



**IN THE HIGH COURT OF SOUTH AFRICA
(EASTERN CAPE DIVISION, GQEBERHA)**

CASE NO: 3281/2019

In the matter between:

SHAUN SLABBERT

Applicant

and

LIBERTY GROUP LIMITED

Respondent

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

.....
DATE

.....
SIGNATURE

JUDGMENT

POTGIETER J

Introduction

[1] The applicant is seeking the following relief in his notice of motion:

“1. Ordering the Respondent to pay the Applicant the permanent impairment benefit referred to in Clause 1.1 of Liberty Life Policy Number 59868044900 in the amount of R3 000 000.00 (THREE MILLION RANDS).

2. Interest at the prescribed legal rate a tempore morae.

3. Costs of this application, only in the event of unsuccessful opposition.

4. Further and/or alternative relief.”

Factual background

[2] The material facts are largely common cause and can be set out briefly as follows.

The applicant is the insured under insurance policy number 5868044900 issued by the respondent on 16 September 2017, with a commencement date of 1 October 2017.

[3] The applicant submitted a claim on 14 February 2018 for a 100% impairment benefit in terms of the policy. The policy specifies various impairment benefit categories linked to a list of health conditions or disorders and the sequelae thereof. The benefit is payable if the insured is diagnosed as having been permanently impaired due to one of the specified health conditions or disorders and its sequelae. The last category set out in clause 15 of the impairment section of the policy is a catch-all provision dealing with the inability to perform Activities of Daily Living (“ADLs”). This benefit category covers all diseases, disorders or injuries which cause a permanent functional impairment but which may not be covered in the list of specific health conditions or disorders. The impairment is measured by assessing the ability of the insured to perform, what is referred to as Basic and Instrumental ADLs. The former includes activities such as washing, dressing, eating and mobility while the latter refers to housekeeping, communication, food preparation, transport, handling

finances and the like. To qualify for a 100% benefit 3 or more Basic ADLs or 4 or more Instrumental ADLs must be permanently impaired.

[4] The applicant's claim was assessed under clause 15 in respect of the impairment of ADLs. The medical report section of the claim form was completed on 31 January 2018 by Dr Groenewald, a general practitioner practising in Kimberley in the Northern Cape Province where the applicant was resident, after he conducted a consultation with the applicant on 24 January 2018. According to the medical report, the applicant was diagnosed with Malignant Hypertension and blackouts (syncope). These conditions are not included in the list of health conditions or disorders covered under the policy. The report further indicated that the applicant was unable to continue performing his work as a transport operator due to the blackouts. He had attended the clinic at the Kimberley Hospital in the past for hypertension and copies of the medical records of Kimberley Hospital were attached to the claim form. The consultation notes of Dr Groenewald dated 24 January 2018 indicated that no answer was received as yet from Kimberley Hospital with regard to their diagnosis. The Kimberley Hospital records indicated that the special investigations, including blood tests, a brain scan and a Doppler study of the applicant's carotid artery, which were performed pursuant to his complaints of blackouts, dizziness and headache, were all normal. The applicant was restricted from driving and he was referred for a social grant. The section of the social grant application form which was completed by a medical doctor at Kimberley Hospital indicated that the applicant's job involved driving and that his condition has limited his ability to drive.

[5] The respondent wrote to the applicant on 7 March 2018 indicating that the medical evidence received to substantiate the claim was assessed and the claim was declined. The reasons given for this decision were that Malignant Hypertension was not included under the listed benefit categories and that only one (as opposed to 4 or more) of the Instrumental ADLs, namely driving (transport) was restricted. The letter indicated that the applicant was at liberty to dispute the decision and could,

inter-alia, provide more information, request a review or lodge a complaint with the Long-Term Insurance Ombudsman.

- [6] The applicant responded on 16 April 2018, objecting to the stance adopted by the respondent and effectively requesting that the matter be reviewed. In addition, the respondent received a note from Dr Groenewald indicating that the applicant was unable to do his work as a truck driver and he could no longer do his basic daily tasks around the house due to blackouts, which affect every aspect of his life. The respondent wrote to the applicant on 10 April 2018 indicating that the claim could not be reviewed in the absence of medical evidence confirming that despite maximum medical treatment, the applicant was permanently unable to perform ADLs. The letter indicated that the respondent would obtain an updated medical report from Dr Groenewald regarding the applicant's current medical status, upon receipt whereof the applicant may be referred for an independent assessment by a specialist physician at the respondent's expense. The updated report was requested from Dr Groenewald in the form of a questionnaire.
- [7] The respondent received a letter of demand from the applicant's attorneys of record dated 16 April 2018 for payment of the full impairment benefit of R3 million under the policy. The respondent replied to the attorneys on 17 April 2018 explaining why the claim was declined and indicating that further information was being obtained from Dr Groenewald. The attorneys responded on the same day vehemently disputing that the applicant had failed to establish the grounds for his claim to be met and repeating their demand for payment.
- [8] On 4 May 2018 Dr Groenewald provided the requested updated medical report indicating that he had last consulted with the applicant on 24 January 2018. He had referred the applicant to Kimberley Hospital where the applicant was seeing doctors and receiving treatment. In response to the question why the applicant's hypertension was not controlled, Dr Groenewald replied that his medication should

be adjusted at Kimberley Hospital. The updated report now indicated that the applicant was permanently unable to perform 4 Instrumental ADLs.

[9] Pursuant to receipt of the updated medical report, the respondent wrote to the applicant's attorneys on 9 May 2018 indicating that its Chief Medical Officer considered the report and suggested that a second opinion be obtained from an independent specialist. The letter provided the names and contact details of 2 specialists in Kimberley and requested that the applicant make a suitable appointment with the specialist of choice for an assessment which would be paid for by the respondent. The attorneys responded on the same day reiterating their earlier stance that the respondent had already been provided with all the necessary information and was in a position to take a final decision pursuant to the applicant's request for a review without the need for a second medical opinion. The letter indicated that if a final decision was not be made on the review request, the applicant was not willing to cooperate to obtain a further medical opinion. The respondent wrote to the attorneys on 11 May 2018 basically repeating what was set out in earlier correspondence that an independent assessment by a specialist physician was required to clarify the applicants condition and its impact on his ADLs. The attorneys responded on 24 May 2018 basically repeating their earlier demands and alluding to legal action being considered. The respondent wrote back on 4 June 2018 repeating that it was unable to finalise the matter without a specialist medical report. The parties had reached a deadlock.

[10] Applicant's attorneys wrote to Dr Groenewald on 7 June 2018 requesting a report on specific aspects of the applicant's condition. Dr Groenewald responded on 19 June 2018 and also provided the respondent with copies of the letter of the attorneys and his reply. Dr Groenewald indicated in his reply that he was not the applicant's regular treating doctor and that he made it clear to the applicant that the respondent required specialists' reports, not a report from a general practitioner such as himself. He pointed out that the applicant was not taking his hypertension medication every day as required and that he was declared unfit by the doctors at Kimberley Hospital

and not by Dr Groenewald. He had no evidence of the applicant's daily black-outs as his request for the family to video record the episodes of blackouts, remained unheeded. On 21 June 2018 Dr Groenewald penned a further letter to the attorneys indicating that objectively speaking further adjustments to the applicant's medication could improve his hypertension, that the applicant's high blood pressure readings could cause blackouts, in his opinion the applicant suffers from resistant hypertension, and on the information at his disposal he could not expressly confirm whether applicant's condition had reached maximum medical improvement or not.

[11] Applicant's attorneys wrote a further letter to the respondent on 22 June 2018 basically restating the argument in favour of paying out the applicant's claim on the strength of the reports of Dr Groenewald and Kimberley Hospital. The respondent replied to this letter on 5 July 2018 indicating that the applicant's claim was again deliberated with the Claim's Review Committee, the Assessor and the medical doctors. The outcome was that the claim should be deferred for a minimum period of three months to allow the recent adjustments of the applicant's hypertension medication by Dr Groenewald to take effect given the recent report that after initial non-compliance, the applicant was now compliant with his treatment. The deferral would allow a determination to be made whether the applicant was on optimal treatment and had reached maximum medical improvement. The letter confirmed that after the expiry of three months the claim would be reviewed upon receipt of an up-to-date medical assessment and report from the treating specialist, a medication compliance report, and documentation supporting any impaired ADLs. The respondent reiterated that the applicant's claim was correctly assessed and declined on the medical evidence received from his treating doctor.

[12] The applicant did not submit the requested reports after the expiry of three months. He did lodge a complaint with the Long Term Insurance Ombudsman which was eventually dismissed. The applicant subsequently launched the present proceedings.

Applicant's case

[13] The applicant contended in essence that the respondent breached its duty to treat him fairly by refusing to pay out his claim. The thrust of his case was that there is a statutory duty imposed on the respondent by the Policyholder Protection Rules ("PPRs") issued in terms of section 62 of the Long-Term Insurance Act, 52 of 1998 ("LTIA"). The crux of his contention is that this duty precluded the respondent from relying on any reasons for repudiating the claim that were not expressly set out in the letter of repudiation dated 7 March 2021 ("March letter"). The applicant referred to this letter as a "*statutory notice*". This is not entirely correct, since there was no operative PPR or other statutory provision that required the respondent in March 2021 to provide a "*notice*" of repudiation.

[14] The applicant's position is that the respondent was absolutely bound by the reasons set out in the March letter and cannot add any further reasons. The respondent must accordingly stand or fall on the following reasons advanced in the March letter:

"The medical information received indicates that you were diagnosed with Malignant Hypertension and placed on medication. Your condition is not covered under any of the listed benefit categories, thus no claim is payable.

We have therefore assessed your claim under the Activities of Daily Living Catch all category benefit definition. The medical information also indicates that you may have suffered with a possible TIA (Transient Ischaemic Attack) on 24 October 2017, which fully resolved and there is no reported evidence of any neurological limitations. We noted that you complained of ongoing dizziness, blackouts and headaches and due to the risk associated with these symptoms you are no longer allowed to drive.

In order to qualify for a 50% payment under the Impairment Catch all benefit definition, there must be evidence that you have a permanent inability to perform one or more Basic ADLs (Activities of Daily Living) and 2 or more instrumental ADLs. Based on the evidence provided, you are still able to perform all the basic ADLs independently (washing, dressing, feeding, continence, mobility and transfers). You are not allowed to perform one of the instrumental ADLs, driving (transport). There are no limitations of any of the other listed instrumental ADLs. Your condition therefore does not meet the impairment definition under the ADL Catch all or any other benefit definition.”

[15] The subsequent report dated 17 April 2018 obtained by the respondent from Dr Groenewald indicated that 4 Instrumental ADLs were indeed permanently impaired. This brought the applicant’s claim within the 4 corners of the policy and rebutted the reason for the repudiation that is set out in the March letter, namely that only one Instrumental ADL was impaired. This further report was obtained during the review of the decision to repudiate the claim, which was requested by the applicant. The respondent was thus compelled to pay out the claim for a 100% impairment benefit of R3 million. Requiring further independent medical assessments amounted to shifting the goalposts and circumventing the March letter which, together with the refusal to pay the claim, amounted to unfair treatment of the applicant in breach of particularly PPR 1.4 (f) and 17.6.3 of the 2017 PPRs. The latter provide as follows:

“FAIR TREATMENT OF POLICYHOLDERS

1.4 An insurer must have appropriate policies and procedures in place to achieve the fair treatment of policyholders. The fair treatment of policyholders encompasses achieving at least the following outcomes:

...

(f) policyholders do not face unreasonable post-sale barriers to change or replace the policy, submit a claim or make a complaint.

CLAIMS MANAGEMENT

17.6 Decisions relating to claims and time limitation provisions for the institution of legal action

17.6.1 An insurer must accept, repudiate or dispute the claim or the quantum of a claim for a benefit under the policy within a reasonable period after receipt of a claim.

17.6.2 An insurer must within 10 days of taking any decision referred to in rule 17.6.1, notify the claimant in writing of its decision.

17.6.13 If the insurer repudiates or disputes a claim or the quantum of a claim, the notice referred to in rule 17.6.2 must, in plain language, inform the claimant – (a) of the reasons for the decision, in sufficient detail to enable the claimant to dispute such reasons if the claimant so chooses.”

[16] The applicant therefore contended that he was entitled in the circumstances to the relief being sought in the notice of motion.

Respondent's case

[17] The respondent contended that the applicant has failed to establish that he suffered a permanent impairment in order to qualify for payment of a benefit under the insurance policy. This required the presentation of *viva voce* expert medical evidence to resolve the dispute between the parties, which the applicant has failed to do. The matter is therefore not capable of resolution by way of motion.

[18] According to the respondent, the applicant's reliance on the PPRs for the contention that the respondent was absolutely bound by the March letter, was misplaced. Firstly, PPR 17.6.3 which was relied upon was not in force in March 2018. Secondly, the rule does not provide that the insurer must state “*all*” its reasons when initially declining to pay a claim at pain of “*forfeiting*” or “*waiving*”

its right to raise further reasons. Thirdly, the claim was declined on the strength of the reports that the applicant provided when submitting the claim. The applicant does not rely on these reports for the contention that the claim fell within the requirements of the policy, but relies on the reports submitted after the claim was declined. The flaw in the submission that the respondent was legally bound by the initial reasons for rejecting the claim which have subsequently turned out to have been unfounded, is that in order to support this assertion the applicant must rely on the reports that were submitted after the March letter. This is illogical. Lastly, the respondent submitted that rule 17.6.3 does not alter the common law position that an insurer or a contractual party need not state all its reasons for rejecting a claim or cancelling a contract at the risk of being seen to have waived other rights that it may have to reject or cancel. It is submitted that a party terminating an agreement and relying on the wrong reason for such termination may rely on any valid reason that was available to it even if such reason was not originally relied upon (*Matador Buildings (Pty) Ltd v Harman* 1971 (2) SA 21 (C) at 28A; *Stewart Wrightson (Pty) Ltd v Thorpe* 1977 (2) SA 943 (A) at 953G; *Putco Ltd v TV and Radio Guarantee Company* 1985 (4) SA 809 (A) at 832C-D). It further submitted that this trite principle of contract is applied to insurance contracts (*Shimi v Mutual and Federal Insurance Company of Namibia Ltd* (2269/2007) [2008] NAHC 109 (28 July 2008) at paragraph 13). Furthermore, the well-established rule of interpretation applies that a statute is not to be understood to vary the common law unless it plainly does so and that rule 17.6.3 (if it applied) accordingly does not clearly alter the common law on any interpretation thereof (*Gordon NO v Standard Merchant Bank Ltd* 1983 (3) SA 68 (A) at 94; *Fedlife Assurance Limited v Wolfaardt* 2002 (1) SA 49 (SCA) at paragraph 16).

[19] The respondent contended that the application should be dismissed for the further reason that the applicant has failed to present affidavits by the doctors who diagnosed him. The reports that he annexed to his founding affidavit constituted hearsay. No reason was proffered for this failure, which could even

have been cured in a replying affidavit which the applicant elected not to file. Contrary to the applicant's contention, these reports were in fact disputed by the respondent. The applicant erroneously conflated the authenticity of the reports with proof of the veracity of their contents.

[20] The reports, even if admitted, do not meet the policy's criteria for a successful claim for benefits. No report was submitted by an appropriate specialist. Dr Groenewald is a general practitioner and by his own admission not a specialist.

[21] The respondent argued further that the applicant failed to comply with the policy conditions by refusing to submit to an examination by an independent specialist. This was a requirement and material term of the policy, the binding nature whereof was unrelated to considerations of reasonableness and the like.

[22] The respondent thus contended that the application should be dismissed with costs.

Assessment

[23] It is clear that PPR17.6.3 of the 2017 PPRs was not in operation when the applicant's claim was dealt with. In terms of clause 2.2 of Chapter 8 of the 2017 PPRs, Rule 17 commenced on 15 December 2018 i.e. 12 months after publication of the PPRs in the Government Gazette. It accordingly finds no application in this matter.

[24] PPR1.4(f) on the other hand, was in operation and applied to the claim. On its plain reading, this rule neither supports the contention that there was a statutory duty on the respondent to disclose all the reasons for declining the claim nor the contention that the rule precluded respondent from relying on any further reasons. The non-applicability of PPR17.6.3 renders it unnecessary to deal with the effect of this provision on the duty of the respondent to provide reasons for repudiating the applicant's claim. It is also not necessary to consider the

applicability of the principle relating to the discovery of further post-cancellation reasons justifying the prior cancellation of a contract. I similarly need not finally comment on the cogency of the conclusion of the Namibian High Court in the *Shimi-matter* referred to above in paragraph [18] that this principle also applies to contracts of insurance, save to indicate that the conclusion commends itself as eminently sensible.

[25] PPR1.4(f) clearly imposed a duty on the respondent to treat the applicant fairly so that he “*does not face unreasonable post-sale barriers to... submit a claim*”. Although the rule appears to deal only with the process of submitting claims, which is not in issue in these proceedings, I am prepared to accept for present purposes that it also regulates the assessment of claims, as the applicant seemed to contend. On this premise, the respondent would have been bound on the strength of PPR1.4(f) to treat the applicant fairly in assessing his claim.

[26] The respondent accepted that it was bound to treat the applicant fairly in assessing his claim as evinced by the contents of the March letter which confirmed that “*we follow a rigorous process to ensure that decisions are fair in terms of Treating the Customer Fairly (TCF) and in line with the terms and conditions of your policy and industry regulatory standards*”.

[27] The crisp issue therefore is whether the applicant has established that the respondent acted in breach of the duty of fairness in repudiating his claim. The applicant in effect contended that the fairness standard required that the respondent should be held to the initial reasons for repudiating the claim and should not be allowed to raise any further reasons. The initial reasons have been demonstrated to be unfounded by the subsequent report dated 17 April 2018 of Dr Groenewald which confirmed that 4 Instrumental ADLs were in fact permanently impaired. The respondent is therefore compelled to pay the claim. On this approach, it would not amount to fair treatment to allow the respondent to go on a fishing expedition for other reasons to repudiate the claim.

[28] It is readily apparent that PPR1.4(f) is aimed at preventing the mischief of introducing unreasonable post-sale barriers to frustrate a policyholder. The provision is clearly aimed at curbing the imposition of unreasonable requirements outside of the policy terms. The latter represent the bargain that was struck between the insurer and the policyholder at the point-of-sale of the policy. The applicable standard of fair treatment of the policyholder proscribed such conduct on the part of the insurer.

[29] By the same token, the implementation of the express terms of the policy can hardly be characterised as unfair treatment on any approach.

[30] It is not in contention that the applicant's claim was assessed on the evidence that was submitted in support of the claim. The diagnosis of Malignant Hypertension is not covered in any of the benefit categories. The respondent therefore correctly determined that no claim was payable pursuant to this diagnosis. This was in line with the policy terms. The applicant does not assail this conclusion. He was well advised in this regard.

[31] The remaining leg of the claim resorted under clause 15 relating to the permanent impairment of ADLs. In this regard the March letter indicated that on the evidence provided, the applicant was not allowed to perform one Instrumental ADL, namely driving (transport). There were no limitations of any Basic ADL nor of any of the remaining Instrumental ADLs. The applicant's condition therefore did not meet the impairment definition under clause 15. This conclusion was strictly in accordance with the policy terms and in line with the evidence provided by the applicant. It therefore cannot be assailed as being unfair or unfounded. The applicant does not impugn the decision based on this reasoning. Its case is based on what transpired in the subsequent review of this decision that was requested by the applicant.

[32] In the course of the subsequent review of the respondent's decision to repudiate the claim, the respondent obtained the further report of Dr Groenewald which for the first time indicated permanent impairment in respect of 4 of the Instrumental ADLs. On the applicant's argument the respondent should be bound by the reasons set out in the March letter where it accepted the report of Dr Groenewald that only one Instrumental ADL was impaired. On this reasoning the respondent should now accept that on the further report of the same doctor, 4 of the Instrumental ADLs were permanently impaired. This falls within the definition of clause 15 and qualifies the applicant for payment of a 100% impairment benefit. The initial repudiation should therefore be reviewed in the light of the new evidence and the claim must be paid out. It is accordingly not in line with the applicable fairness standard for the respondent to be allowed to interpose further barriers to the claim such as independent assessments by medical specialists in an attempt to discover new reasons to repudiate the claim.

[33] While the applicant's argument is beguiling, it is not sustainable in my view. It is readily apparent that the respondent had assessed the claim as submitted on face value. The claim patently did not fall within the 4 corners of the policy and required no further investigation in accordance with the policy terms which regulate the submission and assessment of claims. It was correctly declined. The review process required a reconsideration of the claim. The new evidence presented by Dr Groenewald prompted a further investigation of the claim. This was regulated by the express policy terms which required that the diagnosis and management of all impairments be confirmed by appropriate medical specialists. The respondent's request for medical evidence from the applicant's treating specialist confirming his condition was thus not unreasonable and was in line with the policy terms. The same applies to the request that the applicant arrange for an assessment at the respondent's expense, by a specialist of his choice in Kimberly from the list of 2 names provided by the respondent. None of this can be characterised as a breach of the duty to treat the applicant fairly. No adequate reason was provided why the applicant refused to give his cooperation. The

respondent was not obliged to simply accept the new evidence provided by Dr Groenewald on face value. It was entitled and in fact required by the policy to have this new evidence confirmed by appropriate medical specialists. This is particularly so in view of its own medical advice that hypertension is an eminently treatable condition that generally does not result in permanent impairment. Moreover, the specialist assessment could only have been to the applicant's benefit. His failure to submit to the specialist assessment was the real reason why the review of his claim could not be finalised by the respondent.

[34] It follows that the applicant has failed to establish that the respondent acted in breach of the policy terms or the duty to treat the applicant fairly, in repudiating the claim or not having finalised the review of such repudiation.

Costs

[35] It is apparent that this application has been brought in the form of a test case in an attempt to clarify the obligations of a long-term insurer with regard to providing reasons for repudiating a claim in the light of the 2017 PPRs. The proper interpretation of the relevant provisions of the PPRs is a vexed question as pointed out by leading authors in this field (cf Joubert et al *LAWSA Vol 12(1) Insurance Part 1* 2ed Institution of the Insured's Claim).

[36] The fact that the non-applicability of PPR 17.6.3 in this instance obviated the need to grapple with these challenges, does not detract from the broader objective of the application which was not confined only to the present parties.

[37] In view of its special circumstances, it is not a case where the normal rule with regard to the award of costs should apply. In exercising my discretion with regard to the award of costs, I take into account that the objective of the application had the potential to also benefit the respondent (let alone other policyholders) as well as other long-term insurers in providing guidance with regard to the ambit of the

duty imposed by PPR17.6.3 on the insurer to provide reasons for repudiating a claim. I also take into account that these entities, like the respondent, are all endowed with substantial means compared to the applicant who is unemployed. As submitted in his Parthian shot by the applicant's counsel, this is a quintessential David and Goliath encounter. These proceedings are analogous to litigation for the protection of fundamental rights against the State by individual litigants who lack comparable resources to those that are available to the opponent. Cases abound where the courts have been slow to make adverse costs orders against such parties. The same approach is indicated in this matter.

[38] In my view, it would not be just and equitable to mulct the applicant in costs in the present circumstances, notwithstanding the fact that the application falls to be dismissed. I accordingly exercise my discretion against making an adverse costs order against the applicant in the particular circumstances of this case.

Conclusion

[39] In the result I make the following order:

- (a) the application is dismissed;
- (b) there shall be no order as to costs.

D.O. POTGIETER

JUDGE OF THE HIGH COURT

APPEARANCE

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For the defendants: Adv R Ismail, instructed by Rushmere Noach,
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Date of hearing: 01 September 2022

Date of delivery of judgment: 31 October 2022