THE HIGH COURT OF SOUTH AFRICA
GAUTENG LOCAL DIVISION, JOHANNESBURG

CASE NO: 15304/2016

(1) REPORTABLE: NO
(2) OF INTEREST TO OTHER JUDGES: NO
(3) REVISED.

.....02 March 2017..... .....
DATE SIGNATURE

In the matter between:

NKOSINATHI MASHELE **Applicant**

And

MOMENTUM INSURANCE **First Respondent**

HAPPY NTHABISENG POOE **Second Respondent**

JUDGMENT

RATSHIBVUMO AJ:

1. This is an application for specific performance whereby the applicant seeks an order compelling the first respondent to honour its contractual obligations. On 02 September 2014, the applicant and the first respondent concluded a contract in terms of which the first respondent provided short term insurance cover over the applicant's motor vehicle against loss or damage, in return of him paying the necessary monthly premiums. The applicant lodged a claim against the first respondent following the damage to the insured property which according to him emanates from a motor collision he was involved in on 16 November 2014. The second respondent is the driver the other motor vehicle that collided with his. The first respondent assessed the claim and concluded that it was uneconomical to have the motor vehicle repaired. After a full assessment, the first respondent repudiated the claim. It is that decision that the applicant seeks to reverse through this application. The order sought against the second respondent is in the alternative and will only be dealt with in the event the main relief is not granted.

2. Counsel for the first respondent adopted an approach that the matter should have been dealt with by way of action since there is dispute of fact. This could perhaps explain why the affidavit deposed to on behalf of the first respondent is very scanty. Save for its preamble, its content comprises merely of responses to the affidavit by the applicant without stating anything outside thereof. The heads of argument comprising of just over two paged, prepared by the first respondent's counsel do nothing to rescue the situation. It appears from the affidavit filed for the first respondent that all the allegations outside its knowledge (including the collision) are

denied, putting the applicant to the proof. The existence of the policy issued to the applicant under policy no. MT22339470 is admitted although the first respondent disputes that the applicant complied with all the terms and conditions thereof.

3. Not every bare denial constitutes a dispute of fact. For the court to conclude that there is a dispute of fact warranting oral evidence, first the dispute must be real, genuine or *bona fide*, and second, it should be one that cannot be decided on papers.[1] I now embark on a search for disputed facts. Without divulging much, the first respondent's affidavit refers to the signed contract and avers that the applicant failed to comply with his obligations under claims. As to how he failed, no details are given.[2] The first respondent further refers to a letter "attached" to the affidavit in which the applicant was informed "of the fact that the claim against the policy is rejected as a result of the fact that the applicant did not meet his responsibilities as agreed upon in the agreement between the parties."[3] Had this letter been attached as averred, I am hopeful it would have been more helpful in that information on how the applicant failed to comply with his obligations could be included. When asked for this letter, counsel for the first respondent indicated that reference to the letter was an error since no such letter was written to the applicant.

4. The question this court is seized with is whether the alleged dispute of fact is about a collision having taken place or whether the applicant complied with his obligations emanating from the contract? There is no dispute that the applicant paid the premiums and that such payments were up to date on the date of the collision. An assessment report was attached by the first

[1] *Plascon-Evans Paints LTD v Van Rebeeck Paints (PTY) LTD* 1984 (3) SA 623 (A) at p. 634H - 635A and Miele et Cie GmbH & Co v Euro Electrical (PTY) LTD 1988 (2) SA 583 (A).
[2] See p. 91 para 13 & 14 (Opposing Affidavit).
[3] See p. 93 para 22 (Opposing Affidavit).

respondent which appears to be the basis of its repudiation of the claim.[4] From this report it appears a certain Ettiene (the assessor) was appointed by the first respondent to compile an assessment report. The assessor interviewed the applicant who gave him details of where he was coming from when he was involved in an accident. The applicant was asked for information on "beacons and billings; consent letter to obtain the police, hospital and tracker records; contact details of people to confirm his movements prior to the accident; PQ for the Nokia phone he bought at Edgars after the accident (this after the applicant alleged that his phone was stolen on the night of the accident); and copies of his bank statement). The report does not give reasons or why this information was relevant in order to validate the claim, save to say it was a reasonable request. The applicant declined to give this information at the time of the interview, holding a view that they were invading his privacy asking for information not relevant to the claim.

5. It appears further from the assessment report that the applicant informed the assessor that he was collected from the accident scene by his brother whose contact details were made available to him, but he could not make contact with him. The assessor also had access to the police' AR report where he obtained information on other parties involved. He also made contact with "Johnny" the towing operator who towed the applicant's motor vehicle after the accident. He confirmed the accident to the assessor and that on his arrival at the scene he found the police and parties involved in the accident. The lady who was involved in a collision with the applicant was also contacted. She confirmed the accident to the assessor and that the accident was due to her fault.

[4] See p. 97, Annexure O titled "Reason for referral"

6. According to the assessment report, the AR report also reflects that the applicant had a female passenger in the motor vehicle, contrary to what he had told the assessor that he was alone. The assessor contacted her and she confirmed over the phone having been to the scene of the accident after she was taken there. She denied that she was a passenger though. She refused to give any further information. The assessor concluded the report with a recommendation that since the applicant was given 48 hours to furnish the documents referred to above and he did not comply, the claim should be repudiated for failing to comply with a reasonable request. No repudiation letter was given to the applicant. The only letter close to repudiation was the one demanding that he should avail certain documents within 48 hours.

7. Against this background is the applicant's affidavit which does not only aver the motor collision, but he attaches to it public documents such as the AR report, the accident scene sketch plan, copies of the charges sheet from the Protea Magistrate Court and the admission of guilt receipt – case no. 69/826/15. These public documents confirm that a car accident took place and police officers from Protea Glen Police station opened the case as per Case no. 284/11/14 in which the applicant and the second respondent were involved. Police officers who attended to the incident are named in the AR report. The copies of charge sheet reflect that the second respondent appeared in court on several occasions before she paid an admission of guilt fine of R1000.00, related to the incident of driving a motor vehicle recklessly or negligently on the 16th November 2014.

8. I am convinced that given the assessment report attached to the first respondent's affidavit, the applicant's affidavit and all the annexures attached thereto; there is no real, genuine or bona fide dispute of fact on whether the

applicant was involved in a collision. In the alternative, should it be that there is, such dispute is one that can easily be determined on filed papers.

9. The next aspect which appears to be a genuine issue that gave rise to the repudiation of the claim is whether the applicant complied with the reasonable request by the first respondent as contracted. After initially refusing to furnish the documents requested, the applicant later made the following documents available to the first respondent: an affidavit on a Vodacom letterhead that was signed by the applicant on 04 April 2015 in which he gives permission to Vodacom to avail all the information on his cell phone data to the first respondent; a letter directed to tracker (Mix Telematics) dated 31 March 2015 in which he gives tracker permission to avail the tracking information required by the respondent in respect of the insured motor vehicle; ABSA bank statements and a proof of purchase of a cell phone bought by the applicant (invoices from Edgars store).

10. An email from a certain Ben Badenhorst of the first respondent, dated 24 April 2015 acknowledges receipt of these document followed by a statement to the effect that they have identified the discrepancies which they need to clarify and they would need to meet him in person. No further details were made as to what discrepancies were these or how they impact on the claim. The affidavit by the first respondent does not divulge these either.

11. The applicant avers that he complied with every reasonable request from the first respondent. His initial view was that the request for the information he refused to give was not reasonable. The first respondent held a different view. Without any reason why the first respondent needed the information requested (although this was demanded) from the applicant, the court is not able to find that such a request is reasonable within the meaning of the contract. One would expect that the information to be requested would be

reasonable if it enabled the first respondent not only to verify that the insured property was damaged, but also to help in assessing the damage or the costs.

12. The court is not able to find how the bank statements of the applicant would assist in assessing the claim since one would expect it to have its own records of the applicant's payments of the premiums. The relevance of the proof of purchase of a new cell phone and tracker records can only be found if the court is guided thereto. When the applicant had refused to give these to the first applicant and even pleaded in papers that these were irrelevant and the request thereto unreasonable, the first respondent had a duty to convince the court as to why the same was seen as being reasonable, and it opted not to.

13. Had the applicant not complied with this request, the court would not have any reason to fault him given the fact that the information required appeared to be irrelevant given that the basis for the relevance was not presented to court. The only possible reason in the demand by the first respondent could be to try and find a lie or misrepresentation on the part of the applicant in a desperate search for a reason to repudiate a claim even in circumstances where there appeared to be none. This could explain the demand for a meeting with the applicant in person to talk about the undisclosed discrepancies.

14. I pause to highlight that counsel for the first respondent zoomed into possible misrepresentation by the applicant to the effect that he was alone in the motor vehicle at the time of the collision, whereas the AR report reflected that there was a passenger. This aspect, and any further search for the misrepresentations on the part of the applicant ignores the provisions of sec 1 Act 53 of 1998 (the Short term Insurance Act) to the effect,

> "(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. [Own emphasis].

15. It is for this reason that Meyer AJ held in *Holley v Auto & General Insurance Company Ltd*[5] that

> "the fact that such information was not disclosed in itself does not justify the repudiation of the plaintiff's claim. The defendant bears the onus of proving that the test for materiality as enacted in the amended section 53(1) of the Short-Term Insurance Act 53 of 1998 ("the Short-Term Insurance Act"), was satisfied."

Suppose there was indeed a misrepresentation made by the applicant, the first respondent would have to show that such misrepresentation is such as to be likely to have materially affected the assessment of the risk under the

[5] (04/31731) [2007] ZAGPHC 282 (1 October 2007)

policy concerned at the time of its issue or at the time of any renewal or variation thereof.

16. When this provision was first introduced through the amendment of sec 63 the now repealed 27 of 1943 (the Insurance Act); sec 63 (3) read,

> "Notwithstanding anything to the contrary contained in any domestic policy or any document relating to such policy, any such policy issued before or after the commencement of this Act, shall not be invalidated and the obligation of an insurer thereunder shall not be excluded or limited and the obligations of the owner thereof shall not be increased, on account of any representation made to the insurer which is not true, whether or not such representation has been warranted to be true, unless the incorrectness of such representation is of such a nature as to be likely to have materially affected the assessment of the risk under the said policy at the time of issue or any reinstatement or renewal thereof."

The objective of sec 63 (3) was explained by Kriegler AJA in *Qilingele v South African Mutual Life Assurance Society*[6] as follows,

> "The object of the enactment is manifest, namely to protect claimants under insurance contracts against repudiations based on inconsequential inaccuracies or trivial misstatements in insurance proposals. An insurer's right to repudiate liability on the basis of the untruth of a representation made to it, whether elevated to a warranty or not, was curtailed."

17. I refer to these authorities merely to deal with the failure on the part of the first respondent to deal with the reasons for the demand of information the applicant initially refused to give and the impact of the possible misrepresentation to the claim if any. The refusal by the applicant to comply with the demand for the information is in my view a non-issue since the applicant has since complied with it. I do not suggest though that such a demand was a reasonable request.

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[6] *1993 (1) SA 69 (A) at 74B*

18. The last correspondence to the applicant before the repudiation of his claim was a demand to furnish the information within 48 hours, failure of which would result in the claim being repudiated. Of course, such was not furnished within 48 hours, but in about three to four months later. There is no reason furnished as to why the first respondent demanded compliance within such a short and unreasonable period of time. But it would appear from the totality of the evidence that the first respondent hoped for the applicant not to comply so it could have a reason to repudiate the claim. It is noteworthy that the only time limit provided for in the contract is the 30 days within which the claim should be lodged with the first respondent after the incident.

19. Just as the Supreme Court of Appeal held in *Walker v Sanlam LTD and Others*,[7] the claim of this nature is based on a contract as opposed to delictual liability. The claim is therefore not calculated on the loss suffered but the value of the property insured as per contract.

20. The liability of the first respondent in case of a damage to the insured property is incorporated in the agreement as follows,

> "Our responsibilities:
>
> We have the choice to settle your claim in any of the following ways:
>
> - Paying out cash to you,
> - Repairing the damage at the repairer of our choice,
> - Replacing the item at a supplier of our choice,
> - Any combination of the above.
>
> Where any item claimed for is financed, we will first pay the finance company. Where a claim is settled for lost or damaged items, these items become ours.
>
> If we elect to repair, we will only do so up to the maximum insured value noted on you schedule for the specific section you are claiming under"[8]

[7] 2009 (6) SA 224 (SCA).
[8] See page 3 of the Insurance Contract under "Claims".

> The Insured Value
>
> The insured value noted on your schedule is maximum amount we will pay in the event of a claim, less the excess and any dual insurance, betterment or any depreciation.
>
> If the vehicle is financed, we will first ay the outstanding settlement amount to the finance company up to the maximum amount of the insured value, excluding
>
> - Any early settlement penalties,
> - Additional finance charges,
> - Any arrear instalments and interest.
>
> We will pay you the difference if the settlement amount is less than the insured value, less the applicable excess and the charges stated above.
>
> The insured value of your vehicle and its accessories is determined by the Auto Dealers' Guide…"[9]

21. From the above it is clear that once there was a claim lodged and, the first respondent would be expected to take measures to determine if the insured item is indeed damaged and that it was not damaged under the circumstances that are excluded in the contract.[10] In so doing, the first respondent may have to make reasonable request to help it make such determinations. Where such a determination requires personal and private information of the applicant, the first respondent is obliged to inform the applicant how such information is relevant and necessary for any particular determination based on a contract.

22. From the contract, it is also clear that it is the responsibility of the first respondent to determine the market value of the insured property, pay that amount (less all the charges reflected above if any) to the financing company, and in this case, Mercedes Benz Financial Services. If the market

[9] See page 19 of the Insurance Contract under "Insured Value"
[10] See page 21 of the Insurance Contract where circumstances such as driving without a valid licence, driving under the influence of alcohol, etc. is excluded.

value is above the amount owed, the balance would have to be paid to the applicant. From the Net Assess document compiled by the first respondent and filed by the applicant, the value is reflected as R405 000.00. I am not sure if this is the insured value or not. I have noted that the applicant's counsel indicated that the applicant accepts the value determined by the first respondent. The relief sought by the applicant confuses this acceptance in that R455 576.73 is claimed from the first respondent. This appears to be the closing balance owed to Mercedes Benz Financial Services as of 29 February 2016. A further R113 263.85 is claimed as a reimbursement and there is no basis laid for this. The order for specific performance sought requires that the first respondent complies with the contract entered into with the applicant, and the order shall be in those terms.

23. In the result, I make the following order.

The first respondent is ordered to

23.1 determining the insured value of the insured property as on the date of the damage using the methodology agreed in the Insurance Contract;

23.2 pay the amount of the insured value (less the necessary and agreed charges) to Mercedes Benz Financial Services within 30 days of this order;

23.3 pay the balance, if any into the applicant's account.

The applicant is ordered to

23.4 hand over, deliver or make available the damaged motor vehicle (insured property) in the condition it was after the collision within 15 days of this order, failing which, the first respondent would be entitled to deduct its value as per assessment report from the insured value.

23.5 The first respondent is ordered to pay the costs of this application.

T.V. RATSHIBVUMO
ACTING JUDGE OF THE HIGH COURT

Date Heard:	**30 February 2017**
Reasons Delivered:	**02 March 2017**
For the Applicant:	**Adv. KM Mokotedi**
Instructed by:	**Nukeri Incorporated Johannesburg**
For the First Respondent:	**Adv LK Van der Merwe**
Instructed by:	**DJ Swanepoel & Associates Johannesburg**