The Reasonableness of the Insurer's Repudiation of Permanent Disability Claim Caused by Trauma

PWR v Discovery Life Ltd [2023] ZAGPJHC 282

1 Introduction

The recent High Court judgment in *PWR v Discovery Life Ltd* ([2023] ZAGPJHC 282) (*PWR*) is of considerable interest. First, and most obviously, it addresses the vexed question of whether the insured, who had suffered a string of deeply traumatic events that left him with a combination of post-traumatic stress disorder and unspecified bipolar mood disorder, was totally and permanently unable to carry on his profession as a stockbroker when the cover expired on 30 November 2015. The answer to the first-tier question depends on two key issues. The initial issue concerns whether the insured's condition, and the incapacity it triggered, had become permanent by 30 November 2015. The second is whether, if the insured's condition had become permanent on 30 November 2015, the insurer was nevertheless justified in repudiating the claim. That question invites consideration of the appropriate test to be applied in assessing a life-insurance company's repudiation of a claim. It cannot be gainsaid that in cases of mental illness brought on by trauma, there will inevitably be a lag between the advent of the permanent incapacity and the point at which anybody can say that the incapacity is enduring. The nature, causes and consequences of the insured's condition, coupled with an assessment of the insurer's reaction to the insured's claim, call for academic comment.

2 The facts

The facts as found by Wilson J were as follows. Prior to the tragic demise of his girlfriend during a holiday in Mauritius on 28 December 2014, the insured, PR, was a successful stockbroker. A testament to this accomplishment is the fact that the insurance policy he had taken provided for a payout in the event of permanent incapacity of over R25 million. The policy attracted a monthly premium in the region of R20 000. In the wake of his girlfriend's drowning in a swimming pool at the resort, the insured was charged with murder and was detained pending trial. The ordeal led to psychological deterioration. The Mauritian state psychiatrist initially diagnosed PR with depressive illness. According to his notes, "PR looked mentally and physically exhausted" (*PWR supra* par 8). An expert charged with determining whether the insured was fit to stand trial diagnosed the insured with two conditions: "post-traumatic stress disorder and major depression with psychotic features. She considered that PR might be suffering from bipolar mood disorder" (*PWR supra* par 11 and 14). Following

his acquittal, in March 2016, PR returned to South Africa and was hospitalised. He was diagnosed with post-traumatic stress disorder and major depression. He then contacted the specialist who visited him in prison in December 2015 for further treatment. This led the specialist to offer an opinion to the insured's legal representatives with regard to his insurance claim. PR's treating psychiatrist maintained that the insured suffered from post-traumatic stress disorder and major depression with psychotic features (*PWR supra* par 14). Bipolar mood disorder was not ruled out. On 28 August 2017, PR was admitted to the hospital for several weeks. During the course of his stay, he received psychotherapy, group therapy and various pharmacological treatments (*PWR supra* par 16). The insured's psychiatrist adjusted her diagnosis to post-traumatic stress disorder and unspecified bipolar disorder (*PWR supra* par 17). In a nutshell, the psychiatrist was of the opinion that the insured's condition had a significant and lasting impact on his daily life. PR had "lost who he was" (*PWR supra* par 21).

3 The parties' arguments

The insurer repudiated the claim of R25 million primarily on the basis that the insurance cover had expired on 30 November 2015. Also, there was no evidence that the insured had become totally and permanently unable to perform as a stockbroker by that date (*PWR supra* par 2). In buttressing its position, the insurer contended that "even if there was such evidence, and indeed even if it was true that PR became totally and permanently unable to perform as a stockbroker by 30 November 2015, the legal question before [the court] is not whether Discovery's repudiation of the claim was correct" (*PWR supra* par 2). The crisp legal question before the High Court, the insurer submitted, was whether the repudiation was reasonable on the information that PR had supplied to Discovery when he submitted his claim. Accordingly, even if the court were to determine, as a matter of fact, that PR had become totally and permanently unable to perform as a stockbroker by 30 November 2015, the court could nevertheless not properly conclude that the insurer's repudiation of the claim was unreasonable.

In contesting the insurer's repudiation of his claim, the insured maintained that he did become "totally and permanently unable to carry on that work" between 28 December 2014 and 30 November 2015 (*PWR supra* par 1). In the aftermath of his arrest and detention in Mauritius, the insured was diagnosed with post-traumatic stress disorder and an unspecified bipolar mood disorder (*PWR supra* par 8). After being acquitted of his girlfriend's murder, the insured returned to South Africa. He was hospitalised and later diagnosed with post-traumatic stress disorder and major depression (*PWR supra* par 13).

The insured claimed that his profession required certain distinct character traits, namely that of a strong personality and excellent judgement (*PWR supra* par 6). The evidence from medical experts revealed that the insured was unable to perform his function as a stockbroker owing to the stress he had accumulated since the death of his girlfriend in December 2014. The upshot of the post-traumatic stress disorder and major depression was that the insured was unable to function as he normally would, both in a professional and personal setting (*PWR supra* par 17–20). In a counter

argument, the medical expert for the insurer argued that, although the insured was mentally ill at the time of the trial, such incapacity was not comprehensive enough or permanent enough at the time of the claim in November 2015 (*PWR supra* par 33). According to the insurer, the impediment to full recovery lay at the feet of the insured. It was common ground that he was consuming copious amounts of alcohol and not taking his medication as advised by his medical team at the time (*PWR supra* par 22).

4 High Court decision

The High Court was required to resolve two central issues. The first issue was whether the insured's condition and the incapacity it caused had become permanent by 30 November 2015. If the insured's condition had become permanent by 30 November 2015, the second issue was whether the insurer was justified in repudiating the insured's claim. Linked to that question was a secondary issue relating to the appropriate test to be applied in assessing a life-insurance company's repudiation of a claim.

On the issue of PR's condition and the incapacity it caused, the court found in favour of the insured. The court was satisfied that the medical evidence demonstrated that PR suffered from post-traumatic stress disorder and major depression with psychotic features in the aftermath of his arrest and incarceration in Mauritius. One specialist summed up the effect of PR's condition by saying that he had "lost who he was" (*PWR supra* par 21).

In determining whether there was a possibility that PR's condition would improve with further treatment, the court accepted the expert opinion that there was no significant likelihood of PR's condition improving in the foreseeable future (*PWR supra* par 24). A related and contentious issue raised by the insurer concerned, first, PR's non-adherence to his drug regimen, and second, that he had admitted to sporadic episodes of binge drinking. PR himself conceded to episodes of binge drinking. The insurer's argument overlooked important considerations:

> "PR's drinking was very much a symptom of his condition rather than a wholly independent habit capable of preventing him from recovering to the extent that he might be able to resume his occupation. This was not seriously challenged. In those circumstances, it would be artificial to hold PR's drinking responsible for any failure to recover from his condition. It was not, in any event, seriously contended that, but for PR's drinking, a full recovery from his condition would be possible." (*PWR supra* par 29)

Having regard to the circumstances surrounding the onset of PR's condition, Wilson J concluded that on a balance of probabilities, PR was incapacitated on 30 November 2015. The insured suffered from post-traumatic stress disorder and unspecified bipolar mood disorder. Pivotally, PR had remained incapacitated since then, and the care and treatment that might have rehabilitated him had been exhausted (*PWR supra* par 30 and 34).

In resisting the claim, the insurer raised further alternative arguments. The crux of the submission concerned the reasonableness of the repudiation of PR's claim. The legal question lying at the heart of the matter was not whether it had been established as a fact that PR had become permanently incapacitated by that date, but whether the insurer had unreasonably

concluded that he had not. In advancing this submission, the insurer relied on the policy text, and on the decision in *Southern Life Association Ltd v Miller* ([2005] 2 All SA 371 (SCA)) (*Southern Life*).

Clause 6.3 of PR's policy with Discovery provided that Discovery would pay out a capital sum "once it is established to the satisfaction of the insurer that the life insured is totally and permanently unable" to work as a stockbroker. The parties agreed that the text as parsed meant that the insured had to establish facts that would satisfy a "reasonable insurer in the position of the insurer of the insured's total and permanent inability to perform the plaintiff's nominated occupation as a stockbroker due to sickness, injury, disease or surgery" (*PWR supra* par 36).

The insurer premised its construction of clause 6.3 of the policy on the reasonable-insurer test as a test of general application. In *Southern Life,* the Supreme Court of Appeal formulated the reasonable-insurer test (*Southern Life supra* par 35). *Southern Life* test sets out that where a life policy is expressed in similar terms to clause 6.3, the question is not whether the claimant is actually incapacitated, but whether the insurer's opinion to the contrary is reasonable. If it is, then the insurer is justified in repudiating the claim.

The case concerned a claim for total and permanent disability benefits as a result of a serious knee injury sustained by a maintenance electrician on 25 March 1991, when a mandrill fell on his knees. It was common cause that, as a result of the injuries sustained, he could not carry on the trade of a maintenance electrician. Mr Miller, a member of the provident fund, was unable to claim the disability benefit from the trustees of the provident fund because the insurer denied liability for the claim. Clause 3.1.0 of the policy contains a definition of disablement. It reads as follows:

> "3.1.0 Definition of Disablement
> 3.1.1 *A member will be regarded as totally and permanently disabled if in the opinion of the Southern he has been so disabled by injury or disease as to be continuously, permanently and totally incapable of engaging for remuneration or profit*
> (a) in his own occupation or
> (b) in any other occupation for which he is or could reasonably be expected to become qualified by his knowledge, training, education, ability and experience."

Clause 2.3.0 of the policy, described as the "actively at work condition", is also relevant. It reads as follows:

> "2.3.0 ACTIVELY AT WORK CONDITION
> 2.3.1 *A member must be at work attending to and capable of attending to all his normal duties on the first working day on which his cover is due to start. If he is not so at work his cover will be delayed until he submits evidence of his good health and insurability or completes eight consecutive weeks' service without absence.*
> 2.3.2 The above condition applies separately at the commencement of each type of risk benefit cover." (*Southern Life supra* par 4–5)

On 30 October 1993, he was advised that his post had become redundant. He was given the choice of taking a retrenchment package on termination of his service on 8 October 1993 or requesting his employer to apply on his

behalf for disability benefits from the provident fund and the Compensation Commissioner. He took the second option.

The insurer raised two defences against Miller's claim. First, it pointed out that his employment was terminated as a "draughtsman" and not as a maintenance electrician (in respect of which occupation it was not denied that the respondent was totally and permanently disabled). The insurer also averred, relying on clause 2.3.1 of the policy, that it only came on risk in respect of Miller in relation to his position as a "draughtsman" (*Southern Life supra* par 11). Secondly, Miller was not disabled as defined under the policy.

The High Court found that the member had succeeded in showing that he was entitled to total permanent disability benefits from the insurer. In reversing the findings of the High Court, the Supreme Court of Appeal noted that the judge in the court below erred in not considering the question of whether the appellant acted unreasonably in forming the opinion that the respondent was not disabled within the meaning of the policy (*Southern Life supra* par 33). Accordingly,

> "In the circumstances Counsel was correct in submitting that the question which has to be addressed, which was not considered by the judge, was whether the appellant was unreasonable in forming the opinion that the respondent was not totally and permanently disabled within the meaning of the relevant clause of the policy." (*Southern Life supra* par 35)

Returning to *PWR*, the court found that the wording of the policy in the case at bar was different from that of the *Southern Life* case. While the relevant clause stated that the insurer would pay out on being satisfied with the insured's incapacity, that clause had to be read in the context of the policy as a whole. Clause 6.1.1 of the policy described the Capital Benefit as one which pays "a capital amount in the event of the insured being medically impaired to a degree that he is unlikely to be able to generate an income" (*PWR supra* par 38). The court pointed out that language is objective. The benefit accrues at the point that the impairment comes into existence. The entitlement to the benefit does not depend upon the insurer forming any particular opinion (*PWR supra* par 38).

In response, counsel for the insurer argued that the two clauses had to be read together. According to the insurer, the dual effect was that the benefit vests in PR at the point where his incapacity objectively exists. It is paid out, however, only when PR satisfies the insurer that his incapacity is, in fact, permanent (*PWR supra* par 39). In this regard, the insurer's formulation regarding the policy efficacy brings to the fore the complex and elusive distinction between the advent of an injury and the point at which Discovery could be satisfied that the injury has caused permanent incapacity (*PWR supra* par 41). Sight must never be lost that there will, in most cases, inevitably be a lag between the onset of permanent incapacity and the point at which anyone can say that the incapacity is permanent. A pertinent illustration of the point is "a professional rock climber whose legs are both amputated below the knee cannot fail to satisfy their attending physicians or their insurer at the point of injury that they will never be able to perform as a professional rock climber again" (*PWR supra* par 40). The text in the policy under consideration recognised the drawing of a distinction between the onset of the incapacity and proof to the insurer's satisfaction that the incapacity is permanent.

In the instant case, it followed that the insurer's liability under the policy was triggered at the point that the insured's inability to perform as a stockbroker objectively became permanent. However, the duty to pay out on the policy was only triggered once the insurer could be reasonably satisfied that the insured's condition had become permanent (*PWR supra* par 42) – that is, once there were facts in existence that would have satisfied a reasonable insurer that the insured's incapacity had become permanent. More specifically:

> "The first triggering event – the event that established Discovery's liability – was the onset of PR's permanent incapacity on or before 30 November 2015. The second triggering event – the event that established Discovery's duty to pay out – was the point at which there existed facts that would have satisfied a reasonable insurer that PR's incapacity was permanent. That happened in April 2019, when Dr. Panieri-Peter formed the view that there was no realistic prospect of significant improvement in PR's condition." (*PWR supra* par 43)

Against this backdrop, the subjective reasonableness or otherwise of Discovery's opinion of whether and when PR's condition became permanent was immaterial to its duties under the policy (*PWR supra* par 44). It followed that Discovery became liable under the policy on or before 30 November 2015. It had a duty to pay out, at the very latest, by 1 May 2019, because that is when a reasonable insurer would have known that PR's incapacity was permanent.

5 Commentary

5 1 Insurance law in a nutshell

PWR affords an opportunity to deal with important aspects of insurance law as well as giving insight into trends in the field of insurance. Before the discussion turns to a consideration of the statutory framework, a few words on the concept of Treating Customers Fairly (TCF) are merited. TCF is an outcomes-based regulatory and supervisory approach designed to ensure that regulated financial institutions deliver specific, clearly set-out fairness outcomes for financial customers. Regulated entities are expected to demonstrate that they deliver six TCF outcomes to their customers throughout the product life cycle, from product design and promotion, through advice and servicing, to complaints and claims handling, as follows:

1. Customers can be confident they are dealing with firms where TCF is central to the corporate culture.
2. Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.
3. Customers are provided with clear information and kept appropriately informed before, during and after the point of sale.
4. Where advice is given, it is suitable and takes account of customer circumstances.
5. Products perform as firms have led customers to expect, and service is of an acceptable standard and as they have been led to expect.

6. Customers do not face unreasonable post-sale barriers imposed by firms to change products, switch providers, submit a claim or make a complaint (Financial Services Conduct Authority (FSCA) "Treating Customers Fairly" (undated) https://www.fsca.co.za/Regulatory%20Frameworks/Pages/Treating-customers-fairly.aspx (accessed 2024-04-07)).

By masquerading as something new, it has been pointed out that these outcomes do little to make the meaning of "fairness" clearer (Millard and Maholo "Treating Customers Fairly: A New Name for Existing Principles?" 2016 *THRH*R 594–613; Millard "Through the Looking Glass: Fairness in Insurance Contracts – A Caucus Race? 2014 *THRHR* 547–566. See generally, Mupangavanhu "Fairness as Slippery Concept: The Common Law of Contract and the Consumer Protection Act 66 of 2008" 2015 *De Jure* 116; Rautenbach "Cancellation Clauses in Bank-Customer Contracts and the Bill of Rights" 2010 *TSAR* 637; Sutherland "Ensuring Contractual Fairness in Consumer Contracts After *Barkhuizen v Napier* 2007 5 SA 323 (CC) – Part 1" 2008 *Stell LR* 390; Bhana and Pieterse "Towards a Reconciliation of Contract Law and Constitutional Values: *Brisley* and *Afrox* Revisited" 2005 *SALJ* 865; Lubbe "Taking Fundamental Rights Seriously: The Bill of Rights and Its Implications for the Development of Contract Law" 2004 *SALJ* 395). What is undeniable is that TCF plays no role in the sharp end of legal wrangling between insurer and insured, as illustrated in *PWR* and the recent case of *Ncube v Liberty Life Group* ([2024] 21-23807 (GJ) (25 March 2024)).

South African insurance contract law is primarily governed by the Short-Term Insurance Act (53 of 1998) (STIA) and the Long-Term Insurance Act (52 of 1998) (LTIA), as well as common-law principles (Davis *Gordon & Getz: The South African Law of Insurance* 4ed (1992) 1–52 (Davis *Gordon & Getz*). These laws establish the legal framework for the formation, interpretation and enforcement of insurance contracts, ensuring that insurers and policyholders understand their rights and obligations under the agreement (Millard *Modern Insurance Law* (2013) 1–115). It must be borne in mind that the insurance industry is also subject to the Companies Act (71 of 2008) by virtue of the fact that the relevant services are rendered within the framework of a commercial enterprise. The insurance enterprise is also subject to compliance-based legal mechanisms such as those in the Broad-Based Black Economic Empowerment Amendment Act (46 of 2013) and the BBBEE Codes of Good Practice of 2003 (see generally, Van Eck and Padayachy "Preferential Procurement Paused by the Constitutional Court: Reflections on B-BBEEE Policies and *Minister of Finance v Afribuisness NPC* 2022 (4) SA 362 (CC)" 2022 *ILJ* 2219; Warikandwa and Osode "Regulating Against Business 'Fronting' to Advance Black Economic Empowerment in Zimbabwe: Lessons From South Africa" 2017 *PER/PELJ* 20). Given the inextricably close relationship between insurance-related business and the banking sector, the shared legislative mechanisms also find expression in the Twin Peaks Model that shapes the contemporary financial services industry (see generally, Van Niekerk and Van Heerden "Twin Peaks: The Role of the South African Central Bank in Promoting and Maintaining Financial Stability" 2017 *THRHR* 636; Godwin, Howse and Ramsay "Twin Peaks: South Africa's Financial Sector Regulatory Framework" 2017 *SALJ* 665).

The Insurance Act (18 of 2017) provides a landscape that is consistent and conducive to the fundamental principles contained in the Constitution of the Republic of South Africa, 1996. The Insurance Act provides regulatory guidelines for conducting insurance business, the requirements for the establishment of an insurance entity, and the formalities and regulations to be adhered to in the performance of such services. The Act also stipulates the procedures to be followed in conducting insurance business in South Africa. This Act consolidated the provisions of the STIA and the LTIA into one piece of legislation while maintaining the distinction between short-term and long-term insurance services. The Act does so by requiring an insurer to declare whether it is rendering life-insurance services or non-life-insurance services.

The Financial Advisory Intermediary Services Act (37 of 2002) (FAIS Act) provides for the regulation of intermediaries providing insurance services (Hattingh and Millard *The FAIS Act Explained, A Guide to Understanding the Financial Advisory and Intermediaries Act 37 of 2002* 2ed vii (2010)). The FAIS Act makes provision for the establishment of the General Code of Conduct (GCC) (Financial Services Board "General Code of Conduct for Authorised Financial Services Providers and Representatives" GN 80 in *GG* 25299 of 2003-08-08), which regulates all intermediaries. The GCC ensures that an insured person must be provided with all material information pertaining to their insurance product of choice and that such product must be within the financial reach of the insured client (Havenga *The Law of Insurance Intermediaries* (2001) 36–38; reg 2 of GCC). The GCC's regulation is similar to the obligation to treat the customer fairly, as contained in the Twin Peaks Model.

Noteworthy is the Conduct of Financial Institutions Bill (COFI Bill), which seeks to regulate the conduct of insurers. This Bill aims to consolidate and "streamline" the application of all provisions contained in the STIA, LTIA, and FAIS Act into one piece of legislation that will apply across all sectors (Millard "Discussion Forum: Conduct of Financial Institutions Bill (COFI Bill)" *Juta's Insurance Law Bulletin* 2018 21(4) 81–89 https://www.glacier.co.za/mediacentre/Pages/the-cofi-bill-explained.aspx (accessed 2024-05-07)). Once enacted, the COFI Bill will replace the current FAIS Act.

5 2 Claims, notice and proof of loss

As with a large proportion of cases dealing with important aspects of insurance law, *PWR* arose as a result of the insurer's repudiation of an insured's claim.

It is said that a "contract of indemnity insurance usually requires the insured to supply the insurer such notice of loss, to make a formal claim, and to provide such particulars and proofs as the insurer reasonably needs" (*Norris v Legal & General Assurance Society Ltd* 1962 (4) SA 743 (CC); *Johnson v Incorporated General Insurance Ltd* 1980 (3) SA 641 (C)). Such terms are imposed for the benefit of the insurer. It seems manifest that the insurer wants to know of a loss "immediately" or "forthwith" so that it may investigate the cause and effect under the most favourable circumstances (*Scottish Union & National Co Ltd v National Recruiting Corporation Ltd*

1934 AD 456 466; *Norris v Legal & General Assurance Society Ltd supra* 745). It will be recalled that in *PWR,* one of the contentious aspects for resolution concerned the question of when PR became totally and permanently incapacitated – unlike the situation in *Southern Life,* where it could be easily pinpointed that the member became totally and permanently incapable of engaging in his own occupation when he sustained a serious knee injury on 25 March 1991 from a mandrill falling on his knees. In *PWR,* this turned out to be an intricate matter due to the lag between the onset and the identification of the permanent-incapacity mental-illness case brought on by trauma (*PWR supra* par 31–34).

5 3 The reasonable insurer test

The reasonable insurer test has been refined over the years (Davis *Gordon & Getz* 112–119). In some instances, its application is context-specific. For instance, in the context of the duty of good faith, it is said that there is a duty on both insurer and insured to disclose to each other before the conclusion of the contract of insurance every fact relative and material to the risk. It has been emphasised that a circumstance is material if it would influence the judgement of a prudent insurer in setting the premium or assessment of the risk (Van Niekerk "The Test for Materiality in Insurance Law: The Reasonable Person in Context" 2004 16(1) *SA Merc LJ* 113). The reasonable-insurer test was authoritatively laid down in *Roome NO v Southern Life Association of SA* (1969 (3) 638 AD 641). However, in the celebrated case of *Mutual & Federal Co Ltd v Oudtshoorn Municipality* (1985 (1) SA 419 (A)) (*Mutual & Federal*), it was clarified that the general principle in South African law is that the court applies the reasonable man test – put simply, by deciding upon a consideration of the relevant facts of the specific case, whether or not the undisclosed information materially affected the assessment of the risk. Joubert JA personified the hypothetical *diligens paterfamilias*, i.e., a reasonable man or the average prudent person (*Mutual & Federal supra* 435G–I). The *Mutual & Federal* test was endorsed in *Anderson Shipping (Pty) Ltd v Guardian National Insurance Co Ltd* (1987 (3) SA 506 (A)) (see also *Videlsky v Liberty Life Insurance Association of Africa Ltd* 1990 (1) SA 386 (W) 388–389).

The reasonable insurer test articulated in *Southern Life* is derived from revered English precedents (see e.g., *Moore v Woolsey* (1854) 4 E & B 243 (119 ER); *Braunstein v Accidental Death Insurance Co* [1861] EngR 995; *London Guarantie Co v Fearnley* (1880) 5 App Cas 911 (HL)). In *Doyle v City of Glasgow Life Assurance Co* ((1884) 53 LJ Ch 527), North J put the point thus:

> "The only question in the action is whether the dissatisfaction of the directors with the evidence of death adduced is unreasonable. Now, in respect of that, it must be observed that reasonable persons may reasonably take different views. It constantly happens that a Judge sitting in the Court below takes one view of evidence and the Judge sitting in the Court above takes another. But no one could suggest for a moment that the view taken by either the one or the other was unreasonable." (*Doyle v City of Glasgow Life Assurance Co supra* 529)

The application of the reasonable insurer test means that unless the view taken by the insurer can be shown to have been unreasonable on the

material then before the insurer, the decision of the insurer cannot be successfully assailed on this ground (see also *Machanick v Simon* 1920 CPD 333 338–339). Another instructive case is *Damsell v Southern Life Association Ltd* ((1992) 13 *ILJ* 848 (C)), in which a claim for disability relief based on a similarly worded disability scheme was successfully resisted by the insurer, on the ground that it had not been shown that the insurer's opinion that the claimant was not disabled was not reasonable. Marais JA underscored that the insurer was required to exercise the judgement of a reasonable man:

> "I consider that those words do preclude plaintiff from seeking to challenge defendant's adverse opinion in legal proceedings simply because it is said to be wrong. That is, in my view, the true and only import of the words "in the opinion of the Southern" in clause 6.1.1. If the defendant's opinion is both honestly held and one which a reasonable person could arrive at on the evidence, then it seems to me that the opinion must stand. The mere fact, if fact it be, that the Court before which the question comes, would have decided it differently is not necessarily of itself sufficient to show that defendant's opinion is one which cannot reasonably be held thus enabling plaintiff to avoid the consequences of defendant's adverse opinion." (*Damsell v Southern Life Association Ltd supra* 852 A–C)

In sum, the critical question which has to be addressed is whether the insurer was unreasonable in forming the opinion that the insurer was not totally and permanently disabled within the meaning of the relevant clause of the policy. With respect, the High Court in *PWR* correctly determined that Discovery's adverse opinion with respect to PR's permanent disability was unreasonable.

6 Conclusion

One must agree with the decision in *PWR* that the insured became totally and permanently incapacitated by 30 November 2015. It bears mentioning that total disability does not necessarily imply incapability of doing anything, but should mean that the disability must be such as to prevent an insured from engaging in such livelihood as they might fairly be expected in view of their station, circumstances and physical and mental capabilities. Viewed in light of the reasonable insurer test, the opinion of the insurer that the insured's disability had not become permanent was plainly unreasonable. Had the insurer conducted itself reasonably, it would have become aware, by no later than 1 May 2019, that PR's incapacity had become permanent, and it would have been bound to pay out on the policy by that date. It cannot be emphasised enough that in cases of mental illness brought on by trauma, there is an inevitable lag between onset and the identification of permanent incapacity, which may come months or years later. Only time will tell whether the approach of Wilson J gains support among members of the appellate panel in Bloemfontein.

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