

SOUTH AFRICA / JUDGMENT

Klencovljevic v Discovery Life Limited (46154/2013 , 46155/2013) [2014] ZAGPJHC 191 (18 August 2014)

[2014] ZAGPJHC 191

COURT

South Gauteng High Court, Johannesburg

BEFORE

FJ Becker

CASE / FILE NUMBER

46154/2013 , 46155/2013

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REPUBLIC

OF SOUTH AFRICA

IN

THE HIGH COURT OF SOUTH AFRICA

GAUTENG

LOCAL DIVISION, JOHANNESBURG

CASE NUMBERS:

46154/2013

46155/2013

REPORTABLE

OF INTEREST TO OTHER

JUDGES

In the matter

between: -

KLENCOVLJEVIC,

ALEXANDER.....Applicant

and

DISCOVERY LIFE

LIMITED.....Respondent

JUDGMENT

BECKER, AJ: -

FOR

DETERMINATION

[1] Whether in given circumstances, an insurer was entitled to repudiate an insurance claim, has often been the subject matter of disputes in our courts. Not so, an insurer's failure to assess a claim based on its alleged inability to do so and the consequences of such a failure. When an insurer refuses to abide an insurance contract (policy) while maintaining that it is not repudiating liability in terms thereof, the issue naturally becomes one for a court to resolve.

[2] Stripped of excess, these two applications for payment of the proceeds of two life policies concern the question whether a respondent insurer faced with otherwise perfectly valid claims by a beneficiary, can refuse to either repudiate or honour the policies

until sufficient information became available from certain unrelated third party investigative processes at some indeterminate point in time. The insurer maintains that in determining its right to "a reasonable time to assess the claims" due consideration be afforded its inability to control, direct or dictate these investigative processes in asserting its right to defer its decision and hence, its election.

[3] The applicant qua beneficiary, issued two applications out of this court in which he applies for orders for payment by the respondent of the proceeds of two life policies. The respondent opposed the relief, eventually contending that the applications are premature and that a reasonable time had not elapsed from submission of the claims until the issuing of the applications in order for it to have completed its assessment of the claims. I say "eventually", as this had not been the basis of the respondent's opposition or, in fact, its case in its answering affidavit.

[4] This issue developed rather unexpectedly during argument. Despite the respondent's original stance that it should be permitted to await the results of the third party investigative processes, counsel for the insurer in argument submitted that the matter be adjudicated on a linear time line assessment of the period from the date of submission of the claims until the applications were issued some six months later. The further question is therefore whether the respondent can now adopt such a "that was then, this is now" approach (or, as it was referred to at the hearing, a narrow approach) and escape the consequences of its actions (or more accurately, inaction) by seeking to now rely on a simplistic timeline determination of what would constitute "a reasonable period" in the circumstances.

COMMON CAUSE

FACTS

[5] The material terms of the two policies are substantially similar and the further material facts are identical. It is therefore convenient to deal with the two applications simultaneously.

[6] The following facts are common cause between the parties: -

1. Each of the Essential Life Plan - Superater (commencing 1 October 2010) and the Classic Life Plan (commencing 1 December 2005) ("the policies") is in force;
2. One Geoffrey Wiggill ("the deceased") died on 19 June 2013 of gunshot wounds sustained during a shooting incident;
3. The applicant is not a suspect in the criminal investigation relating to the deceased's death (another suspect had been arrested and is apparently awaiting trial);
4. Before his death the deceased (the insured life in terms of the policies) was suspected of having been involved in illegal activities

both personally and in his capacity as director of First Strut (Pty) Limited ("First Strut") in terms whereof financial institutions were defrauded of some R1 billion;

5. The applicant, a beneficiary in terms of the policies, submitted a claim in accordance with each such policy on 3 July 2013;
6. The respondent called for substantiating documents and information during July 2013 which were duly supplied and the relevant documents and information to process the claims had since then been in the respondent's possession;
7. Later in July 2013 the respondent's representatives informed the applicant that the respondent had been advised that it would not be prudent to pay out any claims in terms of the policies until the South African Police Service's investigation into the deceased's death had been finalised;
8. On 25 July 2013 the respondent also notified one Thyne on behalf of the applicant that it would withhold any further assessment of the claim until the requisite investigations had been completed (which included enquiries into the deceased's dealings with First Strut);
9. First Strut paid the monthly premiums in respect of the policies;
10. First Strut was wound-up by order of the High Court (Gauteng Division, Pretoria) on 16 July 2013;
11. The aforesaid "requisite investigations" include the SAPS investigation into the deceased's death, enquiries in terms of sections 417 and 418 of the Companies Act, 61 of 1973 into the affairs of First Strut and an enquiry in terms of section 152 of the Insolvency Act, 24 of 1936 into the affairs of the deceased's insolvent estate;

12. The respondent has never conducted its own investigation into the alleged illegal activities of the deceased or First Strut and nor has it undertaken any independent assessment of the merits of the claims with the view of (possibly) avoiding liability;
13. A letter of demand for payment of the proceeds of the policies was duly delivered by the applicant's attorney to the respondent in November 2013, to which no response was received;
14. These two applications for payment in terms of the policies were issued in December 2013 and heard on 30 July 2014; and
15. The respondent did not repudiate liability in terms of the policies.

MATERIAL TERMS OF THE POLICIES

[7] The following terms of the policies appear to be material and were referred to in argument; -

1. Clause 12.2 provides as follows:

-“12.2 Death claims

12.2.1 The benefit payment will be made to the nominated beneficiary or cessionary. The beneficiary or cessionary, or any other nominated person, such as the executor of the estate, needs to notify the financial adviser or Discovery Life's service centre of the death claim.

12.2.2 In addition to the forms and protocols required, the beneficiary or cessionary will also be required to provide Discovery Life with the following details within sixty days of the date of death:

the date and cause of death

the contact person responsible for completing the documentation

12.2.3 Should Discovery Life reject the claim and the beneficiary or cessionary wants to challenge the decision legally, the beneficiary or cessionary must do so within six months of the date of rejection. If they fail to do this, they will forfeit any potential benefit payments as a result of the claim. ”

2. Clause 18.1.5 provides as follows: -

“No immediate Life Cover claim will be payable where the life assured died by his/her own act, whether sane or insane or at the hands of justice. ”

3. Clause 18.1.8 provides as follows: -

"The lives to be assured do not engage, nor intend engaging, in any hazardous activities, including occupations and pursuits. ”

4. Clause 18.1.10 provides as follows: -

“Payment of the immediate Life Cover benefit will be made to the beneficiary nominated in the application.”

5. Clause 18.5.1 provides as follows: -

“Disclosure of all relevant facts

You warrant that all information provided to you in terms of any application for assurance, reinstatement of a lapsed contract or membership of any Fund will form the basis of the contract. In this regard you warrant that:

You have disclosed all material information; and you will continue to disclose material information between the date of this application and either the commencement date of the policy, or the acceptance of risk by Discovery Life, whichever occurs last

You understand that any breach of your warranty may result in the contract being declared void by Discovery Life or the terms on which the policy was issued being rectified by Discovery Life and contributions paid being used to offset expenses incurred by Discovery Life. ”

[8] The Application for Assurance form completed by the deceased contained the following question which was answered in the negative: -

“29. General disclosure

Are there any circumstances not already mentioned that may affect the risk relating to the proposed cover? Such factors/circumstances could be that you have indulged in or consumed narcotics (that were not prescribed by a medical practitioner) or that you have engaged in illegal activities such as drug trafficking, extortion, ..., robbery (armed or not). If yes, please give details”

REASONABLE TIME TO ASSESS A CLAIM

[9] In *Union National South British Insurance Co Ltd v Padayachee*¹ it was accepted that the insurer has a reasonable time to assess the insured's claim (prior to either repudiating liability or honouring the insurance contract). The context in which this assessment features in the present matters is however unusual. The respondent contends that it should be permitted to postpone its assessment until the various investigations and enquiries referred to above have been concluded, as they might shed light on the merits of the claims. It is unclear how the respondent would know of, and then proceed, once information becomes available and how, in any event, it would procure access thereto. The respondent acknowledges that it has no right to such information and suggested that it would contact the liquidators and request them to co-operate and supply such information. Mr Mundell further submitted that if such access by consent was refused, the applicant could approach a court to grant the necessary access

orders.

[10] Quite apart from the dubious legal basis for such possible application for access, it is obvious that what the respondent is

proposing is a further drawn-out process. Only after the already time-consuming investigative processes are “finalised” could the issues of access and then the assessing of (possibly helpful) information commence. Litigation regarding access could take years to conclude and the assessing of such information probably further weeks, if not months.

[11] It is further apparent that during a six month period (from submission of claims until the applications were issued) the respondent did not make even the most basic enquiries as to the progress of any of the investigative processes (save for stating that two hearings had been convened) and when it was likely to be finalised.² Furthermore, nothing was placed before me suggesting that these processes were likely to reveal the type of information sought by the respondent in order for it to assess its position, in fact, the high-water mark of its case is stated in the answering affidavit to be thus: -

“7. Had the respondent, at the time of Wiggill’s application for insurance, been notified by him of the extent of the unlawful activities in which he was engaged and that the premiums payable in terms of the relevant policy of insurance may indeed have been part of the proceeds of Wiggill’s unlawful activities, the policy would never have been issued. The issue of a policy of insurance in Wiggill’s favour in those circumstances would not only amount to the respondent acceding to Wiggill’s benefitting from the proceeds of unlawful activities, but would, in the circumstances, be contra bonos mores;

8. Given Wiggill’s failure to disclose the relevant facts (if they are demonstrated to be true through the various enquiries regulated by the Companies Act and the ongoing criminal investigation), the respondent will become entitled to and shall, elect to void the policy of insurance. In doing so the respondent will rely on the provisions of section 59 of the Long-Term Insurance Act, 52 of 1998 and the appropriate empowering provision in the policy contract. Wiggill’s nondisclosures were material to the assessment by the respondent of its risk.” (own emphasis)

DUTY TO DISCLOSE AND SECTION 59 (ACT 52 OF 1998)

[12] Pursuant to much needed regulation of the insurance industry some years ago, section 59 of the Long-Term Insurance Act, 52 of 1998 now provides as follows: -

“59. Misrepresentation and failure to disclose material information

(1)(a) Notwithstanding anything to the contrary contained in a long-term policy, whether entered into before or after the commencement of this Act, but subject to subsection (2) -

(i) the policy shall not be invalidated;

(ii) the obligation of the long-term insurer thereunder shall not be excluded or limited; and

(iii) the obligations of the policyholder shall not be increased, on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any variation thereof

(b) The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular

information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk”

[13] The onus is on the insurer wishing to avoid the contract to establish that material non-disclosures were made and that this materially affected its risk.³

[14] There is no basis in law to suggest that the issuing of a policy under the alleged (albeit as yet, unfounded) circumstances of non-disclosure, would necessarily be contra bonos mores. The line of cases dealing with the prohibition against a beneficiary under a policy of insurance benefiting from the policy when he-or she has engaged in unlawful conduct or activities which brought about the risk-creating event, is not applicable in casu. The allegation is that the deceased (who is not the beneficiary under the policy) was engaged in the unlawful activities (personally or by using the entity which paid the monthly premiums, as vehicle for such activities). Where, as here, there was however still privity of contract between the deceased (the insured life) and the insurer, there appears to be no reason why the contractual duty to disclose would not remain applicable. Issues as to bona fides may then indeed arise.

[15] Generally however, the duty of disclosure of material facts arises (and ceases) upon conclusion of the (insurance) contract. The learned authors, Gordon & Getz in *The South African Law of Insurance* (4th edition, pp 126 to 128) enunciate it as follows: -

“The duty of disclosure continues throughout the negotiations. It terminates when the contract is concluded. Material facts which come to the proposer's knowledge before the contract is concluded, or facts which, though previously immaterial, become material owing to changed circumstances before then, must be disclosed. Once the contract has been concluded, however, the proposer is not obliged to disclose further material facts.

...

In an ordinary life policy the rule is different. The life insurance contract is a continuing contract which the insured has the right to keep in existence by paying the premiums when they fall due.

As the ‘renewal’ is not a ‘new contract’, no fresh duty to disclose arises.

The question of the duration of the duty to disclose material facts arose in *Pereira v Marine & Trade Insurance Co Ltd*, where it was contested inter alia, by the insurer that the duty of disclosure persisted after the conclusion of the contract of insurance, and affected the insured in all his dealings with the insurer including the completion of the claim form, Corbett JA could find no authority to support this argument and he added that 'certainly the purpose and rationale of the pre-contract duty of disclosure could hardly apply after the conclusion of the contract'. The court was not required to decide this point, for the fact that allegedly had not been disclosed was not material to the risk. In addition the 'conditions of policy define and are intended to define the full extent of the insured's duty to furnish information concerning the accident, loss or damage and ... there is no room for any superadded duty to disclose.' "

[16] It would therefore have been incumbent on the respondent to establish that at the time of conclusion of each policy, the deceased had failed to disclose material facts which entitled the respondent to avoid the policies ab initio. There is nothing in the answering affidavits which supports this. Nor has any basis been suggested for a finding that as at the date of inception of each policy (in 2005 and 2010, respectively) the deceased had been engaged in illegal activities and that the proceeds derived from such activities were to be the source of funding of premiums (even assuming the latter to be sufficient to void the policies).

[17] Section 59 of Act 52 of 1998 refers to both a misrepresentation of material facts and the non-disclosure thereof, and restricts any determination thereof to "the time of its issue or at the time of any variation thereof". This is commensurate with the above-stated position that the misrepresentation or non-disclosure must be determined with reference

to the time of the conclusion of the insurance contract, in casu, the parties expressly agreed that the deceased would continue to disclose material information between the date of this application and either the commencement date of the policy, or the acceptance of risk by Discovery Life, whichever occurs first' (clause 18.5.1 supra).

[18] The respondent's expectations as to what information the investigative processes might yield thus become even more remotely

achievable. The information gained from the investigative processes must not only be sufficient to establish a material misrepresentation

or non-disclosure but also, such information must have been germane at the time of commencement of the policies. Any subsequent illegal conduct would be wholly irrelevant to the issue at hand.

FAILURE TO ASSESS AND RIGHT TO DEFER

[19] If an insurer is entitled to a reasonable time to assess a claim, it would seem to follow that if such insurer wishes to avoid liability to make payment in terms of a policy, it is bound to repudiate the claim within a reasonable time. At the risk of oversimplification,

the insurer's duty in this regard may not be entirely dissimilar⁴ to the right of an innocent contracting party following the other party's breach, to elect to either abide or cancel a contract. Nearly a century ago, Watermeyer AJ (as he then was) aptly expressed the nature of the innocent contracting party's election as follows in *Segal v Mazzur*:⁵ -

"Now, when an event occurs which entitles one party to a contract to refuse to carry out his part of the contract, that party has a choice of two courses. He can either elect or take advantage of the event or he can elect not to do so. He is entitled to a reasonable time in which to make up his mind, but when once he has made his election he is bound by that election and cannot afterwards change his mind. Whether he has made an election one way or the other is a question of fact to be decided by the evidence

[20] Mr Subel argued that a period well in excess of a reasonable time has in any event now (a year later) elapsed without the respondent electing to repudiate and instead, the respondent has decided to passively await the outcome of the investigative processes, without proffering a proper basis for expecting it to yield relevant information or provide a basis justifying a repudiation. The applicant is expected

to wait indefinitely for the respondent to eventually make an election. The argument gathers even more momentum given that the

respondent, in failing to assess the claims, has rendered time and the (in)adequacy thereof, irrelevant. Time simply played no part in the respondent's deliberations and in its decision to defer.

[21] I am not aware of English or South African authority on the right of the insurer to defer its assessment or election pending information from third party investigative processes which it hopes to benefit from and the limitations or requirements which the law will impose in such a situation. One can well imagine instances where the insurer's utilisation of such institutional or third party processes would not offend one's sense of reasonableness or fairness. Insurers often rely on, for example, blood test results from a SAPS investigation or reports from (third party) private detectives to inform their decision to either repudiate or abide an insurance contract.

[22] In the end it might simply be a balance of fairness to both insurer and insured in the prevailing circumstances of the matter, which would determine the time which the law would reasonably afford the insurer to exercise its election. It is unlikely that an insured would have an unlimited timeframe within which it can seek to escape liability due to its inability (perceived or genuine) to assess a claim. Litigants are on a daily basis faced with all manner of limitations and obstacles in gathering the necessary evidence and information relevant to their cases. At some point however, time is up and the clock must (and does) stop.

TIMELINE ASSESSMENT

- [23] Faced with the inherent difficulties in “the right to defer” defence, Mr Mundell posted the respondent’s flag to a timeline assessment mast. He argued that given the peculiar circumstances of the matter, a six month period was reasonable for the respondent to have assessed the claims. He submitted that because the six month period between the submission of the claims (July 2013) and the issuing of the applications (December 2013) is not objectively speaking unreasonable, the applications should be dismissed as they were premature. (In this regard, reference was incidentally made to the six month period in clause 12.2.3 supra of the policies.)
- [24] The test to be applied, according to Mr Mundell, was whether the reasonable claims assessor receiving these claims was possessed of all the facts necessary to make a decision in July 2013 and, by extension, any time before the applications were issued in December 2013. The problem of course is that the evidence reveals that the claims assessor was indeed in possession of the documentation and information to process the claims, but that the respondent effectively decided that it would not (have the claims assessor) assess them.
- [25] In developing his argument, Mr Mundell submitted that it was never the applicant’s case that the respondent was taking an unreasonable time to assess the claim. He submitted that had that been so, the applicant would have communicated this and that the applicant was, in any event, obliged to make out such a case in the founding affidavit. I am unpersuaded that a specific reference to what is clearly a necessary inference, is required. The demand and issuing of the applications, in my view, represent clear and strong language that the respondent’s failure or refusal to pay was regarded by the applicant as being unreasonable. Even more so as Mr Subel submitted, when all the jurisdictional requirements for payment in terms of the policies were satisfied by the applicant, before the applications were issued. Conversely, Mr Subel argued that it is the respondent who failed to raise the unreasonableness of the assessment period as a defence, and is now relying on facts in conflict with such contention.
- [26] While it is perfectly permissible for a party to advance alternative propositions in argument, when the basis of its original case is disavowed at the eleventh hour (i.e. during argument), such a party may not be able to escape the consequences thereof ex post facto, if the facts upon which its defence or case was originally predicated do not allow for a materially different approach in argument, the inevitable will follow. Often the “new” approach will lack the necessary factual matrix to sustain itself or worse, may be contradicted by facts in support of the earlier defence. In the end, such a defence may well turn out to be “long in submission but exceedingly short on fact”.⁶
- [27] At first blush the narrow stance now adopted by the respondent may appear attractive. For one thing, it directs the enquiry of “a reasonable time to assess” to a simple timeline assessment which legal practitioners are familiar with. It may also be that a period of six months will in certain circumstances, not be regarded as excessive per se. The answering affidavit however reveals that it had never been the respondent’s case that the time period between the submission of the claims and the issuing of the applicant’s applications was

unreasonable and that it needed more time to assess these claims. The respondent's case has always been that it does not have to make an election until some indeterminate point in time when the investigative processes may unearth some basis for it to either repudiate the applicant's claims or honour the policies. This basis of opposition was proffered in July 2013 and to this day it remains the only reason why it is refusing to honour the policies. No other reason appears to exist for withholding payment and none was suggested in the answering affidavit.

- [28] The respondent asserts the right to be afforded a reasonable time to assess the claims, while it is clear that such time as it had (some six months), was not utilised in assessing the claims. The respondent made this plain within a month of the claims having been submitted. The time period which had elapsed, played no role in the assessment of the claims. The respondent deliberately made no assessment and this period did not enable it to make one or, cause it any immediate embarrassment, in not being able to make one. Nor did the respondent complain of the lack of time or request more time for the assessment (either initially or subsequently). Some five months of the six month period consisted of the respondent simply maintaining its position that it does not have to elect to either repudiate liability or pay out the proceeds.

FINDINGS

- [29] In all the circumstances, I have little hesitation in finding that the respondent has not established any basis for withholding payment and that it has done no more than raise a notional and, in my view, remote prospect that evidence might emerge in due course justifying it to repudiate liability.
- [30] In addition, the respondent has failed to establish that the six month period between the submission of the claims and the issuing of the application constitutes, when viewed objectively, an unreasonable time for it to have assessed the claims, especially given its decision not to do so. In my view, the applicant was quite entitled to force the issue.

COSTS

- [31] Mr Mundell (correctly, I believe) did not oppose Mr Subefs request that costs should include costs of two counsel. I however decline the invitation by the applicant to make a punitive costs

order. There is no basis for holding that the respondent's opposition was frivolous or vexatious. Given the dearth of authority

in both South African and English law and the unusual circumstances of the matters, I find no basis for penalising the respondent because its opposition was, according to the applicant, “as breathtaking in [its] novelty as in the absence of any factual substrate”. Overly cautious as it may have been, the respondent understandably harbours genuine reluctance at paying out substantial amounts of money to the applicant in circumstances where the deceased’s alleged illegal activities may have dictated otherwise. In this it was wrong, nothing more.

ORDERS

[32] I make the following orders: -

In case number 46154/2013: -

1. The respondent is ordered to pay the applicant, within 5 (five) business days of the grant of the order, the extent of the policy proceeds that the applicant is entitled to receive under and in terms of a policy described as an Essential Life Plan - Superater bearing number 513 0526 764;
2. The respondent is ordered to pay interest on such policy proceeds at the rate of 15,5 % interest from 25 July 2013 to 31 July 2014 and at the rate of 9 % from 1 August 2014 to date of payment;
3. The respondent is ordered to pay the costs of this application, which costs are to include the costs of two counsel.

In case number 46155/2013: -

1. The respondent is ordered to pay the applicant, within 5 (five) business days of the grant of the order, the extent of the policy proceeds that the applicant is entitled to receive under and in terms of a policy described as a Classic Life Plan Policy bearing number 513 007 8474;

FJ BECKER

ACTING JUDGE OF THE HIGH COURT

DATE OF HEARING; 30 July 2014

DATE OF JUDGMENT: 19 August 2014

FOR THE APPLICANT:

ADV A SUBEL SC

With him: -

ADV D VETTON

INSTRUCTED BY: -

JOHN JOSEPH FINLAY CAMERON ATTORNEYS

SANDTON

FOR THE RESPONDENT:

ADVA MUNDELL SC

KEITH SUTCLIFFE AND ASSOCIATES INCORPORATED

JOHANNESBURG

11985(1) SA 551 (A) at 560.

2 Enquiries in terms of sections 417 and 418 are rarely finalized in the traditional sense (as was pointed out by Mr Subel).

3 Mutual & Federal insurance Co Ltd v Oudtshoorn Municipality 1985(1) SA 419 (A) at 433E-F, 434C-D, 442F-H and 445D-E/F; Qilínqeie v SA Mutual Life Assurance Society 1993(1) SA 69 (A) at 73E-F and 75G; Clifford v Commercial Union Insurance Co of SA Ltd 1998(4) SA 150 (SCA) at 156D-I; Joubert v ABSA Life Ltd 2001(2) SA 322 (W) at 325C - 327G.

4 The difference of course is that the innocent contracting party procures a right between two remedies and the law can not generally question which it chooses to exercise (provided, in the case of specific performance, there is no undue hardship), whereas, the correctness of the insurer's repudiation of a claim is always open to challenge.

5 1920 CPD 634 at 644 - 645.

6 In the words of Heher JA in Wightman t/a JW Construction v Headfour (Pty) Ltd and another 2008(3) SA 371 (SCA) at 378G (in the context of disputes of fact).

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