IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL DIVISION, PIETERMARITZBURG

Case no: AR 4160/2010

In the matter between:

SHERWIN JERRIER **Appellant**

and

OUTSURANCE INSURANCE COMPANY LIMITED **Respondent**

Judgment

Chetty J (Vahed *et* Poyo-Dlwati JJ concurring):

1. This is an appeal against the judgment of Koen J in which he dismissed the appellant's claim in the amount of R608 772,20 against the respondent, Outsurance Insurance Company Ltd (the insurer). The Order of the court *a quo* was made only on the issue of liability as the parties agreed prior to trial on a separation of the issues of liability and quantum. The appeal centres on the consequences for an insured who fails to disclose to his insurer an incident which may give rise to a claim, even though he does not intend to lodge a claim under the contract at the time of the incident or at any time in the future. In the context of motor vehicle insurance, does this failure to disclose an incident for which the insurer has not and will not be required to indemnify the insured for damages to his vehicle or that of the other driver, permit the insurer to avoid liability when a subsequent claim is later made, for an unrelated incident? The

court *a quo* found that the failure of the appellant to report two previous incidents within the time frames stipulated in the policy, even though he had no intention of lodging a claim under the policy, was sufficient for the insurer to avoid liability. The court *a quo* ultimately concluded at para 34 that:

> "The Plaintiff should have reported these previous incidents within the time frames required in terms of the policy, even if he did not want to claim. He failed to do so. This failure amounted to a material non-disclosure or breach of the terms of the policy, absolving the Defendant from liability."

2. The facts of the matter relevant to the issue for determination on appeal are largely common cause. The appellant owned an Audi R8, a high performance sports motor vehicle, which he purchased either in December 2008 or in January 2009. He entered into a contract of insurance with the respondent to provide comprehensive cover for the vehicle, as well as for his household contents. The respondent furnished the appellant with a written schedule of the insurance cover, under cover of a letter dated 5 December 2008. In terms of the policy, the effective date of the cover was 2 January 2009. In respect of the motor vehicle, the respondent undertook to insure the vehicle against risks set out in the contract, including damage to the vehicle as a result of a collision.

3. The policy schedule issued to the appellant provided for comprehensive cover of his vehicle at retail. This value is not specified, although the record does reflect that the vehicle (according to the appellant) was valued at R1,5m. The appellant intended to insure the vehicle for less than its retail value, allowing for depreciation. The policy schedule issued by the respondent drew to the attention of the insured the following:

> 'OUT bonus Benefits
>
> Should you not claim for three consecutive years, you will receive 10% of all your premiums paid in this period at the end of the third year. Should you not claim for a further period of 2 years, you will receive 20% of all your premiums paid within this period at the end of the fifth year. Thereafter, for each successive claim free year you will receive 25% of all your premiums paid within the year at the end of each year.'

4. With regard to disclosures made by the appellant at the time of the issuing of the contract, the policy schedule records a disclosure by the appellant that he was involved in an accident resulting in damage to his vehicle on 2 April 2008, that being the only 'incident' and claim within three years prior to the inception of the policy. The policy, issued under invoice number OT 2433821, comprised the schedule reflecting the premiums payable as well as the excess, being the amount of R20 000,00. Added to the schedule is what is referred to as a "facility document issued by the insurer", setting out the finer details of the obligations of both parties to the contract. The insurer, as part of its business branding profile as the self-proclaimed leader in the personal insurance market, prides itself on saving the consumer money by consistently offering the best premiums based on the exclusion of brokers, with the result that no commissions are payable and that its premiums are based on an individual's profile. As for the terms and conditions governing its policy, the insurer proclaims to:

> 'Say it simply. There is no fine print in our documents. Our documents are easy to read and user-friendly so there are no hidden surprises.'[1]

Elsewhere the policy document states:

> 'This is a plain language document, ensuring that it is easy to read and conveys the details of your facility in the clearest possible way.'[2]

Unfortunately, it would appear that the wording of the policy is not as simple or worded in plain language as the insurer may have believed. The insurer's intention to reduce the contractual terms of the policy to plain language seems not to have had the intended outcome, with the resultant uncertainty as to what was expected of an insured who may not want to lodge a claim in the hope of preserving his 'Outbonus'. It is this precise scenario that has given rise to the present litigation.

5. The policy places diverse obligations or responsibilities on an insured. There are two particular sets of provisions of the policy which are relevant to the issues on appeal. The first sets out the following:

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[1] Record: p.36.
[2] Record: p.41.

‘**Your responsibilities**

In order to have cover you need to:

- pay your premiums
- provide us with true and complete information when you apply for cover, submit a claim or make changes to your facility. This also applies when anyone else acts on your behalf.
- inform us immediately of any changes to your circumstances that may influence whether we give you cover, the conditions of cover or the premium we charge.
  - E.g. If you sell your car and buy another one, you need to inform us about the change before you can take delivery of this car so that you can be certain that your car is OUTsured by the time you drive off the showroom floor.

  This includes any changes to any information:
    - on your schedule
    - about the financial position of any person covered under this facility, specifically relating to defaults, civil judgments, sequestrations, administration orders and liquidation of companies in which you have an interest;
    - about convictions for offences related to dishonesty by you or any person covered under this facility.’

6. The second set of provisions of the contract imposing responsibilities on the insured sets out the following in relation to the submission of claims:

‘**Your responsibilities**

You have certain responsibilities which are listed below. If you fail to meet these responsibilities, your claim may be rejected.

<u>Time periods</u>

You need to:

- report your claim or any incident that may lead to a claim to us as soon as possible, but not later than 30 days, after any incident. This includes incidents for which you do not want to claim but which may result in a claim in the future. E.g. If your car is involved in an accident with another car and there is no apparent damage to either car, we still want to know about this incident so that

we can take steps to limit the effects of any claim which may be made by the other person.

- report any lost items, fire, theft, hijack (including attempted theft or hijack) or damage caused intentionally to the police within 24 hours of the incident.'

7. The policy further stipulates that the insured is required to provide the insurer with "*all information and documentation within the time frames we set*", and there is a further requirement that the information must be true and complete.

8. On 8 January 2010, the appellant attended to his business affairs during the course of the morning, whereafter he played a round of golf in the afternoon and retired to his restaurant (an establishment owned or managed by him) later that evening to have dinner and a few drinks with his friends. He left the restaurant at about 22h30 that evening, heading towards Umhlanga, where he had another engagement. The weather was overcast with rain, and on the course of his journey he encountered a puddle of water, causing the insured motor vehicle to move sideways, as a result of which it collided with another vehicle travelling in the centre lane. The appellant's vehicle spun around, coming to a standstill at the side of the road. He then contacted the breakdown assist service of the vehicle manufacturer. Not before long, a tow truck operator arrived on the scene, eager to tow away the vehicle. Eventually the appellant made suitable arrangements for the vehicle to be towed away, and reported the incident to the police the following day.

9. The cost of restoring the insured vehicle to its pre-accident condition, according to a repair quotation furnished by the appellant to the insurer, was the sum of R608 772,29. He duly informed the respondent of the accident and complied with all other formalities in respect of the lodging of his claim for this amount. There is no dispute that the policy was operative at the time of the accident, with the appellant being current with his premium payments. It is not disputed that the appellant lodged his claim within the stipulated 30 day time period. On 22 January 2010 the insurer rejected the appellant's claim. The reason for the repudiation, as set out in the insurer's letter, was that the appellant was "*driving under the influence*".

10. In its plea, the insurer elected to avoid the insurance agreement and rejected payment of the claim. In the alternative, it tendered a refund of the premiums paid by the appellant. The reasons put forward by the insurer in its plea, as a justification for its stance, were the following:

> '6.3.1 The warranties, statements and answers given during the application for insurance and at each renewal thereof constituted the basis of the contract of the insurance and were warranted by the Plaintiff to be true and complete;
> 6.3.2 The Plaintiff, at the conclusion of the agreement of insurance and at every subsequent renewal thereof, warranted that:
> 6.3.2.1 The regular driver of the insured vehicle was involved in only one previous incident whether a claim was submitted or not in the last three years being on 2 April 2008 for accidental damage;
> 6.3.3 The statements and answers warranted by the Plaintiff to be true and correct as set out in 6.3.2 above were not true at the conclusion of the agreement and/or at the subsequent renewal thereof, in that:
> 6.3.3.1 On or about 11 April 2009 the Plaintiff who is the regular driver of the insured vehicle was involved in a motor vehicle collision at or near Beach Road, Amanzimtoti wherein the insured vehicle collided with another vehicle with registration number NPN 30285.
> 6.3.3.2 The Plaintiff failed to disclose the above incident to the Defendant.
>
> 6.3.4 The incorrectness of the information, alternatively, failure to disclose this information was of such a nature as to materially affect the assessment of the risk, the acceptance of the risk and the determination of the terms and conditions and the premium applicable by the Defendant under the said insurance agreement.
> 6.3.5 The Defendant consequently elected to avoid the insurance agreement, as it was entitled to do, and to reject the claim made upon it by the Plaintiff, alternatively the Defendant hereby elects to avoid the insurance agreement and tenders repayment of the premium paid by the Plaintiff to the Defendant in respect of the cover provided thereunder.'

11. The insurer further contended in its plea that it was not obliged to pay the appellant any amount in respect of loss or damage to the insured vehicle on the basis that he had breached a condition of the policy as he was under the influence of alcohol

and had a concentration of alcohol in his blood which exceeded the legal limit at the time of the incident. In the proceedings in the court *a quo* the insurer relied on a statement by the former manager of the appellant's restaurant in which the manager had related to the insurance investigator that the appellant had consumed 'nine double Brandy's and Coke between 20h00 and 23h00'. It also emerged that the appellant was taking anti-depressant medication at the time, following a death in his family.

12. The appellant however disputed the contentions advanced in the statement of the former restaurant manager. As the manager was deceased by the time the matter came before the court, the insurer attempted to have his hand written statement admitted into evidence. The court *a quo* concluded that it was not in the interests of justice to admit the statement into evidence. Even if it were, the court reasoned that the statement would not be of sufficient weight to displace the version of the appellant and his friend, who arrived at the scene of the accident on 8 January 2010, that the appellant was not under the influence of alcohol. On appeal before us, that the insurer did not dispute the findings of fact by the court *a quo*. Mr *Pretorius,* who appeared for the insurer, did not pursue the defence based on the alleged intoxication of the appellant. Accordingly, this appeal turns on whether the court *a quo* was correct in concluding that the failure of the appellant to report earlier 'incidents' (in respect of which no claim was lodged), amounted to a material disclosure or breach of the insurance policy, absolving the respondent from liability for the subsequent accident resulting in damages of R608 772,29.

13. In relation to what Koen J termed the "non-disclosure" defence, the plea of the insurer referred to a single incident of non-disclosure, that being in relation to an accident in Amanzimtoti on 11 April 2009. In the course of his discussions with Mr Herbst, the accident investigator appointed by the insurer, the appellant of his own accord disclosed the existence of *two* incidents for which he did not claim. It is noteworthy that when Herbst first interviewed the appellant, he described his role as being to "*motivate the claim*" and that he was a "*mediator*" between the appellant and the insurer. In truth, Herbst was employed by a company retained to assess claims on behalf of the insurer.

14. During the course of his discussion with Herbst regarding the design of the insured motor car, the appellant informed Herbst that he had hit a pothole and consequently damaged his rim, which cost R15 000 to repair. The appellant stated that he paid for the repair himself. At a later stage in the interview, the appellant was asked whether in the last three years he suffered any losses relating to any vehicle and "*whether a claim was submitted or not*".[3] The appellant responded as follows:

> 'Well the rim and the front fender and for me to basically ….'
> [indistinct]

The appellant went on to add that it was not worth his while claiming for the damage and he repaired it himself. When Herbst interviewed the appellant for a second time, the appellant confirmed that he mentioned in the first interview that his rim was damaged and repaired at a cost of R15 000. The interview, which formed part of the record reflects the following conversation:

> 'Mr Jerrier: Ja, the pothole was a rim which was the R15 000 but I also damaged the front bonnet and the front headlight in a different incident which I also didn't claim for, ja.
>
> Mr Herbst: Okay, but this is something that you didn't disclose to me because you said to me at the assessment and please just keep in mind that obviously I had a listen to the conversation again.
>
> ……..
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> Mr Herbst: Okay, no, obviously ja, because I've also ascertained that the previous claim that you had was in excess of about R200 000 where you were in Toti in front of Almega, you were revving the car. The car jumped into gear and you smashed into a bakkie?
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> Mr Jerrier: Yes, but I did not claim anything.
>
> Mr Herbst: No 100%, but remember I asked you any claims, any accidents whether a claim was submitted or not and you told me it was only for the rim and you said

[3] Interview with appellant, p. 263.

> to me the reason why you didn't claim for that is because it was within excess, okay.'[4]

15. In his evidence before the court *a quo*, the appellant admitted that he did not submit a claim against the insurer in respect of damages to his car, on the basis that he initially regarded the incident as being trivial and he estimated the damages at R20 000. He testified that he did not inform the insurer of the incident as he would lose his no claim bonus. He also thought that the accident was his fault, and for those reasons did not claim. In light of him paying the owner of the other vehicle an amount of R12 000, he considered that there would be no prejudice to anyone by him not informing the insurer of the incident. His evidence was further that when he discovered the damage to his car was R200 000 instead of the R20 000 he initially believed, he still did not submit a claim "because it was too late".[5]

16. Under cross-examination, the appellant conceded that he was involved in a collision resulting in R200 000 repairs to his vehicle and paid R12 000 to repair the other vehicle belonging to a Mr Larcher. A short while thereafter, the appellant drove into a pothole resulting in damages totalling R15 000. In relation to the collision resulting in the R200 000 damages, the appellant initially believed the damages to be insignificant. Importantly though, he did not want to lodge a claim as this would cause him to lose his 'no claim bonus'. The insurer refers to this in its policy document as the "OUTbonus". When questioned that his failure to report the accident resulting in R200 000 damages could impact on the amount of his premiums, the appellant disputed this, suggesting that premiums could be upwardly adjusted for clients making frequent claims on the insurer, not for those who do not submit claims.[6]

17. The court *a quo* concluded, and correctly so in my view, that there was no attempt by the appellant to withhold information from Herbst during the course of the interviews. This then leads to the crux of this appeal – whether the appellant was contractually obliged to disclose the two incidents in which the insured vehicle was

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[4] Record: Transcript of recording between Q Herbst and S Jerrier.
[5] Reconstructed record: p.379F.
[6] Record: p. 391 15-20 – check this

damaged or put differently, whether his failure to make disclosure of these two incidents allows the insurer to validly avoid liability in terms of the contract. The reasoning of the court a quo is reflected in the following conclusion:

> 'In my view it would be sufficient if they were incidents which may result in a claim, in the sense of 'could' result in a claim, it being irrelevant whether they ever actually would result in a claim, whether such failure might be due simply to no claim being pursued by any party, or whether a claim is precluded by an inclusive full and final settlement offer in settlement previously made, or for whatever reason.'[7]

18. The evidence of the appellant is that he did not report the two incidents to the insurer because he believed that they would fall within the amount of his excess of R20 000. The further reason proffered by the appellant for not reporting the incidents was that he did not want to lose his OUTbonus. The "OUTbonus' as referred to in the respondent's policy document is what supposedly sets it apart from others in the insurance industry. As the insurer's branding slogan proclaims: "*You always get something out"*.[8] To honour this promise, if an insured does not claim for three years from the inception of the policy, he receives 10% of the total premiums paid back in cash. As the duration of the policy moves on to the 5th year and onwards, the rewards progressively increase, as long as the insured does not claim. The policy document explains in plain terms language that as an insured, *you are rewarded for not claiming*.[9] The document goes on to explain that the:

> 'OUTbonus will be forfeited following the payment of any claim submitted for any incident, including any liability claim settled or where letters of demand or summonses are referred to us and the incident date falls with the appropriate OUTbonus cycle.'[10]

19. It was therefore not surprising that the appellant, in light of the benefits of not submitting a claim, which he in any event believed fell within the confines of the excess which he would be obliged to pay had he claimed, did not submit a claim for the two incidents which took place in 2009. In my view, the manner in which the insurer's

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[7] Judgment, para 29.
[8] Record: Policy document, p.36.
[9] Record: Policy document, p.44.
[10] Record: Policy document, p.44.

policy is designed, it positively discourages its clients from submitting claims. This self-absorption of the risk or damage by an insured is rewarded by the insurer paying the insured 10% of their premiums after the first three years of the policy. The protection of the Outbonus is also allowed even if a client submits a claim, but then decides to withdraw it. Such withdrawal is deemed to be final in terms of the policy.[11]

20. In considering the wording of the policy, it is apparent that the insurer's policy is not similar to other 'conventional' policies, which are subject to an annual renewal and a requirement that the insured inform the insurer on the anniversary of the policy of any change in circumstances that may lead to a reconsideration of the assumed risk. It was submitted that the insurer chose not to require its clients to complete an annual questionnaire, in terms of which it would reassess the risk on a yearly basis. This contention was not disputed. The present matter is therefore distinguishable from that considered in *Whyte's Estate v Dominion Insurance Company of South Africa Ltd* 1945 TPD 382. The respondent's Outsurance policy provides for an indefinite insurance facility for as long as the premiums continue to be paid. The longer a client remains insured with the respondent without claiming, the greater the reward in the form of a percentage of the premiums paid, with the first reward due after a three year claim free period. To this extent, the policy establishes an incentive for clients not to submit claims.

21. In regard to the contractual provisions on which the insurer relies for the contention that the appellant should have reported the two incidents which occurred in the course of 2009, the first is that the insured is required to inform the insurer "immediately" of any "changes to [your] circumstances". The respondent proceeds to give examples of what a "change in circumstances" entails[12]. The respondent does not include in the list of circumstances an accident or collision with another motor vehicle. As I understand the duty to report a "change in circumstances" in the context of the respondent's policy document it relates primarily to the risk assessment of the insured and his ability to continue paying the premiums determined at the inception of the policy. In my view, this section of the policy should be read in the light of the basis

[11] Record: Policy document, p. 44.
[12] Record : Policy document, p.45

on which the insurer elected to assume the risk, and further what premium should be charged. In doing so, the insurer indicates in plain language that "*Your premium is based on your individual profile. In short, we make sure that good risk clients do not subsidise bad risks*".[13] To this extent, the insurer requires that it be immediately informed whether the financial position of the insured is adversely affected by a civil judgment, sequestration, an administration order or the liquidation of a company in which the insured has an interest. This is what the insurer regards as being material to the risk it assumes. In my view, if the respondent intended for this clause to include the occurrence of every 'incident', it should have said so. The requirement to report *immediately* a change in circumstances contemplates, in my view, a change to the insured's personal circumstances rather than a change to the condition of the vehicle.[14]

22. Moreover, to suggest that this clause obliges an insured to immediately report any incident or damage to his or her motor vehicle imposes an uncertain and vague burden on the insured, subsequent to the commencement of the insurance contract. For example, would the insured be obliged to inform the respondent of near misses that he encounters every day when negotiating a busy intersection on his way to work? Alternatively, if the appellant hypothetically had one drink too many and drove home, narrowly avoiding an accident, should he have reported this to the insurer? The permutations of what could constitute an "incident" are innumerable and too wide to begin to define, unless the respondent specifically spelt out in unambiguous terms what it required the insured to report.

23. Mr *Pillemer* SC, who appeared for the appellant, submitted at the outset that in analysing the wording of the contract to determine the responsibilities of the appellant and the insured, the contract has to be interpreted in *contra proferentum* against the insurer. There was no argument from the respondent against this submission and I agree that in respect of insurance agreements in particular, they should be interpreted strictly against the insurer. The respondent, who set out to word

[13] Record : Policy document, p.36

[14] See JP Van Niekerk 'Goodbye to the Duty of Disclosure in Insurance Law: Reasons to Rethink, Restrict, Reform or Repeal the Duty (Part 1)' (2005) 17 *SA Merc LJ* 150 in which the duty to disclose in the context of insurance contracts is considered extensively.

its policy in 'plain language' must to that extent be hoisted by its own petard where the examples of 'incidents' set out in the policy do not encapsulate the requirement to report an accident for which the insured undertakes at the time or at any time thereafter not to claim in order to preserve his OUTbonus.

24. The second contractual provision relied upon by the respondent as to why the appellant was obliged to report the incidents in 2009 is the provision that requires the appellant as soon as possible but not later than 30 days afterwards, to report "*a claim or any incident that may lead to a claim*", including incidents for which the insured does not want to claim but may result in a claim in the future. The respondent proceeds to provide an example in the policy of an instance where the insured vehicle is involved in a collision, but with no apparent damage to the other car. The insurer stipulates that it still needs to "*know*" about the incident so that it can take steps to "*limit the effects of any claim which may be made by the other person*". In my view, the obligation to report a claim or an incident in this provision relates to circumstances where the insured has suffered damages to his vehicle and where the vehicle belonging to the other party has also been damaged. The insured enforces the obligation on the insurer to undertake the necessary repairs to his vehicle. Where the owner of the other vehicle demands payment of its damages, the insured driver may simply refer the claim to the insurer to settle.

25. The obligation to report a claim or an incident only arises if the insured wishes to enforce the indemnification for loss which the insurer is obliged to honour. If the appellant was involved in an accident and the other party, as in the case of Mr Larcher whose bakkie was damaged in the incident at Amanzimtoti in 2009, agreed to accept an offer in full and final settlement for the repairs to his vehicle, there can be no possible reason for the respondent to be informed of the incident. In this instance, the appellant elected to make a conscious decision to absorb the damages to repair his own vehicle and that of the other party. His reward for absorbing the loss is the retention of his no-claim status and the preservation of his Outbonus.

26. The 30-day notice period is a guillotine provision, after which the insurer is exempted from indemnifying the appellant or any other party which has sustained

damages in an accident. In the course of argument on the merits of the matter in the court *a quo*, counsel for the insurer raised the spectre of the appellant settling a claim by the driver of the other vehicle which sustained damages in an accident, only for the other driver at a later stage to contend that he suffered damages in an amount exceeding the amount for which he initially settled. It was suggested by counsel that in such circumstances, an insurer, would be obliged to defend or settle the claim by the other driver. The following interchange, during the course of argument on the merits, is illustrative of the point:

> 'Koen J: Or I knocked into a pedestrian who dented my bonnet slightly. The damage is only a few thousand rand. But it happened when I went down the off ramp down the highway and I was travelling in the incorrect lane down to Durban facing oncoming traffic. The damage is minimal but circumstances indicate that I am reckless.
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> Mr Pretorius: The reasonable would say that this is a circumstance that may influence. And M'Lord, the policy obviously does not stand in isolation. We have to consider the provisions no page 46 as well.
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> Koen J: Yes.
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> Mr Pretorius: That includes the obligation. Again:
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> > 'You need to report your claim or any incident that may lead to a claim to us as soon as possible. That includes incidents for which you do not want to claim but which may result in a claim in the future.'
>
> My learned colleague, unless I understood him wrong, I think failed to keep in mind the possibility of a claim. Your Lordship uses the example of the …
>
> [indistinct]
>
> Koen J: That is just from the old delict lectures.
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> Mr Pretorius: This may relate to such a claim. It may also relate to a third party claim. In the instance of Larcher, a claim by Larcher. Now again, subjectively, which is irrelevant, the plaintiff may have thought "I am sorting out Larcher, no claim will arise."
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> Koen J: Well let us assume that he sorted him out and he got an acknowledgment from him that what he paid him was in full and final settlement of any claim he could ever have.

Mr Pretorius: Yes, M'Lord

Koen J: Would it still [incomplete]

Mr Pretorius: Because Larcher, the plaintiff at that stage thought his damages were R20 000.00. He may have thought that Larcher, just bumping into the tow bar may be R50 000, that is an example. It turns out that as the plaintiff's damages appeared to be ten times more, Larcher all of a sudden had – his damages come to R40 000.00 or whatever.

Koen J: No, that was my example, he discovered that the chassis is bent.

Mr Pretorius: Yes, substantially more. Now he says "I am not going to pay for that." "I disagree that that bent chassis was as a result of me driving into the back of your vehicle". Then there is this possibility of a claim that may arise. Larcher, if he is insured, or his employer, will obviously report it to their insurers, and as Your Lordship knows, at the end of the day the big fight is going to be between Outsurance and whoever those insurance is.

So as I say …..[intervention]

Koen J: Or there may be a knock for knock agreement. Or something.

Mr Pretorius: There might be a knock for knock, one does not know.

Koen J: Yes.

Mr Pretorius: That is why "which may result" objectively.

Koen J: It does not have to.

Mr Pretorius: It does not have to result. M'Lord, the policy places – clearly places an obligation on the plaintiff. The plaintiff in his own evidence, did not inform the defendant at the time, firstly 30 days, and alternatively on the clause on page 45, immediately. He did not inform them. It matters not that he informed them at claim stage. He should have informed them at this stage and he did not. Those non-disclosures, I submit, were material……..'[15]

27. To the extent that the court *a quo* was persuaded by this line of reasoning, I am of the respectful view that the court erred in this regard. Whether the driver of the

[15] Record: p.749 [line 7] to p.751 [line8].

other vehicle seeks to claim either immediately, or after 30 days of the incident or after entering into a settlement agreement, it is immaterial to the insurer. The obligation to indemnify the appellant against all loss to his vehicle arises from a contractual nexus between the appellant and the insurer. A third party who has suffered damages has no contractual relationship with the insurer. As such, the only party against whom it can claim damages is the appellant.

28. Where the appellant elected not to report the matter to the insurer within 30 days in my view marks the end of the insurer's liability. The driver of the other vehicle still has a claim against the appellant; however there is no obligation on the insurer to indemnify the appellant against such a claim. The words "*but which may result in a claim in the future*" can only relate to an election by the insured whether he wishes to claim beyond the 30 day period and in respect of that incident only. In the present matter, the appellant elected not to report the incidents to the insurer and settled his own loss and that of the other driver. As long as the appellant understood that he would have no claim against the insurer for those incidents at the time or at any time in the future, there was no obligation to him to bring the matter to the attention of the insurer. His motives for doing so are irrelevant, but in this case it is known that it was directed at the preservation of his no claim bonus.

29. It was further submitted on behalf of the appellant that the court *a quo* conflated the reporting duties of an insured (to *immediately report* a change of circumstances) and the 30-day period within which the insured must inform the insurer, even if he does not intend to claim but may claim in the future. An accident for which the insured does not wish to submit a claim cannot be construed on any interpretation to mean a "change in circumstances" as contemplated in the insurer's policy. In regard to the 30-day notice period, the common sense interpretation of that clause can only mean that if the insured elects not to report the matter within 30 days, he loses the right to claim his loss in respect of *that incident only.* The election to report the matter is entirely at the behest of the insured. Consider for example if one is in a shopping centre and the attendant at the super market employed as a casual worker gathering shopping trolleys accidently allows a trolley to bump into one's rear fender. The damage is minimal, with barely a scrape of paint. As the owner of the insured vehicle, you are aware that the damage can be repaired with an application of paint compound

or renovating polish available from a local auto spares shop. The cost of repair would be under R500. The damage to the insured vehicle is unrecognisable and in no way whatsoever diminishes the value of the vehicle. As the insured, one declines the generous offer from the trolley assistant to pay for the damages and have the fender repaired immediately. The insured does not wish to jeopardise his no-claim bonus nor risk incurring the excess payment of R20 000 to effect repairs of under R500. Can it possibly be said that this election by the insured not to report the incident may result in the insurer avoiding liability under the contract for damages totalling R608 722 a month later, when the vehicle is involved in a serious collision?

30. The requirement to notify the insurer of every incident may result in insurers being flooded with information on entirely irrelevant events. At the same time, it would create general confusion and uncertainty among the clients of the insurers as to what incidents should be reported.

31. In the case of the appellant, at the time of claiming for the accident on 8 January 2010, he disclosed to the insurer the existence of the pothole incident that damaged the rim and of the incident involving Mr Larcher. To the extent that the latter incident may have resulted in greater damage to the appellant's vehicle than he thought at first, and that it is impossible to tell apart the impact of the previous accidents from that on 8 January 2010, the appellant will only be entitled to the damages that he is able to prove in respect of the last mentioned incident. His failure to report or lodge a claim in respect of the earlier incidents should not have resulted in a rejection of the claim for the subsequent accident because he failed to comply with the 30 day reporting provision.

32. It bears noting that in *Mahadeo v Dial Direct Insurance Ltd* 2008 (4) SA 80 (W) the court considered whether the failure by an insured to declare that he had sustained damage to his vehicle as a result of driving into a pothole was sufficient to allow the insurer to avoid liability based on what it considered to be a material non-disclosure. The plaintiff had been paid out in respect of damages arising from a pothole by a previous insurer. These facts were not disclosed to the defendant, a new insurer, who enquired from the plaintiff whether he had had any accidents or stolen cars claims or 'claims' within the past two years. As the plaintiff did not consider the pothole incident

to be an accident, he replied in the negative. In his mind an accident involved a collision of some sort either between two vehicles or a vehicle and an object. He did not consider the minor damage sustained after his vehicle rolled into a pothole to be an accident as there was no collision.

33. Boruchowitz J considered at para [21] that the issue was:

> '…not the defendant's policies and procedures in relation to the assessment of the risk but whether the reasonable man in the position of the plaintiff would have thought that the pothole incident may have an impact on an insurer's assessment of the risk.'

The Court answered this query in para [21] in the following manner:

> 'The defendant's subjective views and its own internal practices are irrelevant. The essential question is whether the reasonable man would have considered them to be relevant. Whether the reasonable man would have considered all claims for the preceding six years to be relevant depends on the questions asked of the plaintiff in the sales conversation.'

In para [22] the Court concluded that both "positive and negative misrepresentations are to be treated on the basis of the reasonable-person test postulated in the *Oudtshoorn Municipality* and *President Versekeringsmaatskappy* cases and in determining materiality emphasis is not to be placed on the subjective views or practices of the insurer". The Court dismissed the defendant's plea of non-disclosure and found in favour of the plaintiff.

34. With regard to the appellant's failure, in the present matter, to disclose the pothole incident and the accident in April 2009, the court *a quo* concluded in para [30] that:

> 'Both incidents would cause a reasonable man to conclude that knowledge of their occurrence would indicate a change to the plaintiff's circumstances, at the very least from a claims history perspective, but also as a moral risk, that may (not necessarily would) influence whether the defendant would give the plaintiff cover, the conditions of cover or the premium they would charge.'

This conclusion, apart from it being contrary to the approach favoured in *Mahadeo*, in my view, cannot be sustained as it conflates the duty to disclose true and correct information at the commencement of the contract and the duty to disclose during the duration of the contract. At set out earlier, the Outsurance policy is not one which is subject to an annual renewal assessment of risk. As such, there can be no contention that the failure to disclose the two incidents had a bearing on the conditions of cover or the premiums charged. The policy simply does not provide for this on-going duty to report after commencement of the policy. Even if it did (see paras 5 and 6 above) the obligation to report "incidents" is not set out with any particularity and is bound to lead to uncertainty as to what should and should not be reported, especially where the insured has no intention of lodging a claim. To that end, I would uphold the appeal.

35. It is necessary for me to deal with one further aspect of the judgment, where the court a quo in para 9 held that:

> 'It is trite law that Insurance is a contract based on the utmost good faith.'

In my view, the court a quo erred when it held that a contract of insurance is based on utmost good faith. In *Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality* 1985 (1) SA 419 (A) at 433A-D Joubert JA noted that:

> 'The duty of disclosure is imposed *ex lege*. It is not based upon an implied term of the contract of insurance. Nor does it flow from the requirement of *bona fides*…
> Yet the duty of disclosure is not common to all types of contract. It is restricted to those contracts, such as contracts of insurance, where it is required *ex lege*. Moreover, there is no magic in the expression *uberrima fides*. There are no degrees of good faith. It is entirely inconceivable that there could be a little, more or most (utmost) good faith. The distinction is between good faith or bad faith. There is no room for *uberrima fides* as a third category of faith in our law.'

The Court went on further to jettison the concept of *uberrima fides*, holding at 433E-F:

> 'In my opinion *uberrima fides* is an alien, vague, useless expression without any particular meaning in law. As I have indicated, it cannot be used in our law for the purpose of explaining the juristic basis of the duty to disclose a material fact before the

> conclusion of a contract of insurance. Our law of insurance has no need for *uberrima fides* and the time has come to jettison it.'

36. For the reasons set out above, I am of the view that the conclusion reached by the court *a quo* cannot be sustained. The failure of the appellant to report the two previous incidents within the 30 day time bar cannot, on any interpretation, permit the respondent to avoid liability under the insurance agreement in respect of loss sustained in a later, unrelated accident. The appellant resolved not to claim in respect of both incidents and to carry the costs associated with his own damage and that of the driver of the other driver. The underlying intention of the appellant was to preserve the reward of a refund, being of a percentage of his premiums for not claiming. The attraction of the Outbonus to consumers should not be underestimated. It is a key feature that differentiates the Outsurance policy from others in the insurance industry. Other sectors have developed similar models to attract and retain clientele. Airlines offer rewards for passengers' frequent flights, or upgrading their status depending on the number of 'miles' accumulated in a calendar year. Banks offer rewards and points depending on the frequency with which one uses a credit card. The list is ongoing. Seen in this context, it is not surprising that an insured would opt not to claim for damages which he or she elects to self-absorb in order to 'get something out'. This case is a suitable illustration of how difficult it can be for a prospective client seeking insurance to determine either at the commencement of a contract or at any time thereafter, what a reasonable person would have considered to be material for the purpose of ascertaining the risk to be assumed by the insurer.

37. I cannot agree that the failure of the appellant to disclose the two previous incidents constituted 'material' non-disclosure. In this regard see *Regent Insurance Co Ltd v King's Property Development (Pty) Ltd t/a King's Prop* 2015 (3) SA 85 (SCA) where the Court at para 22 held:

> 'The history of the case law dealing with the distinction between material positive misrepresentations and material non-disclosures is set out with great clarity by Schutz JA in *Clifford v Commercial Union Insurance Co of SA Ltd* 1998 (4) SA 150 (SCA). This court endorsed the view that the test for whether a non-disclosure is material to the assessment of the risk is objective. In this regard the court in *Clifford* confirmed the principles adopted in *Mutual and Federal Insurance Co Ltd v Oudtshoorn Municipality*

> 1985 (1) SA 419 (A) at 435G – I in finding that the test was whether the reasonable person would have considered that the risk should have been disclosed to the insurer. But, in interpreting s 63(1) of the former Insurance Act, this court held that the test for determining whether a misrepresentation was material was a subjective one: *Qilingele v South African Mutual Life Assurance Society* 1993 (1) SA 69 (A). In *Clifford* Schutz JA (delivering the majority judgment) considered, but did not decide, that that aspect of *Qilingele* was wrongly decided. (The minority considered that it was not necessary for the decision to pronounce on the correctness or otherwise of *Qilingele* and refrained from doing so.)'

I accordingly agree with Mr Pillemer's submission that the basis of repudiation by the insurer was bad in law, with the result that the appeal should be upheld.

38. In relation to costs, Mr *Pillemer* contended the appeal should be allowed with the costs of two counsel on account of the matter being sufficiently complex and in light of the public interest generated as a result of the decision of the court *a quo*. Mr *Pretorius* opposed such an order in the event of the appellant being successful, contending that costs of only one counsel should be allowed. Where two or more counsel are employed, the provisions of Rule 69(1) are applicable. It provides:

> "Save where the court authorizes fees consequent upon the employment of more than one advocate to be included in a party and party bill of costs, only such fees as are consequent upon the employment of one advocate shall be allowed as between party and party.

39. In *Van Wyk v Rondalia* 1967 (1) SA 373 (T) the Court considered that in determining whether to allow the costs of two counsel, the question asked was 'was it "a wise and reasonable precaution" on the part of the plaintiff to appoint two advocates?'. The amount sued by the appellant is not substantial, but that alone cannot be a determinant in answering the question whether the costs of two counsel should be allowed. Mr *Pillemer* submitted that complex issues of law and interpretation were to be considered on appeal. The issues of interpretation related essentially to the meaning to be given to two sections of an insurance policy and the respective obligations of an insurer under the policy. It is correct that the issues on appeal were novel, but I do not consider them to be of 'undue complexity' to warrant the

employment of two counsel (see *Ehlers and others v Rand Water Board* 2006 (3) SA 299 (SCA)).

40. In the result, I make the following order:

1. **The appeal is upheld with costs, such costs to include the costs of senior counsel.**

2. **The order of the Court *a quo* is set aside and replaced with the following:**
   - **"a. The Defendant is held liable to indemnify the Plaintiff in respect of the collision on 8 January 2010 for such damages, if any, as may be agreed or determined by the Court.**
   - **b. The defendant is directed to pay the plaintiff's trial costs which costs shall include those associated with the preparation for trial. "**

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M R CHETTY

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VAHED, J

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POYO-DLWATI, J

Appearances:

For the Applicant	:	M Pillemer SC & R Naidu
Instructed by	:	Mahes Attorneys C/o Botha & Olivier Inc. Pietermaritzburg – 033 342 7190
For the First Respondent	:	C Pretorius
Instructed by	:	Hardam & Associates C/o Viv Greene Attorneys Pietermaritzburg
Date of Hearing	:	4 February 2015
Date of Judgment	:	7th July 2015