
**THEORISING SOUTH AFRICA’S INSURANCE LAW
DISCLOSURES: *SWANEPOEL V BROLINK (ET
HOLLARD INSURANCE)* S638/18F**

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**[A] SIMPLE INTRODUCTION TO INSURANCE
LAW: *SWANEPOEL V BROLINK* S638/18F**

In South Africa, insurance disputes between an insurer and the insured could be settled either by the courts or alternative dispute resolution bodies, for example, the Ombudsman for Short-Term Insurance. Short-term insurance deals with movable things—such as, vehicle insurance—or, to put it another way, non-life insurance.

A standard method of obtaining insurance in South Africa is for the prospective insured or policyholder to complete a questionnaire, commonly referred to as an underwriting questionnaire, the purpose of which is to identify whether the policyholder is high or low risk. Low-risk status can only be achieved if the insured or prospective insured correctly answers the questions and makes full disclosure. In this regard, an insurer will refuse to accept liability in the event of an incorrect answer or undisclosed risk factor. This is governed by the reasonable person test, as a method of assessing what a reasonable person would have disclosed to the insurer. It is also possible to draft underwriting questions that require specific “yes” or “no” answers. Other questions can be unspecific, for example: do you know of any reason why the insurer should not accept the proposal for insurance, or is all the information disclosed true and correct? For this reason, it is not always clear how the reasonable person test should be applied to insurance contracts (commonly known as insurance policies) to understand whether or not disclosures are required by the prospective policyholder before the inception of the policy. This reasonable person test is acceptable in South African insurance law, but its application is not always understood or appreciated correctly by either the insurer or the insured.

To explain this issue more clearly, we focus on the following case involving the Ombudsman for Short-Term Insurance (an alternative dispute resolution body): *Swanepoel v Brolink*, which was decided in 2019. In brief, the insured, a Mr Swanepoel, purchased a short-term insurance policy on his vehicle. The policy inception date was 14 May 2015. On 8 April 2018, the insured caused a motor vehicle accident and the vehicle was declared a write-off. During the underwriting process (before the inception of the policy), the insurer, in this regard Hollard Insurance Company Limited acting through a binder holder (a type of agent in South Africa) Brolink Property (Limited), did not use any voice recordings to assess the risk of the insured. Instead, Brolink used a written checklist to ask the insured certain relevant underwriting questions that required simple “yes” or “no” answers, as well as requesting any additional information that the policyholder might consider important for the insurer.

After the claim was submitted by the insured (on the 8 April 2018), it was rejected by Brolink on the basis of non-disclosure prior to the inception of the policy. The underwriting question Brolink focused on in this regard read as follows: “Have you, or any other person that will be covered by this insurance, ever had an application for insurance declined or has any insurer ever cancelled your policy or refused to renew your insurance or imposed special terms or conditions on your insurance cover?” The insured answered the question with a “no”. Subsequently, Brolink investigated the “no” answer in order to understand whether “no” was indeed true. During Brolink’s investigation it emerged that the insured, Mr Swanepoel, had a previous Outsurance Insurance Company Limited claim which was cancelled by Outsurance on 17 November 2009, owing to the insured having submitted a fraudulent claim. When one reads the Outsurance repudiation letter, the phrase “fraudulent claim” is used to “cancel” the contract/policy. In other words, Outsurance did not state that the policy was void from the date of inception (due to intentional misrepresentation), but rather that it was “cancelling” the policy. In focusing on the correct terminology in contract law or insurance law, it is apparent that cancellation is a remedy for breach of contract. In this regard, we will discuss whether the insured did not commit breach of contract to allow Outsurance a cancellation remedy. In addition, one can argue that the Outsurance legal department should have used the correct legal terminology, for example the word “void” instead of “cancellation”.

Whatever the case, Brolink did not have a legal department when the insured, Mr Swanepoel, submitted the claim. In this regard, Brolink was simply using a “compare and match” approach (the word “cancellation” in the Outsurance repudiation letter having matched Brolink’s

underwriting question) without considering the correct meaning of the term “cancellation” in the law of insurance. For this reason, Brolink focused on the “no” answer and consequently argued non-disclosure on the Brolink application form—the answer should have been “yes”, because the question contained the word “cancellation”. This was unfortunate and was probably used opportunistically so as not to accept the insured’s claim, even after the insured informed Brolink of the incorrect use of the term “cancellation” in the Outsurance letter. Brolink argued that had it known about the cancellation by a previous insurer, it would never have issued the policy to the insured.

However, Brolink also did not consider the end result of a court case decided in 2012 to understand the correctness of the “no” answer. The police investigated the Outsurance claim for fraud, and eventually the state prosecutor referred to the matter as *nolle prosequi*, in other words there was no evidence of any fraud committed by Mr Swanepoel. By focusing on the latter *nolle prosequi* it indicates that the Outsurance repudiation letter had no legal relevance and that no legal weight could be attached to it—no fraud was committed and therefore no “cancellation” could have occurred for repudiating the Outsurance claim. On this basis, Brolink could not have relied on the non-disclosure of a previous “cancellation” or “fraud” because of the *nolle prosequi* court order. By ignoring the true legal meaning of “cancellation” as a contractual remedy for breach of contract, Brolink’s investigations were therefore unreliable when one considers the factual circumstances relevant to *nolle prosequi*. Nevertheless, on 6 August 2019, the assistant short-term ombuds, Ayanda Mazwi, delivered her judgment as to why the claim submitted on 8 April 2018 by the insured, Mr Swanepoel, should not be honoured by Brolink:

Having regard to the insured’s submissions, our office gave the binder holder (Brolink) an opportunity to provide reasonable proof of the insured’s actual knowledge of Outsurance’s cancellation of the policy prior to underwriting this risk in May 2015. The binder holder was not able to satisfy this request. *It did however point out its reliance on the following declarations made by the insured in the underwriting documents.* (emphasis added).

From the above, it is clear that Brolink was unable to provide any reasonable proof of actual “cancellation” and “fraud”, owing to the fact that the Outsurance policy was never truly cancelled and there was never fraud committed. However, Brolink continued with other underwriting questions in the application form as a method to reject the insured’s claim and relied on the following underwriting question:

The insurer or binder holder could repudiate a claim if they find that information given was incorrect. *Can you please confirm that all of the information* you have supplied pertaining to this application for insurance is correct and that you do not know of *any reason* why an insurer should not grant you cover for the property to be insured? [the insured answered] no (emphasis added).

The reason why the insured, Mr Swanepoel, answered “no”—to the above question quoted—is that Outsurance reported the 2009 claim to the South African Police Service for investigation purposes to prosecute the insured for giving an intentional instruction to a friend to write off his vehicle. The police investigated the matter which was eventually classed as *nolle prosequi* by the state prosecutor, meaning that the state was unable to prosecute the insured since the police had obtained evidence that the insured did not commit any fraud. Bearing this in mind, it seems that the above answer (the insured’s “no”) is the correct answer. However, the assistant to the ombuds held that the insured had a duty to disclose the *nolle prosequi*, without requesting the insured for an oral explanation of *nolle prosequi*. The assistant ombuds stated that a reasonable person would have disclosed this fact to Brolink during the underwriting process. Owing to this non-disclosure of “any other reason”, the assistant ombuds rejected the insured’s claim. Be that as it may, a reasonable person test was also used by Profmed Medical Scheme to reject an insured’s medical aid claims based on non-disclosures. The paragraphs that follow show the different interpretations relevant to the reasonable person test to distinguish between reasonable and unreasonable disclosures in insurance law.

**[B] MIGNON ADELIA STEYN V PROFMED
MEDICAL SCHEME CASE NO: 23378/2018,
2021 (3) SA 551 (WCC)**

Mignon Adelia Steyn applied for Profmed Medical Aid membership in November 2015. Her membership commenced on 1 January 2016, and, during that year, the policyholder, Ms Steyn, underwent several medical procedures amounting to ZAR400,000. Profmed, the insurer, refused to settle these claims on the basis of non-disclosure, subsequently terminating the policyholder’s membership owing to non-disclosure of gastritis, breast aspiration, wrist pains and hip problems. We do not have access to the Profmed underwriting questions, but we believe they were non-specific answers to questions similar to those of Brolink: for example, “Do not know of any reason” in response to why the insurer should refuse to accept the application. The insurer, Profmed, argued that these medical

conditions were not disclosed by the prospective policyholder prior to her acceptance as a member of Profmed. We believe that Profmed could have, instead of rejecting the claims, applied a specific weight attached to wrist pains, breast aspiration, gastritis and hip problems to calculate an additional monthly premium for the policyholder and to deduct it from the claim amount, to equal the premium to the undisclosed risk as a method of honouring the claim submitted. However, Profmed did not consider the later as an option, and to resolve the dispute the policyholder approached the Registrar of Medical Schemes (an alternative dispute resolution body) in relation to section 47 of the Medical Schemes Act 131 of 1998. The Registrar held that a reasonable person would have considered the latter non-disclosures and would have at least disclosed gastric ulcers as material medical information to Profmed and the termination of the policy was therefore justified.

The policyholder subsequently lodged an appeal against the Registrar's decision with the Council for Medical Schemes (also an alternative dispute resolution body) in terms of section 48 of the Medical Schemes Act. During the appeal process, the policyholder also applied for medical aid from Momentum Insurance and subsequently did add gastritis, breast aspiration, wrist pains and hip problems to the application form to secure membership. During the Council for Medical Schemes hearing, Profmed's legal representative used this Momentum application form to support the importance of the non-disclosed gastritis etc. In other words, Profmed used the Momentum application form for the sole purpose of illustrating why a reasonable person would have disclosed these ailments on an application form.

Keeping this application form in mind, the contrary is also true and correct: that is, a reasonable person could consider gastritis, breast aspiration, wrist pains and hip problems to be unimportant medical information. Surely gastritis is not similar to gastric ulcers, wrist pains are not equal to osteoarthritis, and hip problems are not an indication for hip replacements. In addition, breast aspiration is conducted on most women at least once in their life time to detect breast cancer. By comparing these non-disclosures to other similar severe medical conditions like breast cancer, hip replacements, gastric ulcers, osteoarthritis and the like it is possible to argue that on the date of completing the Profmed application form, these non-disclosures were not high-risk medical conditions. To support this, we assume that Profmed's software program for calculating premiums did not assign any weights to these medical procedures or conditions since the court did not indicate which underwriting questions were answered "no". On the other hand, Profmed has been insuring

policyholders for the past 60 years, and we believe that any medical aid application form would contain specific underwriting questions relevant to all severe medical conditions. To support the above views, the Council held that breast aspiration is not a material non-disclosure, in other words it is not a severe medical condition that justifies rejection of claims. This is probably the real reason why Profmed has not included breast aspiration as a specific underwriting question, since it is considered non-material by the medical profession. However, according to the Council, gastritis (although not as severe as a gastric ulcer) and hip problems are considered material facts and should have been disclosed to Profmed. As stated previously, hip problems do not necessarily indicate hip replacements and wrist pains are not necessarily indicative of osteoarthritis; in addition, the Council did not consider which type of gastric ulcer the policyholder suffered from or why hip arthroscopy is a serious medical condition. The Council also did not ask the policyholder for an explanation of these conditions to understand their seriousness. Accordingly, the Registrar and the Council applied the same reasonable person test with two different end results, namely that hip arthroscopy was considered a non-material disclosure by the Registrar but not by the Council. It should be borne in mind that the policyholder is not a medical practitioner but a layperson; hence, why would she have disclosed hip arthroscopy if she were not suffering constant pain nor had any expectations of hip replacements? Nevertheless, the matter was appealed to the Appeal Board (another alternative dispute resolution body) in terms of section 50(3) of the Medical Schemes Act. To consider how difficult it is to understand whether a disclosure is truly required or not, the Appeal Board considered the Momentum application form as well.

[C] THE APPEAL BOARD AND THE HIGH COURT

Before we focus on the gastric ulcer and hip arthroscopy, one should keep in mind that Profmed added additional non-disclosures which were not previously communicated to the applicant and presented those non-disclosures to the Appeal Board to justify the rejection of the claims submitted. The non-disclosures that were added later were the following: possible heart murmur and kidney stones. As stated earlier, generally the calculation of a premium is based on a software program which requires relevant information. If the application form does not contain a specific question pertaining to a gastric ulcer, it is probably because it is considered to be a non-serious medical condition. To a certain extent, this also happened to the insured in the Brolink matter discussed earlier: after

the assistant ombuds realized the inappropriateness of “cancellation”, she turned to other non-disclosures to reject the insured’s claim, for example an undisclosed *nolle prosequi*. Nevertheless, the Appeal Board argued that it is not restricted from considering new arguments based on “new” undisclosed information, since it may consider all information and new information relevant to non-disclosures afresh, for example hip arthroscopy, possible heart murmur and kidney stones. Hip arthroscopy is not a hip replacement, a heart murmur is not heart failure and kidney stones are a common medical condition suffered by many people. These medical conditions are not serious and a software program can attach a specific weight to each condition, having the potential to increase the monthly premium or to be deducted from the claim amount instead of rejecting the claim, as will be discussed later.

Subsequently, the policyholder appealed to the High Court which held that the Appeal Board had made an error in law by not allowing the policyholder an explanation of the relevant non-disclosures and/or to put these non-disclosures in context. The Court held that it is very important to follow the principle of *audi alteram partem* to understand the policyholder’s explanation of these medical conditions—for example kidney stones or the difference between hip replacements and hip arthroscopy—to put the reasonable person test in perspective. To illustrate the importance of this, Profmed abandoned the applicant’s hip problem as a non-disclosure and, instead, raised hip arthroscopy as a non-disclosure to the Appeal Board based on the Momentum application form. The applicant/policyholder was never required to explain how serious hip arthroscopy was. These actions could also be examples of the *in fraudium legis* principle or doctrine. In other words, Profmed’s original arguments and additional arguments were raised with the sole purpose of circumventing liability for the policy (the policy is a contract between the insurer and insured). The High Court held that the onus was on Profmed to prove the materiality of any non-disclosure and why the non-disclosure amounted to a severe medical condition or conditions. The court held that, for the reasons stated above, the policyholder had disclosed all relevant information to Profmed and as a result Profmed should be liable to settle the ZAR400,000 medical claims, as the above non-disclosures (kidney stones, gastric ulcer, hip arthroscopy and heart murmur) were non-material or did not comprise severe medical conditions that could justify a rejection of the policy or claims. Needless to say, Profmed appealed the High Court judgment to a full bench of the High Court (hereafter appeal judgment).

[D] APPEAL TO THE FULL BENCH OF THE
HIGH COURT IN *PROFMED MEDICAL SCHEME*
V MIGNON ADELIA STEYN CASE NO: A
171/2021, [2021] ZAWCHC 60

Profmed appealed the Western Cape High Court decision in *Profmed Medical Scheme v Mignon Adelia Steyn* due to the court a quo's interpretation of what constitutes material non-disclosures, for example gastric ulcers, possible kidney stones, hip arthroscopy and possible heart murmur. The appeal judgment is not complicated, amounting to approximately 12 pages in total. Profmed asked the High Court whether gastritis and hip arthroscopy are in fact material non-disclosures in addition to heart murmur and kidney stones etc. The court focused on the Momentum application form which stated that the policyholder suffered from a gastric ulcer, gastric influenza and certain hip arthroscopies. When Profmed referred to the Momentum application form to avoid the contract between Profmed and the insured, the respondent's legal counsel argued "trial by ambush" or, in other words, *in fraudium legis*. The Council for Medical Schemes established that the policyholder had been admitted to hospital previously for the treatment of a gastric ulcer. The court held that the gastric ulcer and hip arthroscopy were therefore pre-existing medical conditions but did not indicate whether these were serious medical conditions. Kidney stones, for example, could also be a pre-existing medical condition, although they do not generally constitute a serious condition. The court emphasized that Profmed could add any other ground or grounds to support their actions to refuse to settle the ZAR400,000 claim since informal tribunals as alternative dispute resolution forums, such as the Appeal Board, are not bound by the principles of law of evidence: for example the *audi alteram partem* rule is not required to explain these conditions (by leading oral evidence whether they are life-threatening conditions or not). The court held that gastritis could be a serious medical condition and that a medical scheme would most likely increase the monthly premium and/or include a waiting period (of at least 12 months before a policyholder could submit claims) for gastric ulcers claims. In this instance, the exact details of the ZAR400,000 claim were not presented to the court—we do not know whether these claims related only to gastric ulcers and or hip arthroscopy and so forth. For this reason, the most appropriate method would be to implement a waiting period to avoid settling those gastric ulcers or hip arthroscopy claims or add an additional amount to the usual monthly premium to be deducted from the claim, as will be discussed later. For this reason, the court

held that a reasonable or prudent person would have disclosed gastritis and hip arthroscopy only on any application form for any medical aid option or scheme. To understand why the prudent person would have disclosed this, the court focused on the following relevant information: the policyholder underwent an emergency procedure for the treatment of a gastric ulcer. By applying logic, the court held that this non-disclosure was in fact reasonable—a reasonable person would have disclosed previous gastric emergency procedures on an application form. However, the court did not consider how long ago this emergency procedure occurred—15 years ago? And or whether it could still be relevant in the present. Based on this view, the court held that all the informal tribunal bodies (the Medical Registrar, Council of Medical Schemes and Appeal Board)—of which the presiding officers comprise experts on medical conditions—had decided correctly regarding the gastric ulcer and hip arthroscopy, and the technical arguments that the policyholder was given no opportunity to reply to or to explain the gastric ulcers or hip arthroscopy in context were therefore irrelevant.

[E] REVISITING THE *SWANEPOEL V BROLINK* OMBUDS CASE

It is apparent that the Ombudsman for Short-Term Insurance decides on its own procedures for settling a complaint: this includes not taking the law of evidence into account since the Ombudsman is also part of an informal tribunal or dispute resolution system in the insurance industry. The insured, Mr Swanepoel, followed the rules of the Office of the Ombudsman for Short-Term Insurance to appeal the assistant ombuds' judgment to the Ombudsman. However, in 2019 there were no rules on how the complainant should be lodging an appeal to the Ombudsman or how to draft such an appeal on the website of the Short-Term Ombudsman. The Office simply required that documents on record be forwarded to the Ombudsman. The ombuds, Deanne Wood, once again focused on the reasonable person test and that such a person would have disclosed fraud and/or cancellation to Brolink—the ombuds also ignored the legal consequences of *nolle prosequi*, as discussed earlier. The insured, Mr Swanepoel, petitioned the ombuds decision to the chair of the Appeal Board for Short-term Insurance (an alternative dispute resolution body).

The chair is a retired Constitutional Court Judge, Justice Sandile Ngcobo. Justice Ngcobo delivered his judgment in this matter in two pages. Justice Ngcobo held the view that no other court or tribunal would consider the matter differently and the appeal was therefore dismissed.

In other words, the application of the reasonable person test was applied correctly by the assistant ombuds and the ombuds—*nolle prosequi* should have been disclosed on the application form. On the other hand, logic would therefore dictate that if no fraud were committed, then the non-disclosure of fraud or cancellation is in fact non-material and irrelevant. The latter was clearly explained in *Ristorante Limited t/a Bar Massimo v Zurich Insurance plc* (2021) and could be viewed as a very good example for the South African judiciary and or alternative dispute resolution bodies of why no emphasis could be placed on unspecific underwriting questions, such as: have you disclosed all relevant information to the insurer or is there any reason why the insurer would not cover you? Nevertheless, we believe that the retired Constitutional Court Judge could also have considered the following instead of rejecting Mr Swanepoel's claim.

Generally, the calculation of monthly premiums is based on a software program, which needs the answers provided to underwriting questions to calculate the monthly premium. One could argue that most underwriting application forms probably do not include a question that requires an answer regarding *nolle prosequi* and, therefore, the software program does not take it into account and nor does it consider it to be important information when calculating the monthly premium. In this instance, we may assume that no weight is attached to *nolle prosequi*, since if it were an important risk factor an application form would require its disclosure (specifically) for calculating the monthly premium in exchange for cover of the insured's property. As a rule, the insurer can always claim the additional monthly premium at the claim stage or deduct the additional monthly premium from the claim in the event of a non-disclosure. For example, undisclosed *nolle prosequi* equals ZAR100 per month extra on the premium and the monthly premium payable on a vehicle is ZAR500. After 12 months, the insured submits a claim and the insurer realizes *nolle prosequi* was undisclosed. Instead of rejecting the claim, the insurer could use the following calculation: if the claim is ZAR10,000 and the ZAR100 spread over 12 months equals ZAR1200, the insurer will pay only ZAR8800 to settle the claim. The latter option is far better than rejecting the claim as a result of an undisclosed *nolle prosequi*. The assistant ombuds in the *Swanepoel* case could have asked Brolink what the monthly premium would have been in the event of a non-disclosed *nolle prosequi* as calculated by their software program, if any.

[F] CONCLUSION

From the above it is clear that what constitutes reasonable disclosures is by no means clear. It is an inexact science, influenced by the interpretation of the factual circumstances—without the law of evidence applying to informal insurance tribunals. It is clear that it is a flexible test when indicating what a reasonable person would have disclosed or not. However, the reasonable person is not a super human; the reasonable person can make mistakes, even honest mistakes that are relevant to disclosures. On the other hand, it is possible that non-disclosures that are non-reasonable could allow an insurer to reject a policy or to reject the claims subsequently submitted, for example the *Swanepoel* matter as discussed earlier. Instead of rejection of claims, it is possible for the insurer to calculate the correct premium and either deduct the difference in premium from the claim amount or ask the insured/policyholder to pay the extra amount to the insurer. One must keep in mind that, after being in business for 60 years or so, Profmed as an insurance company should be able to draft effective underwriting questionnaires—application forms that contain specific questions and require specific answers to those questions. Even after all this time, South African insurers are still making use of non-specific questions as a method of rejecting the policy or the claims received. For this reason, alternative dispute resolution bodies and or the courts of South Africa should take note of *Ristorante Limited* pertaining to unspecific underwriting questions, for example, to disclose “all of the information” to the insurer, and that such a question should be rejected by alternative dispute resolution bodies and or courts on the basis of unreasonableness.

About the author

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Cases

[Mignon Adelia Steyn v Profmed Medical Scheme Case No: 23378/2018, 2021 \(3\) SA 551 \(WCC\) paras 20-32, 37 & 44-47 \(Lekhuleni AJ\)](#)

[Profmed Medical Scheme v Mignon Adelia Steyn Case No: A 171/2021, \[2021\] ZAWCHC 60 paras 5-15 & 25-35 \(Baartman, Steyn and Wille JJ\)](#)

Ristorante Limited t/a Bar Massimo v Zurich Insurance plc Case No: BL-2020-MAN-000035 Manchester Circuit Commercial Court (QBD), [2021] EWHC 2538 (Ch) electronic pages 4-9 (Snowden J)

Swanepoel v Brolink (et Hollard Insurance) S638/18F 5 December 2019 pages 1-2 (Chairman of Appeal Sandile Ngcobo J)—the decision is attached as an Appendix to this article.

Swanepoel v Brolink (et Hollard Insurance) S638/18F 6 August 2019 pages 1-7 (Assistant Ombudsman Ayanda Mazwi and Ombudsman Deanne Wood)

Legislation, Regulations and Rules

Medical Schemes Act 131 of 1998

PETITION BEFORE THE CHAIRMAN OF THE APPEAL TRIBUNAL

Policy Claim No: 00271980005

Ref: S638/18F

IN Re:

MR. FREDERICK SWANEPOEL

Petitioner

And

HOLLARD INSUREANCE CO LIMITED

Respondent

DECISION

1. The Petitioner is seeking leave to appeal against the Formal Ruling of the Ombudsman. Petitioner had submitted a claim to the Insurer. This claim was rejected by the Insurer and his insurance policy was cancelled. The reason offered was “Undesirable Risk”. He subsequently submitted a complaint to the Ombudsman. In response to the complaint, the Insurer argued that the Petitioner had a duty to disclose the fact that in 2009 he had a claim rejected and his policy cancelled.
2. The Ombudsman found that the Petitioner was under a duty to disclose the fact that previously, he had an insurance claim rejected and his policy cancelled by OutSurance on account of fraud and dishonesty. It concluded that the Insurer was entitled to reject Petitioner’s claim and cancel his policy. He unsuccessfully applied for leave to appeal.

3. I have considered the Petition Against the Refusal of Leave to Appeal together with the supporting documents.
4. I am satisfied that there are no reasonable prospects that the appeal, either in whole or in part, if prosecuted, will succeed.
5. In the event, I make the following decision:

**THE DECISION OF THE OMBUDSMAN NOT TO GRANT LEAVE TO
APPEAL IS HEREBY CONFIRMED.**

A handwritten signature in black ink, reading "Sandile Ngcobo", written over a horizontal line.

JUSTICE SANDILE NGCOBO
CHAIRPERSON OF THE APPEAL TRIBUNAL
DURBAN
5 DECEMBER 2019