



**HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)**

CASE NO: 87941/2016

(1) REPORTABLE: NO. (2) OF INTEREST TO OTHER JUDGES: NO. (3) REVISED. <u>DATE</u> 26 FEBRUARY 2021 <u>SIGNATURE</u> 

In the matter between:

ADVOCATE BOKANG MPHO MOTSHWANE

Plaintiff

and

iWYZE VALUABLES INSURANCE

Defendant

Coram: Davis J

Insurance – rejection of claim; material non-disclosure; extent of obligation of insured; disclosure must be risk related to be material.

J U D G M E N T

This matter has been heard in open court in terms of the Directives of the Judge

President of this Division dated 25 March 2020, 24 April 2020 and 11 May 2020. The judgment and order are accordingly published and distributed electronically.

DAVIS, J

[1] Introduction

- 1.1 The plaintiff took out short-term insurance with the defendant on 14 December 2015 to comprehensively insure his newly purchased Renault Megane motor vehicle.
- 1.2 On 28 February 2016 the plaintiff was involved in a motor vehicle accident and the Renault Megane was damaged beyond economic repair.
- 1.3 On 13 May 2016 the defendant rejected the plaintiff's insurance claim, citing material non-disclosure of refusal by another insurer as the reason.
- 1.4 Both the actual non-disclosure and the materiality thereof are in dispute.

[2] The background facts

Despite what has been stated in paragraph 1.4 above, the surrounding facts of the case are largely not in dispute. Due to rather extensive investigation by the defendant of the plaintiff's claim, even the preceding recorded conversations between the plaintiff and the broker and the plaintiff and the representative of the defendant when the insurance cover was obtained, have been obtained and transcribed (the parties are in agreement with the correctness of these transcriptions). From this and other documentary evidence, the background facts are the following:

- 2.1 On 17 October 2015 the plaintiff took out a short-term insurance policy with the Mutual and Federal Insurance Company (M & F) for another

vehicle of his. At an intersection, someone drove into the plaintiff's vehicle and a claim for R 208 475, 32 was registered with M & F on 2 November 2015, and subsequently paid out. It appears that the vehicle was "written off" and the policy terminated "as cover was no longer required".

- 2.2 Shortly hereafter, the plaintiff purchased the Renault mentioned in paragraph 1.1. He needed to have insurance cover in place before he could drive the vehicle off the motor dealership's floor.
- 2.3 For purposes of acquiring insurance cover for the vehicle, the plaintiff sought and obtained quotations. This was done via a broker and the relevant part of the conversation between the plaintiff and the broker was recorded as being the following:

Broker: *Absa R 5479, Mi Way R 6191, Oakhurst R Highest, M & F, Santam wouldn't give me a quote. Also checked with KP, A & G, New National, but the lowest was Absa.*

Client: *I think I'm actually going to speak to M & F, because I was already an existing client with them, then I doubt from what it was, to that much, yebo.*

Broker: *Ok, because I was there myself, né, I tried to do an E-quote and they wouldn't my ...*

Client: *They wouldn't?*

Broker: *Ja, they wouldn't ... ee risk ratio.*

Client: *Pardon?*

Broker: *The risk, they said that the risk, you are a high risk client, that is what they said.*

Client: *Oh, they didn't, they didn't want to deal with me.*

Broker: *Yes*

Client: *Why am I a high risk ...?*

Broker: *Explains due to the accident, irrespective of whose fault it is.*

Client: *So calling them won't make a difference.*

Broker: *I don't think so, no went I went there, they asked: was this client already insured with us? And I said yes, it was, he was, he was sorry and like but you know they had to get confirmation from other higher authority and they said they won't be able to proceed with the quotation.*

Client: *Not even with a quote.*

Broker: *Sorry*

Client: *Not even with a quote.*

Broker: *Yes, I could not get a quote at all from them.*

2.4 The insurance cover which the plaintiff obtained from the defendant, was preceded by a telephone call which went like this:

“Agent: *iWyze is underwritten by M & F Insurance Company Limited, which is a licensed financial services provider and a member of the Old Mutual group ...*

So who are you currently insured with, it can be for a house or for contents or for another vehicle

Client: *No.*

Agent: *You are currently not covered?*

Client: *I am only covered with life insurance, that is with Momentum and that is not short term.*

Agent: *And for how long have you had uninterrupted short term insurance cover?*

Client: *For a period of two months.*

Agent: *For a period of two months, ok and then have you or anyone you intend covering even been informed by an insurance broker or an Administrator or Insurance Company that your insurance was cancelled or you should seek alternative insurance or you have been refused renewal of insurance, have these ever happened to you?*

Client: *(Deep breath) Ahmm, no.*

Agent: *Ok, thank you, and then have you ever had any accidents, incidents or losses in the past 5 years?*

Client: *In the past 5 years, only this recent one which was in November 2015.*

Agent: *which was in November, ok, and then what happened ...”*

2.5 After this conversation, a quote was prepared, which the plaintiff accepted. This resulted in a “welcome pack” being sent to the plaintiff. This contained: a welcome letter, a policy schedule, general policy terms and conditions, an “iAlert” brochure, a no-claim reward brochure, a statutory notice to short-term insurance policyholders and a statutory SASRIA Soc Ltd notice. All these documents were electronically generated.

2.6 The iWyse “Schedule Summary” consisted of a number of pages. The first page contained the plaintiff’s particulars and an itemized table of the composition and calculation of the premiums, totaling R 2966,05 per month. The vehicle was identified by its registration number. The second page contained details of a R10 404.31 no-claims reward and an advertisement of roadside and household emergency numbers. The third page is headed “DECLARATION” and contains, inter alia, the following (all printed):

“Who were you previously insured with? Not insured

Have you been convicted of any offences? No

*How many accidents or losses have you had
in the past 5 years. This includes accidents,
incidents or losses regardless of whether you
claimed for them or not and regardless of
whether you were insured or not. 1*

Have you or anyone you intend covering ever been informed by any insurance broker, administrator or insurance company that: No

- *Your insurance was cancelled?*
- *You should seek alternative insurance?*
- *You have been refused renewal of insurance?*
- *Have you or anyone you intend covering ever had your insurance policies cancelled due to fraud or dishonesty?*

PREVIOUS LOSSES.

<i>LOSS DATE</i>	<i>LOSS TYPE</i>	<i>LOSS VALUE</i>
<i>02/11/2015</i>	<i>Vehicle Third Party Liability</i>	<i>R323 000</i>

...

You must check all the information that you have provided to make sure that it is correct, including material information. Material information is information that a reasonable person would consider important to provide to iWyze so that iWyze can properly assess your risk. In assessing your risk, iWyze can decide whether or not to insure you or what premium to charge for your risk and whether to apply additional terms and conditions”.

The fourth page contains extensive details of the Renault, including serial numbers, “extras”, immobilizer particulars and particulars of where the vehicle would be kept and who the regular driver would be as well as his licence particulars. The fifth and sixth pages again refer to the extent of cover chosen, including the SASRIA premiums.

- 2.7 The general terms and conditions, included in the next document span some 24 pages with 13 clauses and their sub-clauses in fine print. Clause 4.1 thereof accord with the caution to check all information as well as the descriptions of materiality contained in the abovequoted portion on page three of the policy schedule, to which the following has been added:

“4.2 IMPORTANT: All information provided by you will be validated at claims stage”.

- 2.8 After the inception of the policy, premiums were paid and time progressed. In January 2016, the vehicle was involved in a minor accident, assessed by the defendant's appointed “panel beater” at some R40 000.00. The plaintiff submitted a claim to the defendant, which was paid and the vehicle was repaired after the plaintiff had paid the required excess.
- 2.9 On 28 February 2016, on his way home, the plaintiff was involved in a more serious accident when an oncoming vehicle veered into the plaintiff's lane, resulting in a virtual head-on collision. The vehicle was, after a full investigation and assessment by the defendant, as evidenced by a report with numerous photographs, tests and valuations, determined to be uneconomical to repair. Having regard to the excess payable and the credit shortfall and amount due to Wesbank at which the plaintiff had financed the vehicle, the claim amount determined by the defendant under cover of the policy, was R 322 342, 61.
- 2.10 Initially the defendant indicated that the claim would be entertained and that the merits regarding negligence in causing the accident was not held against the plaintiff. Subsequently, however, on 27 April 2016 the plaintiff was informed that his claim was rejected. The formal rejection letter reads as follows:

“The rejection of the claim is due to the following reason(s):

- *Material Non-disclosure: Refusal of Insurance. Validation of the claim revealed that you failed to disclose to us that you have been previously refused insurance by another broker, administrator or insurer prior to inception of your policy with us. A disclosure opportunity was created for you at sale/quotation stage of your policy and you opted not to disclose this information. The disclosure of the refusal to renew insurance and cancellation is material for consideration by the present underwriter to decide if cover would have been issued, if the risk premium would have been amended or if the confirmation of the cover would have been declined at sales stage”.*

[3] The general principles of disclosure in insurances contracts:

- 3.1 At common law, the principle is trite that, when seeking insurance cover, an insured must make full and complete disclosure of all facts which may be material to the insurer’s assessment of the risk. An insurer can then properly assess and decide at what cost (i.e. the premium) it will assume the risk or whether it will do so at all. See: Regent Insurance Co Ltd v King’s Property Development (Pty) Ltd 2015 (3) SA 85 (SCA) at [20].
- 3.2 In order to preclude insurers from treating misrepresentations or non-disclosures that are trivial as grounds for avoiding insurance contracts and rejecting claims, legislation has been enacted, regulating the position in the short-term insurance market. Since the inception of the Short-term Insurance Act, 53 of 1998, there is no longer a distinction in the test for materiality between misrepresentations and non-disclosures. The test is an objective one and the onus in this regard is on the insurer. See. Clifford v

Commercial Union Insurance Co Ltd 1998 (4) SA 150 (SCA) and Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality 1985 (1) SA 419 (A) (these judgments are still valid on this topic, despite having dealt with section 63 (3) of the Insurance Act, 27 of 1943, see: Regent Insurance above at para [23]).

- 3.3 The abovementioned legislative enactment, being Section 53 (1) of the Short-term Insurance Act, reads as follows:

‘Misrepresentation and failure to disclose material information

(1)(a) Notwithstanding anything to the contrary contained in a short-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 short-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 renewal or 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 short-term insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk'.

[4] The oral evidence

Apart from the common cause facts and documentation constituting the source of the backgrounds facts referred to in paragraph [2] above, the following oral evidence was led:

4.1 The plaintiff:

He testified that he did not consider that his previous insurance policy had been cancelled in any of the manners contemplated in the defendant's insurance questionnaire put to him: he had done nothing wrong or dishonest in respect of his previous policy with M & F and the contract had terminated when it was no longer necessary after the subject thereof was no longer insurable. It was not cancelled by M & F. He did not seek to renew it and had not received any adverse notifications from M & F. He could not understand why M & F would decline to furnish him with a quotation. He did not know that he was deemed to "high risk" and was never furnished with any particulars in this regard. He did not consider the declining of furnishing of a quotation as a refusal to insure. He considered the defendant bound by the impression created by it after his first claim in January 2016 had been approved and paid out after it had been validated. Had that claim been rejected and his policy then been invalidated, he would

have effected the repairs himself and cancelled the policy. In the plaintiff's view, he had answered all the questions put to him, in the manner in which they had been put to him, prior to obtaining insurance cover from the defendant, truthfully. Had he been asked whether a company had refused or declined to furnish him with a quotation, he would have answered that question, but it was never asked in that fashion. The plaintiff was his own only witness.

4.2 Peter Walker:

The defendant's first witness was one of its assessors at the time, Mr Peter Walker. He explained that there are two types of investigation done in respect of a claim. The first is a so-called "desktop" investigation. Although called a "desktop" investigation, it is rather extensive. All information which can be sourced by way enquiries in respect of the client's claim history, previous insurance covers and particulars regarding the incident, the reporting thereof and the people involved and eyewitness particulars are gathered during this investigation. The second type of investigation performed is an "on the road" investigation. During this investigation the vehicle is physically inspected, the accident scene is visited, police records and accident report information are investigated and witnesses and the client are interviewed. Mr Walker was not involved in the plaintiff's first claim under the contract in question in January 2016. Mr Walker was, however, involved in the processing of the plaintiff's second claim, that is the one being the subject matter of the current litigation. After the claim had been registered and sent to the claims department, he received it on 31 March 2016. On 4 April 2016 he did "spot checks" at other insurance companies. This involves sending e-mails to a random selection of other short-term insurance companies to find out if they had any record of the client in question. E-mails were in this instance

sent to Budget Insurance, First for Women and M & F. Lastmentioned company replied some time later. Its reporting was recorded in a claims presentation by one Lawrence Coetzee as follows: *“Good day. Kindly note that the insured had a Motor-sure Personal Lines Policy number with Mutual & Federal and a declined quote due to loss ratio. Please view the claims history for the last 5 years below ...”* (then the claims history referred to in paragraph 2.6 above was set out). Mr Walker made no decision on the claim or on the information obtained by him. He forwarded it to Mr Modupi Mokwena who in turn forwarded it to Mr Lawrence Coetzee who proceeded with the validation process. Mr Walker could not explain what the reference to “loss ratio” was and stated that it was an “underwriting question”.

4.3 Mr Mokgobolotho

This witness was an investigation team leader in the employ of the defendant. He allocated “on the road” investigations and managed teams of investigators. He was the team leader who attended to the plaintiff’s claim in question and who had allocated the claim to aforementioned Lawrence Coetzee (who has since left the employ of the defendant). He noted Mr Coetzee’s report and forwarded it to a management team to consider, which they did one Friday morning, arriving at the conclusion to reject the plaintiff’s claim. At the management meeting, the conversation between the plaintiff and his broker had also been considered. He testified that the issue was not one of “losses” or previous claims, but purely the non-disclosure of a refusal of insurance. According to Mr Mokgobolotho, when an insurance company refuses to provide an insurance quote, it is an indication that they are not prepared to deal with a particular client. For anyone else to deal with the client would require a transfer of risk which would require more information. The answers given provide indications

for underwrites as to whether to accept a client and on what terms and conditions. He confirmed the procedure followed by the defendant as being the following: a client talks to a sales agent telephonically, is asked questions and the answers are recorded. Thereafter a “quote” is generated and a premium is offered to the client who then has to decide to accept it or not. The questions asked are all insurance underwriting related. Had, in this instance, the defendant been informed at the time that the agreement was concluded, that the answer to the underwriting questions (relating to M & F’s refusal “to quote” the plaintiff) was “yes”, they would have declined to insure the plaintiff. In his view, the refusal to quote is the same as refusing to insure. It also results in a client having to seek alternative insurance as his only other option. Mr Mokgobolotho was asked to comment on the wording of clause 4.1 of the policy referred to in paragraphs 2.6 and 2.7 above. His response was that the obligation to furnish information was on the client, but the decision in respect thereof would be that of the underwriter. He further shed some light on the validation process which took place in respect of the plaintiff’s first claim under the policy in question. At that time “checks” were made with Outsurance, MiWay and Callout with no adverse information being obtained. This resulted in the claim being validated and paid. Now that M & F’s stance has become known, the defendant is counterclaiming return of the amount paid. His explanation of “high risk” based on “loss ratio” was that it was an underwriting issue relating to the premiums paid or recovered over a certain period of time and the costs or loss paid out. He could, however, not further elucidate thereon, but reiterated that, if a client had answered to a question put to him by an agent that another insurance company had refused to quote him, the defendant would also refuse to quote the client.

4.4 Mr Tsamayi

Mr Tsamayi was an insurance underwriter with an advanced Diploma in Insurance and with 14 years of experience. He has been employed at Old Mutual iWyze since 1 September 2017 and was accordingly not in the employ of the defendant at the time of either the application for insurance by the plaintiff, the claim/s in question or the rejection in dispute. He was only asked for his advice subsequent to the events. He was, however able to provide evidence of a factual nature regarding the defendant's business practices. He initially stated that the questions contained in the questionnaire referred to in paragraph 2.6 above was to find out from a prospective insurer if he or she has been found undesirable by any other insurance company and if so, to assess whether to insure or not. He contradicted the existence of such "assessment" taking place by giving evidence in line with that of Mr Mokgobolotho, namely that, if any of the answers to the questions was "yes", this would lead to an automatic decline to furnish insurance cover. He contradicted himself again later, to say the answers were necessary to assess the risk and non-disclosure would deny an opportunity to do so. He then later testified again to the opposite by stating that the defendant's business rule was if a policy had been declined by any other insurance company on the basis of "loss ratio" in the preceding 5 years, it would lead to an automatic refusal to provide cover. This would be without further investigation or assessment and by simply relying on the other company's determination. He could not advise how M & F had arrived at its determination in question. He could not fully explain the term "loss ratio" but assumed that it related to the ratio between the premiums and the value of claims over a period of three years. In cross-examination he was directly asked: *"So, if one insurance company declines to quote, due to loss ratio?"* He answered *"If in the past 5 years, we would*

decline insurance. We do not investigate it. We don't go into loss ratio reasons, it would take too long".

[5] Evaluation

- 5.1 From what the various witnesses have testified and perhaps somewhat ineffectually tried to explain, despite questions from the court, it appears that the term "loss ratio" simply refers to the ratio between the total amount of the premiums recovered by an insurance company in respect of a specific policy and the amounts paid out in respect of claims submitted under the same policy. One can understand how it can make business sense for an insurance company to say: "Well, we have received only R10 000 in premiums, but had to pay out R100 000 in claims, at this rate (or ratio) we are working at a loss" (This was the example put to Mr Tsamayi and he agreed that this might be what loss ratio referred to but he was not aware of any other specifics in addition to his evidence summed up in paragraph 4.4 above).
- 5.2 The surprising consequence of this, on the defendant's own witnesses' evidence, is that should any insurance company shout "loss ratio" in respect of its own experience of a particular policy or insured, then the defendant would decline to provide insurance cover, irrespective of what loss ratio formula that other company had applied. On the defendant's evidence, this could mean that if any insured has received a payout of a claim which equals or which is in excess of the premiums paid (or in any other ratio, undisclosed by the defendant) in a period of three years before such an insured seeks (new) insurance cover from the defendant, his application would be declined without ado. Such an insured would also be none the wiser as to why this happened.

- 5.3 Of course, an insurer is entitled to arrange his business in the aforementioned fashion and thereby supposedly limit his risks. I say supposedly, for, unless there are any special circumstances peculiar to a particular insured or unless he is in the habit or business of undertaking hazardous exploits (which are covered by other pre-insurance questions), the chances of an insured having a new car written off within 3 months of his previous car being written off (as was the car with the plaintiff) are presumably slim. It is the epitome of bad luck. Be that as it may, as stated, an insurer is entitled to run his business in that fashion but then, in my view, the question with which it seeks to establish these facts, should be clear and unambiguous. If not, an incorrect answer might not amount to an actual non-disclosure, but simply a truthful answer to an opaque question.
- 5.4 There are, in my view, therefore two issues at stake. The first is whether the questions asked were sufficiently clear to elevate the plaintiff's answers to that of non-disclosure or not. The second issue is more fundamental, that is whether the "loss ratio" issue is one pertaining to actual risk and therefore material to disclose or not.
- 5.5 Dealing with the first issue: were the questions asked on behalf of the defendant sufficiently unambiguous so that the responses on which the defendant seeks to rely on in this matter, justify its avoidance of the insurance contract in question? The four questions relating to insurance cover at other insurance companies than the defendant (quoted in paragraph 2.6 above), are bracketed together in one section of the printed questionnaire which formed part of the policy documents sent to the plaintiff. These documents were sent already completed and reflected the single answer given to the composite question asked by the defendant's agent (as quoted in paragraph 2.4 above). Three of the four questions were, in the transcript of the oral conversation with the agent, rolled into one: "...

have you or anyone you intend covering been informed by an insurance broker or an administrator or Insurance company that your insurance was cancelled or you should seek alternative insurance or you have been refused renewal of insurance have these ever happened to you?" (My underlining). The fourth question reflected in the printed document relating to cancellation due to fraud, was not orally asked, but nothing turns on this.

- 5.6 Upon a simple reading (or hearing) of the questions which were asked, they appear to refer to insurance cover in existence at the time of the three occurrences, being (1) cancellation, (2) referral to alternative insurance and (3) refusal of renewal. The first occurrence, cancellation, clearly refers to instances where an existing policy is terminated by way of cancellation by an insurer. In the plaintiff's case, this did not happen. The third occurrence, refusal of renewal, again, presumably of an existing policy, also did not happen. One of the witnesses for the defendant tried to place a construction on the first time seeking of insurance cover by the plaintiff for his newly purchased Renault as constituting a "renewal", but this clearly cannot fly.
- 5.7 It is the second occurrence, advice to seek alternative insurance, which elicited some argument. The one meaning attributable to the question is that which occurs where a broker or insurer, during the existence of a policy, advises a client to seek alternative cover. The other meaning, is the construction sought to be placed by the defendant on M & F's refusal to quote, namely that such refusal has the result that the plaintiff had to seek alternate cover. Yes, the result of M & F's refusal to quote is that the plaintiff would by default have to seek alternative cover, but there was no such express advice given to the plaintiff by his previous insurer. M & F simply refused to quote, as did another insurer with whom the plaintiff had

no prior dealings (Santam). The question to which the defendant actually sought an answer, if it wanted to rely on the real reason for rejection of the plaintiff's claim as disclosed by Mr Mokgobolotho and Mr Tsamayi, would have been "has any insurance company, whether a company who had previously provided cover for you or not, ever refused to furnish a quotation to you for this vehicle?". Had the plaintiff then said "no", that answer would have been false and would clearly have amounted to a non-disclosure.

- 5.8 What is however of importance, is that in its rejection letter, the defendant did not rely on this issue of advice to seek alternate insurance cover (the "second occurrence" referred to above), but on the issue of refusal only. The issue of refusal in the questionnaire, however, refers to renewal only and not to new cover or insurance for a new item. The plaintiff, in his evidence, also stressed this: he was not seeking to renew an existing policy or to renew the continuation of a policy by changing insurers, he wanted to take out a new policy, hitherto never in existence for a vehicle never owned by him before. The issue of renewal and hence, the relevance of the question, did therefore not arise. The questions asked were therefore so ambiguous, that the plaintiff cannot be faulted for not having disclosed M & F's refusal to furnish him with a quotation.
- 5.9 The more fundamental issue, however, is whether the "loss ratio" was related to the actual risk to be assumed and therefore, material, as contemplated in section 53(1)(b) of the Short-term Insurance Act. Mr Tsamayi was adamant that the "loss ratio" issue was a relevant fact for the defendant (and its underwriter) to consider. He gave this answer in the context of the debate about materiality. In this regard, as already pointed out, the test for materiality is an objective one (Oudtshoorn Municipality – case at 435F – I).

- 5.10 The Supreme Court of Appeal had occasion to consider the impact of the above in Commercial Union Insurance Co of SA Ltd v Wallace NO and Others 2004 (1) SA 326 (SCA) from paragraph [65] onwards. The question to be decided therein was whether an insured had been under an obligation to disclose its financial position when it increased cover in respect of stock (in that case, paper) insured against fire. The insurance company claimed that it did, as a dire financial situation might increase the risk of fraudulent claims (or even arson). The court of appeal disagreed (at [68]) but found that, as the goods that were insured constituted the stock-in-trade of a going concern, what was relevant to have been disclosed to the insurer, was that the insured had ceased its trading activities and that the stock which it wished to have insured, were *“the remnants of its former business, which was of doubtful saleability in its hands”* (at [72]). That information was directly linked to the nature of the goods to be insured and therefore directly related to the risk to be undertaken in providing cover for those goods. This information, the court found at [72] *“... would have presented a true picture of the risk that Commercial Union was asked to insure”*. The information (and the disclosure or non-disclosure thereof) was therefore material for the insured to take a decision on the assumption of that risk.
- 5.11 The learned judge of appeal explained the court’s reasoning further as follows at [71]: *“In my view, there is a clear and material distinction between the risk in each case. In the former case (insuring stock-in-trade) it can generally be expected that the insured will have a positive interest in avoiding the occurrence of the event that has been insured against, ... because of the disruption that will be caused to the ordinary conduct of its business. The insurance, in other words, is taken as a precaution against the occurrence of an unwelcome event. In the case before us, however, Press Supplies (the insured) had no such vested interest in avoiding the*

occurrence of the insured event. On the contrary, its occurrence was likely to be welcomed, for it would have the effect of relieving Press Suppliers of stock that was in any event unwanted, without any trouble at all In my view, the risk that presented itself in this case was materially different to the risk that would have attached to the stock-in-trade of a going concern”.

- 5.12 In similar fashion, in the Regent Insurance-case (referred to in paragraph 3.1 above) it was found to be material to the risk insured (also in the context of fire insurance), that one of the largest co-tenants of the insurer, regularly had flammable material in storage. Information of this nature, was considered necessary to disclose.
- 5.13 Applying the above considerations to the present case, the only possible objectively ascertained material fact relating to the risk attached to the prospective provision of insurance cover to the plaintiff, was that he had submitted a claim in respect of a previously insured vehicle, which has been paid. This fact he had disclosed truthfully when asked. The fact whether another insurance company had assessed that the “loss ratio” between premiums collected by it and the loss paid out, was too high, has nothing to do with the actual risk to be assumed, but is a purely business decision. I hasten to add that, if an insurer is prone to causing vehicle accidents, due to negligence or bad driving habits, and an insurer refuses to insure him for this reason (or charges higher premiums), then those facts are clearly material. All the witnesses however, were clear that such a situation was not what “loss ratio” referred to, neither in general nor in the present instance. In fact, the investigator Walker made it clear that there were no adverse findings made in respect of the plaintiff’s person, his driving skills or any propensity to be involved in accidents. There was also no such reason why M & F labelled him “high risk”, the only reason was the aforesaid “loss ratio”. This “loss ratio”, as explained earlier, is the

“ratio” experienced by M & F in relation to the plaintiff’s previous insurance contract with M & F and the claim paid out thereunder. It was peculiar to M & F at the time and not related to the transfer of risk to any other insurer.

[6] Conclusion

- 6.1 I therefore find that on the facts of this case, the “loss ratio” has not been established by the defendant to be “material” to the risk sought to have been undertaken by it, but was at best a consideration relevant to the exercise of a business decision. There was therefore no obligation on the plaintiff to disclose that M & F had declined to quote the plaintiff on the required insurance cover, unless such a question was clearly and unambiguously asked, which it had not.
- 6.2 It follows that the plaintiff’s claim should succeed and that the counterclaim for the recovery of the amounts paid out in respect of the first incident covered under the policy in question, should fail. Having reached this conclusion, I need not make a determination in respect of the plaintiff’s pleaded reliance on estoppel.
- 6.3 As to the quantum of the plaintiff’s claim, it appears that the plaintiff would have been paid the settlement amount referred to in paragraph 2.9 above in terms of the policy. The policy also had a rental option which would have been paid, in the amount of R 5 380.13, which the plaintiff had thus far paid himself. The plaintiff also paid vehicle storage release fees of R 2 359,80. This, the defendant would have covered, had the claim been processed as it should have been.
- 6.4 The plaintiff however, also claims R 67 500,00 as a loss of fees due to him being without a vehicle. These are consequential damages which were

excluded from the policy. Although he might have experienced this loss as a result of the rejection of his claim, his action was, however, principally based on contract for the amounts covered by the policy only. Insofar as the plaintiff attempted to claim these damages outside the policy, the single sentence pleaded that “*the aforesaid damages are causally linked to the Defendant’s breach of the agreement*” is insufficient to establish a cause of action for this amount. The plaintiff also failed to produce evidence as to why he could not continue to rent a vehicle so as to enable him not to lose the fees or why he could not use alternate transport. The proposition that, had the claim been paid out, he would have purchased another vehicle and would then not have lost fees, was also not sufficiently covered in evidence. I find that this portion of the plaintiff’s claim cannot succeed.

- 6.5 The plaintiff was substantially successful and the defendant unsuccessful, both in respect of its defence and its counterclaim. I find no cogent reason to depart from the customary rule that costs should follow the event.

[7] Order:

1. The defendant is ordered to pay the plaintiff the amount of R330 082,54 together with interest thereon at the prescribed rate of 7% per annum from date of service of the summons to date of payment.
2. The counterclaim is dismissed with costs.
3. The defendant is ordered to pay the plaintiff’s costs of suit.


N DAVIS.
Judge of the High Court
Gauteng Division, Pretoria

Date of Hearing: 16, 17 & 18 November 2020

Judgment delivered: 26 February 2021

APPEARANCES:

For the Applicants:	Adv. P R Msaule
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For the Defendant:	Adv L T Leballo
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