



NOT REPORTABLE

**IN THE HIGH COURT OF SOUTH AFRICA
KWAZULU-NATAL LOCAL DIVISION: DURBAN**

CASE NO: 8713/2015

In the matter between:

**VISHAL SURENDRA MAHARAJ N.O.
VISHAL SURENDRA MAHARAJ
NATASHA CHUNDER N.O.
JOSE ALBERTO DELGADO N.O.**

**FIRST PLAINTIFF
SECOND PLAINTIFF
THIRD PLAINTIFF
FOURTH PLAINTIFF**

and

DISCOVERY LIFE LIMITED

DEFENDANT

ORDER

The following order is granted: -

- 1. All amending contracts to policies of insurance numbered 513005312 (policy 312) and 5130200160 (policy 160) concluded after April 2010 by reason of the submission and grant of service alteration requests are declared void with effect from the conclusion of each such contract.**

2. It is declared that each of policies 312 and 160 otherwise remains in force, subject to the payment by the plaintiffs of the outstanding premiums thereon (the defendant having rejected tenders of premiums), the amounts of such outstanding premiums to be computed after set-off against the plaintiffs' rights to repayments of premiums paid to and accepted by the defendant in respect of the void amending contracts. The said policies as they are declared to remain in force are hereinafter referred to as the "original policies".
3.
 - (a) The defendant's application to amend paragraph 54 of the claim-in-reconvention by the addition of the words "alternatively the amendments thereof" after the word "policies", and by the addition thereto of the words "alternatively the amounts paid to the plaintiffs' as benefits introduced by the amendments" is granted.
 - (b) The plaintiffs are declared to be liable and are ordered to pay to the defendant the difference between the amounts paid to the plaintiffs on claims premised on the validity of the amending contracts, and the amounts which would have been calculated under the provisions of the original policies.
4. The plaintiffs' claims for the payment of severe illness benefits for a "permanent ejection fraction between 40% and 50%" listed under the heading "Severity B" on page 115 of the Life Plan Guide are upheld to the extent that the claims are covered by the original policies 312 and 160.
5. The plaintiffs' claims for payment of temporary Capital Disability Benefits and Income Continuation Benefits are dismissed.
6. An order of absolution from the instance is made with regard to the plaintiffs' claim for payment of a permanent capital disability benefit.

7. (a) The defendant is directed to deliver to the plaintiffs within 30 days a full statement of the financial consequences of the orders made above, including an accounting for premiums and mora interest, duly supported by explanatory notes.
- (b) The parties are directed to debate the said account, with a view to reaching an agreement on it, and if agreement is reached, with a view to reaching agreement on whether and on what terms a monetary judgment or judgments should be made by this court to supplement the present orders.
- (c) If agreement is not reached this case may be set down for hearing again for adjudication of any disputes as to the financial consequences of the orders now made.
- (d) If the course in paragraph (c) above is followed, a clear and concise agreed statement of the disputes required to be adjudicated shall be lodged, as well as comprehensive heads of argument from each side.
8. Costs to date are reserved.

JUDGMENT

OLSEN J

[1] The defendant, Discovery Life Limited, is sued for certain amounts said to be payable by it in terms of policies of insurance which it issued. (The case commenced by way of motion proceedings, but was referred to trial.) The first, third and fourth plaintiffs,

the trustees of the Jai Ambe Family Trust, own the policies. The second plaintiff, Mr Vishal Surendra Maharaj, is the principal insured under each of the policies.

[2] Two policies are involved in this case. The contract for the issue of the first of them was concluded on or about 1 May 2005. On the pleadings and at trial it was referred to as “policy 312”, and I will follow that lead. The contract for the issue of the second policy was concluded on or about 1 November 2007. It will be referred to as the “policy 160”. Each of the policies was governed by the standard terms and conditions set out in a document called the “Discovery Life Plan Guide”, and I will refer to it as the “Guide”.

[3] The Guide comprises 162 pages of terms and conditions, and tables. It is a composite document, providing the governing provisions for various types of insurance cover. The document does not make easy reading, *inter alia* because the defendant has chosen to attach what are, for the uninitiated, somewhat obscure labels to any number of concepts which have been employed in the policy provisions. The general scheme of the policies is sufficiently illustrated for present purposes by quoting a few sentences from page 2 of section 2 of the Guide.

- ‘The life plan provides cover for life-changing events for the whole family. These events include death, severe illness and disability and are fully described in the rest of the life plan.’
- ‘The life plan has as its basis a life fund, which is the financial mechanism of the life plan. The life fund is used to fund benefit payments for the benefits you and your family have selected.’
- ‘Your policy reflects the benefits selected by you. These benefits are defined as a percentage of your life fund unless you have chosen the non-accelerated versions of these benefits. Multiplying the benefit percentage by the life fund at inception of the policy defines the initial monetary amount of cover for each benefit.’
- ‘Benefit payments are defined as any amount of money paid to you as a result of you claiming against your life fund for a life changing event. When you receive an accelerated benefit payment from your life fund, the value of your life fund is reduced by

the amount of the benefit payment (taking into account any conversion rates in the case of AccessCover and AccessCover Plus if applicable).’

[4] Section 3 of the Guide records that the types of cover available are life cover, cover for severe illness, cover for family illness, disability benefits (including capital disability benefits and income continuation benefits, permanent or temporary) and two others which do not feature in this case, namely the "Discovery Retirement Optimiser" and the "Philanthropy Fund". The death of the life assured results in the payment of what is left in the life fund. Payments for other so-called "life changing events" results in the diminution of the life fund unless, presumably for significantly higher premiums, the so-called "non-accelerated benefits" are selected, which means that under certain conditions the amount paid under the relevant benefit is put back in the life fund.

[5] The plaintiffs sued initially for payments of stipulated sums of money following upon alleged life changing events which had arisen in the case of the second plaintiff. The defendant denied liability for reasons to which I will come shortly. I was informed at the outset of the trial that no evidence would be led to quantify the claims, it being anticipated that agreement would be reached between the parties during the course of the trial as to the amounts which would be payable for each of the various permutations of outcomes in the case. A little way into the trial I was informed that this had proved to be an extremely complex exercise, as a result of which had it been agreed that these permutations would be reflected in declaratory orders which the parties would settle before the trial was over. I heard 10 full days of evidence and when the case was argued a week later the declaratory orders had still not been settled. I subsequently received written submissions from the parties on certain issues which had not been fully dealt with in oral argument, which were accompanied by proposed declaratory orders. In essence, then, the issues to be decided at this time concern the validity or otherwise of the basis upon which the defendant has repudiated any liability to meet the unpaid claims of the plaintiffs, and to reclaim benefits which the defendant had paid earlier on; and the validity of the plaintiff's claim-in-reconvention.

[6] Once a policy is issued by the defendant an insured is entitled to ask for changes to the benefits covered under the policy. A request for such an alteration is called a “service alteration request”. If it is accepted by the defendant the result is regarded as an amendment to the policy as it was prior to the defendant’s acceptance of the request. (That such an occasion results in an amendment to the policy is common cause on the pleadings, although that classification of the outcome became the subject of debate in argument, one fortunately ultimately resolved.) In November 2009, May 2012 and October 2013 the plaintiffs submitted service alteration requests in respect of policy 312 which were accepted by the defendant. In June 2010, May 2012 and November 2013 the plaintiffs submitted service alteration requests in respect of policy 160 which were accepted by the defendant.

[7] The defendant repudiated the entirety of each policy (as amended) on or about 31 July 2015. As at that date, and using the defendant’s terminology,

- (a) policy 312 provided the following cover:
 - (i) Life Cover;
 - (ii) Severe Illness Benefit;
 - (iii) Temporary Income Continuation Benefit;
 - (iv) Global Education Benefit;
 - (v) Income Continuation Benefit;

- (b) under policy 160 the following was covered:
 - (i) Life Cover;
 - (ii) Severe Illness Benefit;
 - (iii) Temporary Income Continuation Benefit.

[8] Very broadly stated, the defendant claimed a right to repudiate the policies, and to reclaim benefits already paid, on the following bases.

- (a) When applying for the service alteration requests the second plaintiff failed to disclose that during 2010 and 2012 he had suffered from depression, had received treatment from psychiatrists for such depression, had been admitted to

hospital on 8 August 2012 on account of depression, and had been prescribed appropriate drugs for that condition.

- (b) When making claims under the policies the second plaintiff fraudulently misrepresented his capacity to work on account of the medical conditions which gave rise to his claims, and misled a Dr Schamroth on the same subject, Dr Schamroth having been identified by the defendant as the cardiologist to whom the defendant required the second plaintiff to submit himself for examination in support of the assessment of the claims which had been submitted.

The claim of fraud was pleaded in the alternative to the defendant's contention that it was entitled to avoid the policies in their entirety due to misrepresentation and non-disclosure at the time of the making of service alteration requests.

[9] A little background is necessary before considering the evidence concerning the issues to be decided. The second plaintiff qualified as a clinical technologist specialising in cardiology. He started in private practice in 2000 or 2001. The practice of such a clinical technologist involves both non-invasive and invasive procedures. The former are undertaken at the request of doctors who require tests to be performed on patients who might have cardiac problems. The technologist has equipment for that purpose. In the so-called "invasive" work the clinical technologist is part of the team which works in a cardiac catheterization theatre, commonly called a "cathlab". The team would be a cardiologist, a clinical technologist, a radiographer, a scrub sister and a floor sister. Such a team undertakes both elective and emergency procedures. The clinical technologist is responsible for connecting the patient to monitoring devices, the information from which is sent back to a monitoring room next to the cathlab. For pacemaker implantations the clinical technologist has to program the pacemaker and take measurements, and so on, to ensure that all operates correctly. The cathlab itself is a sealed room. Whoever is in the lab has to wear lead shielded clothing in order to avoid significant ray exposure. The monitoring room is next door to the cathlab and, according

to the second plaintiff, such shielded clothing is not required there. From the monitoring room one can see into the cathlab.

[10] After a while the second plaintiff took on a junior technologist to work under his guidance, and things went well. (Initially the second plaintiff had a partner.) Services were rendered at a number of hospitals. In 2012 the second plaintiff decided to incorporate his practice, which was thereafter undertaken by V S Maharaj Incorporated. At the time when the second plaintiff first fell ill in early 2014 his incorporated practice had rooms at Westville Hospital, St Augustines Hospital and Umhlanga Hospital. It employed a staff of about eight technicians, three secretaries and a counsellor.

[11] The first issue of fact concerns the allegation made by the defendant that in 2010 the second plaintiff suffered from and was treated for depression by a psychiatrist, Professor Nair. In his evidence in chief the second plaintiff stated that a temporary breakdown in his marriage occurred at the time. The couple decided that they should consult a counsellor. Some doctors suggested to the second plaintiff that he should consult Professor Nair. Both he and his wife attended individual counselling sessions with her, he on three occasions. According to the second plaintiff there were also two or three so-called "couple sessions". According to the second plaintiff by April 2010 things were better. He said that Professor Nair suggested that he should take a tablet but that he never took it. He also claimed that there is not a code for marriage counselling in medical aid tariffs, and that she got around this by putting down his condition as "depression", and that she charged accordingly.

[12] Under cross-examination the second plaintiff claimed not to be able to remember the medicine that was prescribed for him by Professor Nair and continued to insist that he did not take it. He denied, when the contrary was put to him, that Professor Nair had told him that she was diagnosing depression accompanied by marital problems.

[13] The defendant call Professor Nair. The court was provided with a typed and very much redacted version of Professor Nair's notes of her treatment of the second plaintiff.

Amongst the excluded material are six pages of detailed notes taken on 10 February 2010. Professor Nair's diagnosis was unipolar depression, which is now called "major depression". She prescribed a drug known as Serlife, 25 milligrams for 5 days and thereafter 50 milligrams per day. Serlife is an anti-depressant. Professor Nair's evidence was that she discusses that drug in great detail with the patient. She explains why she is using it and how it works and how long it takes. She also prescribed Rivotril, a drug used to calm the patients while waiting for the anti-depressant to work. Finally she prescribed Normison, a sleeping tablet, to address the fact that sleep goes out of kilter with depression.

[14] Professor Nair's notes reveal that when she consulted with the second plaintiff on 15 February 2010 he reported that he was taking his medication but had switched the Serlife to the evening.

[15] Professor Nair questioned the second plaintiff on the issue as to whether he had suicidal thoughts. He answered that he had had suicidal thoughts but would not do it. She explained that she is trained in assessing suicide risks and classified the risk in the case of the second plaintiff as low.

[16] Professor Nair's evidence was that she would have told the second plaintiff that he is depressed. She explains depression to patients, where it comes from, how brain circuits change and why, as a result, there is a physical reaction in the case of depression. She stated that she had no independent recollection of doing so but was confident that she did so because that was what she always does. It must be remembered that when she gave evidence she was talking about consultations which had taken place 12 years earlier. She stressed that medical practitioners take notes because they cannot be expected to remember everything that happens in consultation.

[17] In cross-examination Professor Nair explained that a "major depression" can be moderate or severe. What it is not is bipolar in nature. Her diagnosis of the second plaintiff did not put him in the severe category of major depression.

[18] Professor Nair also explained that there is a medical aid code for marital therapy – “Z63”.

[19] I turn now to the second complaint of the defendant, that the second plaintiff was diagnosed with and treated for depression by a Dr Nowbath and that this was not disclosed in making the service alteration requests. In his evidence in chief the second plaintiff explained that he came to suffer from what he called burn-out and stress as a result of the blacklisting of his practice by Discovery Medical Aid, and a claim they made against him for refunds, amounting to about R700 000. He explained that at this time he bumped into a friend of his, a Ms Maharaj, a practising psychologist. She advised him to go and see Dr Nowbath. This was in August 2012. According to the second plaintiff on 8 August 2012 he went to Dr Nowbath’s rooms and saw him as he (Dr Nowbath) was packing his bags to go. Dr Nowbath said that he had no space in his diary to treat the second plaintiff as an out-patient, and told the second plaintiff that if he wanted treatment he would have to be admitted to hospital. The second plaintiff thought that a good idea, and that a few nights good sleep would stand him in good stead. He was admitted and put on a drip, something the nurses said was a matter of standing orders for Dr Nowbath’s patients. He saw Dr Nowbath on Saturday morning and chatted about issues and his practice. That was on the Saturday morning. On Sunday Dr Nowbath said that the medical aid would only authorise the second plaintiff’s stay until Sunday and that he would have to be transferred to a specialist psychiatric facility known as St Joseph Hospital if he wished to be further treated. The second plaintiff declined and, at that, Dr Nowbath stormed out saying that he must agree to “RHT” (which apparently stands for Refused Hospital Treatment). The second plaintiff claims that there was no diagnosis and no treatment plan. He discharged himself from the hospital on Monday morning.

[20] The evidence which would be given by Ms Maharaj and Dr Nowbath, which contradicts the evidence of the second plaintiff, was put to the latter in cross-examination, and met with denials.

[21] Ms Maharaj agreed that she and the second plaintiff had been friends for many years. She practised at the time in the Mount Edgecomb Medical Centre. Again, in her case, the court was initially provided with typed versions of redacted notes. According to Ms Maharaj this was not a matter of a brief chance meeting in a corridor, as claimed by the second plaintiff, but a consultation with her in her rooms. That generated her notes. She diagnosed a major depressive disorder. She recorded that whilst there was no planned or attempted suicide, the second plaintiff had passive thoughts of suicide. For this reason, and also to protect herself as consulting psychologist, she requested the second plaintiff to sign a so-called "suicide contract", which he did. It is a simple document which records that the signatory undertakes not to harm himself, and to contact Ms Maharaj if he found that he could not cope. When it was put to Ms Maharaj not only that the second plaintiff had no recollection of signing such a document, but that he would not have signed it, and didn't sign it, her response was that she had no reason to fabricate notes and to forge a document. At that stage, considering the challenge, the full set of notes was put in as an exhibit. The handwritten notes for 7 August 2012 are quite detailed and take up three pages.

[22] Ms Maharaj recommended that the second plaintiff consult Dr Nowbath, and believes that she may have contacted Dr Nowbath's rooms for this reason.

[23] Dr Nowbath's evidence was that he first saw the second plaintiff in the former's rooms at Mount Edgecomb Medical Centre on 8 August 2012. The patient had been referred by Ms Maharaj. He made six pages of notes on his consultation in his rooms. Amongst other things he found that there had been thoughts of suicide – so-called "suicidal ideation", but that the patient stated that because of his relationship with his daughter, he would not attempt suicide. Dr Nowbath's diagnosis was major depression and he decided to admit the patient and do blood tests and so on, and decided on the prescriptions on that day. The second plaintiff was admitted to Mount Edgecomb Hospital that evening. Arrangements were made by Dr Nowbath's rooms, and he was given a letter to take with him to hospital. Dr Nowbath said that there were no standing orders at the hospitals for his patients, that they should be put on a drip

[24] The notes revealed that Dr Nowbath saw the second plaintiff in hospital on 9 August and on 10 August. The next day he found that the second plaintiff had signed himself out without reference to Dr Nowbath. The nurses reported to Dr Nowbath that the second plaintiff anticipated problems with medical aid paying for his stay.

[25] According to Dr Nowbath, the only diagnosis he made of the second plaintiff was major depression. He informed the second plaintiff of the diagnosis, and indeed would have done so in his rooms on 8 August. He would have explained what he planned to do and why.

[26] The second plaintiff's contrary version of his interaction with Dr Nowbath was put in cross-examination and rejected. Dr Nowbath said that at that time there was no rule that patients could only be kept at the hospital for two days and pointed out that he did not practice at St Joseph's. When challenged as to why he did not follow up with the second plaintiff when he learnt that he had discharged himself, Dr Nowbath said that it was not something he did when patients chose to discharge themselves. He was challenged on the question of why he would have recommended hospitalisation. Dr Nowbath acknowledged that most patients suffering from depression are treated as out-patients, but that in some cases caution suggests hospitalisation. In his case he would have been perhaps concerned about the suicidal thoughts.

[27] Without any difficulty I come to the conclusion that each of Professor Nair, Dr Nowbath and Ms Maharaj were credible and reliable witnesses. In particular I am satisfied that the second plaintiff knew that both in 2010 and in 2012 he had been diagnosed with major depression. Wherever the second plaintiff's evidence is contradicted by those three practitioners, I favour their versions. I am particularly concerned about the distance between what the second plaintiff presented as a brief chance encounter with Ms Maharaj, and her version of events supported in full by her notes. She, like the other two practitioners, had no reason to fabricate evidence. The second plaintiff's version is not credible in the circumstances, and is rejected. I find it

established as a matter of overwhelming probability that in 2010 and 2012 the second plaintiff was diagnosed with and treated for major depression, and that he knew that.

[28] The service alteration request made by the second plaintiff in June 2010 (after his treatment by Professor Nair had ceased in about April 2010) contained a questionnaire which counsel for the plaintiffs correctly points out is considerably less detailed than the one required at the inception of the policy. Amongst the questions posed were the following.

'Has your health changed since the issue of your existing discovery life claim or are there circumstances that would affect the assessment of risk?

Do you suffer from any disease or disorder, including HIV infection, or has there been an increase in cholesterol levels, blood pressure levels or liver enzymes? This includes taking ongoing medication, smoking and alcohol consumption and undergoing any procedure or seeing a medical professional for any reason whatsoever.

(My Emphasis)

The second plaintiff answered both questions in the negative.

[29] The questionnaire had changed by the time the three subsequent service alteration requests were made. The relevant portion contains the following questions.

'(a) Since completing the medical questions on your existing discovery life application, have you been diagnosed with any disease(s) or disorder(s) that requires ongoing or intermittent management (medication, monitoring or other treatment(s))?

(c) Are there any circumstances that may have arisen since the last disclosure you have made for this policy, which may affect the assessment of risk for the cover or benefits you are applying for in this application form? You are also obliged to tell us again of any health circumstances that you have disclosed in the original application form for example, back or neck problems, depression, cancers or growth, however minor'.

(My Emphasis)

The second plaintiff answered these questions in the negative, despite the fact that by that time he had been diagnosed and treated by Dr Nowbath as well.

[30] On the pleadings the defendant's case is that the non-disclosure of the diagnoses and treatment for major depression justified the defendant's decision to declare the policies void in their entirety. However in its final written submission the defendant accepted that what is at stake in the dispute over the failure of the second plaintiff to reveal his diagnoses is the enforceability of the amendments to the policy brought about by the grant, without knowledge of the diagnoses of major depression, of the amendments sought by the plaintiffs after the diagnoses of depression was made. In my view the concession by the defendant was due. The service alteration requests were made and granted with the intention thereby to amend the policies as they were before, and not with the intention of abandoning the policies as they were before. The amendments constituted additions to the scope of the policies.

[31] The question is, then, whether the defendant acquired a right to repudiate or avoid the amendments in question.

[32] The parties are in agreement that this enquiry is governed by s 59(1) of the Long Term Insurance Act, 1998 (which was in force at the material time, but has since been repealed). It read as follows.

'SECTION 59 – MISREPRESENTATION AND FAILURE TO DISCLOSE MATERIAL INFORMATION

- (1) (a) Notwithstanding anything to the contrary contained in a long-term policy, whether entered into before or after the commencement of this Act, but subject to subsection (2) –
- (i) the policy shall not be invalidated;

- (ii) the obligation of the long term insurer thereunder shall not be excluded or limited; and
 - (iii) the obligations of the policyholder shall not be increased on account of any representation made to the insurer which is not true, or failure to disclose information, whether or not the representation or disclosure has been warranted to be true and correct, unless that representation or non-disclosure is such as to be likely to have materially affected the assessment of the risk under the policy concerned at the time of its issue or at the time of any variation thereof.
- (b) The representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to the insurer so that the insurer could form its own view as to the effect of such information on the assessment of the relevant risk.'

[33] Counsel are agreed that the leading case on the interpretation and application of this section is *Regent Insurance Co Limited v Kings Property Development (Pty) Limited trading as Kings Prop* 2015 (3) SA 85 (SCA), a case which dealt with the same provision in the Short Term Insurance Act, 53 of 1998. The fundamental principles emerging from this judgment are the following.

- (a) Whereas at common law a full and complete disclosure of everything material to an insurer's assessment of risk had to be made, and failure in that regard would result in the insurer having a right to treat the policy as void, the legislation in question was enacted to prevent that outcome when misrepresentations or non-disclosures are trivial – see para 20. (In *Qilingele v South African Mutual Life Assurance Society* 1993 (1) SA 69 (A) Kriegler AJA identified the purpose of the then applicable legislation as protecting the insured from “inconsequential inaccuracies or trivial mis-statements in insurance proposals”.)

- (b) The test for materiality is objective. The insurer must prove that the non-disclosure or misrepresentation was material judged objectively (ie not from the perspective of an insured or an insurer). (See para 23.)
- (c) The insurer must prove that as a matter of fact the misrepresentation or non-disclosure caused it to issue the policy and assume the risk. The test for inducement is subjective. (See paras 23 and 27.)

[34] The section we are dealing with is not perfectly worded. The concept of “materiality” is raised in sub-sections 1(a) and 1(b). In the former case the representation must be one which will probably “materially” affect the assessment of risk. The word “materially” in sub-section 1(a) appears to convey that the effect that the representation or non-disclosure has upon the assessment of risk must not be trivial or inconsequential. Sub-section (1)(b) deals with what must be regarded as material. The question is whether the information ought “correctly” to have been disclosed in order to allow the insurer to form its own view as to the effect of such information on the assessment of the risk. Perhaps, reading the two sub-sections together, what is conveyed is that if, objectively, the information is of a type of which the insurer should correctly have been informed in order to form its own view of its effect on the assessment of risk, that satisfies the requirements of sub-section 1 as long as the potential effect of the assessment of risk is not so minimal as to be classified as trivial or inconsequential. However, in this case there is no need to reach any conclusion on such niceties of interpretation as, in my view, on the facts this case is clear.

[35] The exercise to be conducted in order to apply an objective test involves considering the approach of a “reasonable, prudent person”. According to the South African Oxford Concise Dictionary (2ed, 2010) the adjective “prudent” means “acting with or showing care and thought for the future”.

[36] Major depression (which as I understand it is called clinical depression amongst lay people) is a medical scientifically identifiable condition. As Professor Nair explained, it involves changes in brain circuits that actually generate discernible physical outcomes

or reactions. It is a medical condition quite distinct, explained Professor Nair, from the state of mind indicated when the word “depressed” is used in everyday language. It is generally treated with a combination of drugs and psychotherapy. As the evidence of each of Professor Nair, Dr Nowbath and Ms Maharaj reveals, one of the issues with respect to which caution must be exercised by a medical practitioner in treating such a patient is the question of suicide. In order to apply the statutory test set by s 59 of Long Term Insurance Act the “reasonable, prudent person” must be credited with knowledge of these facts.

[37] In my view on this simple basis a reasonable, prudent person would conclude that, upon an application for an amendment to an insurance policy to increase or modify cover, when the policy covers death benefits, compensation for “life changing events” of the medical variety and compensation for lost income, a diagnosis of depression has to be disclosed in order to allow the insurer to form its own view as to the effect of such diagnosis on the assessment of risk. The diagnosis is likely to materially affect the assessment of risk.

[38] The reasonable, prudent person would also pay attention to the information sought by the insurer in the application form for the variation of a policy such as the ones in question here. The earlier form, which post-dated the termination of the second plaintiff’s treatment by Professor Nair by only two months, spoke of “seeing a medical professional for any reason whatsoever”. Given what major depression is, clearly the objective answer has to be that the treatment under Professor Nair had to be correctly disclosed by the second plaintiff so that the defendant could form its own view as to the effect of that condition and treatment on the assessment of the risk it would be asked to take on.

[39] In respect of the subsequent applications postdating the diagnosis by Dr Nowbath the matter is even clearer. Depression is specifically mentioned as a notifiable diagnosis.

[40] The reasonable, prudent person would also have regard to the forms of cover available under the policy under which elevation of the insurer's risk is sought. Of course the consideration of risk in respect of life cover is fundamentally affected by the risk of suicide. As counsel for the defendant has pointed out, one of the medical conditions which generates an obligation on the part of the insurer in terms of the second plaintiff's policy is depression, albeit of an advanced type.

[41] I conclude that the objective test for materiality is satisfied.

[42] On the subjective of the test for inducement, the defendant called a Ms Cooksley, an underwriter in the employ of Discovery Life at the material time, and a Mr Gallagher who was employed by Discovery Life as New Business Underwriting Manager, a post he held at the material time. Each of these witnesses gave detailed evidence both in chief and under cross-examination on the processes followed in the underwriting office with specific reference to disclosures of depression. The cross-examination of these witnesses generated nothing but elucidation of the approach of the defendant in the case of depression. Their evidence established that if the second plaintiff had disclosed what had happened both with regard to the diagnosis by Professor Nair and that of Dr Nowbath, the result would have been a special assessment of risk by the defendant. The underwriters are assisted by a guide, the implementation of which does not deprive them of all discretion. The second plaintiff would have had to fill in a specially designed questionnaire and the psychiatrists would have been requested to provide reports. Mr Gallagher's evidence was clear that if the psychiatrist's report had revealed a diagnosis of major depressive disorder, and the existence of suicidal thoughts, he would have expected the underwriter to decline the request for an increase in benefits. I think it fair to say of the defendant's evidence on this aspect of the case, that its reaction to a diagnosis of the type made with regard to the second plaintiff is very much influenced by a view that the so-called "suicide clause" in an insurance policy is not worth that much as it is so often difficult to establish that suicide is the cause of death. For that reason when suicidal thoughts are an adjunct to a diagnosis of depression, the answer is likely to be

that the cover is declined unless reinsurance can be obtained at a considerable premium.

[43] In the circumstances I conclude that the defendant correctly claims a right to repudiate the contracts by which the insurance policies were amended after the second plaintiff was treated by Professor Nair.

[44] I now turn to the plaintiffs' claim-in-convention and the defendant's claim-in-reconvention.

[45] I should state the outset that it is regrettably necessary to record my view that on these issues this case has become, to put it politely, something of a muddle. I have already mentioned the fact that early on in the trial I was informed that the relief sought by each of the parties would be expressed in declaratory orders because of the difficulty of quantifying both claims and counterclaims. In fact at the outset of argument counsel agreed that I should make a formal order in that regard and did so in the following terms.

'An order is made that the quantification of all claims and counterclaims is separated from all other issues in the case, and is to be decided after judgment is given on those other issues.'

With the supplementary submissions from the parties I received their respective versions of the declaratory orders which ought to be granted in this case. They are in some respects not what I expected. As will be seen I propose to adopt a slightly different approach.

[46] I must make some preliminary observations before proceeding further.

(a) After the second plaintiff fell ill he made claims under the policies premised on the validity of the amendments to the contracts. Where necessary I am going to refer to these claims as "pre-litigation claims". Some of these claims were paid. They obviously do not feature in the claim-in-convention. The decision already made

above concerning the invalidity of the amending contracts means that the claim-in-reconvention for a refund on the paid pre-litigation claims is established. They fall to be reassessed under the policies as they stood prior to the invalid and void amendments.

- (b) As to the claim-in-reconvention for a refund beyond that, the decision must turn on an evaluation of the grounds stated for that relief in the claim-in-reconvention. The onus is on the defendant to establish its right to a full refund, and the grounds for that claim to be considered by the court are those pleaded and no others.
- (c) The position with regard to the unpaid pre-litigation claims is different. There the onus is on the plaintiffs. The plea denies all of the necessary conditions for the establishment of those claims. It goes on also to raise as a defence the same circumstances relied upon by the defendant to justify a counterclaim for a full refund of the paid pre-litigation claims; that is a defence of fraud with respect to which also as defendant in convention, the defendant bears the onus. (I did not understand that to be disputed by counsel for the defendant.)
- (d) A special problem which was never properly addressed before me is the fact that the claim-in-convention is not confined to the unpaid pre-litigation claims which were actually submitted to the defendant in advance of the commencement of these proceedings. The prayer for payment in the declaration is for payment of the amounts set out in annexure "POC2" to the declaration. Annexure "POC2" may make sense to a professional claims assessor employed by the defendant, but it does not to me. There is no doubt that the sum of the amounts set out in "POC2" is different to the sum of the amounts of the unpaid pre-litigation claims. When one examines annexure "POC2" one sees that it contains claims which have never been quantified, notwithstanding notes to the effect that they would be quantified prior to trial. The conditions necessary to be established in order to prove these claims are not pleaded. This generated no complaint from the defendant. Neither was there any complaint about the obtuse manner in which the prayer for payment was stated in the declaration.

[47] The starting point of the claims which are in issue in these proceedings is a diagnosis on or about 3 March 2014 by a Dr Pretorius, a cardiologist. He found that the second plaintiff suffered from symptomatic sick sinus syndrome which required that a permanent pacemaker be implanted. Thereafter the second plaintiff developed cardiomyopathy for which he was treated. Dr Pretorius was the second plaintiff's principal treating doctor and he gave evidence at length.

[48] At the request of the defendant the second plaintiff was examined by a Dr Schamroth, also a cardiologist. He diagnosed viral induced cardiomyopathy. That was initially in October 2014. The plaintiffs also called Dr Schamroth.

[49] Both of these doctors were cross-examined at some length. In the course of expressing their opinions, and stating the facts relative to their contact with the second plaintiff, these doctors relied in part on the results of tests undertaken by other medical practitioners. There was no objection made to this and there is no basis upon which to conclude that those other practitioners did not do their work properly. In particular, there were measurements by others of the so-called "ejection fraction" taken from time to time which were not disputed.

[50] I do not propose to burden this judgment with an analysis of the medical evidence. No evidence of that type was presented by the defendant in order to disturb the diagnoses of Dr Pretorius and Dr Schamroth. The issue raised and relied upon by the defendant is the capacity of the second plaintiff to work.

[51] In this regard the defendant's pleadings are confined to Dr Schamroth's work for understandable reasons. He is on the defendant's panel. His reports are relied on by the defendant when the claims assessors are in doubt or require elucidation.

[52] The second plaintiff saw Dr Schamroth twice. The first visit generated a report of 29 October 2014. Concerning what the second plaintiff said to him, a material part of the report reads as follows.

'The patient continues to remain significantly debilitated and symptomatic. His exercise capacity is markedly reduced and merely walking from the front of the hospital to the consulting rooms he had to walk very slowly and had to stop several times. He is not capable of walking up stairs. He has not been able to return to his former occupation as a medical technologist.' (My emphasis.)

After further analysis of the second plaintiff's medical condition Dr Schamroth continued as follows.

'However the patient is still functionally incapacitated and incapable of working in any form of occupation whether this is sedentary or requiring work and certainly in his previous field as a medical technologist. With his severe systemic hypotension, he will not be able to concentrate at a workstation or function to any significant degree. At the present time the patient is therefore definitely functionally disabled.'

[53] Concerning whether the second plaintiff had been able to return to work, under cross-examination Dr Schamroth was asked whether he takes what the patient says at face value. His answer was that sometimes one is confronted with a patient who makes "a meal of things". He stated that his job is to marry what the patient says with the reports on his medical condition and his medical history, and that if he does not see a conflict then he takes what the patient says at face value. Dr Schamroth's report of 29 October 2014 is certainly not short of medical analysis. He did not accept that there was any inconsistency between the diagnosed medical condition and the second plaintiff's report of his experience of it.

[54] The second plaintiff was seen by Dr Schamroth again in April 2015. That generated the doctor's report of 21 April 2015. The report once again analyses the second plaintiff's medical condition and reports on such things as the ejection fraction

and its changes. After dealing with that, the conclusion of Dr Schamroth was that in terms of cardiac function the second plaintiff was still disabled. Noting an improvement in his ejection fraction, Dr Schamroth noted that the second plaintiff “still presents with persistent hypotension and this obviously limits his ability to exert himself and become functional.” His ultimate conclusion was that the second plaintiff “still remains functionally incapacitated and I do not believe that it is at all feasible to consider him to return to work.”

[55] The defendant has set out its response to this in paragraph 17 of the plea, which is repeated in the counterclaim. It is rolled up with an allegation that the second plaintiff made fraudulent false statements in his claim forms. The defendant’s contentions may be summarised as follows.

- (a) Dr Schamroth’s conclusion is not correct.
- (b) When the second plaintiff completed the claim forms
 - (i) he stated that the last date he was physically able to perform the full duties of his occupation was 25 February 2014 (paragraph 12 of the forms);
 - (ii) the second plaintiff stated that he had not resumed the performance of his nominated occupation (paragraph 14 of the claim forms); and
 - (iii) the second plaintiff stated that he had not been involved in any occupation subsequent to the onset of his condition (paragraph 17 of the claim forms).
- (c) The second plaintiff did not provide any different information to the defendant before his claims were approved and/or paid and did not provide Dr Schamroth with different information “but rather repeated to Dr Schamroth or led him to believe that he was physically unable to perform the full duties of his occupation.”
- (d) In truth the second plaintiff was able to perform the full duties of his occupation at all material times; alternatively he was able to do so from September 2014 at the latest; and did work in his nominated occupation as a medical technician

performing professional services at Umhlanga Hospital from at least September 2014 onwards.

- (e) The second plaintiff intentionally did not tell either the defendant or Dr Schamroth that he could perform the full duties of his occupation.
- (f) Both the approval of pre-litigation claims and the payment of some of them was induced by this fraud.

[56] The evidence tendered by the defendant on the subject of second plaintiff's ability to work was somewhat disjointed. It started with the defendant's first witness, a Mr Chatzkelowitz, a claims manager employed by the defendant. He was sent to investigate the matter and in particular the theatre register at Umhlanga Netcare Hospital. He was taken to the cathlab by a Sister Viljoen. He asked for the registers for the period from the beginning of 2014 to mid-2015 (when he was there). The first one shown to him revealed that on 1 April 2015, 5 May 2015, 11 May 2015 and 13 May 2015 the second plaintiff was at the cathlab to assist in procedures being undertaken under the cardiologist Dr YT Singh. In each instance the second plaintiff was not there alone as the sole medical technologist. Nevertheless Mr Chatzkelowitz told Sister Viljoen that this was the evidence he wanted and obtained copies of those pages of the theatre register which were produced at the trial. He did not look at the remaining registers for the period in question. He explained how to read the register and stated that the access to the cathlab is via the theatres on the first floor of the building.

[57] By consent a schedule was put in indicating the use of the second plaintiff's access card to certain places within the hospital precinct, including the doctors parking and the first floor. It ran from 3 September 2014 to 13 April 2015. It indicates the use of the second plaintiff's card to access the first floor 13 times in October 2014, 21 times in November 2014, 8 times in December 2014 and 10 times in January. There are only three entries for September 2014, one for February 2015 and none for March and April 2015. The card was used for access to the doctors parking on occasions numbered in the 40s in October, November and December. In September 2014 there are 20 entries.

In January 2015 twenty three, in February eighteen, March eighteen, and April one. Except perhaps for November 2014 there is no consistent relationship between vehicle entries to the doctors parking and the use of the access card to get to the first floor where the cathlab is situated.

[58] A schedule compiled from CCTV footage of vehicles entering and exiting the hospital, relating to the second plaintiff's vehicles, lists entries between the 18th and 28th February 2015, and during March 2015, April 2015 and August 2015. The data for February 2015 does not coincide with use of the access card to the doctors parking area. Neither does the data for April 2015, although the discrepancy is minor. But in that month the card was not recorded as used to gain access to the first floor. The CCTV footage for the first seven days of April suggests two entries, whereas the card usage for the first two weeks of April suggests one entry.

[59] A Ms Singh, also a clinical technologist, and one employed by the second plaintiff, was called by the defendant. She said that access cards might have been borrowed on the odd occasion but not by her. She remembered when the second plaintiff fell ill. He was off sick immediately thereafter. There was a point in time when he began to come in again, but she could not say whether it was three, four or five weeks later; she could not remember. When he came in, according to her he performed administrative duties. When asked about his work up to the end of 2014, she said that there was an occasion where she needed his assistance especially with calculations and that she is sure she asked him to come and assist her. He assisted her on that day. The surgeon was Dr YT Singh. When asked about January 2015 and interaction with the second plaintiff in the work context she said that there were rare occasions when she was tired and it was late, and Dr Pretorius was the operating doctor, that the second plaintiff relieved her of her duties. He would take over.

[60] Some of the evidence just discussed was put to the second plaintiff in cross-examination. It was in fact put to him that in 2013 his role was supervision and administration with visits to the cathlab only occasionally. He denied that. It was then

put to him that at least from September 2014 he resumed full activities. He denied that as well. According to the second plaintiff before he fell ill the majority of the work he did was performing the full functions, that is to say the “labour intensive” functions and technical work, of a medical technologist. He said that in the latter part of 2014 he drove to the practice to see if all was in order and deal with queries with billing and payment. However Dr Singh was a special case. The second plaintiff was Dr Singh’s de facto principal medical technologist, and the person upon whom Dr Singh would rely for difficult cases. According to the second plaintiff there were occasions (he said in 2015) where Dr Singh “ordered” him to be present, if only in a supervisory position. Dr Singh was central to the practice, and at the time the second plaintiff did not want the practice to collapse, as it had been functioning with his employed technologists. However he could not wear the shielded lead robe to be inside the theatre, but would be available to monitor or check the technologist during the monitoring.

[61] Dr YT Singh was called by the defendant. He denied that he ever ordered the second plaintiff to be present during procedures, but conceded that whilst the second plaintiff’s employed technologists were well trained, and provided the service for him in the absence of the second plaintiff, the second plaintiff was something special. In a bad case he would have thought “this is one for” the second plaintiff. In my view, putting the evidence of the two of them together, Dr Singh would have liked to have the second plaintiff present for difficult cases, even if only to supervise the allocated technologist, and he was important as a client to the second plaintiff’s practice. In my view is not improbable that the second plaintiff would have regarded a request for assistance from Dr Singh as an “order” in the sense that he could not afford to say no. One has the impression, from the evidence, that Dr Singh was an important experienced senior cardiologist, and that the second plaintiff occupied a not dissimilar standing within the realm of medical technologists specialising in cardiology.

[62] Dr Singh was giving evidence seven or so years after the event, and confessed that he could not say one way or the other whether, when the second plaintiff was present, his activities were confined to the monitoring room.

[63] Reverting to what had been put to the second plaintiff in cross-examination, that he by 2013 had become an administrator with only occasional visits to the theatre, I do not find the proposition consistent with Dr Singh's evidence. There is no other evidence to support the proposition put to the second plaintiff, which is presumably why the issue of how he practised in 2013 was not pressed when he denied the proposition just referred to.

[64] I was not much impressed with the second plaintiff's demeanour when he made suggestions as to why the data of his card use, and the records from the use of CCTV footage of entries of his motor vehicle into the hospital premises, were unreliable. He suggested that perhaps an employee borrowed his card, something which appears unlikely. He suggested also that his wife may have been using his car and that he would have had to be driven into the hospital for his own medical consultations. As to the former, it is unlikely that this would have occurred that frequently, and if it did, there is no explanation as to why the second plaintiff's wife was not called as a witness. She attended the court hearing, as far as I can recall, on every day.

[65] The second plaintiff was adamant when he gave evidence that no charges were raised against the patient (which means the patient's medical aid) when he attended at the cathlab intermittently to supervise or oversee work being undertaken by his own medical technologists.

[66] It is in the light of all of the foregoing evidence that the case sought to be made against the second plaintiff for fraud in connection with the pre-litigation claims and in connection with his consultations with Dr Schamroth, must be considered.

[67] As indicated earlier there are two claim forms involved. The one was completed on 13 March 2014 and the other on 2 July 2014. The defendant has not produced any evidence whatsoever to support the proposition that the statements complained of (of which I have already given an account) were untrue as at either March or July 2014.

The principal claim, that the second plaintiff was able to perform the full duties of his occupation “at all material times” must be rejected.

[68] The second complaint with regard to the claim forms is that in answering paragraph 14 the second plaintiff stated that he had not resumed the performance of his nominated occupation. Question 14 is poorly devised. The principal question asked is not whether the claimant has resumed his nominated occupation, but whether the patient has resumed “the full duties” of the nominated occupation. The answer was in the negative. It was clearly correct at the time. There follows other questions in these sub-paragraphs.

- b. If no, when do you expect to resume your nominated occupation?
- c. On a part-time basis (partial duties)
- d. On a full time basis (full duties)."

Provision is made for the insertion of dates adjacent to each of b, c and d, although the question posed in “b” does not call for an answer by way of a date. The second plaintiff left a blank adjacent to the question “c”, and instead of inserting a date in answer to the question “d” the words “not sure” were inserted. There is no evidence and no claim that there was anything misleading in this response to question 14.

[69] The third complaint is said to be with regard to paragraph 17 of each of the claim forms, that the second plaintiff stated that he had not been involved in any occupation subsequent to the onset of his condition. The reference to question 17 must be an error. Question 17 deals with the issue as to whether, if the claimant is self-employed, the business is presently being conducted on his behalf. The answer was yes and the details were given. It seems that the defendant had paragraph 18 in mind, but overlooked that the question is not whether the claimant was involved “in any occupation”, but whether the patient was involved in “any other occupation”. The answer “N/A” appears appropriate. There is no evidence to contradict that proposition.

[70] The defendant's alternative to the proposition that the second plaintiff was able to perform the full duties of his occupation at all material times is that he was able to do so from September 2014 at the latest, and carried on doing so at the Umhlanga Hospital from September 2014 onwards. The subject matter is "full duties", that is to say the full duties performed by the second plaintiff before he fell ill. Unless one accepts that prior to his illness the second plaintiff did not practise personally as a medical technologist, earning money by his services *inter alia* in the cathlab, but was a mere administrator who supervised sometimes, the proposition contended for by the defendant is not nearly supported by the evidence I have discussed above. (I will revert to this question briefly when dealing with the subject of loss of income.)

[71] The case which the second plaintiff had to meet regarding what he told Dr Schamroth is that he intentionally failed to inform Dr Schamroth that he was physically able to perform the "full duties of his occupation". If as a matter of fact, by reason of his medical condition, the second plaintiff was unable to perform the full duties of his occupation, there can be no complaint that he failed to disclose to Dr Schamroth that he could.

[72] I accordingly conclude that the defendant's contention that it is entitled to repudiate the pre-litigation claims upon the basis that they were induced by the fraud which has been pleaded must be rejected. The result is that the alternative claim based on fraud for return of all the monies paid out by the defendant to the second plaintiff must fail. As I see it, the pleadings not having been amended prior to this judgment, I need not consider the question as to whether, if the alternative claim based on fraud had been more widely framed, the defendant might not have been entitled to judgment for the return of all of the monies disbursed by it in respect of the paid pre-litigation claims.

[73] I now turn to the question of loss of income. The onus of proof on this issue lay throughout on the plaintiffs.

[74] Although the second plaintiff did not accept it when it was put to him in cross-examination, both counsel agree that in terms of clause 7.10 of the policy (ie of the life plan guide) the income protected, because the second plaintiff practiced at all times in incorporated form, was and is (to quote the clause)

'your monthly share of fees for services rendered and gross profit from trading activities, less your monthly share of the business overhead expenses and tax.'

[75] The credit input in a case like this, where the second plaintiff is the sole shareholder and director of the incorporated practice, is total monthly fee income. That had to be proved by the plaintiffs.

[76] A company known as EMD Technologies (Pty) Limited provides a service to medical practitioners. It keeps a record of all medical aid transactions relating to a practitioner or practice. The second plaintiff subscribed to the service. His staff would load the details of all medical aid claims into the system which was sent electronically to EMD. EMD collates and sends out the claims to the medical aids. The second plaintiff accepted in evidence that the EMD records of income from medical aid is the most reliable record of medical aid income. He had a very small practice emanating from private clients. His estimate was perhaps five to ten percent. These do not feature on the EMD records.

[77] EMD records were produced and he was cross-examined on them. They cover the years 2013, 2014 and 2015.

[78] In support of his claims the second plaintiff submitted to the defendant income and expense statements which he says were produced by his bookkeepers, Crissam Consulting, covering the period March 2013 to May 2015. The second plaintiff pleaded ignorance of the basis on which these statements were drawn, saying that these matters were left to his bookkeepers. However, what he relied on is the fact that the statements show that for the period March 2013 to February 2014 he received a director's salary of

R220 000 per month, and that from then onwards he did not receive such a “director’s salary” at all. As I understand the position the defendant’s assessors, in dealing with the pre-litigation claims, worked upon the basis that the loss of income of R220 000 per month had occurred as a result of the second plaintiff’s medical condition.

[79] An analysis of the EMD statements reveals that the practice’s income from medical aid work for the years 2013, 2014 and 2015 shows that, in round figures, the annual income for those three years was, respectively, R3.1 million, R2.93 million and R3.09 million. It was put to the second plaintiff in cross-examination that what is revealed is that no loss of income was sustained at all as a result of his medical condition. Of course he denied that. The closest the second plaintiff got to an explanation was a suggestion that because actual income fluctuated quite markedly, he might have been paid out of an overdraft from time to time. He insisted that he got R220 000 per month in monies worth out of the practice (it paying things like his mortgage bond for him). No financial records of the incorporated practice were produced, and no proper financial statements, audited or otherwise. Payments by the incorporated practice to the second plaintiff on overdraft obviously do not reflect or equate to income earned by the practice.

[80] No issues of cash flow, or anything like that, can explain the disparity between the income and expense statement for the period March 2013 to February 2014, and that revealed in the EMD report. According to the income and expense statement, during that period, in which the second plaintiff is claimed to have earned an income of R220 000 per month from the practice, the turnover of the practice was R5.34 million (in round figures). The EMD report shows that the earnings from medical aid patients for that same period is R2.909 million (in round figures).

[81] Two other factors make matters even worse from the second plaintiff’s perspective.

- (a) If one compares the monthly income reflected in the income and expense statement from March 2014 (the month in which the alleged director's salary was stopped) to May 2015, one sees that it tracks, close enough, the income for those months reflected in the EMD report.
- (b) The bookkeeper who was responsible for the production of the income and expense account upon which the second plaintiff relied was not called. I was informed during the course of argument that he was available to be called but neither party chose to do so.

[82] On the evidence before me it is difficult to resist the conclusion that the page of the income and expense statement dealing with the months of March 2013 to February 2014 carries the hallmarks of fraud in that it overstates by a considerable margin the income of the practice for those months when measured against the EMD records. In addition the second plaintiff was unable to explain how it is that his income from his practice for the year ending February 2014 declared to the Receiver of Revenue in his income tax return was only R159 000. However I do not have to go any further than a finding that the second plaintiff has failed to prove any loss of income sustained by him as a result of the medical conditions upon which he relies in this action, and that he has failed to prove his income for the twelve months preceding his disablement or claimed disablement. (Digressing, I add that in my view the consistency in practice earnings between 2013 and the two following years does not establish that the second plaintiff was not an active technologist, but a mere administrator, during 2013. The phenomenon is equally well explained by the contention of the second plaintiff that his employed technologists took over all the cases he would otherwise have attended to but for his medical condition.)

[83] The defendant has in argument resisted the plaintiffs' claims for a severe illness benefit upon the basis that permanence is required, and has not been established. No other obstacle to the claim was raised or relied upon in argument. The benefits in question are dealt with appendix 1 to the life plan guide. That is divided into types of

illness, the one in question falling under section 2 of appendix 1 headed “Heart and Artery Benefit”. That section is divided into categories of severity. A claim for “permanent ejection fraction between 40% and 50%” may be made under the heading “Severity B”. The final sentence of the introduction to the section on heart and artery benefits, which precedes the table setting out events under various severity headings, reads as follows.

‘Permanence of the ejection fraction impairment will be established in two measurements taken three months apart unless otherwise proven to the satisfaction of Discovery Life.’

[84] Numerous ejection fraction measurements were made with regard to the second plaintiff over the period in question. These were summarised by defendant’s counsel when cross-examining Dr Pretorius. Those measurements taken up to and including 19 February 2015 were as follows.

DATE	PERCENTAGE
25/4/2014	45% - 48%
5/5/2014	49%
10/6/2014	43%
25/8/2014	35%
5/9/2014	24% and 23%
29/10/2014	49% - 50%
26/1/2015	49% and 38%
12/2/2015	57%
9/2/2015	44%

[85] Further measurements taken between April 2015 and May 2018 were also put to Dr Pretorius. They range between a low of 51% and a high of 62%. It was then put to Dr Pretorius that the reduced ejection fractions (which with only one exception fell between 40% and 50% when measured between April 2014 and 19 February 2015) did not prove to be permanent. Dr Pretorius answered in the affirmative.

[86] Counsel for the defendant has argued that the claim rests on actual permanence. His argument is that the provision quoted above with regard to establishing the permanence of an ejection fraction should not be read as a deeming provision; ie as one which provides that condition A will be held to prevail and be operative in certain circumstances, despite the fact that its corollary, condition B, prevails in fact. I do not think that counsel's argument follows the correct approach to the matter.

[87] The event which give rise to the insured's claim is stated in the table to be "permanent ejection fraction between 40% and 50%". Only about ten lines above that we see the section I quoted earlier, dealing with the two measurements taken three months apart. The word "permanent" does not have its ordinary meaning in the table – it is merely used as a reference to the statement in the lines above to the effect that permanence of the ejection fraction impairment will be established in a certain way.

[88] It is clear that the method for establishing permanence is fixed in order to establish a time, or even a date, upon which a right to claim under the heading accrues to the Insured. That it was wise to make such provision, (if indeed not necessary), is apparent from the fact that endless disputes, potentially leading to litigation, would otherwise result over what the word "permanent" means, and whether and when it is established, given that, as this case illustrates, ejection fractions fluctuate. It has nevertheless been rendered possible (by the words "unless otherwise proven to the satisfaction of Discovery Life") for an insured to fix the defendant with liability under the ejection fraction heading, by proving permanence by some other means. That issue does not arise in this case.

[89] With reference to the readings tabled above, counsel for the plaintiff has argued that the defendant's liability under the heading has been established because in fact two measurements taken three months or more apart evidence the ejection fraction impairment.

[90] Against that counsel for the defendant argues that the plaintiff was obliged to establish what he called “exact compliance with the deeming provision in order to establish the deemed fact”. A consideration of what is tabled above illustrates that there are no readings exactly three months apart. I find that an unbusinesslike and insensible construction of the provision, as is the argument that the formula for fixing liability does not apply if it should subsequently turn out that in fact the condition is not permanent. I mention the following amongst the considerations which point against the conclusions contended for by the defendant.

- (a) Assume the insured has tests undertaken three months apart which show ejection fractions between 40% and 50%. The claim is paid for that reason. The condition improves thereafter, for whatever reason (treatment or otherwise), as a result of which the ejection fraction is consistently above 50%. Or every now and then it is about 50%. Is the policy to be read to convey that the defendant has a claim against its insured for repayment of the amount paid under the claim? The answer is obviously in the negative.
- (b) Can the insurer (defendant) delay payment of a claim apparently properly brought under the ejection fraction heading, in the hope that the condition of the insured will improve and release the defendant from the obligation to pay the claim which has already accrued? Again, the answer is obviously in the negative.
- (c) What happens to the right of an insured to claim if a doctor’s appointment to secure a measurement can only be arranged for three months and one day after an earlier measurement showing an ejection fraction of between 40% and 50%? Does it make a difference if the period is three months and ten days; or four months? The requirement that there should be absolute compliance (ie readings precisely three months apart) is insensible and unbusinesslike. If that is what the defendant intended the provision to mean, then it intended to set a trap, something it would no doubt deny.

[91] In my view the provision must be read to convey that a minimum duration of a depressed ejection fraction of three months shall establish permanence for the purpose of the claim. Given that the provision is designed to say when “permanence” is established, the stipulation of a three month period must be read in context to mean at least three months. The period which elapsed between 5 May 2014 and 25 August 2014 (on which dates ejection fractions of 49% and 35% were measured) was three months and 20 days. The table otherwise reveals consistent readings of between 40% and 50% between April 2014 and January 2015 (with one minor exception).

[92] I find that the conditions set in appendix 1 for a claim based on an ejection fraction between 40% and 50% were satisfied in this case and reject the defendant’s arguments to the contrary.

[93] During the course of his opening address on day one of the trial, counsel for the plaintiff said the following.

‘There is a claim in “POC2” relating to permanent disability. The evidence won’t be able to establish that at this stage and it is not being pursued at this stage for the lump sum ...’

The “lump sum” in question is a capital disability claim.

[94] On the tenth and last day of the trial counsel for the plaintiffs announced that he had instructions once again to pursue such a claim which is called a “Capital Disability Benefit”, the one to be pursued being under category D. Section 7 of the Life Plan Guide deals with capital disability benefits and it is there recorded that a category D claim pays out “once it is established, to the satisfaction of Discovery Life, that you are totally and permanently unable to perform your nominated occupation (as indicated on your policy schedule) due to sickness, injury, disease or surgery.”

[95] Counsel for the plaintiffs argues that there can be no prejudice in allowing the claim to be advanced. I do not propose to address the reasons he makes for that submission because they ignore entirely the argument of counsel for the defendant, that there was evidence intended to be led in respect of the claim which was deliberately not led; and cross-examination which was intended to be directed at certain witnesses on the subject, and in particular on the question of permanence, which was not directed because it was unnecessary.

[96] Insofar as my own position is concerned as presiding Judge, when counsel said that a claim of a certain type would not be pursued "at this time", in the absence of a request for an order of separation of issues, leaving that claim to be dealt with separately from all the others, I concluded that what was intended was that the claim would be pursued in another action.

[97] I have no difficulty in deciding that I must accept what counsel for the defendant has said. He curtailed cross-examination of Dr Pretorius and did not traverse the time period after February 2016 when the second plaintiff closed his business. Amongst additional evidence which would have been led, and was not led, there is the evidence of a Dr Obell, which I am told addresses the alleged permanence of the second plaintiff's professed inability to perform his occupation. There would have been additional evidence showing activities carried out by the second plaintiff after February 2016, references to certain documents amongst the 50 or so bundles, to which reference was not made, and a viewing of certain video evidence, as well as eyewitness testimony, directed at establishing that the second plaintiff participated in activities inconsistent with a total inability to work as a clinical technologist.

[98] I accordingly conclude that the claim in question was removed from the ambit of the trial and the present action; it was in effect withdrawn and cannot be put back.

[99] The orders which I propose to make are based on the findings set out in this judgment. The second plaintiff was required to prove all the requirements for its claims

for payment, and where it has been held that it did not do so, his claim for payment must fail.

[100] The fact that the grounds for the counterclaim for repayment of the full amount actually paid by the defendant are based on

- (a) non-disclosures or misrepresentations when seeking amendments to the policies (which has been upheld in part); and
- (b) fraudulent misrepresentation on the sole basis that the second plaintiff hid his ability to perform the “full” duties of his occupation (which has been held not to have been proved)

means that, with regard to the claims paid, the defendant must live with the fact that, for instance, when pleading the alternative basis for its counterclaim for repayment, it did not rely on misrepresentation as to loss of earnings. There is in any event no order sought in the counterclaim declaring the policies void in their entirety by reason of the use of “fraudulent means or devices” to make the claims. The alternative claim for fraud is directed at the repayment of claims paid, and nothing else.

[101] I experience some difficulty in working out what to do with what I have ruled to be the plaintiffs’ failed attempt to resurrect a claim for a permanent capital disability benefit. It was certainly not the subject of a fair trial. Nevertheless it features in the pleadings. I think that an order of absolution with regard to it is the most appropriate outcome.

[102] Any order for costs which I might make in this case must be based on my findings on the merits. However counsel on both sides have approached the question of costs upon the assumption that each has achieved total success. Whilst that is understandable, it is not helpful. I have accordingly decided to reserve costs for the time being, given that this case is not over. If the issue of costs cannot be settled then it can be argued either on its own, or in conjunction with matters upon which I am asked to rule because the financial consequences of the orders which I make cannot be agreed.

I MAKE THE FOLLOWING ORDERS.

1. All amending contracts to policies of insurance numbered 513005312 (policy 312) and 5130200160 (policy 160) concluded after April 2010 by reason of the submission and grant of service alteration requests are declared void with effect from the conclusion of each such contract.
2. It is declared that each of policies 312 and 160 otherwise remains in force, subject to the payment by the plaintiffs of the outstanding premiums thereon (the defendant having rejected tenders of premiums), the amounts of such outstanding premiums to be computed after set-off against the plaintiffs' rights to repayments of premiums paid to and accepted by the defendant in respect of the void amending contracts. The said policies as they are declared to remain in force are hereinafter referred to as the "original policies".
3.
 - (a) The defendant's application to amend paragraph 54 of the claim-in-reconvention by the addition of the words "alternatively the amendments thereof" after the word "policies", and by the addition thereto of the words "alternatively the amounts paid to the plaintiffs' as benefits introduced by the amendments" is granted.
 - (b) The plaintiffs are declared to be liable and are ordered to pay to the defendant the difference between the amounts paid to the plaintiffs on claims premised on the validity of the amending contracts, and the amounts which would have been calculated under the provisions of the original policies.

4. The plaintiffs' claims for the payment of severe illness benefits for a "permanent ejection fraction between 40% and 50%" listed under the heading "Severity B" on page 115 of the Life Plan Guide are upheld to the extent that the claims are covered by the original policies 312 and 160.
5. The plaintiffs' claims for payment of temporary Capital Disability Benefits and Income Continuation Benefits are dismissed.
6. An order of absolution from the instance is made with regard to the plaintiffs' claim for payment of a permanent capital disability benefit.
7.
 - (a) The defendant is directed to deliver to the plaintiffs within 30 days a full statement of the financial consequences of the orders made above, including an accounting for premiums and mora interest, duly supported by explanatory notes.
 - (b) The parties are directed to debate the said account, with a view to reaching an agreement on it, and if agreement is reached, with a view to reaching agreement on whether and on what terms a monetary judgment or judgments should be made by this court to supplement the present orders.
 - (c) If agreement is not reached this case may be set down for hearing again for adjudication of any disputes as to the financial consequences of the orders now made.
 - (d) If the course in paragraph (c) above is followed, a clear and concise agreed statement of the disputes required to be adjudicated shall be lodged, as well as comprehensive heads of argument from each side.
8. Costs to date are reserved.

OLSEN J

APPEARANCES

Date of Hearing: Monday, 30 May 2022 and Tuesday, 31 May 2022
Wednesday, 01 June 2022 to Friday 10 June 2022
and Friday, 17 June 2022 (11days)
Final written submissions – 08 July 2022

Date of Judgment : Friday, 02 December 2022

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