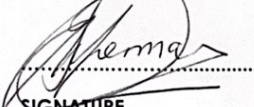


REPUBLIC OF SOUTH AFRICA



IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

Case No: 18301/2018

(1)	REPORTABLE: NO
(2)	OF INTEREST TO OTHER JUDGES: NO
(3)	REVISED.
	<u>29/06/2023</u>
SIGNATURE	DATE

In the matter between:

NEIL ERNEST DELPAUL

Plaintiff

and

HOLLARD LIFE ASSURANCE CO. LTD

Defendant

This judgment was handed down electronically by circulation to the parties' legal representatives by email. The date and time for hand-down is deemed to be 10h00 on 30 June 2023

JUDGMENT

INGRID OPPERMAN J

Introduction

[1] This is a trial which traversed the interpretation of an insurance policy and its application to an event which occurred on 15 August 2015 when Mr Delpaul, the

plaintiff, suffered an acute heart attack. Thereafter he lodged a claim for payment in terms of a written agreement of insurance concluded with the defendant (*Hollard*). Hollard interpreted the policy as entitling him to be paid 25% of the Benefit amount. Quite how the appropriate percentage of the Benefit amount is to be determined is at the centre of this dispute. Hollard paid him the amount that its interpretation of the policy lead it to conclude that he was due. Mr Delpaul takes issue with this interpretation and contends that he is entitled to 100% of the Benefit amount.

[2] The percentage to which Mr Delpaul is entitled is dependent on the interpretation of the policy, the commencement date of which was 1 February 2012 (*the policy*).

The common cause facts

[3] The following facts were, at the commencement of the trial, largely common cause: Mr Delpaul had paid all his monthly premiums as at the date of the heart attack so the policy was in operation. His previous claims history under the policy is as follows.

- 3.1. In April 2012 he submitted a claim under the Cardiovascular Benefit Group for ischaemic heart disease and peripheral arterial disease which resulted in a coronary stent and for which he was paid 10% of the Benefit amount (*Event 1*).
- 3.2. In July 2012, Mr Delpaul submitted a claim for peripheral arterial disease, which resulted in a bi-femoral bypass for which he was paid 90% of the Benefit amount (*Event 2*).
- 3.3. On 15 August 2015 Mr Delpaul suffered the acute heart attack mentioned in paragraph [1] of this judgment. For that he was paid out 25% of the Benefit amount (*Event 3*).

The Policy

[4] The policy provides that the 'Benefit' as specified in the schedule (*Benefit amount*) shall be payable if Mr Delpaul suffers one of the **events** or conditions described in the policy. The amount payable under the policy is expressed to be a percentage of the Benefit amount as reflected for each event. The policy describes (under headings) 13 separate **Benefit Groups**. By way of example, it mentions a Cardiovascular Benefit Group, a Cancer Benefit Group and the 13th and last Benefit Group is a 'Catch-all' Benefit Group.

[5] Each Group identifies 'Events' under sub-headings. The Cardiovascular Benefit Group identifies 12 events and provides that only one payment will be made per cardiovascular event with a single event being defined as all cardiovascular conditions or procedures that occur within a 30 day period.

Evidence presented

Mrs Gonnerman - Hollard

[6] The Benefit amount at the time that the claim was instituted (had no claims been made prior thereto) was R 2 315 250 (*R 2,3 million*). Hollard contends that the Benefit amount is static and upon each claim being submitted under a particular Benefit Group, the balance reduces.

[7] Hollard called Ms Gonnerman, a senior claims manager, to provide context to the policy. She explained that the Benefit amount would reduce by the amount of any payment made and that the remaining balance would be available for further claims. The Benefit amount would reduce according to the percentage pay-out of the event on which the claim is based until such time as there was no longer any benefit in respect of events falling under that particular Benefit Group. When the 100% pay-out point is reached, the cover in respect of the events falling under that Benefit Group

would be endorsed to reflect 100% pay-out. The insured would then have to wait for 90 days for the Benefit amount to be reinstated but it would be limited to a pay-out of 25% if made before Mr Delpaul reached 75 years of age and 15% thereafter.

[8] She explained the reinstatement of the Benefit amount relevant to Mr Delpaul's claim as follows: After 100% of the Benefit amount was paid which occurred after Events 1 and 2, (both of which fell within the Cardiovascular Benefit Group) the Benefit amount automatically reinstated after 90 days up to 25% (as Mr Delpaul was younger than 75). She testified how Hollard had applied this interpretation of the policy to Event 3, which also fell within the Cardiovascular Benefit Group.

[9] In April 2012, when Mr Delpaul submitted a claim for Event 1, the pay-out was made under the event described as 'Coronary Angioplasty/Stent' where the amount of the pay-out is reflected as '10% of Benefit Amount' and this was paid. The effect of this claim and pay-out resulted in the Benefit amount, under the rubric of Cardiovascular Benefit Group, reducing by 10%. The amount available under this Benefit Group was, according to Ms Gonnerman, thus reduced to 90% of the Benefit amount. In July 2012, Mr Delpaul submitted a claim for Event 2 which resulted in a claim under potentially two different Events being either 'Coronary Artery Disease with Surgery' or 'Surgery of the Aorta'. In each instance the amount payable was 100% of the Benefit amount. At this stage, there was only 90% of the Benefit amount available and Mr Gonnerman explained that Mr Delpaul was paid out the full balance i.e. the remaining 90%. After this pay-out, the policy was endorsed to record that his pay-out under the Cardiovascular Benefit Group had been paid out 100% and this triggered 90 days after the Event 2, a limited reinstatement of the Benefit amount to 25% of what

it had been before. This was brought about by operation of the following clause in the policy:

‘ Reinstatement of Benefit Amount

After the 14 day survival period following a claim event, the Benefit Amount for conditions that are totally unrelated, in the opinion of Hollard Life, to the condition or event for which the claim had been paid will automatically reinstate to the Benefit Amount immediately prior to the claim payment.

After 100% of the Benefit Amount has been paid in respect of a condition or event, the Benefit Amount for conditions that are related to that condition will automatically reinstate 90 days after the claim event on the following basis:.....

Claims prior to 75th birthday 25% of the original Benefit Amount plus any benefit increases’

[10] This then, according to Ms Gonnerman, explains why Mr Delpaul was paid 25% of the Benefit amount because Event 3, the event we are dealing with, was a condition *related to* the conditions (Events 1 and 2) that had led to the original Benefit amount being completely drawn down. Thus 90 days thereafter the replenishment (reinstatement) of the Benefit amount had been limited or capped at ‘*25% of the original Benefit amount plus any benefit increases*’ and why Mr Delpaul’s cover in terms of the Cardiovascular Benefit Group was then completely exhausted and he was, once the 25% had been paid to him, no longer ever entitled to any further pay-out under this Benefit Group.

Mr Delpaul

[11] Mr Delpaul testified that he understood the policy to pay out per **event**, that he had not been paid out for the event described as ‘Heart Attack’ prior to this claim as Events 1 and 2 related to other events under the Cardiovascular Benefit Group. He contended that he was accordingly entitled to payment of the percentage shown for

this event which is 100% of the Benefit amount.

Analysis

[12] I am conscious of the dangers of referencing the witnesses' understanding of the policy when interpreting an agreement. As a general rule, such evidence would be inadmissible as it is irrelevant. It is for a court to interpret the agreement/policy, but one may have regard to such evidence for, amongst other reasons, context¹.

[13] Reading the policy as a whole, it is clear that the percentages shown for each event within a Benefit Group, is payable 'per cardiovascular event'. The 'Reinstatement of Benefit Amount' provision, in my view, quoted herein before, supports this construction. If, by way of example, 50% of the Benefit amount for the event described as 'Heart Transplant' is paid, the percentage paid is deducted from the 100% Benefit amount (R2,3 million) and what remains left for that event (being R1,15 million), can be claimed in the future. If that remaining 50% is also paid out, the Benefit amount is reinstated after 90 days, but the subsequent claim for the event of 'Heart Transplant' would be limited to 25% for that event if the claim were made prior to the insured reaching the age of 75.

[14] The 'Reinstatement of Benefit Amount' clause places much reliance on whether the claim was for a related or an unrelated **condition**. If there was a 100% of Benefit amount pay-out for a particular type of **condition** and then a subsequent claim was made for a *related* **condition** then 90 days would have to have passed between the

¹ *KPMG Chartered Accountants (SA) v Securefin Limited and Another* (644/07) [2009] ZASCA 7; 2009 (4) SA 399 (SCA) ; [2009] 2 All SA 523 (SCA) (13 March 2009) at par [39] where Harms JA said: '*...Fourth, to the extent that evidence may be admissible to contextualise the document (since "context is everything" to establish its factual matrix or purpose or for purposes of identification, "one must use it as conservatively as possible"*

two related claims for the Benefit amount to have been reinstated for the policy to respond to the second claim, and even then it would only respond to the extent of 25% of the original Benefit amount provided the insured was under 75 years of age.

[15] If, however, the conditions of the two claims were *unrelated* then a mere 14 days would have to have expired between the first and the second claim and both could in that event be paid up to 100% each as the Benefit amount automatically tops up for *unrelated claims* after 14 days.

[16] The payment of the Benefit amount occurs pursuant to a claim for an **event** as opposed to a **Benefit Group** and provides that the Benefit amount will automatically be reinstated for conditions that are related to that event. On a proper interpretation, this means that if Hollard paid 100% for a specific cardiovascular event, such as the event 'Heart Transplant', the Benefit amount would be reinstated for that event after 90 days subject to a cap of 25% if Mr Delpaul were younger than 75 years of age.

[17] The policy does not provide that once 100% of the Benefit amount in a particular Group has been paid, no further payments will be made for such Group. The policy does however provide that 'Only one payment will be made per cardiovascular event.' Thus, as there are 12 events described under this Group, Mr Delpaul could claim for each event once. He could in principle claim for a different event every 6 weeks. That is so because a single event is defined as all cardiovascular procedures that occur within a 30 day period (4 weeks) and a claim will only be admitted after a 14 day (2 weeks) survival period.

[18] The 'Reinstatement of Benefit Amount' clause insofar as 'related conditions' are concerned, would only become applicable where he were to claim for a second time for an event under this Group and under such circumstances the Benefit amount will only be reinstated 90 days after the claim event and then the claim will be capped to

25% of the Benefit amount (if the claim were made before the age of 75).

[19] The event 'Coronary Angioplasty/Stent' is defined to be a medical procedure used to open narrowed blood vessels of the heart and devices known as 'stents' are used to help keep the arteries open. Crucially, it then provides: 'This benefit covers an unlimited number of procedures.' The policy provides that for each claim, for this event, 10% of the Benefit amount is payable. For Hollard's interpretation of the policy to be correct, this benefit ought to have been limited to 10 procedures because $10 \times 10 = 100$ and when that amount is reached, the Benefit amount would on Hollard's interpretation be depleted. Mrs Gonnerman, confronted with this dilemma, testified that the Benefit amount does not actually cover an unlimited number of procedures as stated in the policy but only 10 procedures, at a payment of 10% of the Benefit amount for each claim to a maximum of 100% of the Benefit amount.

[20] This answer contradicts the express wording of the policy. The sentence in the policy can only be meaningful if one accepts that the policy responds **per event** and the amount payable is a percentage of the Benefit amount. Under this Group we know that only **one** payment will be made **per event** however the policy states that it will respond by paying out a benefit of 10% of the Benefit amount for an 'unlimited' number of procedures.

[21] Mr Mtukushe, representing Hollard, argued that the plaintiff's construction of the policy leads to an absurdity² and that a contract should be interpreted to give it a commercially³ sensible meaning. This is so because having regard to the amount of the monthly premium, being R3 955.75, the parties could not have intended that Mr Delpaul would potentially be paid R2,3 million every 6 weeks.

² *Bothma-Batho Transport (Edms) Bpk v S Botha & Seuns Transport (Edms) Bpk*, 2014 (2) SA 494 (SCA) at para [12]

³ *North East Finance (Pty) Ltd v Standard Bank of South Africa Ltd*, 2013 (5) SA 1 (SCA) at para [24]

[22] No evidence was presented as to Hollard's risk assessment in relation to these various Groups, what the probabilities are of suffering from conditions which would trigger payments and more importantly surviving them to enable a pay-out. In my view this argument has limited persuasive force in the context of this case and on the evidence, or lack thereof, presented to assess this 'absurdity'.

[23] Mr Mtukushe also drew attention to Mr Delpaul's failure to have objected to the manner in which Hollard had implemented the policy i.e. in accordance with its interpretation. Mr Delpaul was confronted with this failure during cross-examination. He was asked why, after Event 2, he had not objected to the 90% pay-out when on his construction of the policy he would have been entitled to 100%. He responded that he did complain to his broker, that he had changed brokers and that when he had instituted action in this case, he had been told that his claim in respect of that 10% short payment, had prescribed.

[24] He was also criticised, during argument, for not having taken that dispute to the Insurance Ombud in the same manner as he had done with the claim under Event 3. In my view, this criticism has limited value as it was not traversed with Mr Delpaul during cross-examination. He was not afforded the opportunity to deal with this. I can think of a number of explanations such as that the amount was relatively small (10%) and that he was recovering from surgery – the reward was simply not worth the effort.

[25] Finally, Mr Mtukushe pointed out that Mr Delpaul was fully aware of Hollard's construction of the policy as it was endorsed to that effect. After the 100% ceiling had been reached, Hollard recorded under the heading 'EXCLUSIONS AND ENDORSEMENTS' on the covering page the following 'Payout under Cardiovascular Group – 100%' and on the last page the following 'It is hereby confirmed that 100% of

the benefit amount has been paid out under the Cardiovascular Benefit Group’.

[26] Mr Wannenburg, quite correctly in my view, pointed out that this unilateral act by Hollard of recording that 100% of the Benefit amount had been paid out is of no legal consequence on the case pleaded before this court. The question is, how are the terms of the policy to be interpreted having regard to the admissible evidence.

[27] The object is to ascertain the intention of the parties⁴ at the time of the conclusion of the agreement and not how they endorsed it along the way. I accept that it is permissible to have regard to the conduct of the parties in implementing an agreement in order to answer this question but I have no evidence before me as to when this endorsement occurred and in any event, Events 1 and 2 happened so shortly after one another that Mr Delpaul might well have reasoned that he was paid the full Benefit amount in a period of 3 months and the 10% shortfall was not worth the effort.

[28] No evidence was presented as to the related or unrelated nature of Events 1, 2 and 3, nor of Hollard having formed any particular view (in a clinical, rather than a mere legal interpretive sense) as to whether the conditions were related or not. That lacuna leaves the Court in the dark as to which of the scenarios contemplated in the automatic reinstatement of the Benefit Amount clause finds application to Mr Delpaul's case.

[29] There was a belated attempt during re-examination of Mrs Gonnerman to suggest that Mr Delpaul's underlying medical condition is atherosclerosis and Events 1, 2 and 3 were all related due to this medical condition. No expert evidence was presented during the trial and the introduction of medical opinion evidence by an

⁴ *Novartis SA (Pty) Ltd v Maphil Trading (Pty) Ltd*, 2016 (1) SA 518 (SCA) at paras [27] – [35]; *Capitec Bank Holdings Limited and Another v Coral Lagoon Investments 194 (Pty) Ltd and Others* [2021] ZASCA 99 (9 July 2021)

unqualified person during re-examination, is inadmissible. But perhaps more problematic is that Hollard seems to have changed its reason for repudiating the claim. Initially and in its letter dated 4 September 2015 it relied on the following exclusion:

‘No claim will be paid under the reinstated cover where, in the opinion of Hollard Life, the claim is a direct consequence of the event for which a 100% payment was made before reinstatement’.

[30] Hollard stated that:

‘Unfortunately the current claim cannot be considered under the re-instated cover as the condition currently being claimed for is directly related to the ischaemic heart disease that resulted in the previous claim paid in 2012. We regret no further claim is payable under the cardiovascular benefit group.’

[31] Yet, Hollard paid 25%. If consistent, it ought to have paid nothing.

[32] The version sought to be advanced during re-examination was that all 3 Events were related. This is a causation issue which would require medical evidence which was not presented.

[33] I was referred to the contra proferentem rule and urged to resolve any ambiguity against Hollard. I have no need to resort to this rule to construe the document against the author being Hollard. I am persuaded by the wording of the policy discussed above and the evidence, or lack thereof, presented in the trial.

[34] I thus conclude that the amount payable for the heart attack suffered by Mr Delpaul and claimed for on 15 August 2015 (Event 3), entitles him to payment of 100% of the Benefit amount as at that date being R 2 315 250 of which he has received 25% being R578 787.50. I intend ordering Hollard to pay Mr Delpaul the balance.

Costs

[35] In respect of costs, it should follow the result except for one feature: The trial commenced on a Monday (23 January 2023) and on the Friday preceding this (20

January 2023), Hollard uploaded 957 pages onto Caselines. Perturbed by this, Mr Delpaul's attorneys of record immediately sent a mail objecting to the late uploading of the voluminous trial bundle and recorded their prejudice in preparing properly for the trial. In response, Hollard's attorneys pointed out that Hollard's discovery affidavit, containing all the documents which were uploaded, was served more than 3 years prior, that most of the documents were already in their possession and that Mr Delpaul's bundle was only uploaded on the Wednesday (18 January 2023).

[36] During a pre-trial held on 19 May 2022 the parties had agreed that the plaintiff would prepare the trial bundles and provide them to the defendant 4 weeks before trial. The defendant would supplement the bundles if necessary, within a week from receipt of the bundles. It is unclear when the trial bundles were made available, but it would appear from the Caselines bundle that it was about 18 January 2023. Both parties therefore did not comply with the timeline agreed to at the pre-trial.

[37] Mr Wannenburg stressed that not a single document of the 957 documents uploaded was used. He argued that they were not only irrelevant but also of a highly confidential nature consisting of amongst other documents, medical reports, pathology reports, laboratory results and the like, all of which were now part of a public record. He argued that this constituted an abuse of the process and that it should attract a punitive costs order.

[38] The awarding of costs is a matter of judicial discretion to be exercised having regard to all the facts of the case. I do not consider that the uploading of the vast amount of documents at the eleventh hour is deserving of a punitive costs order in the circumstances of this case. It seems that both parties were late with their trial preparation. Neither the plaintiff nor the defendant complied with the agreement reached at the pre-trial. Also, there was no request after the uploading of the

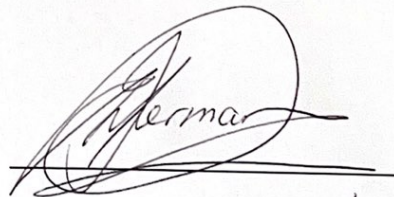
documents to remove same on the basis of confidentiality. The objection related to the timing thereof not to the content of that which was uploaded. As it turns out the documents were not used and as they are confidential they should be removed from the Caselines file within 24 hours of this judgment being handed down, failing which the matter may be enrolled before me for this costs order to be revisited.

Order

[39] I accordingly grant the following order:

Judgment is granted against the Defendant for:

- 39.1. Payment in the amount of R1 736 437.50 together with interest thereon at the rate of 10.25% per annum from 23 May 2018 to date of final payment.
- 39.2. Costs of suit.
- 39.3. The documents at Caselines 0017-1 to 0017-957 are to be removed within 24 hours of this order being mailed to the Defendant's attorneys of record failing which the Plaintiff may set this matter down before Opperman J for the scale of the costs order to be revisited.

A handwritten signature in black ink, appearing to read 'I Opperman', written over a horizontal line.

I OPPERMAN
Judge of the High Court
Gauteng Local Division, Johannesburg

Counsel for the plaintiff: Mr WF Wannenburg

Instructed by: Esthe Muller Inc

Counsel for the defendant: Mr L Mtukushe

Instructed by: Rupert Candy Attorneys

Date of hearing: 23 January 2023 and 13 June 2023

Date of Judgment: 30 June 2023