INSURANCE ODYSSEY 2020

WEBBER WENTZEL

In alliance with > Linklaters

INTRODUCTION

The Insurance Litigation Team at Webber Wentzel presents the first of a series of annual publications focussing on the many aspects of Insurance Law in South Africa and the events around the world that influence and develop it.

This publication called *2020: An Insurance Odyssey*, is a whirlwind tour of 20 judgments handed down by our Courts over the last 20 years or so, in which certain basic and some rather complicated principles of Insurance Law have been set out and developed. These are the judgments which have moulded the way in which insurers have conducted their business and the way in which we have provided advice to clients. It does not constitute legal advice and should not be considered a substitute for legal advice.

These case summaries have been designed to be considered together with our presentation, which we are rolling out to all our clients over the course of the year.

Our thanks to Lara Kerbelker, Erwyn Durman and Ben Rule for preparing the material for this publication and presentation, as well as to all of our partners, associates and candidate attorneys who have had a hand in the presentation of the material to our clients.

We hope that our document is a useful tool as you navigate the complex frontiers of Insurance Law in South Africa.

Maria Philippides and team

"This publication is a whirlwind tour celebrating 20 judgments handed down by our Courts over the last 20 years or so."

INSURABLE INTEREST
GOLDEN ERA CASE (1997)

The Golden Era case is the *locus classicus* on whether or not cover purchased by one party would be for the benefit of another party.

Bophuthatswana National Development Corporation (Lessor) leased industrial premises to Golden Era Printers & Stationers (Lessee). A fire caused destruction of a building on the industrial premises. The Lessor claimed compensation from its insurer, Commercial Union Assurance Company of SA. The Insurer paid the claim and thereafter decided to exercise its subrogated right to recover the compensation from the Lessee on the basis that the Lessee was negligent as it allowed a quantity of flammable paper offcuts to accumulate on the industrial premises. Importantly, the lease agreement stipulated that the Lessor should insure the building against damage by fire and storm.

The main issue before the Court was whether the Lessee and the Lessor were each intended, under the lease agreement, to benefit from the insurance policy taken out by the Lessor in terms of the lease agreement.

The High Court held that the lease agreement was intended to protect the interests of both parties against possible losses caused by fire damage. The Court placed emphasis on the fact that the Lessee bore the cost of the insurance premiums through its rental and it ultimately concluded that the insurance was for the benefit of the Lessor and Lessee as each had an insurable interest. In the circumstances, the Lessor did not have a right to claim damages from the Lessee and it followed that the Insurer did not have a right to a subrogated claim.

LEGAL PRINCIPLE

The Golden Era case illustrates that where a lessee pays the insurance premiums through its rental, it has insurable interest in the property and that an insurer will not have a subrogated delictual claim against a third party, if the damages are covered by an insurance policy in which the Insured and the third party both have an insurable interest.

TAKEWAY

Insurers must be mindful of the impact of the terms of an extraneous agreement on an insurance policy.

Citation: *Commercial Union Assurance Company of SA v Golden Era Printers & Stationers [1997] 3 ALL SA 165 (B)*

REASONABLE STEPS CONDITION
CC DESIGNING CASE (1998)

This case offers valuable guidance in respect of the interpretation of the condition, often inserted into insurance policies, that the Insured should take all reasonable steps to avoid a loss.

The Insured entered into an agreement with a third party to sell a motor vehicle, following an advert for the vehicle being placed in a newspaper. The negotiations and agreement were conducted via telephone and fax.

Pursuant to the agreement the Insured (situated in George) delivered the vehicle to a representative of the third party, but subsequently found out that a false cheque had been written as payment and the deposit slip had been fraudulently altered. The Insured reported this as a theft to the police and notified the Insurer of the theft, making a claim for the loss of the vehicle.

The Insurer rejected the Insured's claim on the grounds that the Insured had failed to comply with a policy condition in that the Insured failed to take all reasonable steps and precautions to avoid the loss of the insured vehicle. It argued that the Insured should have waited for confirmation from the relevant bank that the deposit had in fact been received before making delivery of the vehicle to the third party, and that the failure to do so was a failure to take reasonable steps to avoid a loss which entitled the Insurer to refuse to indemnify the loss in terms of the policy. The Court rejected the Insurer's argument and held in favour of the Insured.

LEGAL PRINCIPLE

Insurance policies, particularly motor insurance policies, are often taken out by Insureds in order to cover their own negligence. The Insured's negligence in a delictual sense (i.e. if the conduct of the Insured satisfies the legal test for negligence set out in *Kruger v Coetzee*) is therefore not sufficient to enable the Insurer to rely on the condition as this would undermine the purpose of insurance in the first place.

TAKEWAY

If the Insurer can successfully prove that the insured deliberately or recklessly Courted the danger of the loss insured against then they would be able to rely on such a 'reasonable steps' condition to reject the insured's claim for cover.

Citation: *Santam Bpk v CC Designing BK [1998] 4 All SA 70 (C)*

SUBROGATION AND MISREPRESENTATION
LOTTER CASE (1999)

Lotter leased a Mercedes-Benz vehicle from the Standard Bank of South Africa (Stannic). Lotter was also obliged to insure the vehicle, which he did. Stannic had purchased the vehicle, at Lotter's request, from a car dealer called Sutherlands Executive.

During the course of the lease agreement, Lotter was told by the SAPS that the vehicle was stolen. His attorney intervened, and ascertained that the police had no documents which proved that the vehicle was stolen, and the police therefore left the vehicle with Lotter. Sutherlands Executive assured Lotter that they had all the necessary documents related to the vehicle. Subsequently, the SAPS again contacted Lotter, and, armed with a warrant, tried to seize the vehicle. However, Lotter's attorney convinced the local magistrate to cancel the warrant, because the SAPS were not in possession of original documents which proved that the vehicle was stolen in England. Lotter again contacted Sutherlands Executive, who assured him that they would send him the documents proving that the vehicle was lawful. Lotter was then contacted by the SAPS a third time, this time accompanied by two British police officials, who identified the vehicle as stolen, and told Lotter that he should not dispose of it as he had no title to it, and that he should inform his Insurer of this.

Later, Lotter decided to switch insurers in order to obtain lower premiums, at which point he was issued a policy by Commercial Union. He did not disclose that the vehicle had been stolen. The car was then stolen from Lotter, and he claimed from Commercial Union, who

"The test for the materiality of a non-disclosure in insurance law is whether a reasonable person would consider that the information should have been disclosed to the Insurer."

rejected the claim on the basis that Lotter had no insurable interest in the vehicle since it was stolen, and that this materially affected the risk, alternatively the assessment of the premium, and therefore should have been disclosed.

The SCA confirmed that the test for the materiality of a non-disclosure in insurance law is whether a reasonable person would consider that the information should have been disclosed to the Insurer, so that it could form its own view as to the effect. The Insurer argued that the fact that the vehicle was stolen compromised its right of subrogation, as it would enjoy no rights in relation to the true owner. The SCA confirmed that it is trite law that an Insurer who has satisfied the claim of an Insured is entitled to be placed in the Insured's position in respect of all rights and remedies against other parties which are vested in the Insured in relation to the subject matter of the insurance. This is by virtue of the doctrine of subrogation, which is part of our common law. The SCA therefore held that the fact that the vehicle was stolen should have been disclosed, and that Lotter was guilty of a material non-disclosure, entitling the Insurer to "repudiate".

LEGAL PRINCIPLE

The test for the materiality of a non-disclosure in insurance law was confirmed to be that of a reasonable person. The doctrine of subrogation forms part of our law.

TAKEWAY

Insurers are entitled to rely on a material misrepresentation or non-disclosure in circumstances where the insured object has been stolen and the Insured has no risk in it, and the insured party fails to disclose this. If an Insured has no insurable interest in the object of the insurance, the Insurer's right of subrogation will be affected.

Citation: *Commercial Union Insurance Company of South Africa Ltd v Lotter [1999] 1 All SA 235 (A)*

INDEMNITY INSURANCE, LIMITATION OF CLAIMS AND INSOLVENCY OF THE INSURED – COETZEE CASE (2002)

Coetzee sustained severe injuries after slipping on a wet floor when visiting Schmidt's house. Coetzee appointed Botha, who is the Insured, as his attorney. Botha negligently allowed Coetzee's claim of R1.5 million against Schmidt to prescribe. The attorney's estate was sequestrated before the claim was finalised and Coetzee substituted the attorney's professional indemnity insurer into the proceedings, seeking to rely on Section 156. Botha's indemnity insurance with the Attorneys' Insurance Indemnity Fund (Fund) was limited to R1 million, however Coetzee's claim (including costs) exceeded the policy limit. Coetzee accepted that the damages recoverable were R1 million, however he argued that his costs could be recovered regardless of the policy limit.

One of the main issues before the SCA, in respect of the indemnity insurance, was whether Coetzee's legal costs were subject to the policy limit and if so, whether they could be recovered from the Fund in addition to the R1 million policy limit.

The following clauses in the indemnity policy were interpreted:
Limitation clause – *"The liability of Insurers in respect of all claims and claimants' costs and expenses and Approved Costs arising out of one event or occurrence shall not exceed the Limit of Indemnity specified in Schedule A"*

Indemnity clause –

- *"1.1 The Insured's legal liability to any third party arising out of the Conduct of the Profession by the Insured which legal liability is the subject of a claim first made on the Insured during the Period of Insurance irrespective of when or where such liability arose"*

- *"1.2 Approved Costs in connection with any claim under 1.1"*

"The SCA held that it would be incongruent to indemnify the Insured against a claim but not against the associated costs."

Approved Costs defined – "*All legal and similar costs and expenses which the Insured may incur with Insurers written consent which shall not be unreasonably*"

The SCA held that by virtue of the aforementioned clauses the policy limit included legal costs. Botha's legal costs were "*Approved Costs*" for purposes of the policy. The SCA held that it would be incongruent to indemnify the Insured against a claim but not against the associated costs. Therefore Coetzee's legal costs formed part of Botha's "legal liability" and were included in the indemnity. Regarding the policy limit, the SCA held that the words "*and claimants' costs and expenses*" expressly included costs in the prescribed policy limit. The claimant was Coetzee and not Botha. Accordingly, Coetzee's claims for his legal costs were subject to the policy limit.

LEGAL PRINCIPLE

The wording of the limitation clause in this case was found to include the legal costs of a third party.

Section 156 does not enable a third party to claim further costs from an insurer by virtue of pursuing a claim against that insurer in terms of the section. The section clearly provides for claims against insurers in this context to be subject to the conditions and limits of the insurance contract.

TAKEWAY

Insurers must carefully consider the limitation clauses included in their policy wording. Standard wording in limitation clauses may be interpreted to mean that a third party's costs in a claim would be recoverable in addition to the policy limit.

When assessing the risk of an action Insurers must bear in mind that they would be liable for the recoverable costs of a third party.

When a claim against an Insurer is brought in terms of Section 156, it becomes subject to all of the limits and conditions which applied in the agreement between Insured and Insurer. A third party claiming in terms of Section 156 will not be entitled to recover either capital or costs from an Insurer in excess of the limit of liability in terms of the insurance policy.

Citation: *Coetzee v Attorneys' Insurance Indemnity Fund [2002] 4 All SA 509 (SCA)*

WILFUL EXPOSURE TO DANGER
VAN ZYL CASE (2002)

The deceased attended a party 110km from his house. He arrived at around 8pm, and left around midnight, driving himself in his own car, alone. He drank brandy at the party, and ate a meal. The next morning, the wreck of his car was found in the veld alongside the road, and appeared to have rolled. The deceased was found dead 25 metres away. His blood alcohol level was 0.19 grams per 100ml, the legal limit for driving being 0.05 grams per 100ml.

His wife sued for payment in terms of his life insurance policy, after the Insurer rejected the claim. The policy provided cover for accidental bodily injury resulting in death or disablement, and contained an exception to liability in the event that death or disability was caused by the wilful exposure to danger.

The Court confirmed that the onus was on the plaintiff Insured to prove that he fell within the primary risk insured against, while the onus was on the defendant Insurer to prove the application of the exception.

The SCA rejected the Insurer's argument that an accident was a probable outcome of driving under the influence of alcohol. Relying on the dictionary definition, the Court concluded that the deceased had died in an accident. Additionally, the fact that the deceased may have been negligent did not prevent the Court from finding that an accident took place.

With regard to the wilful exposure to danger exception, the Court held that "wilful" could mean either obstinately self-willed

"The Court held that an Insurer would not wish to extend cover to a person who behaved perversely, or was obstinately self-willed."

or perverse, or something that is done on purpose, deliberately or intentionally. Since the policy referred specifically to "intentional self-inflicted injury" in the same exclusion, the Court favoured the first meaning of "wilful". Additionally, the Court held that an Insurer would not wish to extend cover to a person who behaved perversely, or was obstinately self-willed. However, on either interpretation, the Court held that the deceased had wilfully exposed himself to danger.

The Court considered that it was not possible to believe that the deceased was unaware of the risks of a long drive, alone in the dark after a long day, after having consumed alcohol. The deceased must have known of these risks, particularly given the amount of publicity given to the perils of drinking and driving in the last few decades. The Court therefore departed from a similar judgment, handed down 24 years prior, which had held that the Insured had not appreciated the risk he was taking, on the basis that times have moved on since then.

As such, the Court held that the deceased acted wilfully in exposing himself to danger, and the appeal was dismissed.

"The deceased must have known of these risks."

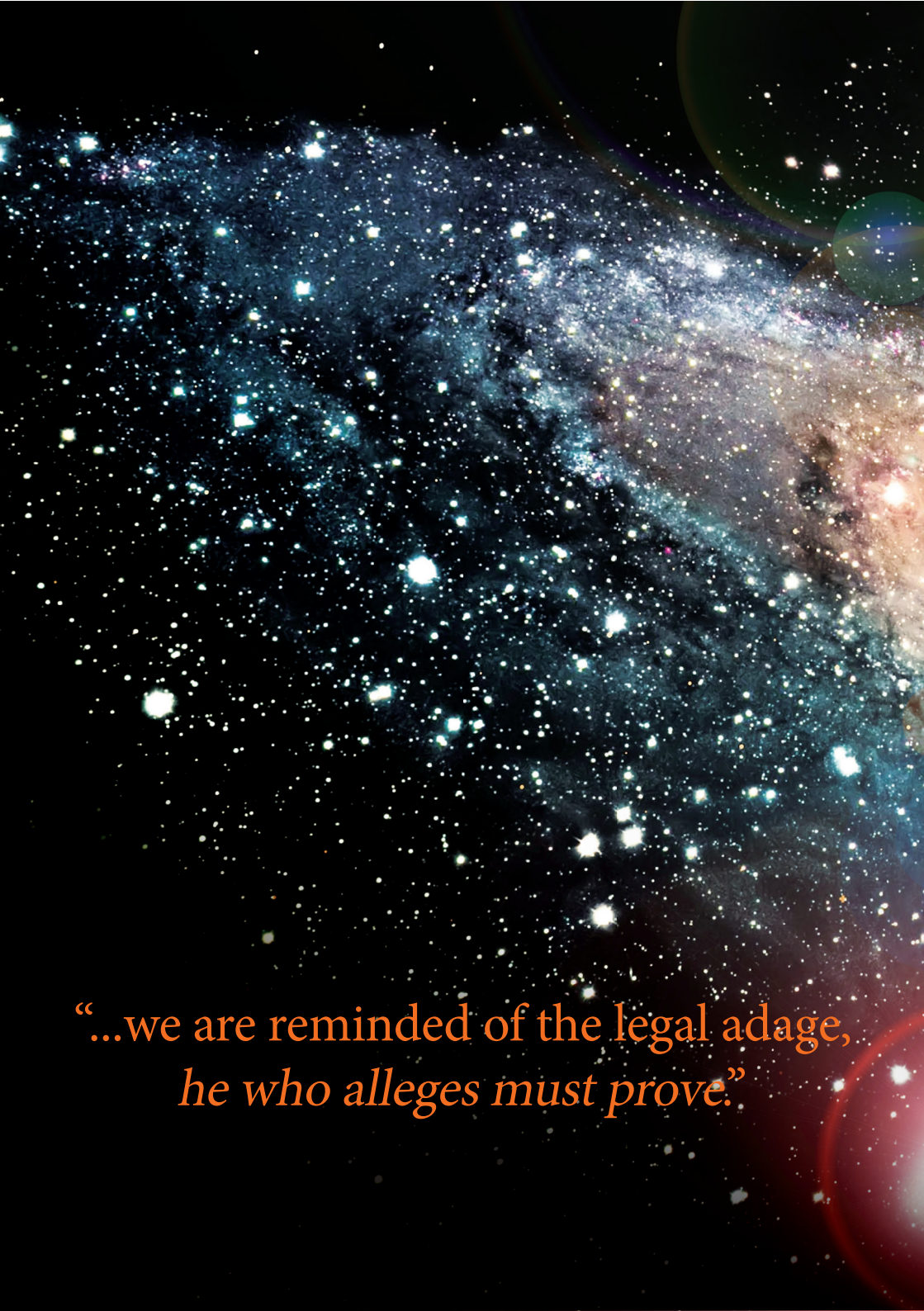
LEGAL PRINCIPLE

The deceased's driving after drinking large amounts of alcohol was found to be wilful exposure to danger as contemplated in the insurance policy.

TAKEWAY

Insurers bear the onus of establishing the applicability of an exclusion clause.

Citation: *Van Zyl NO v Kiln Non-Marine No 510 of Lloyds of London [2002] 4 All SA 355 (SCA)*


"...we are reminded of the legal adage,
he who alleges must prove."

DOES OVERVALUATION OF LOSS AMOUNT TO FRAUD? – SCHOEMAN CASE (2003)

Mrs Schoeman (Insured) obtained insurance cover for household contents from Constantia Insurance Co Ltd (Insurer). On 9 May 1998, whilst the Insured was away, her home was burgled and numerous articles were stolen. The Insured completed a claim form approximating her loss. The Insurer rejected the claim on the basis that the Insured had fraudulently exaggerated the loss. The insurance policy did not contain an express term providing for forfeiture in such circumstances. However, the Insurer argued that the term was implied by law.

The Court *a quo* found in favour of the Insurer and held that the plaintiff had fraudulently inflated the claim and further that forfeiture was implied by law. These were the main issues before the SCA; the former being a factual question and the latter a legal one.

The SCA held that this is a case of alleged post-contractual fraud as the Insured had a valid and legitimate claim which was covered by the policy; however she was accused of knowingly and falsely inflating the quantum by adding an arbitrary 10%. If forfeiture was an implied term, and the Insured was fraudulent, her entire claim, including the portion that was valid, would be rejected. In considering the legal issue the SCA concluded that:

- Insurance companies are masters of their own policies and are free to unilaterally include an appropriate forfeiture clause. These are not implied by law.

- The onus of proof of loss and value burdens the Insured.

"The Insured had a valid and legitimate claim which was covered by the policy; however she was accused of knowingly and falsely inflating the quantum."

- Other sanctions are available that could be used (eg. Punitive cost order)

- All contracts require good faith. If a tacit term was implied in insurance policies there would be no reason it could not apply to other contracts.

Regarding the factual issue, the SCA held that the onus of proving fraud rests on the Insurer on a balance of probabilities. In these circumstances, the Insured was found to have exaggerated the loss but this did not amount to proof of fraud.

The SCA highlighted factors indicating the improbability of fraud, such as the Insured's difficulty to quantify her loss, the provisional nature of the first claim form, her candour in dealing with the broker, loss adjustor and Insurer's staff. Ultimately, the SCA held that it was highly improbable that the plaintiff perpetrated any fraud.

"The Insured was found to have exaggerated the loss but this did not amount to proof of fraud."

LEGAL PRINCIPLE

In the Schoeman case, we are reminded of the legal adage, *he who alleges must prove*. Regarding alleged fraudulent claims, the onus is on the Insurer, on a balance of probabilities, to prove the fraud. A forfeiture of the entire claim in the event of fraud will not be implied by law in the absence of a forfeiture clause.

TAKEWAY

Reliance should not be placed on implied or tacitly incorporated terms as Insurers are masters of their own policies and are therefore unilaterally able to expressly incorporate terms such as a forfeiture clause.

The mere exaggeration of a loss by an insured does not amount to proof of fraud. The Insured must have knowingly, and in bad faith, have exaggerated a claim for this to amount to fraudulent conduct.

Citation: *Schoeman v Constantia Insurance Co Ltd [2003] 2 All SA 642 (SCA)*

TIMEOUS LODGING OF CLAIMS
METCASH CASE (2004)

This case sets out the principles relating to policy conditions which require claims in terms of the policy to be lodged within a certain period of the loss or circumstance occurring.

The Insured's policy with its Insurer contained a clause requiring that a claim with war as a cause of loss must be made within two years of the initial event. The Insured had an interest in a store in Zaire (now the Democratic Republic of Congo) which had burned down in September 1991 in circumstances meeting the definition under the policy for war as the cause of loss. The Insured notified the Insurer in September 1991 that the store had been damaged. The Insured however only lodged a claim for a determined amount in October 1993. The Insurer rejected the claim on the basis that the Insured had not lodged its claim within the 2 years required by the policy. The Insured argued that the notification in September 1991 that the store had been damaged was sufficient to meet the requirements under the policy, and sued the Insurer for the amount of the cover.

The SCA held that the policy was clear in its requirements and what was expected of the Insured. The Insurer could only consider a claim after it had been lodged. The policy requirement that a 'claim' must be lodged within a specific time-period, referred to a claim for indemnification by the Insured in terms of the policy for a fixed or specific amount.

As the Insured had not lodged a claim for a specific amount within two years of the cause of loss, the Insurer was not obliged to indemnify the Insured due to breach of the policy conditions.

LEGAL PRINCIPLE

Failure by an Insured to timeously lodge a claim as required by a policy could result in it being in breach of the policy conditions, which (depending on the policy wording) could disentitle it to indemnity.

TAKEWAY

Policy conditions seeking to provide a time limit for the lodging of claims should be carefully drafted so as to provide a defined date by which the Insured should lodge a claim.

Citation: *Metcash Trading Ltd v Credit Guarantee Insurance Corporation of Africa Ltd [2004] 2 All SA 484 (SCA)*

MEANING OF "RESIDENCE" AND "UNATTENDED" IN EXEMPTION CLAUSE – HARLOW CASE (2004)

The plaintiff, Mr Harlow, had a housebreaking at his home in Constantia, and the replacement value of the goods stolen allegedly amounted to R167 108. He claimed from Santam under his insurance policy, but the claim was rejected on the basis of a specific exclusion, which provided that movable personal property was not covered against theft unless the alarm was switched on and operative whilst the residence was unattended. Santam alleged that the theft took place while the residence was unattended and the alarm was not switched on.

The plaintiff's wife testified that on the day of the robbery she had left the house, and locked it, but had only partially armed the alarm. The alarm in the guest bedroom, study and family room had not been armed, because the family had guests staying, who were expected back later, and had not wished to give them the alarm code. Additionally, she testified that the gardener had been present at the time of the robbery, and that he had access to the garden, the garage and the domestic workers' living quarters. The alarm in these areas had also not been armed. When the plaintiff's wife returned later that afternoon, the robbery had taken place, and burglars had gained access by forcing open the sliding door in the guest bedroom (where the alarm had not been set). The case turned on the interpretation and meaning of the terms "residence" and "unattended".

The Court confirmed that the onus of proof was on the Insured to prove that the risk insured against eventuated, but that the Insurer bore the onus if the risk fell within an exception in the policy. The Insurer therefore carried the onus to prove that the residence was unattended at the time of the robbery. The plaintiff argued

"The case turned on the interpretation and meaning of the terms 'residence' and 'unattended.'"

that because the gardener had access to the garage and the domestic workers' quarters, the residence was not unattended. Based on the dictionary definition, and on the rule that words should be given their plain, ordinary, popular or grammatical meaning, the Court held that "residence" excluded the garage and outbuildings, which were set away from the main house. This was reinforced by the fact that the alarm clause was intended to protect household goods which would ordinarily be situated in the residence. As to whether the residence was unattended, the Court held that "unattended" connoted the absence of supervision of the premises or of someone being in charge of it. The physical presence was not enough, and what was required was the presence of someone whose mind was directed at watching over the residence. As the gardener had not been charged with watching over the residence, and the plaintiff's wife had not taken him to task for failing to look after it, he could not be said to have been in charge of the residence, or have had it under his supervision. In the circumstances, the Insurer was successful.

"The physical presence was not enough, and what was required was the presence of someone whose mind was directed at watching over the residence."

LEGAL PRINCIPLE

Words will be given their ordinary or popular meaning in interpretation. The onus to prove that the loss falls within the policy lies with the Insured, whereas the onus to establish an exception lies with the Insurer.

TAKEWAY

Insurers can escape liability in a case like this, where the alarm is partially armed and only a gardener is present. The case illustrates the meanings of these specific terms in a policy such as this one.

Citation: *Harlow v Santam Ltd [2004] 2 All SA 643 (C)*

TWO INSURERS WITH CO-ORDINATE AND EQUAL LIABILITY – SAMANCOR CASE (2005)

The Samancor case deals with an Insurer's rights of recovery where an asset is doubly insured.

Samacor Ltd (Insured) suffered a loss to an alternator which was insured under two insurance policies. The "works policy" was underwritten by M&F (and others) (M&F) and the "assets policy" was underwritten by Westchester Insurance (Westchester). In terms of the assets policy, Westchester had fully indemnified the Insured for the loss. Westchester paid the claim in full and thereafter sought a subrogated recovery from M&F.

M&F argued that Westchester could not pursue a subrogated recovery against it. The only permissible claim would be for Westchester, in its own name, to seek a claim of contribution from M&F as a co-insurer

The main issue before the SCA was whether Westchester had the right to pursue a subrogated claim against M&F and if not, what right of recovery (if any) it had.

The SCA held that Westchester and M&F had agreed to indemnify the Insured in respect of the same loss. The loss was recoverable from either M&F or Westchester.

Westchester and M&F were co-insurers and their liability was co-ordinate and equal. Westchester's payment of the claim in terms of the assets policy discharged its liability as well as the liability of M&F in terms of the works policy. Accordingly, Westchester did not have a right to a subrogated claim and should have brought a claim for contribution

LEGAL PRINCIPLE

Where there is double insurance and respective Insurers' liability is co-ordinate and equal, only a right of contribution will exist and not a right of subrogation.

TAKEWAY

In the case of double insurance, an Insurer should be aware of what rights of recovery it has in the event that it does pay out a claim.

Insurers should be mindful of the three scenarios that exist: If the primary Insurer pays the claim, it will discharge the general liability of the secondary Insurer and will have a claim for contribution from that Insurer; If the secondary Insurer (who has equal and co-ordinate liability with the primary Insurer) pays the claim, it will only have a claim for contribution from the primary Insurer; and If the secondary Insurer (who does not have equal and co-ordinate liability with the primary Insurer) pays the claim, it will have a right of subrogation.

Citation: *Samancor Ltd v Mutual & Federal Insurance Co Ltd and others [2005] 4 All SA 193 (SCA)*

NOTING AN INTEREST
BARLOWORLD CASE (2006)

This case relates to the question whether by virtue of the contract or trade usage there exists an obligation to pay a third party who has an interest in the insured property before paying the Insured.

The appellant had sold mechanical equipment to a third party (purchaser) in terms of an instalment sale agreement, in terms of which the appellant would reserve ownership in the equipment until final payment. It was an express term of the agreement that the purchaser would insure the equipment and note the appellant's interests on the policy, but the purchaser failed to do so.

Before payment of the final instalment, the equipment was irreparably damaged and the Insurer paid out the proceeds of the policy to the Insured. The appellant sued the Insurer, relying on the alleged contract between itself and the Insurer, alternatively on trade usage, which allegedly required the insurer to pay the seller.

The Court held that although the Insurer had been informed of the third party interest in the insured equipment, there was no evidence to suggest that there exists a trade usage that an Insurer, by mere acquisition of knowledge of a third party's interest, becomes bound, as if by contract, to pay the latter ahead of the Insured.

LEGAL PRINCIPLE

The noting of the interest of a third party on the insurance policy is effectively a tri-partite agreement that the Insurer will pay the third party first before its insured in certain circumstances, provided it is contractually bound to do so, or there exists a trade usage in the office of that Insurer that it will ordinarily do so.

TAKEWAY

It is not sufficient to simply assert that a trade usage exists that an Insurer will pay the proceeds of an insurance policy to the third party whose interests are noted on the policy. Evidence of that Insurer's practice is required.

Citation: *Barloworld Capital (Pty) Ltd t/a Barloworld Equipment Finance v Napier NO [2007] 1 All SA 301 (SCA)*

TIME BAR CLAUSES
BARKHUIZEN CASE (2006)

This case relates to the legal enforceability of a time bar clause in an insurance policy, which requires the Insured to institute summons within a prescribed period following a rejection of a claim by the Insurer, failing which the Insurer will escape liability.

The Insurer rejected a claim by the Insured under a motor vehicle policy, on the grounds that the vehicle (in breach of policy conditions) had been used for business purposes. The Insured served summons two years later.

The Insurer pleaded that it was not liable to the Insured by virtue of the summons being served more than 90 days after the claim had been rejected and in breach of the time bar clause in the policy.

The Insured challenged the constitutionality of the time bar clause, arguing that it violated her constitutional right of access to Court (Section 34 of the Constitution).

The matter was heard by the High Court, Supreme Court of Appeal and Constitutional Court. The latter two Courts agreed.

As a matter of general principle, it is open to Courts to decline to enforce a time bar clause if the clause is unfair and contrary to public policy (for example by virtue of providing an impossibly short period within which to serve summons), however absent a clause being contrary to public policy, Courts should enforce contracts. A 90-day period within which to serve summons is not unreasonable and the Insured had not provided reasons for failing to comply with the time bar clause. The Insurer's defence was upheld.

LEGAL PRINCIPLE

Time bar clauses in insurance policies are legally enforceable if they provide the Insured with a reasonable period within which to serve summons.

TAKEWAY

It is possible for Insurers to escape liability for a rejected claim if an Insured fails to comply with a time bar clause, assuming that the clause in question is enforceable according to the principles set out above.

Citation: *Barkuizen v Napier 2007 (5) SA 323 (CC)*

AN INSURED PARTY CAN COMPEL AN INSURED (POLICYHOLDER) TO CLAIM UNDER POLICY
BRAAFF CASE (2007)

This case deals with whether the named Insured (policyholder) can be compelled by an insured person under a policy to submit a claim.

The plaintiff was a passenger in a vehicle being driven by Braaff's son. Due to the driver's negligence, a car accident occurred, in which the driver died and the plaintiff was severely injured. The car was owned and insured by Braaff. Jacobs was appointed as the executor of the deceased estate. The plaintiff sought an order compelling Braaff to lodge a claim with the Insurer for the remainder of her damages which she had been unable to claim from the Road Accident Fund (RAF). The policy contained an extension clause which provided cover to the Insured in respect of liability to third parties, but specifically excluded the right of any person other than the Insured to claim under the policy.

The main issue was the content of the agreement between Braaff and the deceased with regard to the use of the vehicle. The trial judge held that the extension clause afforded no right to enforce a claim against the Insurer where the Insured did not wish to claim.

On appeal, the SCA overturned the judgment. Braaff's evidence was that his wife and children were aware that there was insurance cover, including for incidents where one of them was driving. He also would have invoked cover in order to avoid the involvement of one of his family members in litigation. The court concluded that a tacit term existed in the agreement between Braaff and the deceased, that if a claim was made by a third party due to the negligence of the deceased, a claim would be submitted to the Insurer. Braaff was therefore ordered to submit a claim in respect of the injuries sustained by the plaintiff.

LEGAL PRINCIPLE

An Insured person under the policy may validly compel a named policyholder to claim from the Insurer under a policy of insurance.

TAKEWAY

Insurers must be aware that even when an Insured (policyholder) does not wish to claim under their policy, an insured party may compel them to do so. Additionally, the SCA commented that it was unclear why Braaff did not wish to assist the plaintiff, but if this was due to the Insurer's attitude, "such conduct is reprehensible".

Citation: *Jacobs NO v Braaff [2007] 4 All SA 966 (SCA)*

FRAUDULENT CLAIM
KRS INVESTMENTS CASE (2007)

The Insured was covered for damage to its Land Rover and damage by fire to its restaurant. On 30 December 1999, the Land Rover was overturned whilst being driven by an unlicensed driver. The policy contained an exclusion of liability in respect of unauthorised drivers. The Insured submitted a claim as a result of the loss (Vehicle Claim). In submitting the claim the Insured fraudulently misrepresented the identity of the driver (Misrepresentation).

On 6 February 2000, after the Vehicle Claim was submitted but before the Insurer paid the claim, the Insured submitted a further claim for damage to its restaurant and its contents which was destroyed by a fire (Property Claim). During an investigation of the Claims the Insurer discovered the Misrepresentation. Consequently, the Insurer rejected the Claims as it would have avoided the policy from the date of the Misrepresentation.

Whilst it is trite in law that an Insurer is not bound to meet a claim that is not covered by the policy; the main issue in KRS Investment was whether an insurer may escape liability for a valid claim (the Property Claim) that arises subsequent to an attempted fraud by the Insured in a prior claim (the Vehicle Claim).

The Insurer sought the recognition of a right to terminate the policy with retrospective effect from the date of the attempted fraud, with the result that the Insured would forfeit rights that accrued before the termination. The trial Court upheld the rejection of the Vehicle Claim but not the rejection of the Property Claim.

To grant the relief sought by the Insurer, the SCA would have to import English law principles of forfeiture in cases of fraud. These are penal principles and would result in the Insured being dispossessed of a valid claim that was untainted by the fraud that accrued before the policy was terminated. The SCA declined to do so.

LEGAL PRINCIPLE

The insurer may only be relieved of liability from the date of termination of the insurance policy and the rights and obligations that had accrued before then would remain extant.

TAKEWAY

Insurers should consider including clauses in their policy wording, to expressly provide for forfeiture, so as to guard against instances of fraudulent claims.

Citation: *South African Eagle Insurance Co Ltd v KRS Investments CC [2007] 1 All SA 566 (SCA)*

MEANING OF "CONTAMINATION" IN AN EXCLUSION OF LIABILITY CLAUSE – EAGLE INK CASE (2009)

St Paul Insurance Company SA Ltd (St Paul) issued a policy of insurance to Eagle Ink, which was a manufacturer of printing inks and related products. Eagle Ink supplied ink to Nampak Polyfoil (Nampak), which, in turn, contracted with an American company known as Bunzl Distribution Southeast Inc (Bunzl), for the supply of several million plastic shopping bags for WalMart in the USA. It was a term in the contract between Bunzl and Walmart that the plastic bags would be free of heavy metal, including lead. As such, Eagle Ink gave a written assurance to Polyfoil, which passed it onto Bunzl, that all inks supplied for export work would be heavy metal free.

However, an employee of Eagle Ink who worked at the Polyfoil plant mixed leftover ink from Polyfoil's printing presses with the lead-free ink delivered by Eagle Ink. He did this in an attempt to save Polyfoil money. Bunzl consequently rejected the bags and claimed the purchase price, along with damages, from Polyfoil. Polyfoil in turn claimed from Eagle Ink, which submitted a claim under the product's liability extension of the policy with St Paul.

St Paul rejected the claim on the basis that the policy specifically excluded liability arising out of seepage pollution or contamination, except where such seepage pollution or contamination was caused by a sudden unintended or unexpected event. On the dictionary definition, the Court held that contamination of the lead-free paint had taken place. Additionally, the Insured's own documents referred to contamination in many places.

As such, the Court found in favour of the Insurer.

LEGAL PRINCIPLE

The ordinary or dictionary definition was applied, in the context of the policy as a whole, in order to ascertain whether the liability had been caused by contamination.

TAKEWAY

An Insurer can reject a claim on the basis of contamination in a case such as this one.

Citation: *St Paul Insurance Co SA Ltd v Eagle Ink System (Pty) Ltd [2009] 4 All SA 46 (SCA)*

ONUS OF PROOF IN INDEMNITY INSURANCE
WALKER CASE (2009)

On 7 August 2002 Mr Walker's (Insured) BMW 323I was hijacked and damaged beyond repair. The Insurers rejected liability on the basis of certain clauses, which deal with general conditions in the insurance policy; however the Insurers failed to state how the insured had breached those general duties. Following the rejection of the claim, the Insured sold the wreck to a scrap dealer for R21 000. The Insurers were notified of the sale of the wreck and accepted the course of action taken by the Insured. The Insured instituted action against Santam Ltd and others (Insurers) for the value of the undamaged BMW (R98 000) less the value of the wreck (and less the excess).

The Insurers' main argument was based on the Davis case which held that evidence based on a percentage of the pre-collision value of such vehicle was insufficient to establish the post-collision value of such a vehicle. However, the Insurers failed to show that there was anything more that the Insured could have or should have done to minimise his loss (i.e. the price obtained for the wreck was reasonable).

The Court a quo found in favour of the insurers and held that evidence adduced by the Insured was insufficient to enable the Court to determine the value of the BMW in its damaged condition.

The SCA held that if the Insurers complied with their contractual obligations, the value of the wreck would not have been an issue because 1) the wreck was not disposed of; and 2) Insurers had a right to salvage. Therefore there was no need to consider the value of the vehicle in its post-damage state. It was held that the Insured, prima facie, took reasonable steps to minimise his loss and the Insurers failed to rebut the prima facie case. There was therefore no reason to reject the claim.

LEGAL PRINCIPLE

The basic principles of indemnity insurance are that the Insured is entitled to recover the actual commercial value of what he has lost through the happening of the event insured against. The Insured must prove that their claim falls within the primary risk insured against. The onus on the Insurer, seeking to avoid liability, is to prove the application of an exception.

TAKEWAY

In a rejection letter it is imperative that the Insurer expressly states the reasons for the rejection.

Citation: *Walker v Santam Ltd and others [2009] 4 All SA 60 (SCA)*

INTERPRETATION OF "SUDDEN AND UNFORESEEN"
AFRICAN PRODUCTS CASE (2009)

This case relates to the interpretation of the phrase 'unforeseen and sudden' (or vice versa), commonly appearing in certain insurance policies.

The Insured claimed an indemnity under the business interruption section of its insurance policy for loss of production in a factory. The factory had ceased production as a result of cable failure after the cable insulation wore away.

The policy section under which the Insured claimed indemnity provided cover for unforeseen and sudden physical damage to machinery. Following an investigation, the Insurer however rejected the claim, arguing that although the damage may have been unforeseen it was not sudden as it was a result of the cables having failed over a lengthy period of time.

The Supreme Court of Appeal heard the matter and held that while the words 'sudden' and 'unforeseen' may have the same meaning in certain contexts, when interpreting an insurance policy Courts should ascribe meanings to words which avoid tautology or superfluity.

'Sudden' in the policy therefore did not mean without warning or unexpected (as argued by the Insured), but was used temporally to mean abrupt or occurring quickly. The interpretive exercise done, the Court found that the damage had been unforeseen, but had not been sudden as it was proved that the cables had failed over a lengthy period of time.

The Insured was therefore not entitled to indemnity under the policy.

LEGAL PRINCIPLE

Where similar words are used in a policy, they are to be interpreted to avoid tautology or superfluity and should therefore be given distinct meanings to the extent that this is reasonable and commercially sensible.

TAKEWAY

If a policy requires that damage should be sudden and unforeseen then the damage should be both unexpected and abrupt or occurring quickly.

Citation: *African Products (Pty) Ltd v AIG South Africa Ltd 2009 (3) SA 473 (SCA)*

PROXIMATE CAUSE
SMD TELECOMMUNICATIONS CASE (2011)

The plaintiff Insured held a policy with Mutual and Federal, the defendant, in terms of which the Insurer would compensate the Insured in the event of the death or disability of one of its managerial staff, occurring as a result of bodily injury caused solely by "violent, accidental, external and visible means which injury shall independently of any other cause be the sole cause of any of the results".

The deceased sustained injuries in a motor vehicle collision, and died seven months later. His death was precipitated by a plaque rupture which caused a heart attack. The Insurer rejected the claim on the basis that the deceased was at a high risk of a heart attack before the collision, and that given the lapse of time, his death could not have been because of the accident.

The Court referred to previous case law, in which the policy had included an exception clause, which had specifically excluded any pre-existing health conditions of the deceased. However, the Insurer in this case failed to place reliance on the exception clause, either in pleadings or during the trial, and it was not possible to seek an amendment on appeal, due to the reverse onus which would rest on the Insurer if it chose to rely on the exception.

The Court held that the inquiry in matters like this would be twofold: the Insured would have to prove that the injury was the proximate cause of the deceased's death, and that the pre-existing condition was not a contributory cause. The onus would then shift to the Insurer to show that the proximate cause was excluded by the exemption clause, although this was not possible in this case.

Based on the evidence of both parties' medical experts, the Court held that the accident was the proximate cause of the deceased's death. The plaintiff's expert's view was logical, attractive to the defendant's expert, and supported by medical journal articles and studies. The appeal was therefore dismissed.

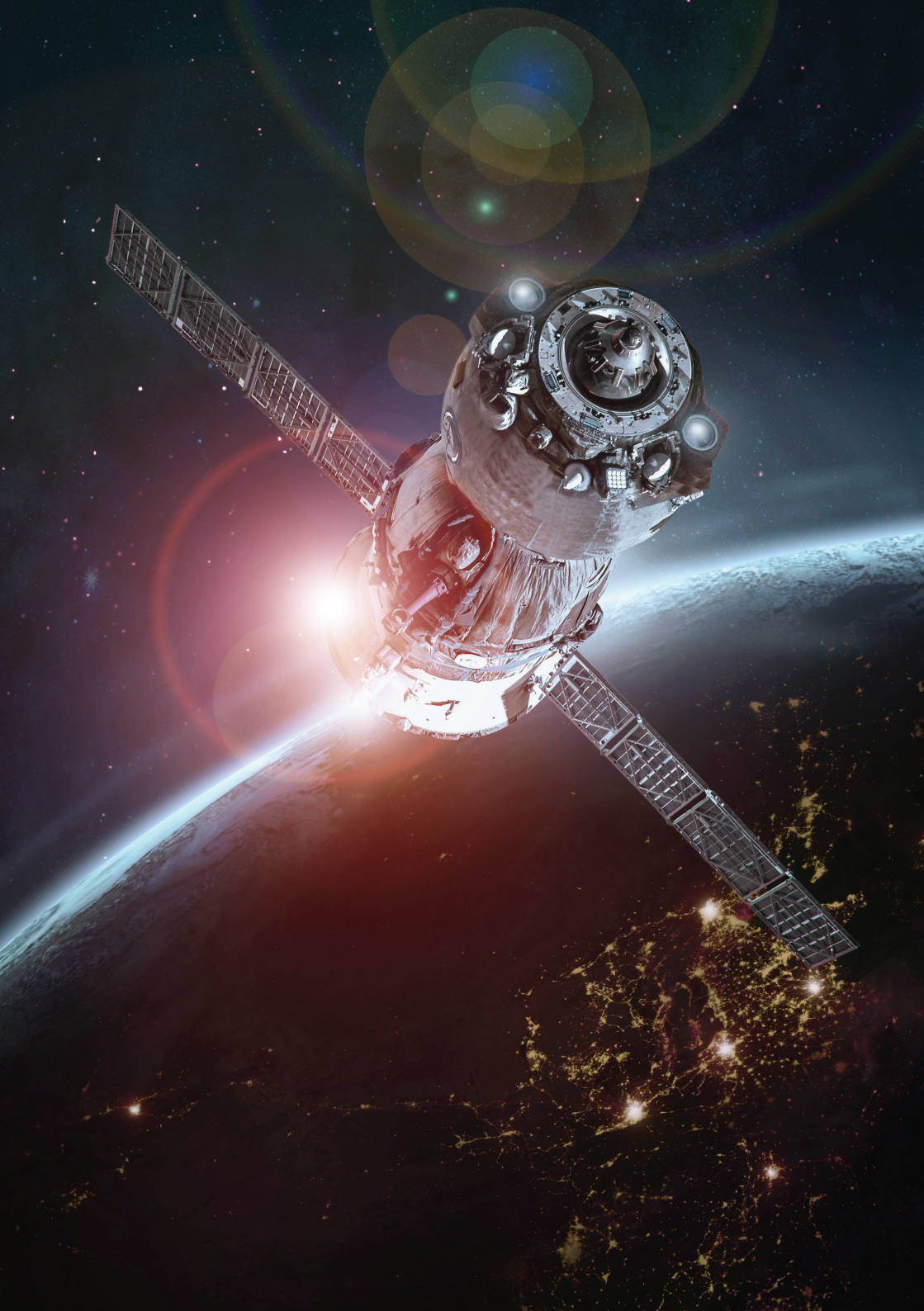
LEGAL PRINCIPLE

An Insurer cannot rely on an exclusion clause unless this is properly pleaded. The onus insofar as exception clauses was again confirmed to be that of the Insurer. The Insured was required to prove the proximate cause of the loss.

TAKEWAY

An Insurer must specifically exclude liability for an underlying condition, in order to reject liability on this basis.

Citation: *Mutual & Federal Insurance Co Ltd v SMD Telecommunications CC [2011] 2 All SA 34 (SCA)*



MATERIAL NON-DISCLOSURE / SURVEY
KING'S PROPERTY CASE (2015)

The King's Property case sets out the test for material non-disclosure and inducement as a result thereof.

On 24 May 2010 a fire burnt down the King's Property (Insured) premises. The property was leased to Elite Fibre, whose business was the manufacture of truck and trailer bodies using resin and fibreglass. Resin and fibreglass are highly flammable material. The fire was caused by Elite Fiber's employees whilst conducting the business of their employer. The Insured claimed the cost of repairs and loss of rental income from its insurer, Regent Insurance Company Ltd (Insurer). The Insurer rejected the claim on the basis that the insured's failure to disclose that the premises was occupied by a tenant whose business entailed the use of highly flammable materials, amounted to a material non-disclosure.

The Court *a quo* held that the Insurer was estopped from relying on the alleged material non-disclosure as the Insured's broker had requested that the Insurer conduct an urgent survey of the premises, which survey would have revealed Elite Fibre's occupation of the premises. However, the survey was not conducted by the Insurer prior to the loss occurring.

There were three main questions before the SCA: Firstly, what was disclosed to the Insurer? Secondly, was there a material non-disclosure in terms of S53 of STIA which induced the Insurer? And thirdly, if this was so, could the Insured establish estoppel or waiver of reliance on non-disclosures?

The SCA held that the Insured had neither disclosed that Elite Fibre had occupied the premises nor the nature of its business. The

"The SCA held that the Insured had neither disclosed that Elite Fibre had occupied the premises nor the nature of its business."

reasonable, prudent person (objective test) would have regarded the non-disclosure as material. The Insurer would not have accepted the cover if it had known that the occupant had a manufacturing business and further would have declined the risk altogether if it was disclosed that the occupant manufactured products using fibreglass and resin (subjective test). Ultimately the SCA found that the non-disclosure had induced the Insurer to place the cover. Regarding the Court *a quo*'s contention of a waiver, the SCA held that a waiver of a right entails knowledge of it. If there was a non-disclosure, there was no knowledge and there cannot be intention to give up the right to rely on it. The SCA found no merit to the defence of estoppel.

The SCA held that the Insurer was entitled to reject the claim and regard the policy as void.

"If there was a non-disclosure, there was no knowledge and there cannot be intention to give up the right to rely on it."

LEGAL PRINCIPLE

Restated the principle that, in order for an Insurer to rely on the defence of material non-disclosure it must show in addition to the materiality of the non-disclosure (which test is objective) that such non-disclosure induced the Insurer to issue the policy (which test is subjective).

TAKEWAY

The request for an inspection of premises (survey) did not extinguish the Insured's duty to disclose all material information relevant to the risk that is to be underwritten.

Citation: *Regent Insurance Company Ltd v King's Property Development (Pty) Ltd t/a King's Prop [2015] 2 All SA 137 (SCA)*

REINSTATEMENT CONDITIONS CLAUSE
WATSON CASE (2019)

This case relates to calculation of the value of a loss suffered by an Insured, which the Insurer was obliged to indemnify under an insurance policy.

The Insured claimed an indemnity for losses suffered as a result of a fire to his print finishing business. The Insured claimed the value of reinstating the premises to the condition which it was in before the fire. The Insurer initially rejected cover under the policy and after lengthy litigation it was determined in Court that the Insured was entitled to cover. Probably conscious of the fact that the cost of reinstatement had been increased substantially over the course of the intervening period, the Insurer claimed that the Insured was not entitled to the reinstatement value as the Insured did not carry out the reinstatement and had abandoned the right to claim it.

The Insured responded that he was not financially able to reinstate the property in the absence of the payment from Insurer. He led evidence that he immediately took steps to restore the factory and continue business, however he was simply not able to restore the factory to its previous condition and eventually ran out of money to keep his business going. The Court found that the Insured had not waived his right to claim reinstatement and ordered the Insurer to pay him the value of reinstating the business to the condition which it was in prior to the fire.

> "The Court found that the Insured had not waived his right to claim reinstatement."

LEGAL PRINCIPLE

If an Insurer makes payment to an insured in lieu of reinstatement and the Insured uses that money for other purposes, the Insurer is released from its obligation to reinstate by virtue of the Insured having elected not to reinstate.

TAKEWAY

The judgment gives a lengthy discussion of the basis of indemnity insurance, reinstatement and replacement value as well as considering a reinstatement value conditions clause. The judgment also serves as a warning to Insurers that delayed handling of claims, or entering into litigation relating to claims, could have the effect of steadily increasing the reinstatement value of a claim.

Citation: *Watson and another v Renasa Insurance Company Ltd [2019] 2 All SA 280 (WCC)*

INTERPRETING POLICIES
OOSTHUIZEN CASE (2019)

This case relates to the interpretation of exclusion clauses in insurance policies, and the interpretation of policies more generally.

Oosthuizen (the Insured) was a financial adviser. He was sued by a former client of his after an investment which he recommended failed completely. He joined Centriq (his Insurer) to the proceedings after they rejected his claim for indemnity on the basis that it was excluded by a clause in the policy. The clause in question excluded Insurers' liability for claims "arising from or contributed to by depreciation (or failure to appreciate) in value of any investments". Oosthuizen argued that the claim against him by his former client fell to be indemnified because the triggers of the exclusion clause had not been met, the clause did not apply and therefore he was entitled to indemnity under the policy.

The Insured's client was successful in her action against him in the High Court and he was found to be liable for her losses. The High Court also found that the exclusion relied on by Insurers did not apply and Insurers were therefore liable to indemnify the Insured. On appeal to the Supreme Court of Appeal, it was again found that the claim against the Insured did not fall within the exclusion. The SCA saw fit in its judgment to set out the principles relating to the proper interpretation and application of exclusion clauses.

"The exclusion relied on by Insurers did not apply."

LEGAL PRINCIPLE

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. For, if that is what the Insured contracted for, that is what he is entitled to and no more. It is not for the Courts to construe exclusions in favour of the Insured simply because it considers them to be unfair or unreasonable.

TAKEWAY

Although an exclusion clause appears to the insured to be unfair or unreasonable, this is not a basis for Courts to re-interpret the exclusion clause to give rise to a more fair or reasonable outcome. If the exclusion clause is enforceable then the meaning of it should be ascribed through interpretation according to established principles, even if that meaning appears harsh toward the Insured in the circumstances.

Citation: *Centriq Insurance Company Ltd v Oosthuizen 2019 (3) SA 387 (SCA)*

WEBBER WENTZEL

in alliance with > Linklaters

Johannesburg
90 Rivonia Road, Sandton, Johannesburg, 2196
t: +27 11 530 5000

Cape Town
15th Floor, Convention Tower, Heerengracht,
Foreshore, Cape Town, 8001
t: +27 21 431 7000

www.webberwentzel.com