REPUBLIC OF SOUTH AFRICA

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

Case Number: 29108/22

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

13 -12-2024
DATE

[redacted]
SIGNATURE

In the matter between:

NAVIGARE SECURITIES (PTY) LIMITED	First Applicant
PAMELLA MONGOATO RADEVE N.O.	Second Applicant
and	
VICKERS AND PETERS FINANCIAL PLANNING (PTY) LTD	First Respondent
DISCOVERY LIFE LIMITED	Second Respondent

This matter was heard in open court and disposed of in terms of the directives issued by the Judge President of this Division. The judgment and order are accordingly published and distributed electronically.

JUDGMENT

KUBUSHI J

Introduction

[1] This is an opposed exception taken by the second defendant against the first and second plaintiffs' particulars of claim. The basis of the exception is that the particulars of claim lack the averments necessary to disclose a cause of action and/or are vague and embarrassing. During oral argument, emphasis was, however, placed mainly on the failure to disclose a cause of action.

[2] The matter revolves around an insurance policy ("the policy") claim. The policy in question is a Group Insurance Policy underwritten by the second defendant as the insurer, whilst the first plaintiff is the insured and/or policy holder. The policy cover is meant for the employees of the first plaintiff. The second plaintiff is the executrix in the estate of the late Mr Vuyisile Onesmus Radebe, one of the employees of the first plaintiff who has since passed away ("the deceased").

[3] The first defendant, pursuant to a mandate given to it by the first plaintiff, acted as the first plaintiff's financial services provider as provided for in section 1 of the Financial Advisory and Intermediary Services Act 37 of 2002. The first defendant, as such, acted as the agent of the first plaintiff in procuring the insurance policy in question.

[4] It was stated during oral argument that this was not the first exception taken by the second defendant. It is actually the third exception. The first exception was upheld by Yende AJ on 21 August 2023 on the basis that the first and second plaintiffs failed to allege fulfilment of a condition precedent for the insurer's liability under the policy, in the particulars of claim. The plaintiffs were granted leave to amend the particulars of claim.

[5] The plaintiffs amended the particulars of claim on 7 September 2023, which appeared not to be to the satisfaction of the second defendant. On 29 September 2023, the second defendant gave the plaintiffs notice to remove causes of complaint before it could except again. The plaintiffs amended the particulars of claim but the second defendant still excepted. The plaintiffs amended their particulars of claim again on 14 December 2023 but the second defendant noted another exception on 25 January 2024. The current exception is thus aimed at the last amended particulars of claim.

Background

[6] The claim emanates from a written contract of insurance entered into between the first plaintiff and the second defendant. Initially, the first plaintiff had engaged the services of the first defendant to act as its agent to procure insurance products ("the products") for the benefit of the first plaintiff's employees. The products sought to be procured were a life cover benefit, payable on the event of death of an employee, and a monthly income continuation benefit payable in the event of disability. The first defendant proposed that the products be placed with the second defendant.

[7] The second defendant provided a written quotation which the first defendant presented to the first plaintiff for the placement of the products with the second defendant. The first plaintiff accepted the quotation. The second defendant, in a written letter of acceptance, gave notice of acceptance of risk in accordance with the quotation and confirmed the installation of the first plaintiff's Group Risk Life Plan. This culminated in the first plaintiff and the second defendant concluding a written contract of insurance on the terms and conditions set out in the Group Risk Life Plan Guide and Benefit Schedule.

[8] In terms of the Group Risk Life Plan it became compulsory for all the employees of the first plaintiff who entered service on or after the commencement date of 1 April 2013, to be members of the Life Plan. Some of the salient terms of the Group Risk Life Plan are that:

a. all benefits available under the policy are limited to the free cover limit set out in the Benefit Schedule;
b. cover in excess of the free cover limit will only be granted once the required medical evidence of health has been submitted to the satisfaction of the second defendant;
c. on receipt of the medical evidence, the second defendant will give the member an underwriting decision in writing; and
d. the second defendant will pay the death benefit as set out in the Benefit Schedule to the first plaintiff or another person if requested so by the first plaintiff.

[9] The Benefit Schedule, on the other hand, set out the benefits to which the employees/members of the scheme are entitled to or rather the cover provided by the second defendant to the employees/members of the scheme. The Benefit Schedule provided for free cover which was stated as nil, and full cover for the benefit schedule disability (called income continuation benefit) which was 75% of the monthly income of an employee, and life cover (death benefit) which was five times of the employee's annual salary. The premiums were calculated on the basis of the cover that is provided for.

[10] The Group Risk Life Guide and a Benefit Schedule are attached as annexures to the particulars of claim. Furthermore, a quote provided by the second defendant to the first plaintiff showing what is to be covered, that is, the underwriting requirements, is also attached to the particulars of claim. It states, amongst others, the names of the original members of the scheme and the cover provided, which is cover in excess of free cover limit and that they will be required to provide medical evidence of good health for the amount of cover that exceeds free cover. The quote also states that the medicals which will be required will be sent to for each Individual.

[11] The deceased is one of the employees that joined the scheme when he became an employee of the first plaintiff. Almost eight months after joining the scheme he was diagnosed with a terminal disease known as motor neuron disease (MND) or amyotrophic lateral sclerosis (ALS) to which he finally succumbed. At the time of becoming a member of the scheme, the deceased was not requested nor did he provide the medical evidence of health. The second defendant only asked him to provide the relevant medical evidence of his health when he had already been diagnosed with MND. The plaintiffs and the second defendant are at loggerheads as to who, between the second defendant and the deceased, was supposed to provide the evidence of health when cover was provided.

[12] Due to the deceased's illness, the first plaintiff submitted a claim to the second defendant for payment of the full cover in respect of the income continuation benefit. This, as the plaintiffs submit, was because the deceased during his lifetime paid a monthly premium that was calculated on the full benefit cover. The second defendant partly paid the claim in an amount which it determined to be the free cover limit.

[13] Pursuant to the deceased's death, the first plaintiff submitted a claim for full cover in respect of the life cover benefit. The second defendant, again, partly paid the life cover benefit in an amount which it determined to be free cover limit, and refused to pay the amount in respect of full cover contending that the deceased had failed to submit relevant medical evidence of good health in order to qualify for full cover.

[14] In this action, the plaintiffs claim payment of the difference between the full cover and the payments received from the second defendant.

Issue for Determination

[15] The crux of this matter is currently whether the exception sought by the second defendant should be granted. Underlying this issue is the determination of the main dispute between the plaintiffs and the second defendant in regard to the provision of the medical evidence of health, and whether the condition to provide medical evidence was a condition precedent. The first question requires an answer as to who bore the responsibility for the provision of the medical evidence of health. It is the plaintiffs' contention that the responsibility fell on the second defendant whilst the second defendant's argument is that it fell on the deceased. The determination of these underlying issues will provide guidance as to whether the exception ought to be granted or not.

Arguments

[16] The second defendant based the exception taken on four grounds. Three of the grounds pertain to the plaintiffs' claims and the fourth relates to the standing of the second plaintiff in these proceedings. To the contrary, the plaintiffs, in opposition to the exception, contend that the grounds of exception raised by the second defendant are unmeritorious and ought to be dismissed.

First Ground of Exception

[17] The first ground of exception is according to the second defendant based on a foundational, fundamental principle of the law of contract, which is the doctrine of the law of privity of contract. Essentially, the doctrine is that unless you are a party to a contract, you cannot sue under that contract. Based on this doctrine, the second defendant contends that the second plaintiff, not being a party to the contract of insurance, has no *locus standi* in these proceedings.

[18] The argument is that since the policy which is a Group Life Policy, was taken out by the first plaintiff as the employer for its employees, it is the first plaintiff that is the insured and policy holder in terms of the policy and not the employees of the first plaintiff. This, according to the second defendant, means that there is a contract between the first plaintiff as the insured and the second defendant as the insurer. There is thus no contract or any contractual relationship between the members of the scheme (the employees) and the insurer. Consequently, members of the scheme do not acquire any direct or other rights against the insurer.

[19] The second defendant contends further that there is simply no basis for the conclusion that the deceased, as a member of the scheme, was a contractual party to the policy. The policy provisions are also not indicative of the intention by the contracting parties that members and/or beneficiaries should be parties to the contract. To the contrary, so it is argued, the indication is quite clear that members and/or beneficiaries are not intended to become parties to the policy. In that sense, the policy does not constitute a *stipulatio alteri* and, as such, no privity was created between the insurer and the deceased. By extension, there is no privity of contract between the insurer and the executrix of the estate of the deceased, so the argument goes.

[20] In response to this ground of exception, the plaintiffs submit that the second plaintiff, in her capacity as executrix of the deceased estate, is entitled to claim payment of the income continuation benefit which was payable to the deceased during his lifetime, when he became incapacitated due to illness, together with payment of the life cover benefit, as the policy provides for payment of the death benefit to the first plaintiff or to another party if so requested by the first plaintiff. The first plaintiff instructed the second defendant, in accordance with the policy, to make payment of the income continuation benefit to the deceased during his lifetime, on account of his disability, and to pay the life cover benefit to the second plaintiff, upon the deceased's death.

[21] The plaintiffs go further to argue that the obligation to pay the proceeds that are due by the second defendant to second plaintiff, in her capacity as executrix, is on account of the instruction given by the first plaintiff to the second defendant in terms of the policy and, therefore, the right to claim such proceeds confers *locus standi* on

the second plaintiff, giving her a direct interest in the matter which is not too remote but is an actual and existing interest.

Second Ground of Exception

[22] The second ground of exception takes aim at claim 1 in the particulars of claim which is based on the alleged waiver of the right to call for medical evidence. It is alleged in claim 1 of the amended plaintiffs' particulars of claim that the second defendant either expressly or tacitly waived the right to call for medical evidence or failed to call for medical evidence within a reasonable time after the deceased was admitted into the scheme.

[23] The second defendant submits that in terms of clause 4 of the policy, it has a right to call upon all employees/members of the scheme and their dependants to submit to such medical examinations and tests as it deems necessary during the currency of the policy, and that such request is to be made directly to the employees/ members of the scheme, or their dependants with the same legal consequences. The contention by the second defendant is that the defect in the particulars of claim is in that the allegation made is that this right, that is the right to call for medical examination, was waived, when they, in fact, should have alleged that the condition precedent was waived.

[24] The second argument on this ground is that the facts which the plaintiffs allege constitute the waiver, are inadequate to establish a waiver and thus render claim 1 fatally defective. The defect is in that the plaintiffs failed, in the particulars of claim, to allege waiver of, in particular, the condition that the second defendant must accept the medical evidence and issue the underwriting decision accepting the risk. According to the second defendant, the component parts of the condition precedent are, the medical evidence and the written undertaking of acceptance of risk. So, the plaintiffs' inference to waive the right is not sufficient to get around the condition precedent, if the waiver of the condition precedent is not pleaded – all components thereof. The submission is that the plaintiffs should have, in essence, alleged that the second defendant waived the requirement that it be satisfied with medical evidence and that if it so satisfied, it issue an underwritten decision accepting the risk, having failed to do so, their claim is defective.

[25] The plaintiffs' argument in defence of this ground of exception is that they do not rely on the suspensive condition for purposes of the first claim of waiver because from inception the policy was never suspended, but was implemented with full cover. They, further, contend that there are allegations in the particulars of claim which state that the insurance policy made provision for the second defendant to request medical evidence from members, that is, from those members who have full cover. The duty, as the plaintiffs submit, was always on the second respondent to request medical evidence from the employees who would not know what tests they must go for in order to qualify for full cover. This duty was never a condition precedent because nowhere in the papers is it said that it was a condition precedent.

[26] Of importance is that the insurance policy was never suspended but came into effect immediately. This is so because the deceased was required to pay the premium for full cover as of day one. The deceased wanted full cover and this is what he contracted for and agreed to pay the premiums for. No free cover could have been provided to the deceased because free cover was stated as nil in the Benefit Schedule, whereas full cover for the benefit schedule disability (called income continuation benefit) was 75% of the monthly income of an employee and full cover for life cover (death benefit) was five times of the employee's annual salary. The deceased's premiums were calculated on the basis of the cover that was provided for, that is, full cover. The deceased could not have taken out a policy and have no cover and yet be expected to pay a premium for full cover. The policy was not suspended and the premiums were paid to get full cover, so it was argued.

Third Ground of Exception

[27] The third ground of exception relates to claim 2 which is said to be based on the doctrine of fictional fulfilment. In the amended particulars of claim, the plaintiffs make the following allegations: firstly, that the policy was subject to the suspensive condition that cover in excess of the free cover limit will only be granted once the required medical evidence has been submitted; secondly, that it was a tacit term of the contract that the second defendant was obliged to request the relevant medical evidence within a reasonable time of not more than 30 days of the deceased becoming a member of the policy; and that the second defendant deliberately prevented the

deceased from submitting the required medical evidence by failing to request same, thereby preventing the fulfilment of the suspensive condition.

[28] The submission of the second defendant, in this regard, is that the suspensive condition upon which the plaintiffs rely for this claim is the condition precedent upon which the doctrine of fictional fulfilment is based. The second defendant argues, therefore, that in this claim, the plaintiffs failed to allege two critical elements of the doctrine of fictional fulfilment, which are, that the second defendant was the cause of the non-fulfilment of the suspensive condition and the deliberate act or duty breached by the second defendant was done with the intention to cause the condition precedent to fail. In support of this argument the second defendant relied on the decision in *Gowan v Bowen*,[1] where the following is stated:

> "the conditions are deemed to be fulfilled when the debtor who has bound himself subject to them, is himself and intentionally the cause of their not being fulfilled. The cause."

[29] The second defendant further referred to the judgment in *McDuff & Co v Johannesburg Consolidated*[2] where the doctrine was found to have application.

[30] According to the second defendant, it was not required to do anything in order for the suspensive condition to be possibly fulfilled. This the second defendant submits is so because the policy empowered the employer and the employee to submit medical evidence themselves. The policy provided that "*employees who require underwriting make use of our smart service TM facility".* In addition, the second defendant's contact details were provided. This is an indication that the second defendant did not have to do something first in order for the employees to submit medical evidence. All that the employees had to do was to make use of the smart service facilities and the contact details provided in the policy. The employees did not need the second defendant to tell them about this policy, they had advisers, the first defendant, to advise them. The employer and/or employees could have at any time made use of this mechanism to provide the relevant medical evidence, and this is what the deceased should have done.

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[1] 1924 AD 550 at 571.

[2] *MacDuff (In liquidation) v Johannesburg Consolidated Investments Co Ltd* 1924 AD 573 at 588 — 589.

[31] The second defendant contends, as such, that the plaintiffs' allegation that it deliberately prevented the deceased from submitting the relevant medical evidence, thereby preventing the fulfilment of the suspensive condition by failing to request the relevant medical evidence has no merit. In order to sustain a cause of action pertaining to this claim, it was critical for the plaintiffs to allege that it was objectively impossible for the medical evidence to be submitted without the second defendant asking for it. By doing so, they would have established causation, and they failed to do so. Causation, according to the second defendant, is absolutely critical and it is that element, which, as the second defendant submits, is not present in the plaintiffs' pleadings. The plaintiffs have, as such, not pleaded the elements for a cause of action based on the doctrine of fictional fulfilment, so the second defendant submits.

[32] The plaintiffs, in rejecting the second defendant's submission on this ground of exception, argued that all the allegations raised by the second defendant for this claim do not form part of the *facta probanda* of a claim based on fictional fulfilment. The contentions, according to the plaintiffs, are legal argument and/or defences that ought to be pleaded and for that reason, the third ground of exception ought to be dismissed.

Fourth Ground of Exception

[33] The fourth ground of exception is based on the damages claim, that is, claim 3. The plaintiffs allege in the amended particulars of claim that it was a tacit term of the policy that the second defendant would: at the time the deceased became a member of the policy, or within a reasonable time thereafter, request the relevant medical evidence; and within 90 days after the date of the aforesaid request, obtain, submit and consider such medical evidence and obtain an underwriting decision as to the deceased's insurability. The second defendant is said to have breached the policy by failing to comply with its duty to request the relevant medical evidence from the deceased at the time of becoming, or within a reasonable time after he became, a member of the policy. Therefore, implicitly the policy is ineffectual because the second defendant breached the policy as aforesaid, and the result is that the plaintiffs suffered damages.

[34] The second defendant argues that in a damages claim, it is important to plead factual causation, that is, facts that establish the loss. The facts pleaded should establish that the loss allegedly suffered is proximately related to the alleged breach.

According to the second defendant, it is this element of factual causation which is deficient in claim 3 which renders the claim defective. The contention is that the plaintiffs should have alleged a critical averment that, if the second defendant had asked for the medical evidence, and if the second defendant had considered the medical evidence, it would have accepted the risk for the full cover for the deceased. The particulars of claim are said to be excipiable on that ground simply because the facts do not tie the alleged breach and the alleged damages. The causal nexus is not established, so it is argued.

[35] Conversely, the plaintiffs, relying on the decision in *Guardrisk*, argued that the test for causation, which is the source of the second defendant's complaint, has been dealt with and the necessary averments the second defendant is alleging are deficient from the particulars of claim, have, in fact, been made. Causation, as is submitted by the plaintiffs, has been alleged in paragraphs 43 and 44 of the particulars of claim, in particular, that, if the medical evidence had been requested, it would have been considered and an underwriting decision of insurability made. Relying on the judgment in *MEC, Department of Education, Eastern Cape v Komani School & Office Suppliers CC,*[3] the plaintiffs submit that they are not required to explain, as part of its cause of action, the reason why the first plaintiff claims damages and that such a contention ought to form part of the second defendant's closing argument at the end of the trial, so it is argued.

[36] Fundamentally, according to the plaintiffs, the insured events in respect of which the deceased paid a premium have actually occurred. The insured events are, as pleaded, first, the loss of income suffered by the deceased due to his illness (and in respect of which the income continuation benefit was payable) and, second, the death of deceased in respect of which the life cover benefit was payable. The first plaintiff paid the monthly premiums in respect of these events which have now materialised.

Applicable Law

[37] Exceptions are regulated in terms of Uniform rule 23(1) which stipulates that where any pleading is vague and embarrassing, or lacks averments which are

[3] 2022 (3) SA 361 (SCA) para 30.

necessary to sustain an action or defence, as the case may be, the opposing party may, within a period allowed for filing any subsequent pleading, deliver an exception thereto and may apply to the registrar to set it down for hearing within 15 days after the delivery of such exception.

[38] Some of the general principles applicable to exceptions are that -

a. The object of an exception is to dispose of a case or a portion thereof in an expeditious manner or to protect a party against an embarrassment which is so serious as to merit the costs even of an exception.[4]

b. An exception is a legal objection to the opponent's pleading. It complains of a defect inherent in the pleading: admitting for the moment that all the allegations in a summons or plea are true, it asserts that even with such admission the pleading does not disclose either a cause of action or a defence, as the case may be. It follows that where an exception is taken, the court must look at the pleading excepted to as it stands together with facts agreed to by the parties, if any, no facts outside those stated in the pleading can be brought into issue – except in case of inconsistency – and no reference may be made to any other document.

c. Where the cause of action is founded on some document, reference thereto should be made in the summons and a copy should be attached to the summons. The annexures must therefore be regarded as being incorporated in the respective cause of action.[5]

d. In order to succeed, an excipient has a duty to persuade the court that upon every interpretation which the pleading in question, in particular the document on which it is based, no cause of action is disclosed.[6]

e. An exception founded upon the contention that a summons disclose no cause of action or that a plea lacks averments necessary to sustain a defence, is designed to obtain a decision on a point of law which will dispose of the case in whole or in part, and avoids the leading of unnecessary evidence at the trial. If it does not have that effect the exception should not be entertained.

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[4] See *Barclays Bank International Ltd v African Diamond Exporters (Pty) Ltd* (2) 1976 (1) SA 100 (W).
[5] See *Volkskas Bank Ltd v Wilkinson* 1992 (2) SA 388 at 389A.
[6] See *Fairoaks Investments Holdings (Pty) Ltd v Oliver* [2008] ZASCA 41; 2008 (4) SA 302 (SCA) at para [12].

f. An exception ought to be dealt with sensibly and not in an over technical manner particularly where the issues are invariably fact bound.[7]

Analysis

[39] It was held in *Guardrisk Insurance Co Ltd v Cafe Chameleon CC*[8] that the interpretation of an insurance contract depends on the intention of the parties but not by having regard to what the parties subjectively believed or thought when the policy was concluded but rather, the interpretation requires an objective analysis, regard being had to the language, context and purpose of the document. Such objective analysis is aimed at establishing what the parties must be taken to have intended and not what their unexpressed thoughts were when they contracted.

[40] All the grounds of exception taken by the second defendant are linked to the phrase 'the medical evidence of health' as provided for in the policy. The view of this court is that the resolution, thereof, will be determinative of all the plaintiffs' claims. It is also the view of this court that the issue for determination calls for the interpretation of the written contract of insurance (the policy) concluded between the first plaintiff and the second defendant, in as far as the phrase 'the medical evidence of health', is concerned. Importantly, the phrase should be interpreted in relation to who bore the responsibility to provide the evidence of medical health and whether to provide the evidence of medical health was a condition precedent, or not.

[41] In the first ground of exception, an interpretation of whether the clause in the written contract of insurance which authorises the second defendant to pay out the benefits as set out in the Benefit Schedule to the first plaintiff or another person if requested by the first plaintiff, confers *locus standi* in these proceedings to the second plaintiff, is required. This, on the basis that the first plaintiff has instructed the second defendant to pay the disability benefit to the deceased during his lifetime and the life benefit to the second plaintiff after the deceased's demise. Portions of these benefits have already been paid out as the first plaintiff had requested.

[42] Regarding the second ground of exception, it is necessary that the written contract of insurance be interpreted to give meaning to whether the contract was

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[7] See *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority* SA 2006 (1) SA 461 (SCA) at para 3.

[8] 2021 (2) SA 323 (SCA) para 24.

suspended pending the availability of the required evidence of health of the deceased and whether such a requirement was a condition precedent.

[43] In as far as the third ground of exception, which deals with the doctrine of fictional fulfilment is concerned, when a contract is subject to a suspensive condition and a party deliberately prevents the fulfilment of that condition, in law the condition is regarded as fulfilled as against that party. There are two elements required to establish the doctrine of fictional fulfilment. Firstly, the defendant must be the cause of the non-fulfilment of the condition – causation; secondly, the defendant must have performed some deliberate act or breached some duty, and done so with the intention to cause the condition to fail. In order to have this claim properly adjudicated, the interpretation of the written contract of insurance is required to determine whether or not the suspensive condition referred to by the plaintiffs is a condition precedent as alleged by the second defendant.

[44] Some of the issues are invariably fact bound and require evidence to be led. For instance, in relation to the second ground of exception, it is the plaintiffs' contention that the second defendant had the duty to request medical evidence from the employees who would not know what tests they must go for in order to qualify for full cover. Whereas the second defendant argues that the information was readily available to the deceased who should have consulted with the first defendant or obtained the information from the second defendant's smart service facilities.

[45] In the third ground of exception, evidence ought to be led to show on what basis it is alleged that the second defendant is the cause of the non-fulfilment of the suspensive condition and the conduct of the second defendant that prevented the deceased, deliberately so, from submitting the relevant medical evidence, must also be shown.

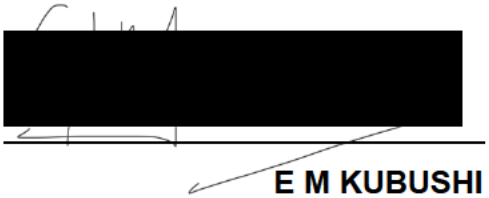
[46] In relation to the fourth ground of exception, it is self-evident from the reading of paragraphs 43 and 44 of the amended particulars of claim that the complaint of the second defendant raised in this ground of exception, holds no water. The averments which it says are deficient from this claim have been clearly made out.

Conclusion

[47] Consequently, the exception cannot be upheld under the circumstances and ought to be dismissed with costs.

Order

[48] The order made is that the exception is dismissed with costs.



E M KUBUSHI

JUDGE OF THE HIGH COURT

PRETORIA

Appearances:

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For the 2nd defendant	:	L M Spiller 079 873 7397 spiller@counsel.co.za
Date of argument:		08 August 2024
Date of judgment:		13 December 2024