THE OMBUDSMAN'S BRIEF CASE.

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(Newsletter of the Ombudsman for Short-Term Insurance)

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OMBUDSMANS ADVICE

Accident not reported to the police within 24 hours

Whilst the Insured was travelling from Hazyview to White River at 20h30, a duiker ran in front of the vehicle and she hit it with the right hand side of her vehicle. She then swerved to the left and hit the curb and sustained so much damage that the vehicle had to be towed from the scene. In view of the fact that no other vehicles were involved, the Insured did not consider it necessary to report it to the Police. When she reported the claim to the Insurer, she was advised that she had to report the accident to the Police within 24 hours after the accident. She ultimately reported the accident to the Police seven days after the accident. The Insurer repudiated liability on one ground alone, i.e. that the Insured had failed to report the accident to the Police within twenty-four hours after the accident.

Ombudsman's response

The Ombudsman pointed out to the Insurer that there were no other parties involved and that the Insured did not consider it necessary to report the accident to the police. Furthermore, she may have been misled by the employee of the Insurer that she had seven days to make the report. In any event, the only possible prejudice the Insurer may have suffered by the Insured's failure to report the accident, is that the Insurer may not know whether the Insured was under the influence of alcohol. If there were any suspicions, it would be straightforward exercise to contact the towing company and establish the facts from them, as they arrived on the scene shortly after the accident. In addition, the Motor Assessor would also be in a position to confirm whether the Insured had hit a buck. The Insurer was then persuaded to admit the claim.

Delay in submitting written details of claim within thirty days of event and authorising repairs without insurer's consent (in terms of a motor warranty policy)

The Insured had a chapter of disasters. He was in Rustenburg on a business trip when he sustained engine damage because of cam belt failure. The brakes and the engine were rendered ineffective. The next morning further damage was sustained to the vehicle with a tow truck because of the brake failure. The same day he contacted his Insurer about the procedure for towing the vehicle to Johannesburg, and he was then informed that the facility was not covered by his Policy. He telephonically informed the Insurer of the accident and confirmed this with a telefax. On the same day, i.e. 31st July 2003, he received from the Insurer a claim form, which clearly stated that the completed claim form, together with supporting documents, are to be forwarded to the Insurer within thirty days of the incident. Almost two and a half months later, i.e. on 10th October 2003, the Insured sent his written claim form to the Insurer. It was received by the Insurer on 16th October 2003. The Insured in the meantime had his vehicle repaired. The Insurer repudiated liability.

Ombudsman's response

The Ombudsman agreed with the Insurer that the Policy clearly spelt out to the Insured that he had to submit written details of the claim within thirty days, and that the Insurer had been prejudiced because it was not given the opportunity to have the vehicle assessed shortly after the loss and before repairs commenced, and thus mitigating the loss. The Insured's reasons for delay were entirely of his own creation, and the Ombudsman agreed with the Insurer that it was entitled to maintain its repudiation in these particular circumstances. Late notification is normally viewed as a technical defence where there is no other reason to decline the claim and Insurers agree to waive this defence.

Factory fitted immobiliser

On 7th March 2004, the Insured's BMW was stolen in Roodepoort. The Insurer repudiated liability because the Insured had failed to provide documentation that the BMW was fitted with a VESA approved immobiliser, although a factory fitted alarm was in place.

Ombudsman's response

The Policy requirement was for a VESA approved immobiliser to be installed in order for theft and hijack cover to operate. The Ombudsman managed to confirm that the factory fitted equipment met with the

V.S.S. standards and should thus be acceptable to the Insurer. The claim was settled.

Alleged that insured's authorised driver was under the influence of alcohol and drove at an excessive speed

On 26th July 2003 and at approximately 20h45, the Insured's Citroen XSARA 2.0, was damaged beyond economical repair. At the time of the accident, the vehicle was driven by the Insured's brother. The collision occurred on the well-known R24 and the Insured's brother was travelling towards the Airport, i.e. in an easterly direction. The Insurer repudiated liability on two grounds, i.e., the driver was driving whilst under the influence of alcohol and he was driving at an excessive speed. The Insurer contended that although the breathalyser test indicated a reading of 0,015, the driver had admitted to consuming three beers and witnesses had described him as being under the influence of alcohol. Witnesses had also stated that the driver had been travelling "at a much higher speed than the allowed 120 Kms per hour".

Ombudsman's response

The Ombudsman pointed out to the Insurer that the Policy wording excluded cover whilst the vehicle was being driven by any person whilst under the influence of alcohol. The onus rested on the Insurer to prove the exclusion. The Insurer was unable to offer any evidence which would have supported the allegation. The witnesses at the scene were not qualified to express an opinion, particularly as the vehicle had rolled several times and the driver suffered injuries and shock which could have created the impression that he was under the influence of alcohol. The other issue raised by the Insurer of the vehicle being driven at an excessive speed, is not relevant in view of the wide cover in terms of the Motor Policy, which includes negligent acts of the driver of the vehicle. The Insurer initially would not concede, but after having been advised by the Ombudsman that he felt strongly about the matter and would consider making a ruling, the Insurer agreed to settle the claim.

Insurer completing a proposal form on behalf of the insured

On 25th August 2003, the Insured's property was burgled. The Insurer repudiated liability because the Insured had a previous burglary claim during March 2003, which she allegedly failed to disclose when she applied for cover two months before the 2nd burglary.

Ombudsman's response

The Ombudsman pointed out to the Insurer that the Insured did not complete the Proposal, which was completed by a staff member of the Insurer and sent to her for signature. The telephone conversation was not recorded and the Insured was adamant that the question relating to previous losses was asked and answered, and whilst she signed the form she did not notice that the question had not been completed. The Insurer accepted the Insured's version of events and settled the claim following the Ombudsman's intervention.

Insurer wrongly presuming material change of risk address

The Insured spent the years 2000 and 2001 working in London, sometimes up to seventy hours per week to accumulate money to purchase a car on his return to South Africa. On his return home, he had difficulty in finding a job, so he decided to further his studies to improve his chances in the market place, as a graphic designer. In order to complete his studies and for future work purposes, he bought his car and took out Comprehensive Insurance. On 29th October 2003, his car was stolen in Johannesburg. The Insurer repudiated liability on the ground that the Insured was guilty of a material change in the risk address where the vehicle would be kept. At the inception of the Policy the Insured had given his address as 129, Yellowwood Place, Morgan's Bay, but his car was stolen in Johannesburg.

Ombudsman's response

The Ombudsman obtained documentation from the Insured confirming that he was not a fulltime student at Greenside College of Design, Johannesburg, but was taking a fifth year BA Honours Degree programme and he accordingly stayed the bulk of his time in Morgan's Bay with his parents and only came to Johannesburg on four occasions during 2003 for one to two-week periods on each occasion. The Insurer was then persuaded to admit the claim.

Factory fitted gearlock

The Insured purchased a Toyota Tazz from Rand Stadium Toyota. Because the Tazz was fitted with a factory gearlock, a standard equipment, the Insured considered that her gearlock was adequate for Insurance purposes. On a Saturday morning, and whilst she was working, the Insured's Tazz was stolen. The Insurer repudiated liability because the gearlock was not VESA approved.

Ombudsman's response

In view of the fact that the Policy contained a condition which read as follows,
"It is a condition precedent to any claim for loss of or damage to the vehicle (other than Sedan type vehicles under R20,OOO in value) arising from theft or any attempt thereat that the vehicle be equipped with at least a VESA 3 Level immobiliser or VESA approved Gearlock." And because the gearlock was not VESA approved, the Ombudsman agreed that the Insurer was entitled to maintain its repudiation. The Ombudsman was also not satisfied that the system met the required V.S.S. standard.

Mechanical breakdown insurance

When the Insured took out his Engine Guarantee Policy on 16th January 2003, he pointed out to the Broker that the Pajero had previously been serviced every 10,000 Kms. until 120,000 Kms. He then arranged to have the service intervals changed from every 10,000 Kms. to every 20,000 Kms. At 176,000 Kms. he had a problem with the Pajero's differential and he when he lodged a claim, it was repudiated because he had failed to service the vehicle every 10,000 Kms.

Ombudsman's response

The Ombudsman pointed out to the Insurer that the Insured had reasonably been brought under the impression that a service every 20,000 Kms. was in order. The Insurer agreed that there was confusion with regard to the service period and that the Insured should be given the benefit of the doubt. The claim was then admitted on condition that in future the Insured serviced his Mitsubishi Pajero every 10,000 Kms. as is in fact provided for by the manufacturer.

Burst geyser: insured appointed his own plumber

The Insured, a Financial Planning Consultant got more than he bargained for on Boxing Day 2003. At about 22h30 his geyser burst — he turned off the geyser's electricity as well as water supply. At approximately 08h30 on Saturday, 27th December 2003, he telephoned the emergency share call number of the Insurer and the message that he received after being transferred to the approved plumber's number, was "the subscriber you have dialled is not available at present. Please try again later". The Insured continued to phone the sharecall number for the next hour, but he continued getting the same message. In desperation he then took his Yellow Pages Directory and found the number of The Drain Surgeon. He decided to use this company as it stated on its advert that it was an Insurance approved plumber. The Drain Surgeon fixed the problem quickly and professionally and the Insured then paid the plumber's bill amounting to approximately R4,700. The Insured submitted his claim to the Insurer, which after taking the Excess of R500 into account paid a settlement in the region of R2,700, leaving a shortfall of R1,500.

Ombudsman's response

The Ombudsman pointed out that the Insured through no fault of his own, was unable to speak to an approved plumber designated by the Insurer and that it had not provided for an

alternative number or even a company name via the sharecall number. The Insurer conceded and made payment of the shortfall of R1,500.

Rebuilt vehicle hijacked

On 13th September 2003, the Insured had the misfortune to have her Volkswagen Citi Golf hi-jacked. The Insurer admitted the claim, but deducted 25% off the value of the vehicle, because the investigator had found out that the vehicle had been rebuilt and consequently this has affected the market value.

Ombudsman's response

It was conceded by the Insurer that they had inspected the vehicle and found it to be acceptable for insurance purposes without any adverse comment about its condition. They agreed that the deduction of

25% was rather harsh and reduced this to 15% which was acceptable to the Insured.

Change in risk address wrongly presumed

"I have had some serious bad luck with cars in Johannesburg, having two cars stolen in six weeks in November and December 2002." The Insured then decided to move to Great Brak River, Southern Cape, which became her permanent residence. Her ex-boss requested her to come and help out at her Boutique in Hyde Park, Johannesburg, for a couple of weeks in August 2003 while two of her staff members were away. The Insured then decided to go North during the month before, to make it a holiday with her fianc6 and visit family and friends. She stayed with her parents in Kempton Park. Bad luck with cars continued to follow her, because on 2gth July she was involved in a collision whilst visiting friends in Pretoria, when an elderly man skipped a red robot. Her vehicle was eventually repaired and two days after receiving the repaired car, she was involved in yet another collision on 29th August 2003, when she got lost following directions from friends in Midrand to Kempton Park and was driven off the road by what appeared to be an oncoming taxi overtaking on a blind sharp bend. The Insurer repudiated liability on the ground that she had failed to advise of the change of the risk address.

Ombudsman's response

It was obvious that there was no permanent change in risk address and the visit to Johannesburg was for the reasons set out above, and to notify an Insurer every time an Insured temporarily visits or goes on holiday, is unreasonable. The Insurer met the claim.

Smooth tyres

The Insured entered a traffic light controlled four-way intersection at a speed of 50 to 60 Kms. per hour. The green light was in his favour and just before he entered the intersection, an Isuzu white Bakkie entering the intersection from the opposite direction executed a turn to the lsuzu's right, i.e. across the direction of travel of the Insured. The Insured applied brakes slightly and noticed that the light was still green for him. To his surprise a Mazda 323 followed the manoeuvre of the Isuzu Bakkie and a collision occurred. The Insured's Toyota collided with the Mazda's left rear door. The Insurer repudiated liability on the ground that the two front tyres were smooth and that liability is excluded as a result of "damage to the vehicle caused by or attributable to an unroadworthy condition of the vehicle".

Ombudsman's response

The Ombudsman pointed out that having regard to the circumstances of the collision, the smooth tyres had no causal connection to the collision and the subsequent damage to the complainant's vehicle. The Insurer was persuaded to meet the claim.

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OMBUDSMAN FOR SHORT-TERM INSURANCE

Who and what is the Short-Term Insurance Ombudsman?

The office of the Ombudsman for Short-Term Insurance (General Insurance) has been in existence since 1989 and it is thus in its fifteenth year. The first Ombudsman was acting Judge Bill Schreiner, and he was succeeded in 1995 by Mike Bennett, an Attorney with Webber Wentzel, who continued until the end of 2001. I have been appointed for a period of five years (renewable).

Other Ombudsmen with whom I interact are:

- Long-Term Ombudsman, Judge Peet Nienaber. He is appointed for a period of five years since January 2003.
- Banking Ombudsman, Advocate Neville Melville. He is appointed for a period of five years (renewable), and his five-year period comes to an end early in 2005.
- Pension Funds Adjudicator, Vuyani Ngalwana, who is on a three-year contract, and he was

appointed 1st March 2004.

- FAIS Ombud, Charles Pillay, who is also on a three-year contract, and he was appointed in the first half of 2003.
- Credit Information Ombud, Manie van Schalkwyk, whose offices are in the same building as the Banking Ombudsman. This is a newly created office and his appointment is for twelve months, and the whole office and appointment will be revised after the initial twelve months period.
- Motor Industry Adjudicator, Johan van Vreden, who has been in operation since 2001. His is an entirely voluntary organisation and thus far he has all the manufacturers *I* distributors on board, save for Land Rover, Ford and Volkswagen.

Statutory opposed to Voluntary

The Pension Funds Adjudicator and the FAIS Ombud, are Statutory Ombudsmen. In other words, the offices have been created by an Act of Parliament. The remaining Ombudsmen are all Voluntary Ombudsmen, i.e. their office has been created by the Industry itself.

What is the effect of being a Voluntary Ombudsman as opposed to a Statutory Ombudsman?

A Voluntary Ombudsman can make its own rules and regulations and they can be amended with little difficulty.

A Voluntary Ombudsman can by agreement determine jurisdiction and be given authorities which are far greater than that given to Statutory Ombudsmen.

The Statutory Ombudsman's jurisdiction and powers are limited and circumscribed by an Act of Parliament.

How independent is the Short-Term Ombudsman?

Mr Helm van Zijl, appointed by the Council for the Ombudsman, which consists of nine members. The constitution of this Board is interesting insofar as the Insurance Industry does not have the majority, i.e. four are from the Insurance Industry, four represent consumers and one is from the Financial Services Board.

What are my powers and jurisdiction?

By agreement with all Insurers, I have the power to make a formal ruling, which is binding on an Insurer and to which there is no right of appeal. My jurisdiction is limited to Personal Lines claims only, i.e. for private individuals in their personal capacities. The maximum amount per claim is R800 000, but this can by agreement be increased. All Commercial claims or claims by Commercial ventures fall outside my jurisdiction. There is a debate that the jurisdiction of the Short-Term Ombudsman should be expanded to include Business claims from small Businesses, i.e. not the huge Businesses who can afford their own Attorneys.

How big is my office?

There are a total of six Claims Handlers and twelve other support staff, making a total of eighteen.

How is my office funded?

My entire budget is funded by debiting an Insurer a fee per complaint. The volume of complaints has increased phenomally over the past two and a half years, with the result that we have been able to reduce the fee in the last two years.

How do we deal with complaints?

We require a written Application form to be completed. This can be submitted to us via our website, by fax or snail mail. The written complaint is submitted to the Insurance Company and very often, because a more senior person who interacts with my office on a regular basis, looks at a claim, it is admitted there and then.

In any event, once the Insurer has responded we may there and then, point out to the Insurer that he is wrong with an adequate explanation, or we may obtain further information from our client. We also meet with Insurers on a regular basis and a number of disputes are resolved at this meeting by way of

negotation. We try to keep the relationship a cordial and friendly one. The essence is to build up mutual trust. There are occasions however, where you have to threaten a ruling and ultimately, make a ruling.

How long does it take to finalise a claim?

I have to report to my Council how many claims are unresolved after six months. The reason for this requirement is that one of the basic principles of an Ombudsman's office is that there must be a speedy resolution. At my very first Council Meeting towards the beginning of 2001, I recorded that there were 650 claims outstanding for more than six months. This was out of approximately 2,500 complaints received in the previous year. Notwithstanding the fact that we have received a considerable increase in the volume of complaints, we succeeded in reducing the six-month list at the end of 2003 to 37. The average time for finalising a matter has been brought down to just over three months per claim.

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INCREASED JURISDICTION OF THE SMALL CLAIMS COURT

In terms of the Small Claims Court Act 61 of 1984, as amended, the jurisdiction of the Small Claims Court has been increased from R3000 to R7000. This is in keeping with a growing recognition for the need to address disputes being resolved in a speedy, cost effective manner and to same extent, to avoid the costs and adversarial approach of litigation - especially in the Magistrates Court. The amendment has an effective date of 1st April 2004.

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POTOCNIK V MUTUAL & FEDERAL INSURACE CO LTD

2003 (6) SA 559 (SEC)
[Sandi J]

Non-disclosure — Financial history of insured— Materialiy-Test for— Objective reasonable person test — Reasonable person in position of insured
Non-disclosure — Financial history of insured— Materiali{y -Proof of Marine insurance

Facts

In the present case the insured had, through his insurance broker, insured a boat with the insurer concerned for R1 million, which was also the value of the vessel as set out in the agreement. For this purpose a proposal form of some three pages had been completed by answering the 1 8 numbered questions in it. They dealt with matters such as the insured's personal particulars, his naval skills, criminal records, previous insurances and claims, and details of the boat.

The proposal form also contained a statement that 'failure to disclose all material information, ie information which is likely to influence the acceptance of the risk and the terms applied, could invalidate the insurance'. The statement further warned that if the insured was in any doubt as to whether any information was material, it should be disclosed. A final question on the form enquired as to any other information which is likely to influence the insurers in regard to the proposal, that the insured left this question unanswered. Finally, immediately above the insured's signature, the proposal form contained a declaration by him that 'to the best of my knowledge and belief, the particulars and answers are true and

correct and that I have not withheld any information which is likely to influence the decision of the insurers in regard to this proposal'.
The proposal was accepted and the insured paid his annual premium of just over R24,000.
Some months later, en route to the Seychelles, the insured vessel was irreparably damaged and a claim instituted against the insurer. The latter denied liability and sought to avoid the contract '*ab initio'* on the ground of an alleged non-disclosure by the insured of material facts pertaining to his financial position at the time the insurance contract was concluded. The premium paid by the insured was tendered and later repaid by the insurers through the insured's broker. The insured deposited it into his bank account.
The facts pertaining to the insured's financial position during the four years preceding his application for the insurance and not disclosed to the insurer were not in dispute and included that be had borrowed money from two financial institutions for, amongst other things, the purchase and construction of the boat in question; that one of the institutions had obtained three default judgments against him; and that the other one had obtained judgment against him and had attached the vessel, the attachment order being rescinded after he had settled the debt.

The insurer relied for its defence firstly on the non-disclosure of material information.
On behalf of the insured it was argued that the final question on the proposal form had not been put to him by his broker, nor was it explained to him by the broker that it was important for him to disclose all material information. Further, the insured stated that even if the question had been put to him, he would not have known what to disclose as the question did not give any indication of what information was sought from him. Lastly, he thought that at the relevant time he was in any case not in any financial difficulty and would have answered in the affirmative to any question whether he was in a sound financial position.

The Court held that the insured 'cannot escape the fact that the Insurer had entered into the contract with him on the acceptance of the information furnished in the form and that he alone had knowledge of the judgments entered against him'.

Accepting that the insurer bore the burden of proving the facts on (the non-disclosure of) which it relies, their materiality, and the insured's failure to disclose them, the Court held that the insurer had demonstrated the facts in question, that the insured had knowledge of them, and that he had not disclosed them to the insurer.

Even in the absence of the expert evidence tendered by the insurer, the Court concluded, it was clear that the information the insured had failed to disclose was material and that the insurer should have been apprised of it so that it could decide whether to undertake the risk and, if so, at wvhat premium. In all probability, had the insurer here known of the insured's adverse financial position and of the high moral risk that presented, it would have been difficult for it to assess a proper premium and it would, in all probability, not have entered into the insurance contract in question.

Comment
The financial position of an insured and the non-disclosure of facts relating to it, is increasingly a reason why insurers refuse to pay out claims on insurance contracts, even if that financial position has little or nothing to do with the loss being claimed for, and even if it has no bearing on the insured's ability to pay, and on the actual payment of, the premiums. The mere fact that, it has something to do with the assessment of the risk in question (that it may increase the moral hazard by increasing the risk, eg, that the insured may himself in some way or another contribute to or connive at the occurrence of the loss, even though that cannot in any way be established to actually have been the case) is, given the current state of our law in this regard, enough to provide the insurer with a valid defence.
For that, the decision must be considered as being correct in law.

Thirdly, although the case predates the amendment of is 59(1) of the Long-term Insurance Act 52 of 1998 and s 53(1) of the Short-term Insurance Act 53 of 1998 in 2003 by the statutory imprimatur given then to the objective reasonable person test for materiality may well have a bearing on the practical application of the newly formulated statutory test for materiality.

While that test is pertinently a reasonable person test, and not a reasonable insured or reasonable

insurer test (the amended sections now refers to a reasonable, prudent person), one must assume that that is no different from a reasonable person), one of the objections against this test has always been the fact that it smacks of super objectivity. The reasonable person must be contextualised for the test to make sense and to be capable of practical application. For all the pretense of super objectivity by not being seen to benefit either the insured or the insurer, it has been suggested that the reasonable person must be placed in the position of one of the parties to the insurance contract for the test to be applied effectively and that, more specifically, he or she should be put in the place of the insured. After all, we are concerned here with the disclosure of information to enable the assessment of the risk and it is the insured, and not the insurer, who is the party burdened with that duty of disclosure.
The Court in *Potocnik* explained that the Court does not judge the issue of materiality from the subjective point of view of the insured but from that of a reasonable man *in the insured's position.* And if this is correct, the question which crops up is whether there is in fact then any fundamental difference between the reasonable person test for materiality and the reasonable insured test for materiality? Or is it merely a question of semantics?

Acknowledgements: J P van Niekerk – (2004) Juta's Insurance Law Bulletin, pages. 16-21

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BPC INSURANCE BROKERS (PTY) LTD V SCHULTZ

Insurance broker— Duly to inform insured of change o insurer, identity of new insurer, and presence of onerous terms in new insurance contract not present in replaced contract

Insurance broker— Duly not to give insured no or wrong advice as regards latter's obligations under insurance contract

Insurance broker— Liability for damages for breach of contract — Causation —Causal link between brokers breach and insured's loss (i.e., insurer basis for repudiation of insured's claim)

Materiality — Test for— Whether reasonable person would, on own initiative and without being asked, have realised that ought to disclose particular- information in proposal for insurance

Facts
At issue in the case was whether an insurance broker had breached its contractual obligation to give correct information to an insured concerning the making of a claim against the underwriters and, further, 'whether the broker was liable for the loss suffered by the insured when his claim was repudiated by the underwriters.

The insured's vehicle, insured with underwriters at Lloyd's, was damaged in an accident when it left the road. The insured's broker had some time before without the insured's knowledge transferred the insurance of the vehicle in question from a local insurer to underwriters at Lloyd's . Crucially it appeared that the Lloyd's policy required in the event of an accident an immediate report to the police in all cases, while the insured's previous policy had less strictly merely required so if the accident involved theft or loss of property.

On informing the broker telephonically of the accident and requesting a claims form, the insured was allegedly told by one of its employees that as no other vehicle was involved and as no one had sustained injuries in the accident, it was not necessary to report the accident to the police. Given this information, the insured ignored a statement on the brokers' standard letter, which accompanied the requested claims form it received that accidents should be reported to the police. A claim was submitted to the underwriters - without the matter having been reported thus The employees of the broker involved denied having talked to the insured at all or about the need for a police report specifically and in fact

suggested that he obstinately insisted that it was not necessary to report the accident.

Subsequently the insured also informed the assessor appointed by the underwriters that he had been told by the brokers that it was not necessary to have obtained a police report as no third party had been involved. On being told by the assessor that it was in fact a policy requirement, the insured wanted to report the accident immediately to the police but the assessor informed him that it was already too late.

The underwriters rejected the claim on the basis that the accident had not been reported to the police as was required by the policy. The insured therefore instituted an action for damages against the broker.

The insured alleged that it was a term of his contract with the broker that the latter owed him a duty of care, and that this duty had been breached by the broker not informing him of the need to report the accident to the police. The broker admitted a duty of care and the existence of a contractual obligation not to perform its mandate negligently.

The insured alleged three elements of breach: that broker had failed to tell him to report the accident to the police and to submit a police report with his insurance claim; that the broker's employees had misstated to him the requirement of a police report when an insurance claim was to be submitted; and that the broker had failed to inform him after the transfer of the vehicle's insurance of that fact, the identity of the new insurer and the terms of the new policy, in particular the term relating to his obligation to report accidents to the police and to submit a police report with his insurance claim.

The broker, in turn, disputed that it had breached its obligation by not informing or misinforming the insured about this obligation to report the accident.

Further, the broker raised the defense that the underwriters here had rejected the insurance 'claim not, or not solely, based on the insured's failure to report the accident to the police, but (also, if not primarily) on the basis of the insured's failure to disclose material facts to them about the nature of the insured vehicle. The insured had namely merely disclosed that the vehicle was a Ford Mustang, and not that it had been fitted with a Cobra conversion with a supercharger. In support of its defense the broker relied on evidence from the underwriters concerned.

The Court at first instance held the brokers liable to the insured on the basis that the latter had established that the broker's employees had either failed to inform him or had misinformed him about the need to report the accident to the police. It further held that the underwriters had rejected the insured's claim on the basis that he had failed to report the accident to the police as was required by the insurance contract.

As to the breach itself, the Court firstly held that the insured had correctly alleged and had established that the broker's failure to inform him of the change of insurer, the identity of the new insurer, and the terms of the new policy, constituted a breach of its contractual obligation. The broker had exclusive knowledge of these matters and the insured could rely on the broker to disclose them.

Quite clearly, the Court thought, the insured's failure to report the accident gave the underwriters a valid ground to reject the insured's claim, irrespective of whether they in fact
thought so or would actually have relied on it had the insured resorted to litigation. In any event, it appeared that their underwriting managers had in composing a letter of rejection
which was forwarded to the brokers, clearly elected to rely on that as a ground of repudiation rather than on non-disclosure.

As to the underwriters' possible reliance on the alternative defense of non-disclosure, the Court pointed out that in order to succeed, the broker had to show that the underwriters would legally have been entitled to repudiate the insured's claim on the basis of his non-disclosure. If it would not have been so entitled, the question of whether it would have done so (and in fact had here done so) became irrelevant.

Despite the fact that the underwriters suggested in evidence that they would not have insured the vehicle had they known that it was a sports car or had been modified (the Court pointed out in passing that it should have been clear to any reasonably astute insurer that a Ford Mustang was an imported vehicle and a sports car, the Court pointed out that the test for (the materiality of) common-law non-disclosure is whether a reasonable person would have realised that the performance of the vehicle

to be insured was a material consideration in assessing-the risk of insuring it. And there was no evidence 'that a reasonable person should, on his own initiative and without being asked, realize that he ought in his proposal to disclose' information bearing on the vehicle's engine capacity or horse power.

Therefore, the broker had not established that the insurer would have been legally entitled to refuse the claim on the alternative ground it suggested in an attempt to show that its breach had not contributed to the insurer's repudiation and the insured's loss and the broker was held liable.

Comment

When an insured seeks to recover damages from a broker, it must establish that the broker had in fact owed it a duty and further that the broker had breached that duty.

In the present case, the existence of the duty was admitted by the broker and its breach established by the insured. While it is not the duty of a broker to inform its insured of the contents of the latter's policy generally, unusual terms or, as in this case, terms imposing a stricter obligation than did a replaced policy are matters of which the insured must he informed. Likewise, the insured must be informed of the fact the insurance cover had been switched from one insurer to another and of the identity of the new insurer.

Furthermore, the insured had established that the broker's employees had failed to inform him or had misinformed him of the need to report the accident in question to the police. That, too, was a breach of the broker's duty to give its insured proper and correct advice on the latter's duties in terms of the insurance contract.

Acknowledgements: J P van Niekerk (2004) Juta's Insurance Law Bulletin, pages. 60-65

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LAW REPORTS

Insurance

Non-disclosure of material fact by agent: In *Certain Underwriters of Lloyds of London v Harrison* 2004 (2) SA 446 (S CA) the appellants were underwriters of a policy of motor insurance which was issued to the respondent. In terms of the policy the appellants undertook to indemnify the respondent in the event that the insured motor vehicle was lost,
stolen or damaged. After damage of the vehicle the respondent's claim was declined by the appellants on the ground that the vehicle had been unlawfully imported into the country without an import permit having been issued and was accordingly liable to be forfeited to the State. This fact of unlawful importation had not been disclosed to the appellants.

The High Court held that the insurers were liable to indemnify the insured. The appeal to the SCA was upheld with costs. The court reiterated the well-established principle that an insured has a duty to disclose to the insurer, prior to the conclusion of the contract of insurance, every fact relative and material to the risk or the assessment of the premium of which the insured had actual or constructive knowledge. This principle also applies if material facts are withheld by an agent who has been appointed by the insured to negotiate the contract on his behalf.

In the instant case the respondent's husband, who was an importer of vehicles, and who arranged the insurance on her behalf, was aware that there was no import permit. The court said that whether or not the respondent was made aware of her husband's non-disclosure was not material as it was he who applied for the insurance on her behalf and was bound to disclose facts that were known to him and

were material to the risk. The fact that the vehicle was unlawfully imported was material to the risk that was sought to be insured against and ought to have been disclosed. Quite apart from that, an insurer generally has an interest in the salvage of the goods that have been insured. That interest is compromised if the goods concerned are liable to be confiscated by the State.

Comment:
The fact that the vehicle had been illegally imported, are facts within the exclusive knowledge of the insured and in terms of the reasonable person test as per *Mutual & Federal v Oudtshoorn Municipality* and the amended Sections of the Short Term Insurance Act, as amended, facts that ought to have been discussed. The insured's failure to disclose such facts compromise the insurers assessment of the risk, as well as their decision whether to accept/reject such risk.

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STAX MASANGO v LLOYDS OF LONDON

Unreported WLD, case no. 99/25706

Plaintiff = Insured
Defendant = Insurer

The plaintiff was employed in a senior managerial position by Vodacom. While he was so employed, Vodacom provided him with a Mercedes Benz motorcar, which it owned and insured. In November 1998, he was involved in an accident on the N3 highway, in which the car was damaged. He reported the matter to Vodacom, which claimed compensation from its insurers. The plaintiff signed the claim form on behalf of Vodacom, in his capacity as Group Executive.

On 31 March 1999 the plaintiff left the employment of Vodacom. At the same time, he bought the car from Vodacom. His erstwhile employer informed him that it would keep the existing motor vehicle insurance cover in place until the end of April 1999.

On 15 April 1999, having read an advertisement in a newspaper, the plaintiff telephoned the defendant's agent, which is known as Hotline Administrative Services (Pry) Ltd ('Hotline). The purpose of the call was to arrange insurance cover for his car, his wife's car, and the contents of their household. He was put through to one Jaco van Niekerk, who was a sales operator. Mr. van Niekerk informed him that the conversation would be recorded. They had a lengthy telephonic discussion, during which various aspects of the proposed insurance were discussed. The conversation concluded on the basis that they had reached agreement
that Budget Insurance (which Hotline represented) would provide insurance cover for the two cars and the household contents, at an agreed premium.

Mr van Niekerk stated that he would send the plaintiff the policy documents, which would list the conditions and exclusions that would apply to the policy, as well as 'all the information you've given me on the vehicles and drivers'. He stated further that all the information is printed, and that the plaintiff should read it. Through carefully and contact the company if there were any errors. (1 should state that here and elsewhere I rely principally on the transcript prepared by the plaintiff. Where that is not clear, I have had reference to the transcript prepared by the defendant to clarify the matter.)

The policy documents provided that the plaintiff would have insurance cover for the two cars and the household contents from I May 1999.

On the evening of 29 May 1999 the plaintiff went to a 21st birthday party at a conference centre in Woodmead. He left the keys of his car on the table at which he was sitting. At some stage they must have been removed by someone, because he subsequently could not find them. He obtained a lift to go

home that night - or more accurately in the early hours of the following morning leaving his car, which was locked, in the parking area. He told the security guard that the car was his, and instructed him to ensure that no one removed it. When he returned to the conference centre on the afternoon of 30 May 1999, he found that the car had been taken by someone. It had been stolen.

The plaintiff duly submitted a claim to the defendant. This was done telephonically, in accordance with the defendant's procedures. On or about 26 July 1999, the defendant repudiated the claim.

It was therefore proved that the car had been insured under the policy; that it had been stolen; and that the plaintiff had suffered a loss, which was agreed at R146 500 after the deduction of the excess under the policy. The onus was therefore on the insurer to justify the repudiation.

The insurer alleged that the insured had failed to use all reasonable care and take all reasonable precautions to prevent or minimise loss; by failing to give the Insurer true and complete information in regard to the circumstances surrounding the theft of the vehicle; and by not informing the insurer of his previous losses or claims or accidents.

1. Failure to take all reasonable care in respect of the vehicle
   The Court pointed out that the question however is not delictual negligence. It is whether the insured's conduct met the test set out in *Santam Ltd v CC Designing CC* 1999 (4) SA 199 (C) at **211,** namely whether his conduct was such that one could conclude that he recognised the dangers to which he was exposed, and deliberately courted them by taking measures which he himself knew were inadequate to avert them, or about the adequacy of which he simply did not care.

   Putting one's keys on the table at which one is sitting does not amount to the recklessness which is required. The same applies to leaving a locked car in an area to which one can only gain access through a boom, and which is protected by a security guard, who has been instructed not to permit anyone to remove it. It is of course true that the fact that the keys had possibly been stolen heightened the risk. But I do not think that it can be said that the plaintiff's conduct amounted to recklessness of the kind which is required, and it was not suggested to him that it had.

   It was held that accordingly, there was no basis for a repudiation on this ground.

2. Failure to inform the defendant of his previous losses or claims or accidents
   This was really the heart of the defense which was raised. The defendant relied on two passages in the discussion between the plaintiff and Mr Van Niekerk, and on a section in the policy document.

   The first passage reads as follows:
   Q Now when last have you claimed for a vehicle accident?
   A Probably 5 years ago

   The *second* passage read as follows:
   Q …did you had (sic) any vehicle claims in the last two years?
   A No

   Q Any accidents or losses where you never claimed for in the last two years?
   A No

   The passage in the policy *document* read as follows:

   Claims submitted/losses suffered in the past 2 years for the regular driver and spouse:
   None declared

   The answer given to the question in the first passage was, if the question is taken literally, correct. The insured had not 'claimed for a vehicle accident' in the past five years. He had an accident in 1998, but the vehicle had belonged to his employer, which had claimed on its insurance policy.

   The same applies to the first question in the second passage: the insured had not had any vehicle

claims in the past 10 years.

On the same basis, the declaration in the policy document is correct. The plaintiff had not submitted any claims or suffered any losses in the past two years.

It was the second question in the second passage which led to most of the debate when this matter was heard. What is the correct answer depends on whether the question asks about situations where the plaintiff could have claimed, but chose not to do so, or whether it also refers to any accident or loss in respect of which he did not himself make a claim, but some other person made a claim. If the question bears the first meaning, the correct answer was given. If it bears the second meaning, an incorrect answer was given.

The evidence of insurers was that an answer 'yes' to this question would have led the computer system to take the conversation back to the first passage, which would have been apparently inconsistent, The result would have been that the defendant would still have given the plaintiff insurance cover, but at a premium which was higher than that which was in fact charged.

In determining whether the plaintiff honestly answered the question, one must have regard to the context in which it was asked. Ambiguity is partly contextual. What is crystal clear in one context, may be ambiguous in another. We have practical examples of this every day in the courts. Words in a statute or a contract may be ambiguous standing on their own. The courts seek to interpret Them in the context of the whole, and in the context of what precedes them and what follows them. On that basis, the courts decide what the words mean, and may often conclude that in their context, they are not ambiguous at all.

The Court further held that the difficulty with telephonic contracts such as this is that the questions require off-the-cuff answers to oral questions. They allow no opportunity for subsequent reflection. Questions are asked in a context in which the client has no way of knowing what questions are coming next, which might clarify the meaning of the question which has just been asked. The method allows no opportunity to review the questions and answers after the event, to check whether, in the light of the fuller context, the answers indeed provided the information required. This can lead to much greater ambiguity than if the- questions are put in writing, in a manner which gives the

prospective client an opportunity to reflect on the questions and answers, and make such corrections as are necessary.

In determining whether a question is ambiguous one needs also to have regard to the fact that it is unrealistic and inappropriate to undertake the sort of precise dissection of the words of the question which is possible afterwards, for example under cross-examination at a trial. The context in which the prospective client receives the question makes this unrealistic from a practical point of view.

What all this means is that if an insurer chooses to conduct its business in this manner, it must accept that there is a heightened risk of ambiguity. That is the choice which it makes.

The Court held that the question was indeed ambiguous, particularly given the fact that it was raised in a telephonic conversation, and its context, which was an immediately prior question about claims which the plaintiff had made.

The onus is on the insurer to prove a misrepresentation or failure to provide information which it had requested. In the Courts view, the insurer failed to prove such a misrepresentation or failure- The insured can not be held responsible for what he was not asked, or what be reasonably did not think he was asked.

There is a further basis on which, in my view, the defendant is not entitled to rely on the alleged prior misrepresentation or failure to provide information.

The defendant says that the contract was written, and is reflected in the policy documents, but relies upon what it says was a prior misrepresentation or failure to provide information during the telephone conversation. As I have stated, Mr van Niekerk told the plaintiff that he would send him the policy documents, which would list the conditions and exclusions that would apply to the policy,

as well as all the information you've given me on the vehicles and drivers', Mr van Niekerk stated further that all the information is printed, and that the plaintiff should read it through carefully and contact the company if there were any errors. In my view it was entirely
reasonable for the plaintiff to check the written documents which he received, and if he was satisfied that the information in those documents was correct, to accept that the information given on the telephone, on which the defendant relied, was correct. The plaintiff was not given a copy of the transcript and asked to check the written information against the transcript of the conversation.

Even if there had been no ambiguity in the telephone conversation, the defendant was not entitled to rely on what was said in that conversation, and which was not reflected on the written contract, which its agent had said would contain all the information which he had given it.

The repudiation

Although the defendant repudiated the claim, it continued to accept the premiums in respect of the other items, which the plaintiff had insured, and to provide insurance cover. Mr *Berridge* contended that this amounted to an approbation and reprobation, and that the defendant could not claim validly to have elected to avoid the contract on the grounds of misrepresentation or failure to provide information, while it continued to accept premiums and provide cover under the contract. The contract therefore remained valid and binding - see Gordon and Getz *The South African Law of Insurance* (4TH ed by D M Davis) at 128, and Gordon v *AA Mutual Insurance Association Limited* 1988 (1) SA 398 (W) at 408D.

The Court therefore concluded that even if there was a misrepresentation or incomplete information such as to entitle the Insurer to avoid the contract, it did not elect to do so.

Conclusion

The Court then held that the Insurer had not proved that it was entitled to repudiate the claim, or that it validly did so. The Insurer was accordingly held liable for the claim.

Comment

1. Failure to take reasonable care

   Insurers often seem to lose sight of the fact that an insurance policy does cover an insured for his/his employees negligence. To rely on this defence an insurer must prove not only that the insured had knowledge and appreciation of the risk he is taking but also that his insurance policy would cover such risk, and that he nevertheless recklessly proceeded. This is tantamount to proving almost intention on the insured's part and would be a difficult, if not almost impossible onus to satisfy.

2. Failure to disclose/misrepresentation

   Mistakes made by an insurer at underwriting stage cannot be corrected at the claims stage. The Insurer could perhaps have questioned the insured/prospective insured further with a view to eliciting the information it sought in order to correctly assess the risk and premiums. Any shortcomings in this respect by the insurers representative cannot then be used to justify a rejection/repudiation of the claim. The case further highlights the point that where questions are asked relating to an insured's insurance and claims history, the insurer should be more specific and precise in the questions asked. A failure to elicit such information properly, might result in an insurer not having grounds to repudiate a claim. If an Insurer requires knowledge of not just the insured's own previous insurance and claims history, but also that in which he may not have been the insured, (for eg. Here an employee of the actual insured who had lodged a claim with its insurer), it should be more detailed in eliciting such information. Insurers beware!

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