REPUBLIC OF SOUTH AFRICA

THE SUPREME COURT OF APPEAL

Case No 329/96

In the matter between

WILLEM STEENBERG PRETORIUS en

SCHALK WILLEM VAN DER MERWE NNO APPELLANTS

and

CHRISTINA JOHANNA SOPHIA KALTWASSER RESPONDENT

CORAM: VIVIER, EKSTEEN, HOWIE, ZULMAN JJA et VAN COLLER AJA.

HEARD: 4 September 1997 DELIVERED: 19 September 1997

JUDGMENT

VIVIER JA:

This appeal is mainly concerned with the interpretation of an insurance policy. The respondent, who is a former employee of the Industrial Council for the Motor Transport Undertaking (Goods) - Industrial Administrators (Pty) Ltd ("the insured") brought an application on Notice of Motion in the Witwatersrand Local Division against the appellants who are the joint judicial managers of Crusader Life Assurance Corporation Ltd, a company under judicial management ("the insurer"). Although the relief sought by the respondent was expressed as monetary claims, the application was essentially for an order declaring that she was entitled to benefits under the policy. The application, which was opposed by the appellants, came before Roos J who granted an order in terms of the Notice of Motion but gave leave to the appellants to appeal to this Court.

The insurance policy in question ("the second policy") was described as a Group Permanent Health Insurance Policy renewable on an annual basis and was issued to the insured by the insurer during 1983, commencing on 1 December 1983. It was embodied in one document, contract no 83/167, together with a separate though related policy ("the first policy"), called a Group Personal Accident and Illness Policy, which was issued to the insured and commenced on the same date but was underwritten by another insurer, Crusader Insurance Co Ltd. The latter company was later replaced by other insurers. Both policies extended benefits to the insured's employees ("the members") upon the occurrence of the events insured against.

It was common cause on the affidavits that on 8 September 1991 and during the life of both policies, the respondent, while she was employed by the insured, fell on the stairs of a hospital

in Johannesburg and sustained severe injuries to her back as a result of which she became totally disabled on that day. The respondent's allegations that she broke her back in three places as a result of which she was severely crippled and classified as a paraplegic so that she can only move around with the aid of a walking ring and then with difficulty and that she has since been unable to find any employment, were not denied by the appellants.

The respondent received benefits under the first and thereafter under the second policy. The latter policy was validly terminated by the insured with effect from 31 August 1993. On 29 March 1994 the insurer was placed under judicial management. The appellants thereafter repudiated liability under the second policy on the ground that in terms of the express provisions of the second policy the insurance had terminated before the insured event occurred. Payments under the second policy ceased in April

1994.

An examination of contract no 83/167 shows that both policies have a common schedule and both are subject to the same General Conditions. In addition the second policy is subject to certain rules which I need not refer to. The policies run in tandem and there is a progression, in time and condition, for qualifying for benefits under the two policies. There is no defined period of insurance in either policy: as long as the insured is prepared to pay

the premiums the underwriter under the first policy and the insurer under the second policy are obliged to grant the benefits described in the respective policies.

In terms of section A of the Table of Benefits in the first policy the insured event is accidental bodily injury resulting in the member's death, disablement or temporary total disablement as defined. Permanent total disablement is defined as a number of

physical conditions which may or may not have any bearing on the member's ability to continue in employment. Temporary total disablement is defined as disablement rendering the member totally unable to perform the duties of his occupation or employment immediately prior to the insured event. Section B provides for a benefit payable in the event of a member contracting an illness, as defined, which leaves him disabled and totally unable to perform the duties of the occupation or employment in which he was engaged immediately prior to the event giving rise to the claim. The benefits provided for in sections A and B are, firstly, death and permanent total disablement benefits consisting of lump sum payments equal to 104 weeks' regular taxable salary (or a percentage thereof) and, secondly, temporary total disablement and illness benefits consisting of monthly payments equal to 100% of the regular taxable salary of the member for a period not exceeding

104 weeks. In the case of the temporary total disablement and illness benefits the period of 104 weeks is calculated from the date of expiry of the "waiting period" as defined in section D of the Table of Benefits. There the waiting period is stated to be one week in the case of temporary total disablement and four weeks in the case of illness benefits during which respective times the member must be disabled before qualifying for temporary total disablement benefits.

The second policy provides for a benefit payable to members equal to 75% of the member's monthly salary for each complete calender month of disability, subject to certain limitations. It is provided that if a member is totally disabled after the "deferred period" his benefit shall begin to be payable and shall continue to be payable for as long as "this Policy shall provide".

The expression "totally disabled" is defined to mean:

> "(a) [A]fter the expiry of the Deferred Period, and thereafter for a period of two complete and consecutive years, only such complete incapacity, as determined by the Corporation and resulting from a medically determinable physical or mental impairment, which causes the Member to be totally unable to perform the duties of his occupation or employment in which he was employed at the commencement of the Deferred Period, and (b) after the expiry of the two year period mentioned in paragraph (a) above and for the remainder of any continuous period of disability, such complete incapacity resulting from a medically determinable physical or mental impairment, which causes the Member to be totally unable to perform the duties of any occupation or employment for which he is or may become suited by his knowledge and training, having due regard to his earning ability."

"Deferred period" is in turn defined as meaning the period of 104 complete and consecutive weeks plus the waiting period in the first policy during which a member must be totally disabled before qualifying for any benefit under the second policy. After the

deferred period has elapsed the definition of "totally disabled" requires a condition, as determined by the insurer, to exist at stated points in time. For a period of two complete and consecutive years following the deferred period "totally disabled" means such complete incapacity as determined by the insurer which renders the member totally unfit for the occupation or employment in which he was engaged at the start of the deferred period. Thereafter "totally disabled" means such complete incapacity as defined which renders the member totally unfit for any occupation or employment for which he is or may become suited by his knowledge and training.

The second policy was terminated, as I have said, with effect from 31 August 1993. Assuming that the deferred period (comprising 104 complete and consecutive weeks plus the applicable waiting period of one week) commenced to run on 8

September 1991 when the respondent was injured and became totally disabled, it is clear that the termination occurred well before the deferred period had expired.

Counsel for the appellants submitted that the insured event under the second policy can only take place once the deferred period has expired when a defined physical or mental condition must exist. He submitted that since the insured event did not eventuate during the currency of the second policy the insurer did not become liable. As I understood counsel he used the expression "insured event" in the sense of being the entire occurrence which will render the insurer liable, and I will continue to use it in that sense.

Unlike the first policy, which refers to the event giving rise to the claim, and the General Conditions, which refer to the occurrence of the insured event, there is no reference in the second

policy to the insured event. If the two policies are read together it is clear, firstly, that the second policy provides cover against the further consequences or progression of the same accidental bodily injury or illness which caused the loss under the first policy. Secondly, the scheme underlying the two policies is to provide continuous cover for the members, at first during the initial period of 104 weeks (after the waiting period) under the first policy and thereafter under the second policy. The policies run in tandem, as I have said, so that benefits are paid under the first policy for a period of 104 weeks and thereafter continue to be paid under the second policy, provided only that the member is then still totally disabled as defined in the second policy.

It seems to me therefore that on a proper construction of the two policies the insured event under the second policy is the same accidental bodily injury or illness which gave rise to the claim

under the first policy and which results in the member being totally disabled, as defined, after the expiry of the deferred period. As I have indicated it was admitted in the appellant's answering affidavit that the respondent became "totally disabled" (obviously as defined in the second policy) on 8 September 1991 as a result of accidental bodily injury suffered that same day. I have also pointed out that the respondent's allegations in her founding affidavit to the effect that she was permanently so totally disabled were not denied in the answering affidavit. The effect of these admissions is that it must be accepted that the respondent was totally disabled with the degree of permanence required by the second policy on 8 September 1991. In my view it follows that the insured event occurred on 8 September 1991 during the life of the policy with the result that the insurer became liable under the second policy.

The provision for the deferred period to have expired, if read in its proper context, means no more than that payment under the second policy was delayed or postponed without affecting the occurrence of the insured event. (See The Oxford English Dictionary, 2nd ed, vol IV p 379 sv "defer".) This construction is confirmed by the provision in the second policy, to which I have already referred, that a member's benefits shall "begin to be payable" if he is totally disabled after the deferred period. Similarly, the words "qualifying for any benefit" in the definition of deferred period means no more than to become entitled to payment.

I am accordingly of the view that on 8 September 1991, the peril insured against was already in existence and the respondent's loss was complete with the result that even though the policy was thereafter terminated the insurer remained liable. See Ivamy,

General Principles of Insurance Law, 6th ed at 402; Appleman, Insurance Law and Practice (1981 ed) Vol IC para 613 at 143-144.

Counsel for the appellant submitted that in terms of clause 13 of the General Conditions the respondent lost her rights to payment under the second policy upon termination of the policy because the time for payment under that policy had not yet arrived. Clause 13 provides that the termination of the policy as a result of the insured failing to pay premiums shall in no way affect any benefit due and payable at the date of such termination. The submission was that a benefit had to be payable if the right thereto was to survive the termination of the policy. In my view this clause does not affect the rights which the respondent had acquired prior to termination. The emphasis in the clause is on benefits and it does not apply to a case such as the present where the policy is

terminated after the insured event has occurred but before the expiry of the deferred period. In my view the termination of the second policy did not affect the insurer's liability to the respondent. It is significant that clause 17 of the General Conditions, which provides that a benefit payable under the policy shall cease to be paid or to accrue upon the occurrence of certain specified events, does not list the termination of the policy by the insured under these events. The conclusion is justified that the present termination did not affect the respondent's rights to payment under the second policy.

For the reasons which I have given I am of the view that the Court a quo correctly granted the application.

The appeal is dismissed with costs.

W. VIVIER JA.

EKSTEEN JA) HOWIE JA) ZULMAN JA) VAN COLLER AJA) Concurred.