel guarantee to Total SA (Pty) Ltd in respect of purchases to be made by Shaman Filling Station from Total. It was alleged that the second appellant, Ms Motake, stood surety for Shaman Filling Station's obligations under the guarantee agreement.

Shaman Filling Station owed around R2 million to Total. Total claimed against the guarantee, and received R500 000 from Garagesure, under the guarantee. Garagesure claimed this amount from the appellants as principal debtor and surety.

The appellants alleged that Garagesure had no legal standing because the insurer was party to the guarantee contract, and not Garagesure. It was argued that Garagesure did not have a sufficient interest in the relief claimed, and were not adversely affected by any alleged wrong. On the evidence, Garagesure was not even used as a conduit for the money. The guarantee was paid directly out of the insurer's bank account. The court found that Garagesure was not entitled to sue as agent of the insurer. The court noted that generally, an agent has no locus standi to sue in their own name on behalf of the principal unless the agent has acquired contractual rights in their own name. An agency agreement was not pleaded and no evidence was presented to clarify the terms of the agency agreement between the insurer and Garagesure.

Garagesure therefore lacked legal standing and this should have been the end of the matter. The court went on, however, to deal with the second ground of appeal "in the event that this might be an incorrect conclusion."

The suretyship agreement was difficult to interpret. The guarantee relied on was also not properly placed on record before the court. The court accepted that suretyships were required but whether enforceable suretyships were entered into is a different matter. It was conceded by the respondent in cross-examination that the surety agreement did not stipulate that in the event of Garagesure (or the insurer) having to make payment to Total, that it would be entitled to claim the amount paid from the appellants. The court accepted that the parties probably had in mind the signing of a counter indemnity. In this matter Garagesure, who was probably responsible for drafting the agreements, sought to merge the counter indemnity and suretyship into one agreement, creating "serious confusion" in the process. If the insurer (or Garagesure) intended that the appellants be liable to fully reimburse them for any amounts paid under the guarantee, this should have been agreed to in clear terms, which on the evidence, was not done. Garagesure's claim therefore failed.

Discussion
Evidence must be properly placed before the court. Insured's also sometimes make the mistake of suing the agent and not the insurer. All policy documents and disclosures should provide clear details of the insurers not only to be statutorily compliant, but to avoid the situation where the agent is incorrectly sued. Claims have to be in the name of the principal, not the agent, unless there is a formal transfer of rights.

PSG Wealth Financial Planning (Pty) Ltd v Louw and Others
(556/2019) [2019] ZAECGHC 63 (June 18, 2019)

Restraint of trade for broker

Keywords
- restraint of trade
- ownership of clients
- confidentiality
- contract
- reasonableness

PSG Wealth Financial Planning is a financial services firm that sells investment products and insurance policies to clients. The respondent, Mr Louw, is a broker who had an association agreement with PSG, and sold policies for PG. The relationship ended in January 2019 and PSG approached the court to enforce a restraint of trade in the association agreement. The initial agreement between the parties had a six month restraint. The later (current) agreement had an 18 month restraint.

Ownership of clients
The broker argued that the agreements made a distinction between PSG clients and his own clients. The court did not accept that interpretation. The agreement could not be logically read that way and the court could not understand how, after concluding the agreement, ownership of clients could remain with the broker. He serviced them as his clients and in the capacity as an independent contractor for PSG, for which PSG was paid a 30 per cent share of the commission.

The FAIS Act was not raised in argument by the parties but the court found it necessary to point out that section 13 of the FAIS Act records that agents/representatives of financial services providers (FSPs) provide services under mandate from the principal. The principal is responsible for the acts of the representative – this would also apply to independent contractors acting for FSPs, under an association agreement such as the parties had. The broker serviced clients under PSG's FSP licence, and therefore the clients belonged to PSG.

The respondents tried to argue that they did all the work in procuring and interacting with clients and that the connections that were created as a result belonged to the respondents as would happen in a franchise context. The court did not accept that the agreement between the applicant and respondents was a franchise agreement. The court also quoted the case of *BKB Limited and Another v Collins and Another* in which that court stated that:

"[I]n the absence of an agreement between the broker and the financial services provider specifying otherwise, the accepted norm is that the financial services provider retains a proprietary right to all information which it has collated in respect of clients who have appointed the financial services provider as a broker or insurance agent to act on their behalf. The extent of a broker's rights to commission for insurance policies sold remains dependent upon the contractual agreement concluded between the broker and the financial services provider."

The court agreed with the above sentiment and added that who the FSP is, is determined by the licence on which the clients are dealt with. The licence determines the party that is accountable in terms of the FAIS Act, and consumers should not be prejudiced by the contractual arrangements between the broker and FSP.

Parties can contract regarding ownership of clients but the court stated that ownership of a client cannot only be a matter of contract if the contractual arrangement does not align with the regulatory framework and may prejudice consumers who could suffer damages due to inappropriate advice.

Even if the broker had relationships with some clients prior to entering into the association agreement with PSG, the agreement with PSG changed that nature of those relationships and the clients became clients of PSG. PSG's brand may also have strengthened the existing relationships. The relationship between the broker and PSG continued for 14 years, strengthening the notion that PSG did acquire protectable interests, and protected those interests via a valid restraint of trade clause.

From PSG's investigations they found out that the broker began soliciting clients to move to another FSP in late 2018. The broker cancelled the agreement with PSG in January 2019, alleging a breach by PSG. The broker then sent emails to PSG clients and actively solicited their business. The broker moved around 100 policies (around one fifth of its book with PSG) to the new FSP. This was in breach of the restraint of trade which bound the broker not to use the confidential information of PSG and perform any work in direct competition with PSG for a period of 18 months after termination of the agreement.

Reasonableness of restraint

The broker argued that the confidentiality provisions and the restraint of trade were unreasonable and therefore should not be enforced. In interpreting restraints of trade, courts always weigh up the right to contract (and the importance of the enforceability of contracts) with the right to engage in the trade of one's choice. Restraints of trade are generally allowed, as long as they are reasonable. The nature, extent and duration of the restraint are some of the factors considered when determining the reasonableness of the restraint.

The onus of proving that the restraint is unreasonable is on the party alleging unreasonableness.

The broker tried to argue that the restraint was excessively unfair and therefore should be held unenforceable under the Consumer Protection Act. The court did not accept this argument because the relationship between the parties is adequately governed by the FAIS Act and the Insurance Acts. Even if the Consumer Protection Act applied, the broker failed to prove that the agreement was excessively one-side

Length of restraint

The initial agreement had a 6 month restraint period whereas the current agreement had an 18 month restraint period. PSG argued that a 12 month restraint would be reasonable because policies are normally renewable after 12 months, The court did not understand this reasoning because policies are taken out at different times and therefore anniversary rates would not all be the same. The court found 9 months to be a reasonable period of restraint because it would be sufficient for a new PSG broker to acquaint themselves with PSG's clients. It is also not so long as to unduly hinder the leaving broker from freely offering its services even to the clients of PSG.

Discussion

No one "owns" the client. The client is the principal and chooses the agent. Insurers and brokers or FSPs can agree between them who will have rights to act and who will be restrained from acting. Those restrained cannot accept the business from the client.

Khuthala Chalale v Mas Corporation (Pty) Ltd t/a Mascor Vryheid (NCT/128553/2019/75(1)(b)) [2019] ZANCT 93 (June 25, 2019)

Legal standing of insured after insurer pays a claim

Keywords
- legal standing
- subrogation

This matter concerned a dispute between Ms Chalale and Mas Corp, a vehicle dealership that was meant to assess and repair Ms Chalale's car. There was a dispute between the parties relating to whether Mas Corp had damaged the car further and who was responsible for the damages. The issue was referred to the Motor Ombud and then to the National Consumer Tribunal.

Of relevance to insurers is the argument made by Mas Corp that Ms Chalale had no legal standing to pursue the matter because her insurer eventually stepped in to assist and repair the vehicle and therefore her claim no longer existed, or was extinguished by the principle of subrogation. The National Consumer Tribunal held that a consumer has a right to demand quality service from suppliers. Suppliers providing poor service or engaging in prohibited conduct face a range of penalties under the Consumer Protection Act. The Tribunal also said that the "fact that a third party such as an insurer may have stepped in to assist a consumer does not mean that the supplier concerned did not engage in prohibited conduct. Further this does not mean, in my view, that the Applicant no longer has legal standing to argue that she did not receive quality service."

Discussion

This is also in accordance with the law of indemnity. The indemnity by the insurer paid for and provided to the insured, cannot be relied on by the third party to defeat the insured's claim.

Mustek Limited v Mutual and Federal Risk Financing (Pty) Ltd (2017/41419) [2019] ZAGPJHC 235 (July 29, 2019)

Rectification of credit guarantee

Keywords
- credit guarantee
- rectification
- mistake
- common intention

The plaintiff, Mustek Limited, approached the court to rectify a credit guarantee, by removing a suspensive condition put into the guarantee by the guarantor, Mutual and Federal Risk Financing (MFRF).

Mustek Limited sells computer products on credit to retailers. A customer, Fantastic 1 Mobile (Fantastic), wanted to purchase a huge volume of goods, which exceeded the prudent credit limits previously afforded to Fantastic. Mustek Limited therefore required additional security in the form of a credit guarantee. Mustek Limited and a broker for MFRF discussed the terms of an unconditional guarantee and agreed those terms on February 28, 2017. The terms of the guarantee offered by MFRF in writing on March 3, 2017 differed from the February discussion because it contained a condition which required payment of a premium and the provision of collateral before a given date, otherwise the guarantee would automatically lapse. The representative for Mustek Limited accepted the MFRF guarantee without reading it and assumed the agreement was as discussed in February.

Mustek Limited needed to call on the guarantee but their claim was rejected because they had not fulfilled the conditions. Mustek Limited therefore sought to have the guarantee rectified to reflect the earlier unconditional agreement.

The nature of a credit guarantee

The court summarised the nature of a credit guarantee:

A credit guarantee is a contract between the guarantor and the creditor. The debtor is not a party to this contract. It consists of a unilateral offer in writing addressed to the creditor who accepts the offer upon delivery of the document without the need to sign it, or signify acceptance in any manner other than receipt thereof. The guarantor insurer requires, at least, a premium to be paid in exchange for the guarantee. Generally the debtor pays this premium, although it is irrelevant who actually pays the guarantor. The procurement of the premium and the collateral is the subject matter of another contract (usually between the guarantor and the debtor).

Requirements for rectification

The court set out the requirements for rectification of a written contract. That is, a mistake that resulted in an inaccurately documented contract and the common and continuing intention of the parties to be bound on the unstated terms. The common intention is assessed "as it existed at the time when the agreement was reduced to writing."

Mustek Limited contended that the written agreement deviated from the common continuing intention of the parties.

MFRF disputed that any mistake was made and alleged that the evidence showed a deliberate addition of the clause containing the suspensive condition. The common intention that may have existed during the time that the unconditional guarantee was discussed did not continue on March 3, 2017 when the guarantee including the condition was signed and sent to Mustek Limited.

Mustek Limited's representative was shown an unconditional guarantee by a representative of MFRF in February, and she approved that guarantee. There were ten communications between MFRF and Fantastic about the premium and collateral. Mustek Limited's representative was not alerted to the changes to the document that added the suspensive condition. MFRF argued that Mustek Limited was constructively notified of the change by delivery of the final guarantee document. Mustek Limited tried to argue that the addition of the condition was inadvertent. The court could not accept this argument – while the omission of a clause might be inadvertent, the addition of a clause is unlikely to be so, for reasons of logic and probability. The facts do not demonstrate a mistake by MFRF but rather, a prudent business decision not to expose themselves to a risk that had not been paid for.

Mistake was not proven and there was found to be no continuing common intention between the parties to provide an unconditional guarantee regardless of payment of premium and provision of collateral. Therefore the case for rectification of the agreement failed.

Discussion

There is no basis for a rectification claim unless the evidence shows that both parties held a common intention that they fail to record in writing.

Branco v the State
(A86/2016) [2019] ZAGPJHC 443
(October 31, 2019)

Fraudulent insurance claim

Keywords

- fraud
- criminal conviction

This was a criminal case that related to a fraudulent insurance claim. The insured claimed that her car had been stolen and claimed under her motor policy's theft clause. The car was a BMW. She sent her key to the insurer, and her claim was paid out shortly thereafter.

The insured's vehicle was implicated in a police investigation into a syndicate of motor thefts. An undercover police officer bought the vehicle from the crime syndicate. After investigation and in coordination with the insurer, the police discovered that the key sent to the insurers could not open or operate the vehicle. Witnesses from BMW confirmed that each vehicle has its own unique key. The key handed to the undercover officer from the crime syndicate (when he "bought" the vehicle from them) could operate the vehicle. It was therefore alleged and proved that the insured's vehicle was never stolen, since the alleged thieves had the correct key, whereas the insured sent a key she alleged to be her vehicle's key, to the insurer, as part of her claim.

The court found that the insured had fraudulently claimed under her insurance policy. She was sentenced to five years imprisonment, which was wholly suspended on condition that she repay the insurer the amount they had paid to her under the policy.

Discussion

This case is a reminder that while fraud is not often proved, appropriate circumstances do exist where insurers can find recourse through the criminal justice system. The case is unusual because it is one of a handful of successful insurance fraud prosecutions.

Joint Venture Between Aveng (Africa) Pty Ltd and Strabag International GmbH v South African National Roads Agency Soc Ltd and Another
(8331/19) [2019] 3 All SA 186 (GP)
(March 22,2019)

The right of a contractor to intervene when the employer calls on a construction guarantee

Keywords

- performance guarantee
- retention money guarantee
- legal standing

The case involved a dispute between a contractor, a Joint Venture Between Aveng and Strabag International (ASJV), and the employer, South African National Roads Agency (SANRAL). The construction contract included a performance guarantee and a retention money guarantee. The contractor aimed to interdict the employer from making a demand under the guarantees. They alleged that the employer must first comply with the terms of the building contract before it could present the guarantees for payment.

The insurer, Lombard, only participated in the matter in order to assist the court in explaining the nature or categorisation of the guarantees, and agreed to abide by the court's judgment.

The court began by noting the current legal position in South Africa, which is that "in the absence of allegations of fraud, the contractor is not entitled to challenge payment of construction guarantees, even where there are contractual disputes in terms of the building contract."

ASJV was awarded a tender to construct a bridge on the N2 Wild Coast Toll Road. They entered into a standard FIDIC construction contract with SANRAL. They also provided a performance guarantee of around R245 million (covering proper performance) and a retention money guarantee of around R81 million (covering the potential need to rectify any defects in the work actually done). The insurer required the insured contractor, as per usual practice, to sign counter-guarantees in favour of the insurer (for the insurer to recover against the contractor in the event of a claim).

ASJV stated that it validly cancelled the building contract due to a force majeure that lasted more than 84 days, that is, riots around the construction site. It alleged that the employer must follow the prescribed steps set out in the contract before it can demand payment under the guarantees, otherwise the employer would be in breach of the contract. ASJV alleged that SANRAL was only entitled to present the guarantees for payment under limited circumstances set out in the construction contract, for example failure by the contractor to extend the validity of the guarantees or failure by the contractor to remedy a default within 42 days of agreement or determination.

SANRAL's view was that the underlying contractual dispute did not affect its ability to claim under the guarantees. On the facts, SANRAL contended that there was no state of force majeure and therefore ASJV's cancellation was invalid. SANRAL did not accept the termination and instructed ASJV, through the engineer, to continue work, failing which it would regard ASJV's actions as a repudiation of the contract and SANRAL would cancel the contract on the basis of ASJV's repudiation. They also alleged that ASJV had no legal standing to apply to court to interdict them regarding the guarantees. The parties approached the court to urgently determine whether SANRAL is entitled to call on the guarantees.

The court noted that the Supreme Court of Appeal has not decided on this type of issue but that there are some relevant High Court decisions.

The court rejected the argument that the contractor is not party to the guarantee contract and therefore has no legal standing to intervene regarding demands made under a guarantee – the court held that the contractor has an interest in the manner in which and the reasons for which a guarantee is presented and therefore does have legal standing regarding the guarantee contract. According to the court, the autonomy of a guarantee contract also appears to be no longer relevant and the construction contract does play a role in enforcing the guarantee. If the contract contains requirements or conditions that must be met before the guarantee can be presented for payment, the contractor is entitled to apply for interdictory relief, stopping the demand for payment under the guarantee, until the contractual requirements are met.

However on the facts the court stated that it did not have to make a ruling on these issues (legal standing and the autonomy of the guarantee contract). The declaration of rights must be made in the context of the specific case. In this case, it was found that ASJV was not entitled to rely on the force majeure clause for cancellation because SANRAL was engaging with the community to stop the riots. ASJV's stance was to continuously invoke the force majeure clause without making any effort to resolve the problems or to be a party to SANRAL's problem-solving efforts. Therefore objectively it seemed that there was no force majeure and also, the force majeure (had there been one) was not properly notified under the contract's terms either. For example, the contract provided that ASJV would have had to refer its dispute to the Dispute Appeal Board, which it did not do.

ASJV's refusal to return to the site as instructed and its subsequent cancellation of the contract on the basis of force majeure were held to have no legal basis. SANRAL will be justified in terminating the contract and presenting the guarantees for payment.

Discussion

The decision is important because it recognises the right of the contractor, who is not a direct party to the guarantee, to intervene in relation to enforcement proceedings between the direct parties if the contractor's rights are affected.

Long-term insurance ombuds' final determinations

The offices of the ombud for long-term insurance and the ombud for short-term insurance merged on January 1, 2020. The two offices still operate independently, but there is now only one ombud in the adjudicative role dealing with both long-term and short-term insurance. The current ombud is retired judge, Justice Ron McLaren.

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 determine the matter.

Four 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.

Case 35 Informally adopted child covered

Whether a child informally adopted can be covered under the policy. Insurer ordered to pay the claim based on equity and fairness. This case set out the ombud's stance on its equity jurisdiction in some detail – equity jurisdiction does not have to operate within the confines of the insurance policy. Also, treating every policyholder exactly the same is not necessarily the same as acting fairly in the circumstances.

Case 36 Policy loans – Interest: In duplum rule

The policyholder took out a loan on the policy of around R5000 in 1999 and was informed in 2018 that the arrear interest on the loan amounted to over R50 000. The insurer argued that the in duplum rule (that arrear interest cannot exceed the capital amount) did not apply to this type of loan. This argument failed. The insurer was ordered to adjust the outstanding amount, to comply with the in duplum rule.

Case 37 Lapsing

The insurer lapsed a policy after two unpaid premiums but reinstated the policy thereafter, with a lesser benefit. The insured assumed cover would be provided on the same basis as the original policy. The insurer was ordered to pay full benefit (as in the original policy) because the policy lapsed after three unpaid premiums and not two, and the insured still had time to reinstate the policy – lapsing the policy was premature.

Case 38 Funeral benefits – When cover commences

The life insured passed away within the waiting period before cover commenced, according to insurer. The insurer was ordered to pay the claim because the insurer's system error caused the cover start date on the participation certificate to be incorrectly stated. The interpretation of the 6 month waiting period was also ambiguous and the contract was therefore interpreted against the drafter of the contract (the insurer).

Short-term insurance ombuds' 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.

Edition 1

Case study 1

Misrepresentation/non-disclosure during underwriting

The insured submitted a claim following a motor vehicle accident. The insurer rejected the claim because during the initial sales call, the insured answered "No" to the questions relating to whether he had been involved in criminal or civil litigation and whether he had been convicted of any offences. It was discovered that three charges had previously been laid against the insured relating to drunk driving. None of the cases had ever proceeded to court. The ombud agreed with the insured that the words "litigation" and "convicted" did not extend to the charges made against him and the insurer was ordered to pay the claim.

Case study 2

Breach of policy conditions

The insured was involved in a motor vehicle accident. The car in front of him slowed down abruptly so he served and hit the car to his left. He drove away from the scene and only reported the incident at a police station a week later. The insurer rejected the claim due to a breach of policy conditions (that included the obligation to report an accident to a police station within 24 hours). This is also an obligation in terms of the National Road Traffic Act. The insured's argument that he feared that the vehicle in front of him was attempting a hijacking was not compelling, based on the evidence. The ombud upheld the insurer's rejection.

Case study 3

Reasonable precautions clause

The insured collided with a road barrier and drove his vehicle around 900m before it stalled. The insured rejected the claim because it alleged that the insured should have realised the engine was leaking oil, based on the light indicated on the dashboard, and should not have driven the vehicle. The insured alleged that he needed to remove the vehicle from the flow of traffic and needed to get out of a dangerous area. The ombud analysed the "reasonable precautions" clause and took the view that the insurer needed to prove recklessness on the part of the insured to avoid the claim. On the evidence the insured's actions were held to be reckless and the ombud upheld the insurer's rejection of the claim.

Case study 4

Failure to prove a misrepresentation at claims stage

An insurer attempted to reject a motor vehicle accident claim based on its allegation that the insured's version of events contained misrepresentations and non-disclosures. However, the insurer's allegations were not backed up by its loss adjuster's report and therefore the insurer failed to prove the misrepresentation or non-disclosure. The ombud recommended that the insurer settle the claim, which they did.

Edition 2

Case study 1

Retail value – defined in the policy

An insurer settled a claim for the theft of a vehicle based on the vehicle's retail value, according to the TransUnion auto dealer's guide. The insured disputed the settlement amount, alleging that he was not informed that this was how the value would be determined. The schedule did not set out how the value would be determined but the insurer did refer the insured to the Insurer Plan Guide which set out the valuation in detail. The ombud was satisfied that the insurer fulfilled its obligations in making the insured aware of the method of valuation and therefore the insurer was justified in its reliance on the definition of retail value set out in its guide. The insurer's settlement offer was upheld.

Case study 2

Insufficient circumstantial evidence of DUI

The insurer rejected a motor vehicle accident claim because they alleged the driver was under the influence of alcohol when the accident occurred. However all of the witnesses and the video evidence presented by the insurer were insufficient to prove that the driver was under the influence of alcohol. The ombud recommended that the insurer settle the claim, which it did.

Case study 3

Misrepresentation/Non-disclosure

The insured submitted a claim for theft of his motorcycle. The insurer rejected the claim due to the insured failing to take steps to prevent the loss and failing to disclose a change in risk address. The insurer failed to show that the change in risk address was material to its acceptance or underwriting of the risk. The insured was also not reckless and did not court danger in the location and manner of parking his vehicle, and therefore his actions did not lack due care. The ombud recommend that the insurer settle the claim, which it did.

Case study 4

Wear and tear is not covered

The insured submitted a claim for water damage to her cupboards, walls, tiles and plugs as a result of a burst pipe in the flat above hers. The insurer rejected the claim on the basis that the damage actually resulted from wear and tear, which was not covered. The assessor's report also showed that some of the damage was not due to water damage. The assessor's report included photographs and was compelling evidence. The ombud upheld the insurer's rejection of the claim.

Edition 3

Case study 1

Change in use of the residential property not proved

The insurer rejected a claim for fire damage to an outbuilding because they alleged the building was being used for business purposes, and the building was only covered for private use. The insurer did not submit sufficient evidence to prove that the building was used for business. They also could not prove that if the building had been used partly for business, that it would have been material to the loss in the circumstances. The ombud recommend that the claim be settled, which the insurer did.

Case study 2

Disclosing material information at the start of the policy

The insured claimed for a motor vehicle accident. The insurer rejected the claim on the ground that she failed to disclose a cancellation of a previous policy due to fraud or dishonesty. The insurer also voided the policy on the basis of this misrepresentation and refunded the insured's premiums. The insured tried to argue that the previous cancellation was not material and that the proposal form did not clearly ask about previous cancellations. Her arguments failed. The ombud upheld the insurer's decision.

Case study 3

Failure to take reasonable steps to safeguard a cell phone

The insured claimed for theft of her cell phone but the insurer rejected the claim, alleging that the insured had not taken reasonable steps to safeguard the mobile device at the time of loss, which was a condition of cover. The insured had left her phone outside on her patio table and the device was at risk to being stolen from passers-by and neighbours. The ombud upheld the insurer's rejection.

Case study 4

Selecting the repairer

An insured claimed for motor repairs but elected to have the vehicle repaired at his panel beater of choice, despite the insurer informing him that their panel of service providers provided a cheaper service. The insured insisted on choosing his panel beater based on the fact that the panel beater offered him a courtesy car, whereas the insurer's panel beater did not. The insurer offered an amount based on their assessor's quote on repairs, and paid that amount in full and final settlement of the claim. The insured was charged more than the settlement amount by his panel beater. The ombud did not allow the insured's claim for payment of the difference and upheld the insurer's position.

Edition 4

Case study 1

Failure to prove dishonesty or driving under the influence of alcohol

The insured claimed for a motor vehicle accident. The insurer rejected the claim because they alleged that the insured provided inaccurate information relating to the accident and that the driver was under the influence of alcohol at the time of the accident. The ombud found that the discrepancies in the insured's account of events were immaterial. The other evidence of the insurer was found to be speculative and circumstantial. The insurer therefore failed to prove that the driver was under the influence of alcohol at the time of the accident. The ombud recommend that the insurer settle the claim, which it did.

Case study 2

Consequential loss

The insured claimed for a motor vehicle accident. The processing of the claim was delayed and the insured was provided with a rental vehicle. Two months later, items were stolen from the rented vehicle (the insured was still driving the rental vehicle). The insurer offered to settle the claim based on its all-risks policy under which the insured was covered for the items. The insured argued that he should be compensated for the full amount of his loss because the only reason the items were stolen was due to the insured's delay in sorting out the motor claim (he alleged that the items would have been more difficult to steal from his own vehicle). The insured waived the excess and also offered an ex gratia amount of R5000 for the inconvenience but argued that it could not be held liable for the theft. Also, the motor policy did not cover consequential loss. The insured still claimed the full amount. The ombud accepted the insurer's settlement offer as reasonable and, fair and in line with the contract of insurance and upheld the insurer's settlement amount.

Case study 3

Material misrepresentation and dishonesty

The insured claimed under an all-risks policy for theft of a laptop and camera out of the boot of her motor vehicle. The insurer rejected the claim on the basis of misrepresentation and non-disclosure because on assessment of the claim, the insurer discovered that the insured had made numerous claims under her previous insurance policy, which were not disclosed at the time of underwriting the current policy. Based on the evidence, the ombud upheld the insurer's rejection of the claim and voiding of the policy (and the insurer refunded the premiums).

FAIS Ombud determinations

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.

Tsupe v Zwelonke Burial Association and Maseti – Case No FSOS 00192/17-18/WC 2

The respondents were liable to pay a legitimate claim under a funeral policy. The respondents allegedly had not paid the claim due to lack of funds. The respondents were ordered to pay the claim of R10 000 plus interest.

Roux t/a Grande Roux Stud and Feeds v Top Life Financial Services CC and Roodt – Case No FAIS 02596/18-19/GP3

The complainant's broker did not place the appropriate type of insurance cover for his horses (they were insured under a short-term policy, but the insured specifically requested that the broker procure life insurance policies for his horses, which the broker confirmed that he did). The 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 R180 000.

This determination is wrong in that it did not take into account the fact that there cannot be life cover for a horse. It would seem that the non-life cover secured by the broker for the horses was not the required bloodstock insurance covering the death of the animals.

Nchukana v African Compass Funeral Services and Mfado – Case No FSOS 00238/17-18/WC 2

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 under a funeral policy issued by it of R18 020.

Global outlook

Here are some notable judgments from abroad, two from the UK and two from the USA.

UK insurers preparing for Brexit

Aviva Life and Pensions UK Limited and Royal London Mutual Insurance Society Limited

In at least two cases in the UK, insurers operating in the European Economic Area (the European single market) applied to court to transfer portions of their business to Ireland.

For example, in the cases of *Aviva Life and Pensions UK Limited* and *Royal London Mutual Insurance Society Limited* the London High Court allowed the transfers. This will allow for contract and service continuity for policyholders. The move was necessary because insurers are concerned about the impact of Brexit and whether they will lose "passporting rights" that enabled them to rely on its authorisation in the UK to carry out regulated activities in other EEA member states. The order includes the provision that there must be a transfer of assets along with the transfer of policies, in order to meet the solvency capital requirements under Solvency II of 150 per cent.

Insurers made these applications in early 2019, pre-empting the possible effects of Brexit, to ensure that when Brexit finally plays out, they are able to service policyholders regardless of the regulatory impact of Brexit.

Premiums funding litigation costs insurance recoverable (UK)

West v Stockport NHS Foundation Trust and Demouilpied v NHS Foundation Trust

ATE Insurance (After-The-Event Insurance) became popular in the UK around 20 years ago, following the restrictions on the availability of legal aid. Claimants would usually take out ATE insurance before their claim was launched, to cover legal costs, and it often operated alongside a "no win no fee" arrangement with the attorney. A successful litigant usually paid the ATE insurance premium out of the proceeds of their award, although some policies required upfront payment of the premium.

The clinical negligence cases of *West* and *Demouilpied* dealt with whether the ATE insurance premium was recoverable as part of a costs order. The defendant, the National Health Service, argued that if the court held these premiums to be recoverable, that they be assessed in proportionate and reasonable sums. The NHS tried to argue that cheaper or more reasonably priced comparable insurance was available, and that the premium amounts owed by the plaintiffs in these cases was unreasonably high.

The court allowed the recoverability of ATE premiums and held that there is limited scope for defendants to challenge the reasonableness of these premiums. Defendants can challenge the premium of a bespoke policy, for example on the grounds that the risk was incorrectly assessed, but there is much more limited scope for a challenge to block-rated premiums (*West* and *Demouilpied* both had block-rated premiums). A challenge to block-rated premiums would require a wider challenge to the ATE insurance market in general, and the position set out in this case was that the current block-rated premiums are reasonable, at least until there are identifiable changes to the market.

Coverage for class action asbestos suit and related exclusions (USA)

R.T. Vanderbilt Co., Inc. v Hartford Accident and Indemnity Company et al

This case related to coverage for a large number of asbestos injury claims of employees of the insured. The insurance aspects of the case dealt with the "unavailability of insurance rule". The court held that insurers are proportionally liable for the period during which insurance for a certain risk is not available in the market (the insured was unable to obtain insurance after 1985).

With regard to exclusions, the court held that the pollution exclusion did not apply to these asbestos claims, because that exclusion related only to "traditional" environmental pollution and not asbestos exposure while working in an indoor environment. However, the occupational disease exclusion raised by some of the defendant insurers was upheld. This case was notable in the USA for its ground-breaking decisions, especially relating to interpretation of exclusions.

Insurer's duty to settle a claim (USA)

First Acceptance Insurance Co. of Georgia Inc. v. Hughes

The insured in this case brought a "failure to settle" claim against the insurer. The court had to determine whether the insurer had a duty to settle in a case where the offer of settlement from the injured parties did not set a deadline for the insurer to respond. The court held that the offer to settle must be valid and within the policy limits in order to trigger the duty to settle. In this case, the failure to set a deadline for settlement did not trigger the duty. The insurer therefore did not act negligently or in bad faith in failing to settle the claim.

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