Deneys

The Big Read Book Series Volume 30

Significant South African Insurance Judgments 2025

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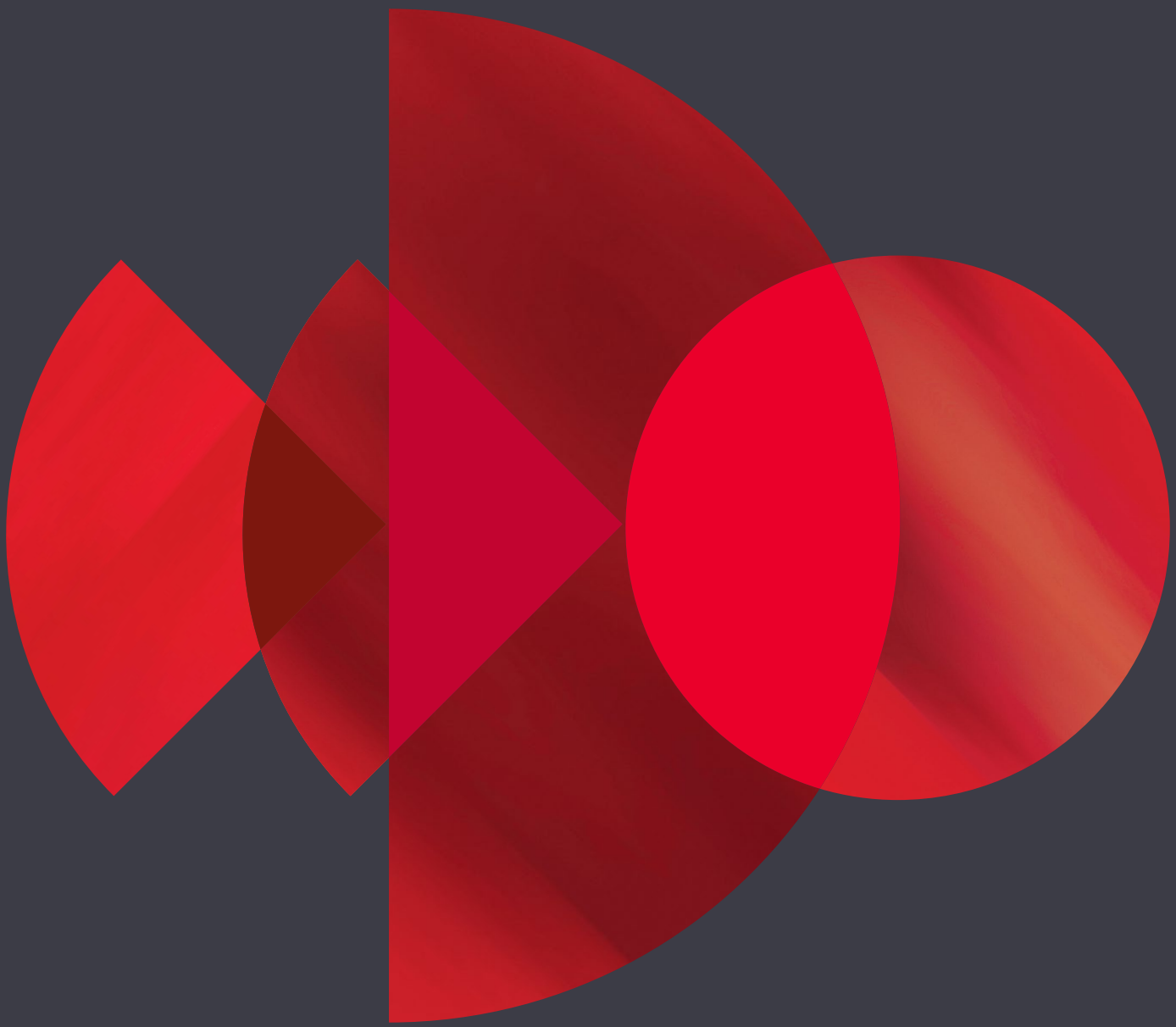


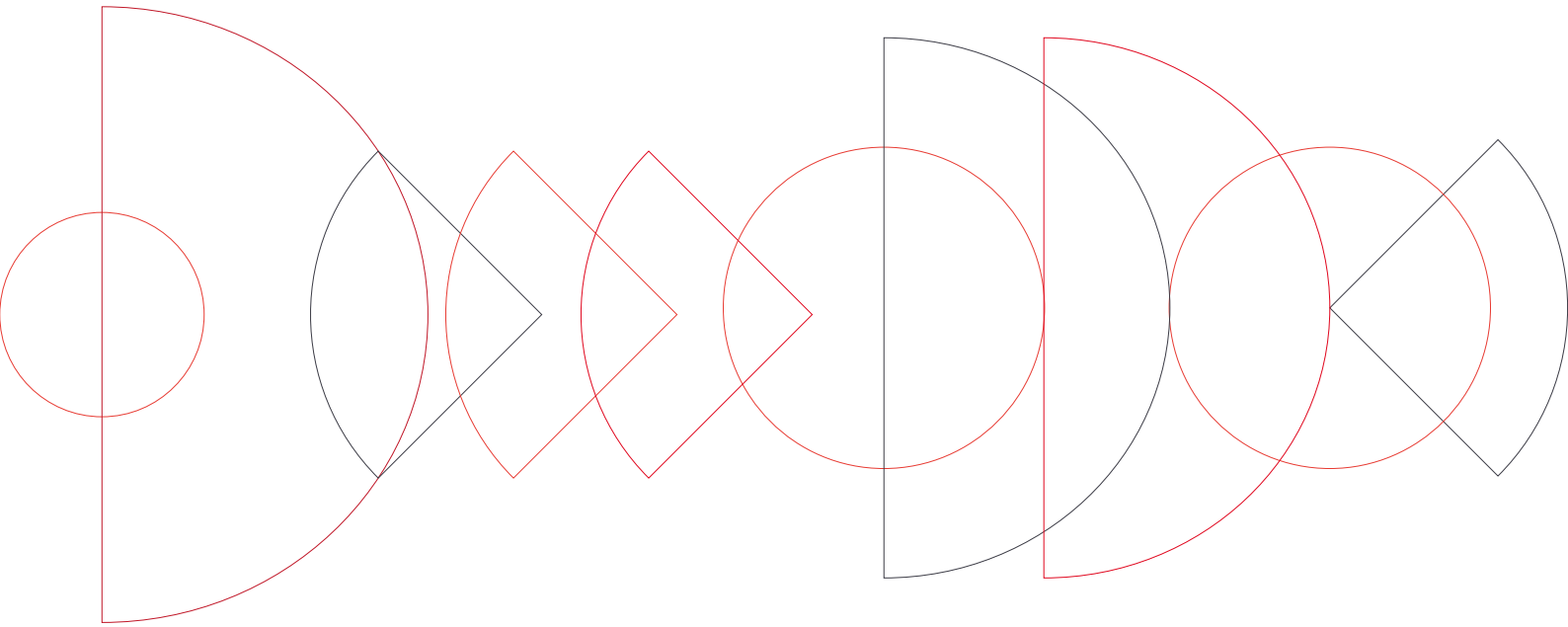
As the world moves

Contents

Dearest reader

Welcome to *The Big Read Book Series.* This volume reviews significant South African insurance judgments handed down during 2025, covering a broad range of topics including arbitration, brokers and agents, guarantees, directors' and officers' liability, life insurance, policy interpretation, motor claims, regulatory oversight and subrogation. The selected decisions highlight important legal developments and provide practical guidance for insurers, brokers, underwriting managers, financial advisers, policyholders and legal practitioners operating within the insurance industry.

An online version is available on our website at https://www.deneys.co.za/thinking/insights.



ARBITRATION

Insurer succeeds in compelling insured to arbitrate loss dispute

Lewis Group Limited v Emerald Risk Transfer Proprietary Limited and Others

It is unusual for an insurer to force its insured to arbitrate an insurance dispute but in this judgment the insurers successfully obtained an order compelling the insured to arbitrate their loss dispute rather than to litigate in the high court. The court stayed the litigation, pending determination by arbitration.

The insurers relied on a common policy term regarding arbitration when liability under the policy had been admitted:

> ***"ARBITRATION*** *If any difference shall arise as to the amount to be paid under this Policy (liability being otherwise admitted) such difference shall be referred to an arbitrator or arbitrators to be appointed by the parties concerned in accordance with the applicable statutory provisions in force. The making of an award shall be a condition precedent to any right of action against the Insurer to recover such amount in dispute."*

The insurers had admitted liability under the policy. The difference that arose between the parties was the amount to be paid, but the insured instituted court proceedings to seek relief instead of pursuing arbitration.

The insurers relied on Section 6(1) and 6(2) of the Arbitration Act of 1965, which provides that a party to an arbitration agreement may apply to court for a stay of court proceedings in favour of referring the matter to arbitration. A court will stay proceedings under section 6(2) unless sufficient countervailing reasons exist for the dispute not to be referred to arbitration.

The burden to prove that the dispute should not be referred to arbitration lay squarely on the insured's shoulders. The insured unsuccessfully argued that disputes involving limits of cover are for the exclusive domain of the courts. Even if the amount to be paid requires legal interpretation on the facts of the case, the legal interpretation had to be the subject for arbitration. The insured also sought to convince the court to exercise its discretion under Section 3(2)(b) of the Arbitration Act not to refer the matter to arbitration.

The court held that central to the exercise of the discretion to allow a party to opt out of arbitration is the sanctity of the contract, and the onus was on the insured to advance good cause to escape the agreement. The insured had shown no good cause at all.

In the circumstances, the court stayed the litigation, pending referral of the relief sought for determination by way of arbitration.

BROKERS AND AGENTS

Sureties of broker held liable to insurer for repayment of commission advances

Momentum Group Limited v Maswil Finansiele Adviseurs CC and Others

The plaintiff, Momentum Group Limited, sued its former broker for repayment of commission advances and related debts. The proven debts were held to be payable by the sureties.

Maswil was contracted to Momentum as a broker. They concluded an updated broker agreement, in which Momentum offered loans (advances) to brokers that had fallen into debit balances to continue earning a commission while repaying the debit balance. R600 000 was advanced to Maswil, which cleared the debit balance. Maswil was to repay that amount in 15 equal monthly instalments. These instalments would be paid by debiting Maswil's commission account held with Momentum (commission accrued would be set off against the amount owed).

After Maswil was liquidated, Momentum abandoned its claim against it and proceeded against the fourth to seventh defendants as sureties for Maswil's debt.

The court found that the defendants had signed deeds of suretyship binding them as sureties and co-principal debtors for all obligations of Maswil arising from debit balances on its commission account. On interpretation, the suretyships were continuing suretyships covering future debts arising from the broking relationship, not only existing debts at the time the suretyships were signed.

Maswil received monthly commission statements and raised no objections within the contractually stipulated period, accepting their correctness. Momentum was entitled, under both the broking agreement and the suretyships, to prove indebtedness by a certificate of balance, which the defendants failed to rebut. The defendants elected not to testify, even though they were present in court.

The defendants were held jointly and severally liable for the amount claimed.

Binder agreement validly cancelled for issuing unauthorised foreign guarantees

Old Mutual Alternate Risk Transfer Insure Limited v SA Guarantee Specialists Proprietary Limited and Another

The court held that an underwriting manager breached its binder agreement by issuing unauthorised foreign guarantees beyond the insurer's licence and mandate, and that the insurer validly terminated the agreement. The underwriting manager was also compelled to provide the insurer with information required to manage the business.

The respondent underwriting manager, SA Guarantee Specialists (SAGS), had a binder agreement with the applicant insurer. The binder agreement set out the terms of the mandate given to SAGS, to enter into and administer policies. SAGS was obliged to transact insurance business only within South Africa. The insurer is licensed for South African business only.

The insurer was called by a client of SAGS, who complained about non-payment under a guarantee, relating to a loan agreement concluded in Europe. The insurer referred the matter to SAGS, since it was unaware of this guarantee (it had not been listed in SAGS policy list) and noted that it exceeded the insurer's licence conditions and treaty limits. SAGS was in breach of its binder agreement. The binder agreement was terminated on 90 days' notice.

When questioned by the insurer, SAGS stated that no other foreign guarantees had been issued. However, the insurer subsequently discovered another foreign guarantee.

The insurer then began protracted correspondence with SAGS, demanding access to information relating to all guarantees issued. SAGS failed to accede to these demands. The insurer then approached the court for urgent relief.

SAGS argued that the binder agreement had not been validly terminated (but rather that the insurer had repudiated the agreement) and that it had until the end of the 90-day termination period to hand over documents and data. SAGS alleged that the insurer actually sought an Anton Piller order (those orders are for situations where there is a concern that evidence will be destroyed and are brought *ex parte*, to preserve the element of surprise) and had abused the court process to embark on a pre-litigation fishing expedition. There was no risk of harm in completing the process over 90 days and the matter was not urgent.

The insurer responded that it sought specific performance of its contractual rights under the binder agreement, and that SAGS was obliged, under the agreement, to provide access to all the information requested. The matter was urgent because the insurer needed to know whether SAGS had concluded any other guarantees in its name and beyond its authority and because the insurer had taken over SAGS' business under the binder agreement and needed information to continue running it.

The court agreed with the insurer. While the relief sought was intrusive, it was different from an Anton Piller order. The risk created by the issue of unauthorised guarantees was substantial and warranted the intrusion.

The court found that the cancellation of the binder agreement was valid. The agreement permitted cancellation on 90 days' notice irrespective of any breach. The insurer had a right to the information it sought, under the binder agreement. Because the order requested by the insurer amounted to a type of raid, similar to the type of inspection conducted in an Anton Piller order, the court sought to balance the interests of both parties and minimise the invasive nature of the raid. The court issued an order, suspended for a period of 15 days to give SAGS a chance to comply and for the parties to cooperate, before a more 'nuclear' option was adopted.

Restraint of trade against former broker enforceable

TWK AGRI (Pty) Ltd v De Lange and Another

The court upheld a restraint of trade against an insurer's former broker, finding he indirectly solicited clients and that customer relationships belonged to the insurer. It also ordered that the restraint remain in force pending appeal to prevent irreparable harm to the insurer.

The first respondent was employed by the applicant as a non-life insurance broker, in its insurance division. The employment terms included a restraint of trade and confidentiality agreement.

The first respondent gave notice of his resignation to the applicant and commenced employment with the second respondent after his notice period ended. The second respondent is a large insurance brokerage and a direct competitor of the applicant, although it usually operates in a different geographical region to the applicant. Some clients cancelled their policies with the applicant and wished to move to the second respondent.

The applicant applied to court for enforcement of the restraint of trade and confidentiality agreements.

The respondent argued that he had not solicited the clients and that they chose to come to him due to poor service from the applicant. The court held that the respondent's conduct at least amounted to indirect solicitation, which is also impermissible under the restraint.

The respondent tried to argue that the clients belonged to him and that, as an insurance broker, he acts as an intermediary between an individual or a business and one or more insurance companies. The court did not accept this and held that relationships with customers are part of the trade connections of the business.

The respondent failed to demonstrate that the restraint of trade was unreasonable. The court upheld the restraint agreement.

The broker then appealed the decision, and the applicant applied to court to enforce the June 2025 restraint order pending the outcome of the appeal. The court ordered that the June 2025 order will continue to remain operative pending the outcome of the appeal because the applicant will suffer irreparable harm if the order is not enforced pending appeal (and there would be minimal inconvenience to the broker and the insured clients, who remain insured, if the June 2025 order is enforced).

Restraint of trade against former broker upheld

TWK Agri (Pty) Ltd v Holtzhausen and Another

The court upheld a restraint of trade against a former broker of the insurer, finding that her claim that numerous clients independently followed her to a competitor was far-fetched, and that she posed a risk of disclosing confidential information.

The first respondent was employed by the applicant as a non-life insurance broker, in its insurance division. The employment terms included a restraint of trade and confidentiality agreement.

The first respondent gave notice of her resignation to the applicant and commenced employment with the second respondent the day after her notice period ended. The second respondent is a large insurance brokerage and a direct competitor of the applicant. Twenty three clients then cancelled their policies with the applicant and wished to move to the second respondent so that the first respondent could service their policies.

The applicant applied to court for enforcement of the restraint of trade and confidentiality agreements.

The first respondent did not deny that she serviced several of these clients. She denied soliciting the business and contended that they cancelled their policies voluntarily and that the clients contacted her.

The court found this version far-fetched and stated:

> "While one accepts and understands that a broker must be intimately acquainted with the client's needs, it does not follow that every client is in regular, and frequent, contact with the broker. …the first respondent does not explain how it came about that the clients became aware of her departure, or how they accessed her contact details…it is too much of a coincidence that so many clients decided to terminate their policies (with the applicant) and migrated to MRA shortly after first respondent joined it."

The first respondent also denied disclosing or sharing confidential information, trade secrets, or customer connections, with the second respondent. However, the court stated that the applicant did not need to show that first respondent actually disclosed confidential information: it need only show that she could potentially do so. Where an employee becomes engaged with a competitor, there is a risk of disclosure, and the employer is entitled to protect its commercial interests.

On the facts, the court had already found that first respondent breached the restraint. In the circumstances, the burden lies with the first respondent to show that the restraint is unreasonable. Given that the applicant only sought partial enforcement of the restraint and did not seek to extinguish the first respondent's ability to work in the industry, the burden of proving that the restraint was unreasonable is heavier.

The first respondent did not expressly take issue with the matter, area, or duration of the restraint. Instead, she argued that she did not contract with the applicant as an equal party. The evidence did not bear this out. In the circumstances, the first respondent failed to demonstrate that the restraint is unreasonable.

The court therefore upheld the restraint of trade agreement.

Restraint of trade enforceable and operative pending appeal

Simah Risk Advisors (Pty) Ltd v Van Niekerk and Others

A non-life insurance broking company successfully applied to enforce confidentiality and restraint of trade undertakings against former broker employees. The court found that the broker's interests were protectable and restrained the former employees from being employed by another broking company and using their former employer's confidential information.

The employees applied for leave to appeal that decision. The broker in turn launched an urgent implementation application in terms of the Superior Courts Act, to confirm that the operation of the original court order would not be suspended for the duration of the application for leave to appeal and would continue to operate and be executed until the final determination of all present and future leave to appeal applications and appeals.

The applications for leave to appeal and for implementation of the original court order were heard together.

Notwithstanding that the application for leave to appeal was dismissed, the court considered the implementation application and the relief sought by the broker.

The determination of whether to grant an implementation order involves the exercise of discretion concerning all the facts. To be successful, an applicant must demonstrate exceptional circumstances, that the applicant will suffer irreparable harm if an order is not made, and that the respondents will not suffer irreparable harm if an order is made.

The court recognised that even though the employees' leave to appeal application was refused they may apply to the Supreme Court of Appeal for leave to appeal and in the unlikely event that an appeal is then heard, the restraint periods would either have expired or a substantial portion of the restraint periods would have expired, rendering any judgment on appeal moot and the relief sought by the broker company enforcing the restraints of trade would be forfeited. In the interim, the employees continuing to act contrary to the court order had caused considerable harm to the broker.

This conduct would continue to cause further damage and harm to the broker company, which was not likely to be realistically recoverable from the employees. This was balanced against the possible losses that the employees might suffer if the implementation order were granted, which if established, would be recoverable by them from the broker company.

The court held that the implementation application must succeed despite the dismissal of the application for leave to appeal. The final order confirmed that the implementation of the initial restraint of trade order would not be suspended and would be enforceable for the duration of the application for leave to appeal and prospectively, including any application to the Supreme Court of Appeal and any further proceedings pending final determination.

In making the order, it is unclear if the court considered that the Superior Courts Act affords an automatic right of appeal to the aggrieved party (in this case, the employees) in these circumstances and provides that the order confirming implementation would be automatically suspended pending the outcome of such an appeal.

Underwriting manager cannot be sued as an insurer

Norman Luxury Tours (Pty) Ltd v Stalker Hutchingson Admiral (Pty) Ltd

Where a plaintiff sues the underwriting manager for cover, it is enough to plead that the underwriting manager acts as the insurer's agent and that any liability proven would rest with the insurer.

Norman Luxury Tours sued Stalker Hutchinson Admiral, described in the summons as acting "on behalf of" Santam Insurance Company, after a bus it owned was written off in June 2019 and the claim was declined. SHA pleaded that it was not the insurer, and that the bus never appeared on the schedule. Norman Luxury Tours challenged the defences raised. The court disagreed and dismissed the exception with costs.

The rules of court provide that pleadings must contain clear and concise facts, but it does not insist on perfection; a challenge will fail unless the impugned pleading is truly unintelligible or discloses no sustainable defence. Read as a whole, the court held that SHA's plea was lucid: it acts as Santam's underwriting manager, the policy schedule omitted the damaged bus, therefore no cover exists.

The judgment corrects a common misconception. Where a plaintiff sues the underwriting manager, it is enough to plead, as SHA did, that it acts as the insurer's agent and that any liability proven would rest with the insurer. That statement of agency satisfies the requirement that pleadings be clear, defeats an exception based on vagueness and leaves the defences to be decided on its merits. Substance over form remains the touchstone.

Wealth insurance manager reasonably dismissed for negligence and misconduct

Standard Bank Insurance Brokers v Dlamini and Others

The Labour Court concluded that a broker that serviced high profile wealth clients had reasonable reasons for dismissal of a wealth manager and that the employee's explanation for her misconduct was unacceptable. The court explained that the arbitrator should have considered what was reasonable and fair for an employer in the applicant's position, rather than deciding what the arbitrator personally thought was a fair reason for dismissal.

The applicant, a non-life insurance broker and financial services provider licensed under the FAIS Act, dismissed the employee, who was employed by the broker as a "wealth insurance manager", for negligence and misconduct in fulfilling her duties. The employee referred her matter to the Commission for Conciliation, Mediation and Arbitration (CCMA), arguing that she was unfairly dismissed.

It was not disputed that the employee was guilty of the alleged misconduct. For example, she failed to manage renewals for several client policies, which went against her duties as a FAIS representative. Despite this, the CCMA arbitrator found in favour of the employee. The broker asked the Labour Court to review the CCMA decision.

The CCMA arbitrator decided that negligence, as opposed to gross negligence, was not serious enough to justify dismissal. He considered the harm to the broker to be only reputational and potential since no formal complaints had been made by clients or regulators. The arbitrator also noted that there was no written policy outlining the employee's duties. He considered her long service and the fact that her final written warning had expired, concluding that she could be rehabilitated and that the trust between employer and employee was only slightly damaged.

The Labour Court disagreed with the arbitrator's findings, stating that the arbitrator had made significant errors of law. The court emphasised that failing to comply with FAIS requirements has serious consequences for the applicant. The FAIS Regulator can impose penalties ranging from fines to suspending or cancelling the applicant's operating licence. Compliance is therefore a critical regulatory issue, not just an internal company rule. The court found that focusing on the difference between "negligence" and "gross negligence" was overly formalistic and simplistic. Based on the undisputed facts, the employee's actions were a significant breach of her responsibilities under the FAIS Act. Furthermore, the employee did not see her failure to perform her regulatory duties as a problem, explaining that the system would automatically renew policies. However, the one-on-one client renewal process she ignored is specifically required to prevent automatic renewals, which would breach the relevant FAIS Code.

Therefore, the dismissal was fair, and the arbitrator's decision was set aside.

Application for urgent enforcement of anti-churn clause dismissed

Clientele Life Assurance Company Limited v B3 Insurance Brokers (Pty) Ltd

The court dismissed an insurer's urgent interdict application to enforce an anti-churn clause preventing the broker from moving funeral policies, finding the matter was not urgent because arbitration was already underway, no immediate harm was shown, and the insurer could obtain substantial relief in due course.

In 2021 the respondent insurance broker approached the insurer to take over as underwriter of its funeral policies, because the broker was involved in a dispute with its then-underwriter. The insurer agreed and took over the policies following compliance with regulatory requirements. In 2022 the broker asked to amend the agreement, due to cash flow constraints. The insurer agreed to help by paying R100 million upfront, as an advance on the premiums to be received. In return, the insurer required the broker to add an anti-churn clause to the agreement, which prevents the broker from migrating the policies to another underwriter.

In 2024 the insurer was made aware of a letter, unaddressed but marked as confidential, written by the CEO of the broker in regard to "re-broking" the relevant policies.

The insurer wrote to the broker, demanding compliance with the anti-churn clause. The broker responded belligerently, refusing to honour the clause and alleging that the insurer was in unlawful possession of a confidential letter (which the broker claimed was an internal document that had never been sent to anyone).

After some back and forth, the parties agreed to take the dispute to arbitration. The arbitration process began, papers were filed, and an arbitrator agreed upon. The parties agreed that the arbitration would be concluded in 3 to 4 months, and that the process would decide the legality of the contract.

The insurer asked for an undertaking that the no-churn clause would be upheld in the meantime, but the broker refused.

Therefore, the insurer applied to court for an urgent interdict, preventing the broker from moving the policies. The insurer claimed that the trigger for the court application was the broker's refusal to give it an undertaking to not move the policies. The insurer alleged that the harm done by moving the book would be irreversible and that it would be left only with a damages claim against the broker.

The broker argued that the no-churn clause was unenforceable because it forced the broker to contravene its obligations under the FAIS regulations. For example, if an individual client sought advice on which policy was best, the broker would not be able to advise on all of the policies in the market.

The insurer responded that the terms of the contract do not prevent the broker from advising individual clients but is aimed at a wholesale churn of the book to another insurer.

The court noted that it did not need to decide on the above arguments. The court found that the application was not urgent, because the insurer could not show that it would not be able to get relief in due course. It was agreed that the arbitration process would take 3 to 4 months and the broker had bound itself, if not by the anti-churn provision, then by the obligation to give the insurer at least 90 days' notice of a client's instruction to change or cancel its policy. There was no immediate harm. In the course of the court proceedings, it was also established that the deal described in the confidential letter (to move the book to another insurer) had fallen apart.

The court found that the insurer would be able to get substantial relief in due course, through the arbitration proceedings. Therefore, the insurer's urgent application for interim relief was dismissed.

Claw-back of commission not a credit agreement

Momentum Metropolitan Life Limited v Lakhoo

The High Court found that an acknowledgment of debt signed by a financial adviser agreeing to pay an insurer clawed-back commission was not a credit agreement governed by the National Credit Act (NCA) because it settled an existing obligation rather than extending new credit and was enforceable.

The respondent financial advisor signed an acknowledgment of debt in May 2010, agreeing to repay a life insurer commission advances that had been clawed back due to policy lapses. The respondent later contested the validity of the acknowledgment of debt, arguing that it was subject to the NCA and that the life insurer had failed to comply with the NCA's requirements, including registration as a credit provider and assessment of over-indebtedness.

The court's analysis of the acknowledgment of debt focused on the nature of the agreement and its classification under the NCA. The court noted that the acknowledgment of debt was a result of the respondent's obligation to repay unearned commission advances, which did not constitute a credit agreement as defined by the NCA. The court emphasised that the NCA primarily governs credit agreements where there is an extension of credit by a credit provider to a consumer. In this case, the acknowledgment of debt was a settlement of an existing obligation rather than an extension of new credit.

In light of these findings, the court held that the acknowledgment of debt was valid and enforceable, and the appellant life insurer was entitled to recover the amount specified in the agreement.

CREDIT INSURANCE

Bundled insurance unfair for insureds who could never benefit from portions of the cover

National Credit Regulator v JDG Trading (Pty) Ltd and Others

The court upheld the National Credit Regulator's appeal, finding that JDG Trading contravened the National Credit Act by unfairly selling bundled credit insurance to pensioners, disabled and unemployed consumers who could never benefit from certain cover components, and referred the matter to the National Consumer Tribunal to determine an appropriate penalty.

The National Credit Regulator appealed a National Consumer Tribunal decision in relation to practices of JDG Trading, the respondent.

The respondent, a credit lender, offered credit for household goods and furniture, which consumers purchase at retail stores. Upon an application for credit the consumer is required to purchase credit insurance for the loans advanced. A consumer has a choice to either purchase the insurance that the respondent offers or may obtain and provide their own insurance. The respondent's credit life insurance includes cover for disability and retrenchment in a bundled form.

It was not disputed that the respondent sold this form of cover to pensioners, disabled persons and consumers receiving social grants, who were already disabled or unemployed when they signed up for the credit. The Regulator submitted that the respondent therefore offered and sold credit insurance as a bundle to people who will never benefit from the cover, as they will never claim for disability being already disabled or for retrenchment cover since they are no longer employed.

The respondent argued that the cover supports access to credit and is at a low cost. The cover was sold in the form of a bundle, there was only one premium which included cover for various risks, and it was sold using group premium rates. It was argued for the respondent that this form of cover is the only way to ensure that the price is kept to a minimum. The consumer is given a choice to obtain their own cover but would not find cover any cheaper elsewhere. The consumer gets life cover, which would not ordinarily be offered to pensioners and disabled persons, and at a low cost. The insurance is convenient because the respondent's qualification requirements dispense with the delays in waiting periods and costs for medical examinations, and this benefits the consumer. The Regulator did not provide evidence of cheaper products and therefore failed to prove that the bundled insurance was unreasonable.

The court noted that while the credit provider should look to sustainability of its offering, providing cover for a claim that could never manifest was found to be unfair, no matter that the price was at its lowest.

The claimant in this instance is entitled to hold a reasonable expectation that they have cover and can claim in the event of any loss. A disabled person who signs up for such cover, for example, cannot hold such expectation, and logically would not agree to pay for such cover. If the claims will never manifest, the Regulator will not be in a position to present evidence of a claimant who was misled, confused, or misguided, to meet its evidentiary burden.

The court stated that it was cognisant of the accepted practice of providing wide cover for a group of insured persons, which was usual in certain insurance products. However, this case was concerned with a particular kind of consumer, and understanding this individual consumer was critical. The respondent would secure a source of revenue, in pensioners and disabled consumers, but carry no risk. This is unfair and unreasonable.

The fact that no cheaper options are available should not be seen as an invitation to relax on the pensioner's and disabled person's rights to dignity and fair economic activity. If their premiums are the same as all others in the group they are entitled to the same benefits as all others in the group, for the agreement to be seen as fair.

The court therefore found the respondent to have contravened the NCA and referred the matter to the Tribunal for the determination of an appropriate administrative penalty and further adjudication.

DIRECTORS & OFFICERS LIABILITY

Defence costs recoverable against individual insured

AIG South Africa Limited v Molefe

The court held that the insurer could pursue repayment of defence costs (paid under Eskom's Management Liability Policy) from the former CEO of Eskom personally without joining Eskom.

A dispute arose from the payment of defence costs of approximately R4.4 million by the insurer in terms of a Management Liability Policy taken out by Eskom as policyholder, which extended cover, as insured parties, to its directors, officers, and employees, including the then-CEO of Eskom. Each of the insured persons was insured independently and separately under the policy.

The former CEO requested indemnity for defence costs under the policy in respect of litigation against him. The insurer, AIG, provided the cover subject to the condition, which was also in the policy, that if the insured were found to have acted unlawfully or gained an improper advantage, the defence costs would be repayable by the insured to the insurer. In the litigation against the insured CEO, the court found that the insured's conduct was unlawful. In the circumstances, AIG sought to recover the paid defence costs from the insured CEO. AIG also sought an order that the arbitration agreement be set aside and that the matter proceed in court.

AIG alleged that by notifying it of the legal proceedings and claiming payment of his defence costs, the CEO accepted the benefits of the policy and agreed to be bound by its terms. Further, AIG sent a letter to the CEO in 2017 advising that it would advance defence costs on a without prejudice basis, and, if in due course it was concluded that the respondent was not entitled to an indemnity under the policy, he would refund such costs in full and on demand. AIG claimed repayment based on the policy, and of the 2017 correspondence, and in terms of unjustified enrichment. Each of the claims was brought distinctly, in the alternative.

The former CEO argued that he did not agree to the provisions of the policy and was not bound under the policy. Also, he did not agree to repay the defence costs in terms of the 2017 correspondence.

He argued that Eskom should have been joined to the proceedings. He alleged that AIG must look to Eskom for repayment, because Eskom is the policyholder and signatory to the policy. AIG stated that Eskom had no legal interest in the matter and declined to join it in the proceedings.

The policy contained an arbitration clause. The insured CEO sought to enforce the arbitration clause in respect of all three claims, despite arguing that he was not bound by the terms of the policy and that Eskom was the insured.

AIG submitted that two of the three causes of action against the insured were not rooted in the policy. The first claim was based on the policy and therefore subject to the arbitration clause. The second was a claim based in the contract in the correspondence, independent of the policy for a conditional payment of the costs. The third claim was for unjustified enrichment. The second and third claims did not arise in terms of the policy and could not be determined under the arbitration clause of the policy. As a result, the insurer argued that all three claims should be determined simultaneously by the high court and not by an arbitration tribunal.

The court held that each insured person was insured separately under the policy and could be sued alone. Eskom did not need to be joined to the proceedings.

In granting the insurer's application to dispense with arbitration, the court decided that all three claims should be dealt with simultaneously in a single court proceeding. The insured CEO's stance that he is not bound by the policy results in the insurer being unable to prosecute its claim arising from the policy in terms of the arbitration clause. Therefore, all three claims cannot be dealt with under the arbitration clause. In the circumstances, it will facilitate the administration of justice if the claims are heard together by a court.

The court highlighted that whilst our courts generally defer to litigants' agreements that disputes be determined in terms of arbitration clauses given the autonomy of litigants to make that choice, courts retain jurisdiction over such disputes. An arbitration clause does not oust the jurisdiction of a court.

GUARANTEES

Co-principal debtor liable under guarantee

Guardrisk Insurance Company Limited v Basil Read Holdings Limited and Another

The court held that a holding company remained liable as co-principal debtor under the indemnity for losses incurred by the insurer after payment under a construction guarantee, finding that the subsequent cession and absence of a formal demand did not extinguish or limit its indemnity obligations.

The insurer issued a guarantee to SANRAL on behalf of the second respondent, Basil Read Limited, to secure its contractual obligations under a construction contract. Basil Read Limited (the second respondent) and its holding company, Basil Read Holdings Limited (the first respondent) executed an indemnity in favour of the insurer, in relation to any loss or liability arising from the guarantee issued by the insurer and bound themselves as co-principal debtors for liability incurred by the insurer.

The second respondent was placed under business rescue and could not complete the contract, triggering the guarantee. The insurer, SANRAL, the second respondent and the new contractor entered into a Memorandum of Agreement (MOA), which ceded the second respondent's rights and interests under the construction contract with SANRAL to the new contractor, for completion of the works. In terms of the cession, the insurer as guarantor made payment of R26 million for the additional cost of completion of the outstanding works under the contract.

The insurer then demanded payment under the indemnity, from the first respondent.

The first respondent opposed the claim, arguing that it was not a party to the MOA, had not indemnified obligations arising from it, and that the payments were not made pursuant to a formal demand under the guarantee.

The court rejected these arguments. It held that the first respondent's liability flowed from the indemnity, not from the MOA. As a co-principal debtor and surety, the first respondent remained liable for losses arising from the issuing of the guarantee. The cession to the new contractor did not extinguish liability for the second respondent's historic default, and the indemnity expressly waived defences arising from cession of the principal obligation. The fact that the payments by the insurer were not triggered by a formal demand was found to be immaterial. The indemnity is engaged upon the insurer incurring any liability, arising from the issuance of the guarantee and not solely upon receipt of a formal demand.

The court ordered that the insurer's claim be paid.

Interpretation of expiry of guarantees

Globeleq-Mainstream South Africa Renewable Power (Pty) Ltd v ABSA Bank Limited and Others

The court had to decide whether various guarantees were enforceable. On interpretation, it upheld guarantees under the wind energy projects, but determined that the guarantees under the solar projects had expired.

The applicant was appointed a preferred bidder, under the Department of Mineral Resources and Energy's Request for Proposals (RFP) for renewable energy procurement. The applicant was appointed for six onshore wind projects and six solar projects. A requirement of the RFP, to confirm preferred bidder status, was to procure a guarantees. The applicant furnished 12 guarantees (one for each project), totalling around R254 million. Guarantees for the six wind projects guaranteed the amount of R164 million and for the solar projects, R90 million.

The guarantees remained in place until either the expiration of the Bid Validity Period (referred to in the RFP or until Financial Close had been reached, and performance had occurred. The guarantees could be called if preferred bidder status was revoked for any reason.

The applicant failed to meet conditions for the parties to reach commercial close. The guarantees were called, and the applicant applied to court to interdict the bank from paying the guarantees, alleging that the guarantees had expired.

The question to be determined was whether the guarantees could be validly called on at that time, and when the bid validity period expired.

Implementation agreements for the solar projects were concluded in December 2022. Commercial close was extended to June 2023. Under the implementation agreement, if the conditions were not met by commercial close, neither party had any claim against the other. The bid validity period expired on 30 June 2023, and the guarantees lapsed on that date. The guarantees were called in 2024 after expiry. The court therefore interdicted the bank from paying the guarantees relating to the solar projects.

No implementation agreements were ever concluded regarding the wind projects, so they were governed only by the RFP. The guarantees, according to the RFP, were to be valid until the bid validity period expired or when the implementation agreement was complied with. Since no implementation agreement was signed, nothing triggered expiry of the guarantees. The guarantees for the onshore wind projects were still valid when called on in 2024. The interdict was refused for the wind projects.

Guarantee was issued, despite absence of original document

Development Bank of Southern Africa v Fusion Guarantees (Pty) Ltd and Another

The court held that Fusion Guarantees had issued a performance guarantee and was liable to DBSA under it, finding that the absence of the original document and the unexplained “cancelled” stamp did not negate the clear evidence that the guarantee was prepared, signed, and relied upon after payment by the contractor.

DBSA awarded a construction contract to the second defendant’s joint venture (the contractor). The contractor was obliged to procure a guarantee in DBSA’s favour, against performance of the contract. A guarantee was sought from Fusion Guarantees. The contractor failed to complete the works, even after an extension was granted, and DBSA cancelled the contract and appointed a new contractor, to complete the contract, at a higher cost.

DBSA claimed against the guarantee. Fusion argued that it had never issued the guarantee and was not liable. Fusion argued that the original guarantee document was never handed over to DBSA and that the original document is required for constitution of the agreement. The court disagreed. It was common cause that the copy of the document that DBSA had was a copy of the original. The only issue for determination, therefore, was whether the guarantee was actually issued.

DBSA argued that apart from the fact that the document it received was a copy, it is no coincidence that the guarantee was prepared, signed, embossed, and sent to the contractor on the same day the contractor paid R97 000 to Fusion. Fusion’s defense that the guarantee was never issued based on the existence of the “cancelled” stamp should be rejected because there was no evidence to show who placed the “cancelled” stamp on the guarantee, and when it was stamped.

On the evidence, the court stated that the probabilities suggest that Fusion issued the guarantee. The contractor was aware that delivery of the guarantee was an essential requirement of the agreement, and the contractor would not have been allowed to commence with the works until it had provided the guarantee. The timeline of events clearly showed that the contractor did approach Fusion to secure the guarantee and paid R97 000 in this regard. Soon after the contractor made this payment, Fusion prepared and signed the guarantee and sent a copy to DBSA. Fusion cannot, on the one hand, issue a guarantee, hand a copy to the contractor and DBSA, and at the same time keep the original, while demanding that DBSA produce the original it kept. There was no explanation for the cancellation of the guarantee, nor any evidence that the contractor or DBSA were notified of any cancellation.

The court held Fusion liable to pay under the guarantee.

Payment of guarantee upheld

Umzwilili Environmental Solution v Rockwood Fund 1 GP (Pty) Ltd

The court dismissed an application to interdict payment of a guarantee on the basis of fraud.

The applicant and the first respondent (Rockwood) entered into a sale agreement relating to shares and associated claims in a company. The sale agreement set out the purchase price, related payments and their structure and formulae to calculate various payments. Payments were guaranteed by the second and third respondents (subject to specified limits), under identical demand guarantees.

Rockwood made a demand on the guarantees based on its calculation of the amount owed by the applicant, which it alleged fell short and the demands were triggered. The amount in dispute (the difference between the applicant's and Rockwood's calculation of the amount payable) was subject to international arbitration. The applicant approached the court to interdict the payment of the guarantees, on the basis of fraud.

The court stated that Rockwood's interpretation of the sale agreement was not so implausible as to warrant an inference of fraudulent intent. Further, if the banks had immediately paid the guarantee without asking for details regarding the computation of the claim, they may have breached their obligations, but this was not the case. The banks are not required to make a finding on indebtedness.

The applicant argued that it would be left exposed if the banks paid an incorrect amount. The court said that the banks, acting on independent legal advice and by interpreting the guarantee instrument, should determine the amount payable based on the wording of the guarantee, but the parties had not approached the court for a finding in that regard. It is a matter for international arbitration, which had already commenced.

Payment of the guarantees was upheld.

Guarantee upheld due to guarantor failing to reject the demand in time

Exxaro Coal Mpumalanga (Pty) Ltd v ABSA Bank Limited

The court held that a bank was obliged to pay under an on-demand guarantee because it failed to reject a distinct demand within the stipulated time and could not later rely on technical non-compliance or unconscionability to avoid payment.

The beneficiary of an on-demand performance guarantee issued by a bank to secure work done by a construction company terminated the construction contract and called on the guarantee for the full amount (R32 million) on 10 June 2020. The bank rejected the demand, for non-compliance with signatory conditions. The beneficiary made a second demand on 19 June 2020 for a reduced amount (R22 million), on the day before the guarantee expired. The bank did not reject the second demand, nor did it pay, arguing that the second demand was part of the first demand and had already been rejected.

The court held that the two demands were distinct and that the bank was required to respond to each, separately. Although both demands were technically non-compliant with the conditions of the guarantee, the bank had only rejected the first demand. The terms of the guarantee provided that if the guarantor does not reject a guarantee for non-compliance within five days of demand, it was precluded from relying later on the defects in the demand. The beneficiary's conduct was found to be reasonable when the bank argued that ordering the bank to meet the demand was unconscionable. Further, the court held that unconscionability is not a recognised ground for refusing to meet an otherwise effective demand.

The bank was ordered to pay the amount of the second demand (R22 million).

On-demand guarantees not affected by disputes relating to the underlying contracts

Set Square Developments (Pty) Ltd v Power Guarantees (Pty) Ltd and Another

The appellate court reaffirmed settled law that on-demand guarantees are autonomous and payable upon compliant demand, irrespective of disputes under the underlying contracts.

This appeal related to three on-demand performance guarantees issued by Power Guarantees (Pty) Ltd in favour of Set Square Developments (Pty) Ltd, securing a contractor's obligations on a housing development project.

Set Square had cancelled the underlying construction contracts due to the contractor's alleged defaults and made demands under all three guarantees. Power Guarantees refused payment.

Set Square's demands complied strictly with the guarantees' terms, including stating termination for contractor default and attaching termination notices. Any enquiry into whether the cancellations were valid, or who was in breach, was impermissible. Fraud was not established, and the allegation of unconscionability of enforcing the guarantees was not recognised as an independent exception to payment under on-demand guarantees. The court ordered that the guarantees be paid.

Court upheld guarantee

Concor Construction (Pty) Ltd v Old Mutual Alternative Risk Transfer Insure Ltd and Others

The high court denied urgent relief to a contractor (member A) who sought to stop the enforcement of a performance guarantee, finding lack of urgency, and held that the contractor would not suffer irreparable harm if the interdict was not granted.

Two consortium members, operating together, were contracted to provide services on a windfarm project. According to the terms of the consortium agreement, the consortium member (A) assumed 29% of the liability, whilst the other consortium member (B) was responsible for the rest. To protect the project's employer, a primary insurer issued a performance guarantee covering the total value of the project. A secondary guarantor then provided a "back-to-back" guarantee to the primary insurer for member A's share.

Problems arose during the project which led to member B entering business rescue. As a result, the employer demanded payment in respect of the performance guarantee from the primary insurer. The primary insurer in turn made demand on the secondary guarantor for the portion of the performance guarantee it covered.

Member A sought an urgent interdict to stop the secondary guarantor from paying the primary insurer under the guarantee, alleging that no genuine liability existed for member A and that member B should bear 100% of the risk, since its alleged breach triggered the revision of the members' respective liabilities. Member A further alleged that if the secondary guarantor paid the primary insurer in accordance with the demand, then Member A would be liable to the primary insurer when member B was in fact liable. Member A also claimed that the primary insurer's demand for payment was made fraudulently or in bad faith because it knew that only Member B was responsible for the breach to employer.

Member A alleged that after member B was placed in business rescue the consortium agreed that Member B would indemnify Member A for 100% of liabilities, and that the insurer was informed of this. But when underlying agreements are altered – such as a consortium's internal reallocation of liabilities – this does not necessarily affect the enforceability of performance guarantees from the perspective of third parties.

Member A's application was struck for lack of urgency. Member A suffered no imminent harm or prejudice from the secondary guarantor's payment to the primary insurer, that could not be resolved through standard legal remedies in future.

The case highlights how courts in urgent applications scrutinise the element of irreparable harm. Additionally, any allegations seeking to frame a call on a guarantee as "fraudulent" must be clearly substantiated; mere declarations of "not owing" under the underlying contract are insufficient where the guarantee is in force despite underlying disputes.

Payment under a chain of demand guarantees enforced

EPCM Consultants SA (Pty) Ltd and Another v Guardrisk Insurance Co Ltd and Others

The High Court knocked back an attempt to prevent payment by an insurer under a chain of demand guarantees intended to facilitate a Tanzanian construction project, finding the guarantees had not expired, there was no evidence of fraud by the insurer, and the applicants lacked a direct contractual right to restrain payment.

The second applicant (EPCM Tanzania) contracted with the fourth respondent (TSK) and agreed to construct two bagasse boilers. The first applicant (EPCM SA) concluded indemnity agreements, in terms of which an insurer would issue counter-guarantees for the performance of the construction agreement.

The insurer issued a performance guarantee and an advance payment guarantee, payable on first demand to the second respondent (Standard Chartered Bank (SCB) SA). There were several back-to-back guarantees issued with other parties due to insurance licensing requirements across borders (the parties operated in both South Africa and Tanzania). The obligations under the guarantees were to be triggered as follows: the contractor, TSK, would make a demand on SCB Tanzania. SCB Tanzania would then make a demand on SCB SA. SCB SA would make a demand on the insurer. The insurer in turn would look to EPCM SA under the indemnity agreements.

The guarantees were called on. The applicants sought to interdict demand and payment by the insurer under the guarantees, alleging that the guarantees TSK called on had expired and that the demands were fraudulently made by TSK.

The court dismissed the application because the evidence showed that the guarantees had not expired, and there was insufficient evidence to ground an allegation of fraud.

The court found that the maxim that "fraud unravels all" does not extend up a chain of contracts: the fraud must be committed by, or known to, the party sought to be restrained. The insurer was not alleged to have acted fraudulently, nor to have knowledge of any fraudulent act. The fraud was alleged on the part of TSK and could not interfere in the contractual obligations of the insurer, which were solely with SCB SA and EPCM SA.

The requirements of an interdict had not been met. Further, there was no contract between the applicant (a Tanzanian company) and the insurer (a South African insurer) due to the chain of contracts that existed between the various parties, leaving the applicant without a direct right to enforce their guarantee against the insurer. The applicant could continue to pursue their alternative remedy (arbitration under the construction contract) to resolve the dispute.

The case makes it clear that an applicant seeking to prevent payment under a demand guarantee faces an uphill battle. So long as the demand itself is validly made, the underlying reason for the demand will not be grounds for refusing payment except on proven fraud on the part of the party being restrained.

Suretyship upheld despite non-advanced electronic signature

Momentum Metropolitan Life Limited v Lavender Hill Trading 544 CC and Another

The court held that the second respondent was liable under the deed of suretyship despite using a non-advanced electronic signature, finding her admission to act as surety sufficient to uphold the agreement.

An insurance company entered into a financial service agreement with the first respondent close corporation. The second respondent bound herself as surety and co-principal debtor to the insurance company through a deed of suretyship. Pursuant to the deed of suretyship, the insurance company sought payment from the second respondent for the first respondent's debts, together with interest and costs on an attorney-client scale.

The second respondent challenged the validity of the deed of suretyship, arguing it was invalid due to non-compliance with section 6 of the General Law Amendment Act and sections 13, 37, and 38 of the Electronic Communications and Transactions Act (ECTA).

According to Section 6 of the General Law Amendment Act, a suretyship agreement must be written and signed by the surety to be valid.

Section 13 of ECTA states that when a "signature" is legally required, as in the case of a suretyship, this requirement is only fulfilled by using an advanced electronic signature. An advanced electronic signature is defined as an electronic signature resulting from a process accredited by the Accreditation Authority.

It was common cause between the parties that the electronic signature used by the second respondent when signing the deed of suretyship was not an advanced electronic signature. The court found the second respondent's arguments were untenable as she had admitted to binding herself as a surety in favour of the insurance company.

The court's decision emphasises the significance of understanding legal formalities in suretyship contracts, particularly the implications of electronic signing under South African law. The court's substance over form approach is encouraging.

On-demand guarantee upheld

Imvula Roads and Civils (Pty) Ltd and Others v Holland Insurance Co. Ltd and Another

The High Court held (yet again) that a contractor cannot go behind a compliant demand under an on-demand guarantee in the absence of proof of fraud by the beneficiary.

The applicant was appointed by the Western Cape Government (the second respondent) to provide road rehabilitation services for two stretches of roads. The contract prices were R96 million and R184 million, and the applicant was obliged to obtain performance bonds in an amount equal to 5% of the value of each contract. The insurer (first respondent) issued performance guarantees for both contracts.

The guarantees were called, after which the applicant urgently sought an interdict to prevent the Western Cape Government from calling up the guarantees pending resolution of the underlying issues. The insurer agreed to abide by the decision of the court, while the Western Cape Government opposed the application.

The applicant argued that the guarantees were conditional (rather than on-demand) and that the conditions for calling on the guarantees were not met. Alternatively, if the guarantees were found to be on-demand guarantees, the demands made by the Western Cape Government were fraudulent, because the construction contracts had not been validly cancelled.

The court held the guarantees were on-demand guarantees: a compliant written demand obliged payment without adjudicating the underlying cancellation dispute at this stage. The guarantee did not require proof of a valid cancellation and that separation reflects the autonomy of demand guarantees. The court said that there would be no purpose in having a guarantee if the defaulting party could raise defences relating to their failure to comply with their underlying obligations as these are separate issues that have nothing to do with the performance guarantee. The construction contract provided for dispute resolution mechanisms and arbitration, which is where the validity of cancellation fights belongs.

A call on an on-demand guarantee can only be interdicted in exceptional cases of clear fraud by the beneficiary in their calling upon the guarantee. Fraud must be distinguished from an "innocent" breach of the underlying contract. The applicant in this case was unable to prove fraud as they (i) treated alleged invalid termination/mistake as 'fraud', (ii) didn't identify who supposedly acted fraudulently, and (iii) overlooked that even if Western Cape Government misapprehended its rights, that is an underlying contractual dispute, not fraud for guarantee purposes.

The applicant argued that in the absence of fraud, the common law should be developed to accommodate an unconscionability exception. The court noted that the common law did not need development, since the Constitutional Court had already stated that any contract contrary to the public interest will not be enforced.

The application to interdict the calling on and payment of the guarantees was dismissed.

INTERPRETATION

Rectification of insurance policy refused

AIG South Africa Limited and Others v Azrapart (Pty) Ltd and Another

The Supreme Court of Appeal refused to rectify the insurance policy to exclude infectious disease cover, holding that the signed placing slip and final policy accurately reflected the parties' true intention and that rectification requires clear proof the written agreement misrepresents the original common intention.

Rectification is a narrow, exceptional remedy. It requires clear proof that the written agreement does not reflect the parties' common intention at the time of contracting. It is not a way to improve a bad bargain after the fact.

The insureds, co owners of Fourways Mall, claimed business interruption losses under an ICD extension. COVID 19's status as an infectious and contagious disease was not in dispute. The insurers disputed that the policy was the true agreement and, if it was, they argued that it should be rectified to exclude infectious disease cover. Only an underwriting manager persisted with an appeal to the SCA. The SCA rejected the rectification bid, finding that the signed placing slip and the final policy, which both included ICD cover, reflected the true agreement.

The chronology is important. The initial request to quote from the insureds' broker expressly sought ICD cover and instructed that any restrictive or different terms should be clearly highlighted. This was in line with POLDRA, which comprises drafting instructions used for assets-all-risks placements and binds all participants to a common process. However, over months of back and forth, the documents exchanged between the broker and the insurers alternately included or excluded ICD cover, due to unhighlighted edits in dense text and the use of PDFs versus Word files.

The contenders for what was the true agreement between the parties were the following:

- a final quoting slip which the broker sent to all the insurers with ICD excluded, and which all but one of the insurers signed;
- a subsequent placement slip, with ICD included which all the insurers signed;
- the policy with ICD included which only the lead insurer signed;
- under POLDRA, the policy had to be drafted in accordance with the signed placing slip, and any deviation required renegotiation and a signed endorsement. None was sought.

The SCA reiterated that a party seeking rectification must prove that the written agreement does not reflect the true common intention of the contracting parties as it existed when recorded (due to a mistake) and that the party seeking rectification can show the exact wording of the true agreement.

Against this backdrop, the rectification bid fell short. POLDRA's rules, which bind participants to a common document trail and clear highlighting of changes, cut against the notion of a shared intention to exclude ICD when the agreement was reduced to writing.

The court dismissed the appeal.

LIFE INSURANCE

Rescission of judgment handed down in error

Firstrand Bank Limited v Vellem

The court rescinded the judgment in favour of the executor of a deceased estate under a life policy because the summons was served on the incorrect legal entity at an address that was neither its head office nor registered office of the defendant bank as required. Summons were served at a branch of FirstRand Limited.

The court noted that proper service is fundamental to the validity of proceedings. The misidentification of the party materially affected by the outcome constituted an error in law and fact.

The court noted that the matter revealed multiple irregularities, which collectively justified rescission.

The judgment highlights the importance and benefit to insurers of ensuring that the identity of the relevant insurer is effectively communicated both in the policy documentation, disclosure documents, and any related correspondence. That applies especially to the proper description and name of the insured. Policies often refer to the parties in shorthand which can create confusion and wasted costs.

Life policy claim where beneficiary is suspected of murder

Mashaba v Master of the High Court and Others

The court postponed a decision on whether a life insurer must pay policy proceeds to a beneficiary suspected of murdering the insured, highlighting the tension between promptly honouring valid claims and preventing a suspect from potentially profiting from their own wrongdoing. The court made no finding but gave some useful reminders of the rights of the insured and the insurer.

During July 2021, the insured was murdered at the home of her husband who was the sole beneficiary under her life insurance policy. The crime prompted a criminal investigation by the South African Police Service. The insurer received an anonymous tip-off from a person claiming to be a family member of the insured, implicating the husband. Subsequently, the investigating officer identified the husband as a suspect in the ongoing investigation.

The insurer declined to pay the policy proceeds to the husband, because it was waiting for either a post-mortem report confirming the cause of death or written confirmation from SAPS that the husband was to be tried or was no longer a suspect. Its approach was based on prior case law and public policy considerations which prohibit someone from profiting from their own crime.

The husband sought an order compelling the insurer to pay the policy proceeds, notwithstanding that he remained a suspect.

The court did not make a final decision. Instead, it postponed the matter, requiring further affidavits, including on the status of the investigation.

The judgment emphasises two obligations of life insurers that can pull in opposite directions. On the one hand, insurers must honour legitimate claims within a reasonable time to avoid financial hardship to grieving families. On the other hand, insurers should not allow criminals to benefit from their crimes.

Unfortunately, as borne out in this case, implicated beneficiaries and insurers should be prepared for prolonged delays in criminal investigations, especially considering the detective crisis involving almost two million unresolved dockets (as of 2025).
If policy proceeds are paid to a beneficiary who it subsequently transpires caused the insured's death, then the insurer is entitled to recover the amount paid but that may be of little help.

Rejection of claim for material misrepresentation and non-disclosure upheld

Naidoo v Discovery Life Limited and Another

The high court ruled against a beneficiary's R6 million claim after the insurer proved material misrepresentation and non-disclosure by the life insured policyholder.

The court decided that the insured had falsely inflated her income in her insurance application, and failed to disclose other simultaneous life insurance applications, affecting the insurer's risk assessment.

The insured applied for a R6 million life insurance policy, declaring an income of R35000 per month as a supervisor. However, evidence showed that she was actually a front-end controller earning around R5000 per month. The insurer argued that if it had known her true earnings, it would have either rejected the application or offered significantly lower cover.

The insured failed to disclose a simultaneous life insurance application with another life insurer, which was submitted on the same day through the same broker. The defendant insurer's underwriters testified that if they had known about this application, they would have either reassessed or outright denied the cover.

Further investigations uncovered suspicious financial activity in the insured's bank account, raising concerns about possible involvement in an insurance fraud syndicate.

Applying the reasonable person test, the court found that a reasonable insurer would have considered the non-disclosed information as material in assessing risk. The court reaffirmed that insurers are entitled to avoid policies based on material misrepresentation or non-disclosure and that non-disclosure amounts to fraud, justifying policy cancellation. Material misrepresentation and non-disclosure can lead to a policy being avoided from inception, even after the life insured's death.

The court ruled that the insurer was misled into issuing the policy and was entitled to avoid the contract. The claim was dismissed, and the claimant was ordered to pay punitive costs.

Group life proceeds and s 37C of the Pension Funds Act

Machipi and Another v Palabora Mining Company Board of Trustees of Palabora and Others

A February 2025 high court judgment incorrectly found that a pension fund's group insurance policy was not governed by s 37C of the Pension Funds Act (PFA).

The dispute arose following the death of a mine employee. Mine employees were members of the pension fund, which had arranged group life insurance cover for the employees with an insurer. The deceased had nominated his grandmother and aunt as beneficiaries under the policy, allocating 40% and 60% of the benefits to them, respectively. However, after his death, the trustees of the Fund allocated only 5% and 15% to them and allocated the remaining 80% to the deceased's minor child, who had been born after the nomination form was signed.

The central issue was whether the policy proceeds should be governed by the Pension Fund Act. The claimants (grandmother and aunt) argued that the policy benefits should be paid to them according to the nomination form. The Fund contended that the benefits should be allocated under section 37C of the PFA, which is designed to protect the interests of the deceased member's dependants and ensure that they are adequately provided for. Section 37C allows the trustees of a pension fund to exercise their discretion in distributing benefits, despite the deceased member's wishes as indicated in a nomination form.

The insurer providing the group life insurance cover, which also featured as a respondent, sided with the approach of the Fund on the basis that according to the policy terms, death benefits had to be paid in accordance with the Fund rules, which are governed by the PFA. It also argued that the policy was a group scheme policy held by the Fund, not by the deceased.

The court decided in favour of the claimants, finding:

1. The benefits payable from a pension fund are distinct from those payable under a group life insurance policy. The PFA governs the former, while the latter is determined by the applicable insurance laws. The court seems to have taken the view that even though the policy terms refer to the Fund rules, the Fund rules only address the payment of pension fund benefits, and not policy benefits.

2. The nomination form signed by the deceased was a valid instruction for the payment of life insurance benefits. The trustees of the pension fund had no jurisdiction over the allocation of these benefits.

3. The trustees acted beyond their powers by attempting to allocate the life insurance benefits. The allocation of benefits under the policy should be administered according to the nomination form and not influenced by the trustees' discretion under the PFA.

MISREPRESENTATION

Fire insurance, misrepresentation and reasonable precautions

Biologicals and Vaccines Institute of Southern Africa (Pty) Ltd v Guardrisk Insurance Company Limited

An insurance fire claim was rejected on the basis of misrepresentation and failure to take reasonable precautions. On misrepresentation, the insurer contended that, during a pre-inception survey, the claimant's representative stated it had valid electrical certificates of compliance for all distribution boards in the affected building, when this was not true.

The court held that the insurer bears the onus to prove that the misrepresentation was made, apart from materiality and inducement. Neither the surveyor nor the claimant's witness directly recalled what they discussed regarding electrical compliance certificates during the survey. The court acknowledged that contemporaneous documents (such as the survey) can be persuasive, but only if it is reliable. Here, the survey recorded that there were no flammable liquids on site, despite an obvious, marked flammables store. That error undermined the survey's reliability as a record of what was said. The court thought that the surveyor probably "ticked the box" confirming that electrical compliance certificates were in place, consistent with a favourable overall risk impression rather than recording a specific representation.

On reasonable precautions, the insurer relied on a clause requiring the claimant to take reasonable steps to comply with statutory and regulatory duties, arguing that the absence of electrical compliance certificates breached that obligation.

The court accepted that, in an all-risks policy, losses caused by the claimant's negligence are usually covered. For a reasonable precautions defence to succeed, the claimant's conduct must amount to recklessness, requiring the claimant to "have actually recognised the danger to which it was exposed, and have done nothing or too little about it". Mere inadvertence or administrative failure does not suffice. The records showed a well-maintained facility, favourable expert impressions of the electrical installations in the past, and no evidence that the claimant knew of non-compliance or was indifferent to it. On those facts, the defence failed.

There is a growing consensus in the High Court that an insurer must prove recklessness and not negligence when raising a reasonable precautions defence. Recklessness is difficult to prove.

The issues were decided in the claimant's favour. A trial on the remaining separate issues was postponed.

MOTOR VEHICLE CLAIMS

Default judgment rescinded in motor claim due to insurer's speeding defence

Momentum Insure Company Limited v Chetty

The court rescinded a default judgment against the insurer after accepting its administrative error and finding it had a potential defence, in that telemetry data suggesting excessive speed could exclude liability under the motor policy, despite the insured's challenges to the admissibility and confidentiality of that evidence.

The respondent insured claimed under a motor vehicle policy for damage to his Porsche, sustained during a single vehicle accident. The claim was rejected by the insurer on the basis of a download of the vehicle's telemetry system which was interpreted as recording speeds significantly above the speed limit. The insured argued that he was travelling at or under the speed limit at the time of the accident.

The insured was awarded default judgment against the insurer due to the insurers' failure to submit its notice of intention to defend. The insurer applied to have the default judgment rescinded.

The insurer explained its failure to submit its notice of intention to defend as an administrative error that occurred in its head office at the time of receipt of the summons and claimed to have been made aware of the case when it was served with a writ of execution of the default judgment.

The court accepted the explanation for the lack of filing a defence and accepted that the application for rescission was not made with the intention of merely delaying the plaintiff's claim. The court then had to consider whether the insurer had raised a bona fide defence. The court stated that there is at least some authority for the proposition that reckless driving beyond the permitted speed limit may act to exclude liability on the part of the insurer. Further, the court accepted that it is a term of the policy that the insured must take reasonable care to avoid harm and must submit claims honestly.

The insured argued that the assessment report that supposedly established the speed of the vehicle was not admissible as evidence, because the manufacturer of the vehicle (Porsche) contractually precluded downloading data to compile a report such as the assessment report relied on by the insurer, and that the report is confidential in favour of the plaintiff (and the confidentiality had not been waived). The court said that neither a contractual limitation on obtaining evidence, nor confidentiality would necessarily be sufficient grounds (at least on the face of it) to resist a demand that such a report be discovered, or to resist the introduction of that report in a civil trial. Evidence other than the assessment report may also point to the speed of the vehicle at the time of the accident.

Having established that the insurer had a notional defence, the court rescinded the default judgment.

Repudiation of claim upheld due to insured's breach of policy terms

Mavela v Outsurance Insurance Company Limited

The high court decided that the rejection by an insurer of a claim for indemnification under a motor vehicle policy was lawful due to the insured breaching the terms of the policy by providing false information during the assessment of his claim and driving his vehicle whilst under the influence of alcohol.

The insured and the insurer entered into a valid non-life insurance policy by which the insured's motor vehicle was comprehensively covered against damages arising out of a motor vehicle collision. Subsequently, the insured's motor vehicle was damaged beyond economical repair in a collision.

The insured informed the insurer that his motor vehicle was at a stop street when he heard a bang on the left side of his vehicle. He did not know how the collision occurred, what the road looked like or that he collied with another vehicle. The insurer's investigation revealed that the collision was caused by the insured's motor vehicle moving across the barrier lines of the road, whilst being out of control, and veered off the road to the right side causing the collision with another vehicle.

The insured denied he was driving under the influence of alcohol at the time of the collision. However, during the insurer's investigation, the insurer established that the insured was charged with reckless and negligent driving and driving under the influence of alcohol in respect of the collision.

In rejecting the insured's claim for indemnification under the policy, the insurer relied on the policy terms which entitled it to reject a claim if the insured was driving under the influence of alcohol, or if the insured submitted a claim or information that was in any way fraudulent or dishonest.

The main issue before the court was whether the insured had materially breached the terms of the policy by providing false, misleading, or incomplete information, and by driving under the influence of alcohol at the time of the collision.

The court decided that the insured had provided false information to the insurer during the assessment of his claim, which was material to determining the claim. Further, the insured drove his motor vehicle whilst under the influence of alcohol at the time that he caused the collision. As a result, the insurer's rejection of the claim was lawful due to the insured's breaches of the terms of the policy.

Court reject's insurer's application to strike out claim

Shabalala v Madikane and Another

The claimant sued the insured for damages arising from a motor vehicle accident. The insured's insurer was also sued, as second defendant, on the basis that it was jointly and severally liable with the insured. The insurer excepted unsuccessfully to the particulars of claim, alleging that there is no allegation that the insurer played any role in the plaintiff's loss, and there was no cause of action against the insurer.

The court agreed that a reading of the pleadings to allege that the insurer is jointly and severally liable with the insured could not be sustained. However, when reading the particulars of claim as a whole the court noted that it is clear the insurer had really been joined on the basis that it is liable to the insured in its capacity as insurer for damages that the claimant may eventually prove. The insurer's complaint should have been one of misjoinder since the plaintiff cannot claim directly against the insurer. The insurer's interest in the claim, if any, would be as a third party. That interest arises if the insured claims under his policy.

Since the insurer did not ask the court to remove the unsustainable allegation of joint and several liability, and did not complain about misjoinder, but asked only that the plaintiff's claim be struck out, it could not succeed. The court said that it is not clear that the insurer has no interest in the case at all. The precise nature of the insurer's interest in the case, if any, is yet to be established, so it would be premature to strike out any claim against it. The court dismissed the application to strike out the claim and said that the insurer was free to pursue exceptions on the other grounds (misjoinder or the striking out of the joint and several liability allegation).

Rejection of claim for misrepresentation upheld

Tshipu (Ngako) v Bryte Insurance Company Limited and Another

The court upheld an insurer's rejection of a motor vehicle claim for misrepresentation. The insured represented (in the insurance proposal) that his vehicle was fitted with a vehicle tracking device. The policy conditions provided that the vehicle had to be fitted with a tracking device which had to always be in working order and activated.

On the evidence before the court, it was clear that there had been a misrepresentation by the insured because the vehicle had not been fitted with a tracking device. The court concluded that the insurer was entitled to reject the claim.

This was a straightforward factual dispute in which the insured surprisingly persisted in its claim despite the clear basis of the rejection communicated by the insurer, and the absence of suitable evidence to prove the fitting of a tracker. The insured even applied for leave to appeal, but this was dismissed.

REGULATORY OVERSIGHT

Upliftment of debarment of representative remitted to Tribunal for reconsideration

Paulina Binfa and Associates t/a PBA Financial Services CC v Dabrowa and Others

The court reviewed and set aside the Financial Services Tribunal's decision to lift a former representative's debarment, finding that the Tribunal materially erred by treating her misconduct as merely contractual rather than properly assessing her honesty and integrity under the FAIS Act's fit and proper requirements, and remitted the matter for reconsideration.

The representative was a registered representative licensed to sell life insurance, health insurance, pension benefit investments, and short-term insurance. She was employed by PBA as a registered representative and key individual in 2017 and was dismissed in 2022 on various counts of misconduct. The representative was also debarred under the FAIS Act, due to the finding that her actions had been knowingly dishonest and in contravention of her employment contract and industry standards relating to honesty and integrity.

The representative appealed the debarment to the Tribunal, and the debarment was set aside, on the basis that her conduct amounted primarily to a breach of her employment contract, not a regulatory contravention justifying debarment.

The FSP sought judicial review, arguing that the Tribunal committed a material error of law, failed to consider relevant factors, and considered irrelevant ones, and misapplied the fit and proper test required under the FAIS Act.

The court upheld the review. It found that the Tribunal impermissibly narrowed the enquiry, focused incorrectly on contractual issues, and failed to assess the representative's conduct against the established fit and proper requirements, including honesty and integrity. This constituted a material error of law and a failure to consider relevant considerations under PAJA.

However, the court declined to substitute its own decision for the Tribunal's decision. The full record was not before the court, factual disputes existed, and the matter required oral evidence, which the Tribunal has the power to hear. The court ordered that the matter be remitted to the Tribunal.

Court upholds Tribunal ruling (against Prudential Authority) on key appointments and penalties

Prudential Authority of South Africa v Financial Services Tribunal and Others

The court upheld the Financial Services Tribunal's decision that there was no breach of legislation where key appointments were retrospectively approved, that a reduced penalty for late notification was reasonable, and that the regulator had no power to impose a retrospective penalty under repealed legislation.

The Prudential Authority imposed administrative penalties on the Land Bank Insurance Company SOC Limited and the Land Bank Life Insurance Company SOC Limited for contraventions of the Insurance Act. The insurers appealed to the Financial Services Tribunal. The FST found that the PA was not entitled to take regulatory action against the Land Bank Insurance Company and its decision was therefore beyond its powers '(ultra vires). The Land Bank Life Insurance Company did not seek reconsideration of the PA decision but submitted that the penalty imposed was unreasonable. The FST reduced the penalty from R2 million to R250 000.

The PA brought a legality review against the FST, arguing that the FST decision was irrational and that the FST exceeded its powers or exercised its powers incorrectly.

As a preliminary point, the court found that the PA did have legal standing to review the FST's decision.

The court then went on to decide whether the insurers had contravened s14 of the Insurance Act, which requires approval by the PA on the appointment of key persons. It was common cause that key persons had been appointed without PA approval and that the approval was sought and granted a year later.

The PA explained that it had retrospectively approved the appointments to prevent unbusinesslike results. The insurers explained that the COVID lockdown had interfered with their functioning as well as the fact that they had lost members of their compliance control function which created gaps in their compliance processes. The insurers had also extended certain directors' appointments to avoid a lack of a quorum. All of these factors caused the delay in complying with s14.

The court found that there can only be approval after an appointment is made. The PA cannot approve a non-existent appointment. An appointment was not to be confused with the legal effect of the approval. Section 14 does not set out that before an appointment is made there must be approval and does not make reference to any specific time period. Further, as a retrospective approval deems the approval to have been granted on the date of appointment, there could be no breach of the Act in that case.

The FST had correctly found that s14 of the Act had not been contravened.

The court then considered whether the FST could alter the amount of the administrative penalty for the Land Bank Life Insurance Company's contravention of s16 of the Act. Section 16 provides that the PA must be notified of the termination of the appointment of a key person within 30 days of the termination. Contravention of s16 was admitted (notification was done between 12 and 6 months after various terminations), but it was argued that the penalty was excessive and inappropriate. There was no evidence that shareholders and policyholders were affected by the breach.

The PA conceded that the FST could substitute the PA's penalty determination with its own, but that in terms of the law the FST was obliged to remit the penalty determination back to the PA. The FST should not have usurped the powers of the PA and estimated an amount.

However, the PA had not ever explained what amount of the globular penalty was for which contravention. This is problematic because if, like in this matter, the respondents are found not to have contravened s14(1) what portion of the penalty falls away? The same problem lay with determining which portion of the penalty was to be allocated to s16. The PA had not provided the method of how the penalty was computed. The court could not find that the FST acted irrationally when considering the amount of the penalty imposed by the PA for the contravention of s16.

The FST took into account the factors set out in s167 of the FSR Act, and the court accepted this as appropriate.

Finally, the FST accepted that the Land Bank Insurance Company had breached s23 of the Short-term Insurance Act (STIA) in not seeking approval to increase its share capital. It was common cause that the FSR Act commenced on 1 April 2018 and that the Land Bank Insurance Company was no longer registered under STIA when the penalty was imposed in 2022 for a breach in 2015. The only issue the FST had to decide was whether the penalty imposed was done in terms of the applicable law at the time that the penalty was imposed.

The PA's penalty letter expressly stated that the penalty was imposed in terms of s167 of the FSR Act. The question then is whether the transitional arrangements provided that the PA could penalise for contraventions of the repealed STIA in terms of s167 of the FSR Act.

On interpretation of the transitional provisions, the STIA and the FSR Act, the court held that s167 cannot be used retrospectively. Therefore, the court was satisfied that the FST was correct in finding the PA acted *ultra vires* when it imposed the penalty for the contravention of s23.

The PA's application for review of the FST's decision was therefore dismissed.

ROAD ACCIDENT FUND

High Court confirms RAF must pay medical expenses despite medical aid contributions

A.S.B and Another v Road Accident Fund

In September 2025, the High Court reinforced the Road Accident Fund's statutory obligation to compensate victims of road accidents for all reasonable past hospital and medical expenses, even where those expenses have already been settled by a third party, such as a medical aid scheme. The court rejected arguments advanced by the RAF that sought to avoid liability on this basis, confirming that claimants remain entitled to recover the full amount of such expenses from the RAF.

The court's approach is firmly rooted in the statutory framework governing the RAF, which is designed to ensure that victims of road accidents are fully compensated for their losses. The existence of a contract between the claimant and a third party such as medical aid cover is irrelevant to the RAF's liability.

The court emphasised past judgments stating that the RAF cannot rely on internal directives to avoid its statutory obligations where the claimant has received payment from a third party. The principle of independence of third-party payments was highlighted: the RAF's obligation is to the injured party, and any recovery from medical aid is a matter of private contract, not a limitation on the RAF's liability.

This case is one in a series of similar findings in 2025 and previous years.

SUBROGATION

Only parties, not insurers, can file discovery affidavits in subrogated cases

Esperance Vineyards Farming (Pty) Ltd and Others v Liebenlogistics (Pty) Ltd

The High Court held that only a party to the proceedings, not their insurer, can depose to a discovery affidavit, since the insurer in subrogated proceedings is not a party.

The dispute arose after the insured respondent failed to deliver a proper discovery affidavit, instead submitting an affidavit deposed to by a director of the insurer, who claimed that the insurer had taken over the respondent's rights under subrogation and was in possession of the relevant documents. The court had to decide whether the insurer, not formally joined as a party, could make discovery on behalf of the respondent.

The court confirmed that court rules require discovery to be made by the party to the litigation, not by a third party such as an insurer. The court explained that, while subrogation allows an insurer to pursue claims in the insured's name, the insurer does not become a party to the proceedings.

The insurer could, therefore, not make discovery on behalf of its insured nor act as the litigant. The court ordered the respondent to comply with the discovery notice within ten days, failing which the applicant could apply to have the respondent's claim dismissed.

The judgment serves as a reminder that procedural compliance is essential, and that insurers must respect the formal roles of parties in the litigation, even when acting under subrogation. Subrogation gives the insurer the procedural right to control the proceedings and not the right to become the party to the proceeding.

Subrogation and parallel actions

Le Bonheur Wine Estate (Pty) Ltd v Stellenbosch Vineyards (Pty) Ltd

This High Court decision has raised eyebrows for its misreading of both the common-law principles of subrogation and the express wording of the policy at issue as well as its support for parallel actions for a single claim.

After fully indemnifying its insured and launching recovery proceedings, the insurer suddenly found itself ousted when the insured appointed new attorneys with instructions to withdraw the action. The court endorsed that substitution, but joined the insurer as a co-plaintiff, thereby stripping it of the control traditionally recognised as the insurer's subrogation right. In doing so, the judgment leant heavily on authorities that either do not support its reasoning or have been expressly overruled by later courts, while overlooking the policy clause granting the insurer "full discretion" in conducting recoveries.

The position under our common law of subrogation, as well as the express provisions of the policy, are that the insurer is entitled to control the insured's recovery claim against the defendant. In those circumstances, the insured was not entitled to exclude the insurer from control of the action and to direct control thereof through its own attorneys.

The insurer does not acquire the insured's claim against a third party, which claim remains vested in the insured. But the insurer acquires the rights to control as owner of the case (dominus litis) enforcement of the insured's right of recourse against a third party. That does not affect a third party's rights against the insured. Our courts, including the Supreme Court of Appeal, have consistently said that subrogation is a matter between the insurer and insured and does not affect the position of the defendant in one way or the other.

While it is correct that any recovery claim remains vested in the insured, it is incorrect to conclude that the insured retains control over the enforcement of the claim.

The court's remedy of joining the insurer to the action is inconsistent with the primary rule of subrogation that it makes the insurer the controller of the litigation. The insurer does not have a separate cause of action which it can enforce. There is no basis for two plaintiffs' pursuing in parallel the same cause of action as plaintiffs in the proceedings, or even separate proceedings. The court's recognition of the insured's right to control its claim and even withdraw it, is entirely inconsistent and it is worthless to suggest that in those circumstances the insurer still has a claim to pursue.

The action was subsequently settled without the matter proceeding to appeal.

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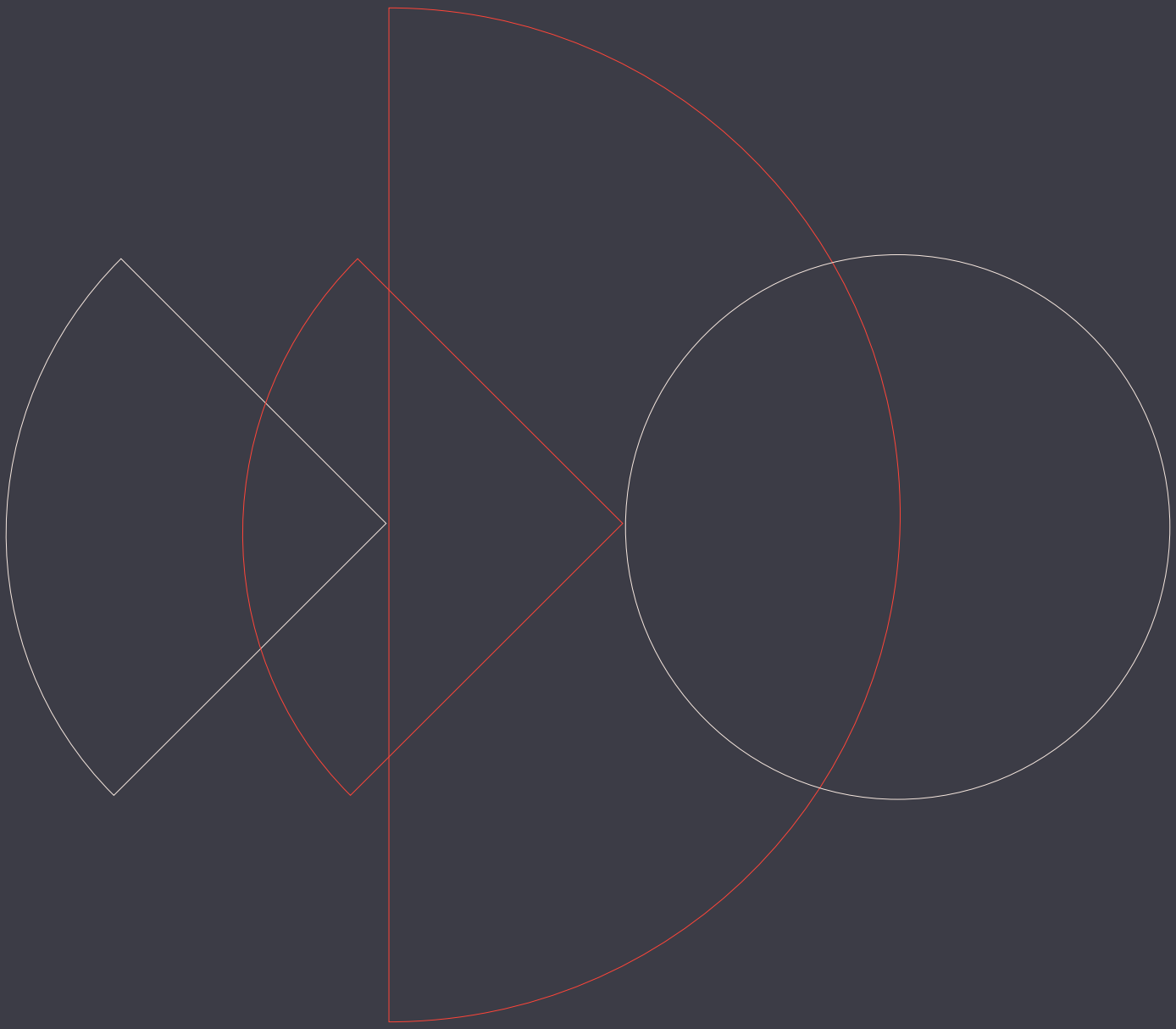

As the world moves