**THE HIGH COURT OF SOUTH AFRICA**

**GAUTENG LOCAL DIVISION, JOHANNESBURG**

**CASE NUMBER: 2014/10011**

**DATE OF HEARING: 30 JANUARY 2018**

**DATE OF JUDGMENT: 16 APRIL 2018**

In the matter between:

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

..... .....
DATE SIGNATURE

**B E** Plaintiff

and

**HOLLARD LIFE ASSURANCE COMPANY LIMITED** Defendant

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**J U D G M E N T**

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**AVVAKOUMIDES, AJ**

**INTRODUCTION**

[1] The plaintiff, who is the surviving spouse of J B, ("the deceased" or "the insured"), instituted action against the defendant for payment of the sum of R1 160 000.00, such amount being in respect of compensation arising from a life policy taken out by the deceased with the defendant.

[2] The plaintiff is the beneficiary under such life policy.

[3] The defendant rejected the claim of the plaintiff on the grounds of the deceased's alleged misrepresentation, and non-disclosure, of certain facts to the defendant at the time when application was made for the life policy.

[4] The defendant pleaded, *inter alia*, that the insured breached the terms and conditions of the contract of insurance in that he misrepresented the truth relating to a lung mass/dot which according to the insured was noticed in June 2010 on an X-ray and that such mass/dot was "*nie kwaadaardig*".

[5] The four grounds of non-disclosure relate to the insured not having disclosed that:

[5.1] he had a heart or circulation ailment;

[5.2] he suffered from a breathing or lung ailment;

[5.3] he suffered from depression;

[5.4] that a proposal for life insurance on the insured's life was previously declined.

**ISSUES FOR DETERMINATION**

[6] In the pre-trial minute dated 29 November 2017 the parties agreed that the issues to be determined by the court will be the following:

[6.1] "*did the insured misrepresent and omit or conceal facts in the proposal stage of the application for insurance and thereafter? and/or*

[6.2] *was the misrepresentation and non-disclosure material*?"

[7] I shall deal with additional issues raised by the parties during the trial hereunder.

**THE DEFENDANT'S EVIDENCE**

[8] The quantum was agreed and because of the defendant's rejection the defendant had the duty to begin and carried the *onus* of proof. Ms Hayley Taylor testified that she is head of underwriting at the defendant and has been

head of underwriting at the defendant for two years. She was previously an underwriting manager with the defendant for close to 13 years. Ms. Taylor explained each section of the proposal form which was submitted and used in order to assess the risk that the defendant would undertake in insuring the life of the insured. Ms. Taylor testified on the contents of paragraph 8 of the proposal form as well as the policy wording in so far as the non-disclosure clause and the warranty portion thereof is concerned.

[9] Her evidence dealt with the particular wording of the questions in the proposal form and that the insured, in terms of the proposal form, warranted that all the information provided in the proposal form, and all the documents that have been, or will be signed by him, in connection with the intended application for insurance were, to the best of the insured's knowledge true and complete.

[10] The insured agreed that the application and any declaration, together with all relevant documents that had been, or were to be signed by the insured, or any person whose life was to be insured in terms thereof, formed the basis of the contract between the defendant and the insured, and that if any material information whatsoever is withheld, the benefits and all monies paid to Hollard Life shall be forfeited.

[11] Ms. Taylor explained that the insured's proposal form and application for life assurance was accepted by the defendant and at underwriting stage the only tests that were called for were the HIV, Random Glucose, Gamma GT, ALT, Random Cholesterol and HDL tests. During cross examination Ms. Taylor

testified that the reason why these tests were called for was due to the insured having stated in the proposal form that he had never been tested for these and furthermore, these tests are the standard tests which are done by the defendant when underwriting any application for life assurance. Ms. Taylor further testified that additional tests are only called for by the defendant when the defendant deems it necessary, after taking into account the disclosures made by the insured in the proposal form and any other documents which may be submitted by the insured.

[12] In this case the insured disclosed, in the proposal form, that he had an ailment or illness in the muscles, skeletal joints (e.g. rheumatism, arthritis, back or neck trouble, gout). He further answered yes to the question whether he had *"sought or received medical treatment in the past 5 years in connection with any symptom or condition or been a patient in a hospital or nursing home not mentioned in the proposal form or undergone any medical examination"*. The insured then later on elaborated by stating that he had "*X-strale van longe – verlengde brongitis (nie longontsteking nie)*". The insured had further disclosed that he had a small spot on his left lung which the doctor noticed with an X-Ray during June 2010 and that the spot was not malignant.

[13] Ms. Taylor testified that the defendant works on a principle of good faith and, given that the insured disclosed that the dot on the lung was *"nie kwaadaardig*", and that the disclosure of gout and one episode of bronchitis does not raise any "red flags" at underwriting of a life assurance policy, the

defendant did not deem it necessary to send the insured for any additional tests.

[14] Ms. Taylor testified that she was informed that the insured had passed away when the defendant's claims department sent the proposal form and several personal medical reports to the underwriting department to re-underwrite the policy. She said that policies are sent back to the underwriting department when a misrepresentation or non-disclosure is discovered at claim stage. The underwriters are then requested to re-underwrite the policy to determine whether the underwriter would have reached a different outcome when assessing the risk and whether they would have offered to insure the insured on different terms or not at all had they been aware of the misrepresented or non-disclosed facts at the underwriting stage.

[15] In this case the policy was sent to the underwriting department for re-underwriting given that the claims department at the claims stage had identified one misrepresentation and four non-disclosures in respect of the insured's policy. Ms. Taylor dealt with each non-disclosure and the misrepresentation separately.

[16] In the proposal form the insured was specifically asked whether any proposal for life, sickness, accident or disability insurance on the insured's life had ever been declined, deferred, withdrawn or accepted at special terms or on special rates. The insured answered "no" to this specific question.

[17] At the claims stage the plaintiff as well as the insured's broker each submitted a letter to the defendant requesting that the defendant review its decision rejecting the plaintiff's claim. In the broker's letter, discovered in terms of rule 35 by the plaintiff, he referred to an application to Old Mutual in December 2010 which was rejected due to the dot on the lung. During cross-examination the broker, Mr. De Waal, testified that he obtained this information from either the plaintiff or the insured's daughter; he was unable to recall which one.

[18] The plaintiff's letter, she also refers to the Old Mutual Policy which was rejected in December 2010 and mentions a Momentum Policy application which was also declined. The plaintiff did not testify and therefore was no cross-examined as to the contents of this letter.

[19] Ms. Taylor testified that, aside from the insured disclosing that there were other applications that were declined, there is no other way for the defendant to establish this information.

[20] At the proposal stage the insured was specifically asked whether he was suffering, or had ever suffered from difficulties with the nervous system (e.g. concussion, fainting, paralysis, dizziness, depression, anxiety, persistent headaches?) to which the insured responded "No".

[21] The plaintiff, in her admissions sought by the defendant, admitted that the insured was diagnosed with depression during 2008/2009 and that the insured received treatment for depression and was cured. The plaintiff

admitted that the insured did not disclose that he suffered from depression in 2008/2009.

[22] Ms. Taylor referred to the personal medical attendant report submitted by Dr Van der Merwe at claim stage (the contents of which was admitted by the plaintiff as being correct) which shows that the insured had symptoms of depression and consulted with Dr Van der Merwe on 28 August 2003, 4 August 2009 and on 3 September 2009, the insured had symptoms of, and consulted with Dr Van der Merwe, for tension, prior to policy inception.

[23] Ms. Taylor also referred to the personal medical attendant report submitted by Dr Rian Smit at the claims stage (the contents of which was also admitted by the plaintiff as being correct) which shows that the insured had symptoms of, and consulted Dr Smit, for chronic depression on 19 August 2009, prior to policy inception.

[24] Ms. Taylor referred to the Old Mutual report completed by Dr Van der Merwe (the contents of which were admitted by the plaintiff) which shows that the insured was on anti-depressants during 2008/2009. Ms. Taylor's evidence was that had the insured disclosed at application stage that he had suffered from depression, the defendant would have asked for additional medical information and would have investigated the severity of the depression and, depending on the results of the investigation, the defendant could have applied a permanent suicide clause, as a condition to the policy.

[25] During cross-examination Ms. Taylor testified that the insured was obliged to disclose that he had previously suffered from depression as this would affect how the defendant assessed the risk it was to undertake in insuring the insured and that the duty is on the insured to disclose what conditions he had.

[26] At the proposal stage the insured was specifically asked whether he had ever, or currently suffers from heart or circulation ailments (e.g. Blood pressure, chest pain, heart murmur, palpitations, rheumatic fever, stroke) to which the insured responded “No”. Ms. Taylor referred to the personal medical attendant report submitted by Dr Rian Smit at the claims stage (the contents of which was admitted by the plaintiff) which shows that the insured had symptoms of and consulted with Dr Smit for early cardiac heart failure on 14 February 2011 and for which he was treated for prior to policy inception.

[27] It was put to Ms Taylor under cross examination that the insured had undergone a cardiac failure test by Dr Smit on 17 February 2012, after policy inception, and one year after the insured’s initial symptoms and treatment for cardiac failure. Dr Smit reported that cardiac failure was not supported by pro BNP (300) on 17 February 2012. The plaintiff failed to call the relevant doctor to explain the reason for this test, one year after the initial symptoms and treatment for cardiac failure.

[28] Ms. Taylor testified that had the insured disclosed at the application stage that he had suffered from cardiac failure, the defendant would have obtained a full

medical ECG and reports from the treating doctor and the defendant would have asked for additional medical information.

[29] It was further put to Ms Taylor that the reason why the cardiac failure was not disclosed is because the question was not clear and “to suffer” was understood to mean “to have a prolonged issue” whereas the insured was treated for the medical condition and cannot be said to have suffered from it. Ms. Taylor maintained that the insured, even though he had been treated for cardiac failure, should have still disclosed that he had suffered therefrom given that this is a condition that would affect how the defendant assessed the risk it was to undertake in insuring the insured.

[30] At the proposal stage the insured was specifically asked whether he had then, or ever before suffered from a breathing or lung ailment (e.g. persistent cough, shortness of breath, tuberculosis, asthma, bronchitis) to which the insured responded “No”. The plaintiff however admitted that the insured had symptoms and was diagnosed with chronic obstructive pulmonary disease (COPD) prior to the inception of the policy. In the Old Mutual Medical file report dated 17 November 2011, prior to inception of the policy, and completed by Dr Van der Merwe, it is indicated in three different sections, that the insured had been diagnosed with COPD and that he suffered from COPD for approximately 10 years.

[31] Ms. Taylor testified further that the ECG submitted to Old Mutual by Dr Van der Merwe states that the patient coughed a lot and this could be due to the

insured suffering from COPD. Ms. Taylor testified that had the insured disclosed at the application stage that he had suffered from COPD, the defendant would have called for lung function tests and a pulmonologist's report for the defendant to assess the risk it would be undertaking in insuring the insured.

[32] Ms. Taylor testified that when an applicant, suffering from cardiac and pulmonary disease, applies for cover, the defendant would not have offered terms to the applicant and would have declined the policy application. In the proposal form the insured was asked whether he was aware of any other health condition (past or present) which may influence the risk attached to the application, to which the insured answered "yes" and went on to elaborate that he had a small spot on his left lung which the doctor noticed on X-rays. The insured went on further to state that the dot was not malignant and inserted a date of "6/2010".

[33] Ms. Taylor testified that an ASISA search (common data based search) was performed on 30 September 2011, which showed that Old Mutual had recorded that the insured had a benign lung tumour and that the ASISA search is based on what the other insurers capture on the system based on the information which they have. Ms. Taylor testified that there had been nothing in any report to indicate that there was a diagnosis to the effect that the dot was not malignant prior to policy inception. She referred to the X-Ray report verified by Dr Louw dated 5 October 2010 which indicated that the insured had a mass lesion and that a tumour cannot be excluded.

[34] Ms. Taylor testified further that the report submitted to Old Mutual by Dr Van der Merwe in which he referred to a mass lesion detected on a test X-ray, shows that Dr Van der Merwe suggested to the insured that he should go for a CT Scan, but the insured's response was that he would go later. Dr Van der Merwe in the same report and at a different section wrote "query tumour on lung". Ms. Taylor pointed out that in the clinical file Dr Van der Merwe again refers to the tumour on the lung and states that the insured was reluctant to go for a CT Scan.

[35] She drew the court's attention to Dr Van der Merwe's personal medical attendant's report which indicates that on 5 October 2010 he recorded that the insured has a mass lesion on his left lung and does not want to undergo further tests. Ms. Taylor testified that had the insured indicated that the spot had not been diagnosed, the defendant would have called for an exact diagnosis and only once the defendant was aware of what it was acting on, would it be able to assess the risk properly. Ms. Taylor testified that without a diagnosis the defendant would have deferred the application until there was a diagnosis and, upon a malignant diagnosis the defendant would only consider cover on terms 3 years post completion of treatment.

[36] During cross-examination Ms. Taylor, when questioned on Dr Van der Merwe's report to Old Mutual in which he had stated that the insured had never been diagnosed, treated or had symptoms of cancer, growths or warts of any kind, responded that the reason for Dr Van der Merwe's response, is

because the dot had not been diagnosed due to the insured being reluctant to undergo further testing.

[37] Ms Taylor maintained that the misrepresentation by the insured on the benign status of the dot on the lung lies in the following: from 5 October 2010 when Dr Van der Merwe identified the mass lesion in the lung and reported that the insured did not want to undergo further investigation, up until April 2012, when the insured was diagnosed with lung cancer, there were no other investigations on the lung and the insured could thus not at the stage of inception have known that the dot was not malignant. The fact that he ascribed a benign status to the dot on the lung is the crux of the misrepresentation.

[38] Under cross examination Ms Taylor was asked whether the defendant had not "*seen the red light*" when faced with an application in which mention is made of a dot on the lung and that the insured had in addition disclosed that he smoked 15 cigarettes a day. She responded that a dot on the lung is not unusual and 15 cigarettes per day are not excessive. Ms. Taylor testified that there was no disclosure which warranted the insurer requesting further tests.

[39] Ms. Taylor stated that at the re-underwriting stage the underwriters look at the policy as well as the doctor's reports and decide whether they would have still offered cover on terms if they had those doctors reports with them at the underwriting stage and confirmed further that underwriters do not look at the

cause of death at all when re-underwriting a policy. The cause of death is kept separate from the enquiry and only the medical reports are looked at.

[40] In conclusion, Ms. Taylor testified that the doctors' reports referred to above were only given to the defendant at claim stage and the defendant did not have these reports at the underwriting stage. Furthermore Ms. Taylor reaffirmed that the defendant would not have offered cover on terms based on the combination of cardiac failure and COPD as well as the undiagnosed tumour.

[41] Ms. Susan Mary Gonnerman, an employee of the defendant, confirmed that the doctor's personal medical reports and all medical reports referred to only came to the defendant's attention at the claim stage. She testified that when the defendant receives a claim within three years of date of inception of the policy, the defendant always requests personal medical reports from the treating doctors. Ms. Gonnerman went on to testify that the defendant refunded the premiums to the plaintiff after rejecting the claim.

[42] In addition, the defendant paid out the insured's funeral policy as is customary, given that at that stage the defendant would not have had any reports and should the defendant after re-underwriting the policy, decide to reject or avoid the life policy, the funeral payment would be considered an *ex gratia* payment and not be claimed back.

[43] Ms. Gonnerman testified that payment in respect of the funeral policy was made at 10h00 am on 29 August 2012 and Dr Van der Merwe's report was received at 11h00 am on 29 August 2012 and that when medical reports are received by the defendant they are allocated to the assessors who have a 5 to 10 day turnaround time. The plaintiff's counsel's cross examination on this point did not achieve anything, save to suggest that perhaps the report of Dr Van der Merwe had been received earlier and that, by paying the benefit under the funeral policy, the defendant had elected to be bound by the life policy, in terms of which the funeral benefit is not a stand-alone benefit, but linked to the life cover.

[44] Initially the plaintiff's counsel informed Ms Gonnerman that the plaintiff denied having received repayment of the premiums and with the leave of the court, and no objection from the plaintiff, Ms Gonnerman returned to court on the next day of trial with documents evidencing the repayment.

**THE PLAINTIFF'S EVIDENCE**

[45] Mr Krige De Waal testified that he sat with the insured and completed the proposal form with the answers furnished to him by the insured. Under cross examination he testified that the insured signed the proposal form after Mr De Waal had completed same for the insured. Mr De Waal testified that he asked the insured if he was currently (i.e. at that stage) suffering from any of the conditions listed in the proposal form, and not whether he had in the past suffered from any ailment. This he explained was so because he knew there

was a question further on in the application dealing with any other conditions which the insured would have to disclose, and from which he may have suffered in the last 5 years. Under cross examination Mr De Waal conceded that the proposal form does not read “any current conditions” but reads “do you, or have you ever...”, so phrased in Afrikaans.

[46] Further under cross examination, Mr De Waal explained that the failure to disclose the depression in paragraph 8 of the proposal form was because he was mistaken about the preamble to the wording of paragraph 8. Mr. De Waal explained that the disclosure of the dot on the lung and that it was not malignant was what was conveyed to him by the insured. The insured further informed Mr De Waal that he had consulted a doctor but did not know what it was, that it could be anything, and this is why it was disclosed. Mr De Waal testified that he expected the defendant to have performed tests on the dot but only enquired about this at claim stage. None of the other undisclosed conditions were dealt with in the “5-year question” to which Mr De Waal referred.

[47] Mr De Waal accepted that the insured, acting through Mr De Waal, agreed to be bound by the answers set out in the questionnaires as well as the declarations made by, or on behalf of, the insured.

[48] Mr De Waal testified that he asked the insured if he at that stage was suffering from any “*aandoening van die hart of bloedsomloop*” to which the insured answered “no”. It was only during cross examination when his

attention was drawn to the phrasing of the question: "*Ly u, of het u al ooit gely aan die volgende*?" that Mr De Waal conceded that he had not conveyed the actual the question to the insured. No evidence was presented that the insured in actual fact read the pre-amble and/or read the question itself.

**THE DEFENDANT'S CONTENTIONS**

[49] The defendant argued that the insured had a lung mass which his doctor noticed in June 2010 and which the insured represented to have been benign, whereas in fact the insured had refused further treatment and/or investigation and therefore could not have known whether the lung mass was benign or malignant.

[50] The insured had symptoms of, and sought medical treatment for COPD and that the condition was diagnosed and treated prior to the date of completion of the policy application form. However on the proposal form the insured indicated that he did not previously, or at the time of the proposal stage, suffer from a breathing or lung ailment.

[51] The insured had symptoms and sought medical advice for early cardiac failure and received treatment for the cardiac failure, however on the proposal form the insured indicated that he did not previously, or at the time of the proposal stage, suffer from a heart or circulation ailment.

[52] The insured applied for two life insurance policies that were declined prior to the proposal stage, one by Old Mutual and one by Momentum, however on the proposal form the insured indicated that no proposal for life, sickness, accident or disability insurance in respect of the insured had ever been declined.

[53] The insured suffered from chronic depression and was treated for this condition in 2008 and 2009, however on the proposal form the insured indicated that he had not previously, or at the time of the proposal stage, suffered from difficulties with the nervous system (e.g. concussion, fainting, paralysis, dizziness, depression, anxiety, persistent headaches).

[54] The insured signed a declaration in which he warranted that all the information provided in the application, and all the documents that had been or would be signed by him in connection with the intended application were, to the best of his knowledge, true and complete. The insured agreed that if any material information whatsoever was withheld, the benefits and all monies paid to Hollard Life would be forfeited.

[55] The insured was afforded 30 days to review his policy and to ensure that the policy met his expectations and was informed that "*the owner and all persons claiming under the policy are bound by all questionnaires and declarations answered or made by or on behalf of the owner*".

[56] The defendant contended that the insured misrepresented or failed to disclose the above facts and that these facts were material to the assessment of the risk, and that the misrepresentations and non-disclosures induced the defendant to enter into the agreement, even though that this is not a requirement given that the insured had breached the warranty.

**THE PLAINTIFF'S CONTENTIONS**

[57] The insured indicated in the questionnaire that he had not, and did not at the time suffer from any "*aandoening van die hart of bloedsomloop*". It was conceded that the insured should have answered this question in the affirmative, given the content of Dr Smit's report. However, the plaintiff argued that the evidence of Mr De Waal on how the questionnaire was completed is important. Mr De Waal completed the questionnaire in his own hand writing. He solicited a yes or no answer from the insured to each question.

[58] Evidently the insured only suffered this once off cardiac failure, no further evidence was presented of any other or further cardiac failure(s). The defendant's answer to this was obviously that if it was aware or had been made aware of the insured's cardiac failure, prior to inception it would have requested further medical tests in this regard.

[59] The defendant pleaded that the insured failed to disclose that he had symptoms and sought medical advice for COPD and that this was diagnosed and treated prior to the policy inception. The plaintiff admitted the report of Dr.

Van der Merwe and one would have expected that the insured would have answered this question in the proposal form in the affirmative. One has to however consider this in the light of Mr De Waal's evidence to understand why the answers were furnished in the manner in which they were. Mr De Waal's evidence was that although the insured indicated that he had a lung problem the nature, extent and severity thereof was to be disclosed elsewhere in the questionnaire.

[60] In respect of the prolonged bronchitis the insured disclosed this to such an extent that he was admitted to hospital and X-rays of his lungs were taken by Dr Van der Merwe and the insured then indicated that he has spot/mass on his lung.

[61] The plaintiff's main contentions were that the insured had completed the questionnaire through Mr De Waal, and that Mr De Waal incorrectly understood and conveyed the question dealing with previous ailments, that in respect of the dot/mass, the defendant should have been alerted by the mention thereof and should have sent the insured for more tests or declined the application. The same applies to the question regarding the depression.

[62] The defendant's witness Ms Taylor testified that the defendant has a very lenient policy in respect of depression. Thus even if the insured had answered the question, as he was obliged to, correctly, it would not have made a difference at all.

[63] The defendant's reliance on a letter written by Mr De Waal wherein he indicated that an Old Mutual policy was declined in 2010 is misplaced and the context of Mr De Waal's evidence is important. Mr De Waal had not seen a formal letter of rejection from Old Mutual but was advised thereof after the death of the insured by either the plaintiff, or her daughter.

[64] The defendant's reliance upon this letter is ill founded because, despite the agreement on the contents of the discovered documents, no witness was called to verify the letter, neither has the letter from Old Mutual been discovered. Ms Taylor had testified that the defendant could not obtain the letters of rejection from Old Mutual and Momentum.

[65] In this case the plaintiff admits that the insured failed to disclosure certain facts however the manner in which the two questions were phrased was confusing and the insured acted in the honest belief that he was answering correctly. According to the plaintiff once it is shown that the insured acted *bona fide* and with an honest belief, it cannot be regarded as misrepresentation.

[66] The plaintiff argued that under these circumstances the representations made by the insured were not misrepresentations. Furthermore and given the evidence of Ms Taylor, and in particular in response to question 8.5 of the proposal form, the plaintiff argued additionally that the non-disclosures were not material. The defendant bears the *onus* to show the non-disclosures and in particular in regard to question 8.14 of the proposal form were material and

failed to do so. The defendant relies on inadmissible hearsay evidence to anchor its case by failing to show any evidence that the two prior policy applications were indeed declined in 2010 and 2011.

[67] In respect of the non-disclosure and misrepresentation regarding the COPD, the plaintiff admitted that the insured did not disclose that he had COPD, but argued that the insured did disclose that he had been treated for prolonged bronchitis, which is one the examples listed in question 8.2 of the proposal form and that he had a spot/mass on his lung and this is the information which the Defendant required to assess its risk.

[68] The insured did disclose a potential life threating condition, which in his opinion was benign, acting presumably on medical advice. The insured disclosed what he knew.

[69] Thus the mere statement of an opinion is *prima facie* not wrong, even if the insured's opinion turns out to be wrong. Secondly, and if the court finds that it was a misrepresentation it can never be said that it had been brought on by the insured.

[70] Insofar as the insured's apparent refusal to seek medical advice is concerned, it cannot be overlooked that the insured disclosed a potential life threatening condition, but the defendant chose to ignore the possible consequences thereof. Once again the question as phrased in the questionnaire needs to be considered. The defendant had the necessary resources to assess and ask for further advice in this regard, which it failed and/or refused to do.

[71] In relation to the defendant's recourse when a material breach to an agreement has occurred or misrepresentation(s) was/were made, the plaintiff referred to Segal v Mazzur 1920 CPD 634 at 644-645 (applied in Trust Bank van Afrika Bpk v Eksteen 1964 (3) SA 402 (A) ). The plaintiff relied on this case to show that the defendant in paying out the funeral benefit to the plaintiff, elected to be bound by the policy despite having purportedly repudiated the policy. The reasoning is that the funeral benefit is not a stand-alone cover and forms part of the life policy. Watermeyer AJ, in Segal, illustrated the position of a party to a contract who is entitled to resile from a contract and that such party has to elect what to do, after which he is bound to his election.

[72] The plaintiff argued thus that any material misrepresentations would constitute forfeiture of *all* benefits in terms of the agreement. Accordingly, if the defendant submitted that the misrepresentations were material and therefore the life insurance benefit was forfeited, the same misrepresentations would have rendered the funeral benefit forfeited as both benefits are regulated by the same agreement. This notwithstanding, the funeral benefit was paid to the plaintiff.

[73] The policy does not provide for an *ex gratia* payment. The defendant is either liable to perform or not, given the fact that it did perform by paying the funeral benefit, the defendant accepted that it is liable.

**THE LEGAL POSITION AND JUDICIAL REASONING**

[74] Section 59 of the Long-Term Insurance Act, 52 of 1998, reads as follows:

"*Misrepresentation and failure to disclose material information (Heading substituted by section 19 of Act 17 of 2003)*

*(1)(a) Notwithstanding anything to the contrary contained in a long-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 long-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 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 insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk. (Section 59(1) substituted by section 19 of Act 17 of 2003) (2) If the age of a life insured under a long-term policy has been incorrectly stated to the long-term insurer, the policy benefits shall, notwithstanding subsection (1), be those which would have been provided under that policy in return for the premium payable had the age been correctly stated: Provided that if the nature of that long-term policy, or kind of long-term policy, is such as to render such arrangement inequitable, the Registrar may direct the long-term insurer to apply such different method of adjustment to the policy benefits of that long-term policy, or type of long-term policy, as the Registrar considers equitable in relation to the misstatement of age*."

[75] An insurer has the right to avoid a contract of insurance not only if the proposer has misrepresented a material fact but also if he has failed to disclose one. The burden of proving materiality is on the party alleging the misrepresentation or non-disclosure. See: Fransba Vervoer (Edms) Beperk v Incorporated General Insurance Ltd 1976 (4) SA 970 (W) 977 and Clifford v Comme4cial Union Insurance Co of SA Ltd ZASCA 37; 1998 (4) SA 150 (SCA) at 156E. There is a duty *ex lege* to disclose in insurance contracts.

[76] In Tucker Land Development Corporation (Pty) Ltd v Hovis 1980 (1) SA 645 (A) the following was held: "*It should therefore be accepted that in our law an*

*anticipatory breach is constituted by the violation of an obligation ex lege, flowing from the requirement of bona fides which underlies our law of contract. It would also be desirable, in order to obtain clarity of thought, to jettison the terminology of offer and acceptance in this regard, and to denote a creditor's decision to act upon an anticipatory breach not as an 'acceptance' but as an election*. *(Cf Kerr Law of Contract 2nd ed at 289 - 90.) Once the existence by operation of law of an obligation not to commit an anticipatory breach is accepted, the question remains as to how that obligation can be violated. The answer generally given is: by repudiation*."

[77] The learned authors, Gordon & Getz in The South African Law of Insurance (4th edition, pp 126 to 128) describe the duty of disclosure as follows: "*The duty of disclosure continues throughout the negotiations. It terminates when the contract is concluded. Material facts which come to the proposer's knowledge before the contract is concluded, or facts which, though previously immaterial, become material owing to changed circumstances before then, must be disclosed*".

[78] Once the contract has been concluded, however, the proposer is not obliged to disclose further material facts. In an ordinary life policy the rule is different. The life insurance contract is a continuing contract which the insured has the right to keep in existence by paying the premiums when they fall due. As the 'renewal' is not a 'new contract', no fresh duty to disclose arises. See: Pereira v Marine & Trade Insurance Co Ltd 1975 (4) SA 736 (A).

[79] Closely coupled with the duty to disclose is the duty of good faith. In Mutual and Federal Insurance Company Ltd v Municipality of Oudtshoorn (240/82) [1984] ZASCA 129; [1985] 1 All SA 324 (A) (16 November 1984) the court jettisoned the concept of utmost good faith or *Uberrimae Fides*. This did not result in the law of insurance contracts no longer requiring the parties to act in good faith but emphasized that there cannot be degrees of good faith and did away with the term "utmost good faith" in favour of plain and simple, "good faith".

[80] For a non-disclosure or a misrepresentation to be legally relevant it must be material. The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the information constituting the representation, or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk.

[81] The defendant's application and proposal form, in my view, is clearly worded and unambiguous. Both the insured and Mr De Waal used the Afrikaans language and the form was printed in Afrikaans. There can thus be no question of having misunderstood the form. Mr De Waal himself conceded that he misunderstood the preamble of paragraph 8 of the form and this does not assist the plaintiff at all. Mr De Waal in his capacity as the insured's agent would therefore have bound the insured to the contents so disclosed.

[82] In the latter regard, the authors Gordon and Getz refer to the case of Rabinowitz & Another NNO v Ned-Equity Insurance Co Ltd 1980 (1) SA 403 (W) at 407 G, wherein the legal position of the broker was clarified. The insured in Rabinowitz, who had effected a whole – life insurance policy as well as an aviation accident policy, was killed in a glider crash and the two insurers repudiated liability on a number of grounds. The company with whom the insured had effected the life policy repudiated liability, *inter alia*, on the ground of misrepresentation. The insurer had requested information in respect of the purpose of the proposed policy as well as a statement of the assets and liabilities of the insured. It was alleged by the insurer that the information had been supplied by the insured to his broker and from the broker to the insurer. As the information supplied was incorrect, the insurer repudiated liability on the basis of a misrepresentation.

[83] Nicolas J, although holding that the statements had not been proved to be false, dealt with the plaintiff's contention that in any event the contents were not imputable to the insured. The court stated the following:

"*It was pointed out that it was specifically provided in the form that the statement (which was signed by the broker) should be completed by the broker, and that there was no evidence that the deceased supplied the information or authorised the broker to communicated it to the first defendant… Nevertheless I am satisfied that the deceased was bound by the statement as fully as if he had signed it himself. Where a person employs an insurance broker to obtain insurance for him, the broker is his agent and*

*responsibility for the acts and omissions of the broker is governed by the ordinary law of agency. The communication of information relevant to the proposed insurance during the course of negotiating therefore is plainly within the authority of an insurance broker*."

[84] The failure to answer the relevant questions truthfully therefore falls short of what is required to overcome the breach of the warranty pleaded by the defendant. On the question of the dot on the lung, in my view the defendant, although not obliged to do so, could reasonably have sent the insured for tests and this would have alerted the defendant to an issue with the insured's lung. The aforesaid however does not exclude the remaining and material information that was not disclosed by the insured, neither does the defendant's failure to further investigate the dot on the lung take the matter any further.

[85] The question of the previous refusals to insure by another insurer is in my view simple. That there were two applications which were declined is an objective fact. This is on the plaintiff's own version. The plaintiff's reliance on the absence of documentary proof thereof is misplaced because this information fell within the knowledge of the insured and the plaintiff prior to the conclusion of the life insurance policy. The evidence of the previous two applications being declined is hearsay evidence however, whilst being hearsay evidence it is the hearsay evidence of the plaintiff's own witness.

[86] Therefore the plaintiff was in a position to call "*the person upon whose credibility the probative value of such evidence depends*" however elected not to do so. The plaintiff argued that the hearsay evidence must be excluded on the basis that the plaintiff (who could confirm the previous rejections) did not testify, thereby rendering Mr de Waal's evidence as hearsay. When this is viewed in conjunction with the other aspects set out in section 3 (1) (c) of The Law of Evidence Amendment Act, 45 of 1988, it may be that the evidence regarding the previous two applications having been declined should be admitted in the interests of justice. I thus cannot accede to the plaintiff's line of argument.

[87] The plaintiff's submissions regarding the payment of the funeral cover costs also do not assist the plaintiff. The defendant's evidence was clear. After it was established that the insured had passed on the defendant usually processes these claims quickly in order to assist the family of the deceased. Only after payment of such proceeds did the defendant establish that there were material non-disclosures and misrepresentations and the policy fell to be voided. The defendant chose not to recover the funeral benefit paid out to the plaintiff and considered this to be an *ex gratia* payment. I find that nothing turns on this and it befalls the defendant to waive repayment of these costs without it affecting the repudiation of the main benefit and main claim.

[88] Even if waiver was pleaded, the plaintiff would have had to prove that the defendant had knowledge of right to avoid the policy and abandoned such right. The evidence was that the funeral cover was paid 1 hour prior to receipt

of the medical reports which ultimately evidenced the non-disclosures and misrepresentations.

[89] Consequently the representations by the insured were not true. The insured failed to disclose, or disclosed information which he warranted to be true and correct, which was not true and correct and in circumstances where the representations and non-disclosures were likely to have materially affected the assessment of the risk by the defendant under the policy . The defendant was accordingly entitled and justified in avoiding the policy.

[90] As a consequence of the voidance of the policy the defendant repaid the premiums to the plaintiff on 7 December 2012, 15 months prior to institution of the action. No evidence was led by the plaintiff suggesting that the premiums so repaid, were not accepted.

**ORDER**

[91] The plaintiff's claim is dismissed with costs.

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**G. T. AVVAKOUMIDES**

**ACTING JUDGE OF THE HIGH COURT**

**GAUTENG LOCAL DIVISION, JOHANNESBURG**

**DATE**: **16 APRIL 2018**

Representation for parties:

For Plaintiff: D F Claassens

Instructed by: Faure & Faure

For Defendant: M Rodrigues

Instructed by: Marques Soares Fontes