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IN THE HIGH COURT OF SOUTH AFRICA

(EASTERN CAPE DIVISION, GQEBERHA)

Case Number.: 3387/2023

In the matter between:

M[…] D[…] L[…] Applicant

and

LIBERTY GROUP LIMITED Respondent

JUDGMENT

Beshe J

[1] The applicant approached this court for an order in the following terms:

'1. It is declared that the Respondent has failed to comply with Policyholder Protection Rules promulgated under section 62 of the Long Term Insurance Act, Act 52 of 1998 when it repudiated the Salary Protection Claim and cancelled Liberty Policy number SPA00375 by notice dated 1 July 2022;

2. In the event that this Honourable Court makes an order in terms of prayer 1 *supra*, that the Respondent's notice of repudiation and cancellation of the Respondent's policy number SA00375, which notice is dated 1 July 2022, be and is hereby set-aside retrospective to date of issue thereof (1 July 2022);

3. In the event that this Honourable Court makes an order in terms of prayer 2, that the Respondent be ordered:

3.1 to forthwith reinstate the salary protection benefit provided for in the policy retrospective to date of repudiation and/or cancellation (1 July 2022);

3.2 to pay the Applicant an amount equal to the amount payable in terms of the temporary disability for the period from 31 March 2022 (date of last payment) to date of this order as reimbursement of benefits for the same period.

4. Costs of the application.

5. Further and/or alternative relief.'

<u>The parties</u>

[2] Applicant is an adult female person who resides at 1[…] R[…] G[…], M[…] Street, Westering, Gqeberha. The respondent is Liberty Life Limited, a public company and long-terms insurer duly registered in terms of the Company Laws of the Republic South Africa, with its principal place of business being 1 Ameshoff Street, Braamfontein, Gauteng.

<u>Applicant's case</u>

[3] The policy in respect of which applicant seeks to enforce her rights was taken with the respondent during 2021. She was issued with a copy of the policy dated 4

February 2021. In the said document the policy is described as a salary protection cover: injury only. She confirms that prior to the issuing of the policy the insurer telephonically asked her a number of personal and health related questions. According to applicant, during 2015 she had also applied for long-term insurance policies from the respondent, assisted by respondent's agent Ms Munna. For purposes of the 2015 application, she informed the respondent of all her pre-existing medical conditions generally and more specifically of the fact that she had previously suffered a heart condition (cardiomyopathy) depression/anxiety disorder as well as hearing loss. As a result of the disclosures she made, she was required to submit further information which she did. Her application was declined due to medical reasons. Again in 2017, she applied for cover as aforementioned which she described as long-term indemnity insurance. Her application was once again declined for the same reason as her previous application.

[4] Regarding the policy under consideration in this matter, applicant states that during August 2020 she contacted respondent's agent, Ms Munna with a view to apply for a long-term insurance polity with the respondent. She was provided with a pre-populated form and told to sign the last page of the application which she did on the 2 September 2020. She reminded the agent she was dealing her medical conditions as disclosed in respect of previously declined applications. The underwriting department required her to undergo further medical assessments. She could not get round to undergoing the assessments due to her workload at the time. By so doing, she abandoned the application for this cover.

[5] In respect of quotations she would receive from the respondent, she was required to sign an introduction letter. This contained a declaration where the insurer agrees that "*the information contained in its declaration applies to all products and services whereby you have entered into an agreement with us*".

[6] During December 2020 she felt the need to obtain a cover against severe bodily injury. In a bid to secure such cover, whilst looking, she came across respondent's Website on the internet and found an advertisement of a policy that was underwritten by the respondent, being the same underwriter that assessed her

previous applications. She submitted an application for cover telephonically. During that telephone call she was asked a number of personal and health related questions.

[7] Her application was successful. According to the letter addressed to applicant in this regard dated 4 February 2021, the policy in question was "*a salary protection cover: injury only*". Attached thereto was a document containing her answers to medical questions she was asked.

[8] Having fallen victim to attempted hijacking at her place of residence and injuring her right arm and hand I on 25 March 2021, her services were terminated by her employer as a consequence of the injury. On 5 May 2021 she submitted a claim to the respondent based on the insurance policy aforementioned (salary protection against injury). The outcome of her claim was not forthcoming. This led to her lodging a complaint with the Ombud for Long-Term Insurance in September 2021. This had the effect of interruption of prescription in respect of her claim. Her complaint was closed by Ombudsman as per notice she received in this regard on 4 July 2023.

[9] In a letter dated 1 July 2022, she was informed by the respondent that the payment in respect of the policy has been stopped. She was informed that she does not have a valid claim as the agreement between the parties is considered null and void on the basis of non-disclosure of pertinent medical information. Further that, had she disclosed the information concerned during underwriting in the quotation process, the insurer would have been able to assess her risk more accurately.

[10] It is applicant's contention that this information was at the respondent's disposal due to the fact that she had disclosed same during her previous applications. Further that, she correctly answered all the questions as they were posed to her in respect of this policy when applying for same. She also points out that the respondent approved her application for insurance cover previously despite the medical conditions she had disclosed.

[11] Applicant further contends that the policy only provides for injury related disability not one arising from illness hence her application for illness related cover was not successful. This therefore renders the cancellation of her policy to be unreasonable, unlawful and or unfair.

[12] Applicant complains that the respondent's notice of cancellation did not contain sufficient details of its reasons for repudiation/cancellation relating to the "*non-disclosure*" of information. Applicant asked the respondent in this regard why it could not access information she had previously provided which was within its realm. Further that, failure to provide sufficient reasons for the cancellation left her with no option but to approach this court. It is further contended by applicant that by failing to provide her with sufficient reasons for cancellation, the respondent acted contrary to the Policyholder Protection Rules (PPRs). Section 17.6.3.(a) of which obliges the insurer to inform the claimant in plain language of the reason for its decision, in sufficient detail to enable the claimant to dispute such reasons if the claimant so chooses. Applicant draws the court's attention to other provisions of the PPRs being *inter alia* Rule 20. Rule 20 provides for the termination of policies, and the periods provided for giving of notices in this regard.

[13] Applicant asserts that the respondent's conduct in the process of repudiating her claims and cancelling her policy infringed upon her constitutional rights, being:

Right to equality.

Right to human dignity.

Right to access to information.

This because it caused her humiliation forcing her to rely on loans and assistance from others even though she had taken insurance to safeguard herself should she be unable to work due to disability caused by an injury.

<u>Respondent's case</u>

[14] The answering affidavit is deposed to by Ms Kagiso Elizabeth Klaas who describes herself as a Senior Specialist Legal: Dispute Resolution, attached to respondent's legal department.

[15] Ms Klaas confirms that in 2021 respondent issued three policies to the applicant, two of which were disability policies and the third one under consideration in this matter, a salary protection policy. She further confirms that in July 2022 a letter was addressed to the applicant repudiating her claim for the salary protection benefit. The reason for such being the non-disclosure/misrepresentation by her at the time that the salary protection policy was issued.

[16] Ms Klaas asserts that the relief sought by the applicant is akin to a review of an administrative or public law decision yet the relationship between the parties was a contractual one.

[17] Regarding the allegation that the respondent failed to comply with the Policyholder Protection Rules, Ms Klaas retorts as follows:

> Applicant knows why respondent issued the policy in question even though she had disclosed certain facts in previous applications. Something that was comprehensively dealt with before the Ombudsman. Furthermore, applicant did not make any representations as contemplated in Rule 17 after receiving respondent's letter of the 1 July 2022. Instead, she proceeded with her case at the Ombuds office. She cannot now decide to revive the process she opted not to follow on receipt of the 1 July 2022 letter.

[18] According to the respondent, there exist a dispute of fact which will require the evidence of witnesses/experts as the question whether respondent could raise non-disclosure as a reason for repudiation. That, this can only be decided on a balance of probabilities and not in application proceedings.

[19] That, in any event, even if respondent's letter is set aside, applicant will still need to show or prove that she falls within the insuring clause of the salary protection policy by means of medical evidence.

[20] Regarding facts relevant to applicant's case, the following is revealed:

Applicant completed an online assessment on Liberty Direct, a division of Liberty which used to trade as Frank.Net. Frank.Net was an insurer with a separate licence but became a wholly owned subsidiary of Liberty. In 2016 Frank.Net policies were transferred to the respondent but administered by Frank Financial Services. From 2020 all communications were Liberty Branded. Ms Klaas states that Liberty Direct is different from Liberty's "*intermediated*" business where insurance brokers and financial advisors consult with prospective insured in person. Whereas with Liberty Direct policies are concluded over the telephone and Frank Financial Services/Liberty Direct does not have access to the systems of Liberty. Having completed an online assessment, applicant was contacted by an employee of Frank Financial Services who asked her certain questions on 3 February 2021. This culminated in three insurance policies being concluded, one of which was the policy in question (the salary protection policy). On 18 February 2021 applicant called Liberty Direct to cancel one of the policies, a Life Policy and to procure a further Disability Policy. Once again, a Frank Financial Services employee called her and posed the same questions as were asked in respect of her earlier concluded policies. A policy contract in this regard was then sent to applicant shortly after the 4 February 2021. Regarding medical disclosures, the following was communicated to the applicant in the policy:

> 'CHECK YOUR ANSWERS TO THE MEDICAL AND LIFESTYLE QUESTIONS
>
> The medical and risk assessment questions that you answered, during the telephonic call when you took out the product, are the basis for this agreement and are included in the summary of cover. Please go through the

answers and make sure that you agree with them. Contact us immediately if you find any inaccuracies.

All calls are recorded to ensure that we have a complete record of our conversations. A copy of the call can be made available on request. It is imperative that all information given is honest and factual, as the answers that you give during the call will be verified in the event of a claim and any errors could result in an unsuccessful claim.' [emphasis supplied]

She was also provided with the answers she gave when she was applying for the policy.

[21] On 8 May 2021 applicant submitted a claim for disability cover alleging that she suffered the following "*bruised forearm, paralyzed hand*". She further stated that she was dismissed by her employer, who is her ex-husband, an advocate trading as Labour Law South Africa.

[22] On 12 October 2021 applicant lodged a complaint with the Ombudsman for long-term insurance. On 14 October 2021 respondent addressed a letter to the applicant regarding her complaint to the Ombud. It is apposite to reproduce the said letter as it sets out the history of the dispute between the parties.

'**COMPLAINT OUTCOME**

According to your Long-Term Insurance Ombudsman complaint description, your complaint is two-fold, we have investigated the merits of your contentions raised and our response is as follows:

1. **Claim Outcome Delays**

On 08 April 2021, you lodged a claim detailing that on 25 March 2021 were involved in an attempted hijacking which resulted in a severe injury to

your right forearm and hand rendering your right-hand thumb, index and middle finger paralyzed inclusive of nerve damage.

According to the email sent to you by our claims team dated 15 September 2021 (Annexure 4), the insurer is awaiting your UIF, IRP and bank statements as part of the validation process. We have stated that an alternative to the outstanding information, your employer may provide proof that payments were made to SARS and UIF. Furthermore, we require the details of your Physiotherapist.

2. Insurer's banking details

The insurer's billing option is Debit Order only. Regrettably we do not have any options for direct deposits and therefore there are no banking details that we may avail to you in order to facilitate a direct payment for your premiums.

3. Lifestyle Choice Changes

The insurer refers to page 7/12 of your agreement which states the following:

"**TELL US ABOUT CHANGES TO YOUR LIFESTYLE OR OCCUPATION**

Any changes to your lifestyle (not your health) could affect this cover. Let us know if any of the following changes.

- Your smoking habits.
- Your participation in any risky sports or activities
- Your occupation.

- Your intent to spend more than 30 consecutive days outside South Africa in one of the following regions: The Middle East, Asia, Suth or Central America or in the rest of Africa.

After being informed of any of these changes, we may adjust the agreed payout and monthly payments or not be able to provide cover. However, if you don't let us know, any future claims could be affected or even refused.'

[23] Applicant's claim was provisionally accepted, and certain information was required from her. Applicant refused to be examined by an occupational therapist appointed by the respondent. Liberty decided to assess her claims based on all the information it had at its disposal. In addition to this information, it also came to respondent's attention (fortuitously) that applicant may not be disabled as she was sending correspondence on behalf of her ex-husband, Advocate De Lange.

[24] Regarding the merits of the application, it is contended on behalf of the respondent that applicant misunderstands the purpose and application of the PPRs. Further that, it was at respondent's right to avoid the policies in question due to non-disclosure/misrepresentation and notes that applicant does not deal with the other policies, being the disability applications.

[25] The letter addressed to applicant dated 1 July 2022 provided applicant with detailed reasons why Liberty avoided the Salary Protection policy and was in compliance with the provisions of Rule 17.6.3 of the PPRs. Furthermore, it is asserted that applicant was not relieved of her duty to disclose material facts when applying for the policy on the basis that respondent was already in possession of such information through her previous applications. That in any event as it emerged also in relation to the complaint to the Ombud's office though Frank Financial Services is part of Liberty Group, it does not have access to Liberty Group database at sales stage. Besides, applicant did not refer the consultant she was speaking to on the phone to refer to information in respect of her previous applications but answered the questions she was asked. So, there was no reason for the respondent

to search its database for information about applicant's unsuccessful applications. Respondent insists that applicant did not answer truthfully to a number of questions.

[26] It is contended that what she purports to be her understanding of the questions posed and *vis-à-vis* what was required from her itself constitutes a dispute of fact which cannot be resolved on the papers.

[27] It is common cause that the answering affidavit was filed out of time even after an indulgence was granted to the respondent by those representing the applicant in this regard. To this end, respondent is seeking condonation and fully explains the events that resulted in the late filing of the answer even though respondent is of the view that it was not properly served with the application since service was by means of electronic mail and not effected by the Sheriff as provided for in the relevant Rule.

Applicant's reply and condonation application

[28] In reply, applicant complains that the respondent has failed to deliver a notice in terms of Rule 41A(2)(b) relating to mediation and asks that the court takes this into consideration when making a costs order.

[29] I note that the respondent was not called upon to answer to this complaint in the founding affidavit.

[30] Applicant once again places the nature of the application into perspective when she states that it is concerned with whether the respondent has breached applicant's rights as a policy holder to be provided with sufficient detail to place her in a position to dispute its allegation of material disclosure on the part of the applicant.

[31] Applicant also opposes respondent's application for condonation for the late filing of its answer, citing as grounds for opposition:

(a) The reason for delay being the unavailability of counsel. A number of reasons were provided by the respondent in this regard and not only the unavailability of respondent's counsel.

(b) The degree of lateness, the answering affidavit was filed approximately two months outside the 20-day period provided by the rules.

[32] It is worth mentioning at this stage that both parties filed a myriad of annexures to their respective papers, applicant's span from page 57 to 257 and respondent's span from 319 to 491. In my view, it would have required extensive consultation and procurement of volumes of documents on the part of the respondent before they could file an answer. Whether all the annexures were necessary to support/prove applicant's case in light of the relief sought is something else. None of the annexures are described in the index. Both parties merely list an annexure with reference to a number/letter e.g. annexure AA and so on. This is in contravention of Rule 9 of the Joint Rules of Practice for High Courts in the Eastern Cape. This rule provides that "*the index must contain information to enable the court to identify every document without having to refer to the document itself*". This practice is not acceptable, and it is decried.

[33] I am however of the view that the respondent has provided good reasons for the delay in filing its answer. Respondent accounted for the entire period when the answer was not filed. I am of the view that the respondent has made out a case for condonation of the late filing of its answer.

[34] In reply, applicant also points out that the PPRs have the power of the statute and requires strict compliance therewith in dealing with policyholders. This in order to ensure fairness to them. Applicant further points out that not to comply with any of the rules in the PPRs may attract a penalty or a fine.

Issue(s) for determination

[35] 1. Whether the respondent, in repudiating the policy in question complied with Policy Protection Rules promulgated under Section 62 of the Long-Term Insurance Act.

2. Whether the respondent was entitled to cancel the policy on the basis of non-disclosure of material facts given that such information was at the disposal of the respondent. This in view of the fact that the information was provided in respect of applicant's previous applications. Whether it was fair and reasonable for the respondent to cancel the policy in circumstances where it accepted applicant's request for cover despite having this information at its disposal.

Applicant, although she asserts that this information was at respondent's disposal, she also claims that she answered the questions as she understood them. She also seems to be suggesting that her medical conditions were not material to the cover provided to her by the respondent which was purely for injury related disability.

Legal framework

[36] Section 62 of the Long-Term Insurance Act[1] provides for the protection of policyholders and provides that the Financial Services Conduct Authority may by notice in the Government Gazette, prescribe rules not inconsistent with the Act aimed at ensuring policyholder protection.

[37] During 2018, the Deputy Registrar of Long-Term Insurance promulgated the replacement of Policy-holder Protection Rules (PPRs) in terms of Section 62 of the Long-Term Insurance Act. Rule 17 of the PPRs provides for the Management of claims by policy-holders. Applicant's complaint is mainly directed at Rule 17.6.3, the allegation being the respondent failed to comply therewith. This subrule stipulates that:

[1] Number 52 of 1998 (LTIA).

> '17.6.3 If the insurer repudiates or disputes a claim or the quantum of a claim, the notice referred to in rule 17.6.2 must, in plain language, inform the claimant—
>
> (a) of the reasons for the decision, in sufficient detail to enable the claimant to dispute such reasons if the claimant so chooses;
>
> (b) that the claimant may within a period of not less than 90 days after the date of receipt of the notice make representations to the relevant insurer in respect of the decision;
>
> (c) of details of the internal claim escalation and review process required by rule 17.5;
>
> (d) of the right to lodge a complaint to a relevant ombud and the relevant contact details and time limitation and other relevant legislative provisions relating to the lodging of such a complaint;
>
> (e) in the event that the relevant policy contains a time limitation provision for the institution of legal action, of that provision and the implications of that provision for the claimant; and
>
> (f) in the event that the relevant policy does not contain a time limitation provision for the institution of legal action, of the prescription period that will apply in terms of the Prescription Act, 1969 (Act No. 68 of 1969) and the implications of that Act for the claimant.'

Applicant alleges that the respondent fell foul of this subrule by failing to provide her with sufficient reasons for the repudiation in plain language.

<u>Applicant's submissions</u>

[38] Applicant submitted that respondent has not made out a case for condonation of its late filing of the answering affidavit. It stands to reason that should condonation be refused, the court will not have regard to the answering affidavit. Applicant had raised *in limine* respondent's alleged failure to give consideration to the provision of Rule 41A of the Uniform Rules of this Court (Mediation). This objection was however abandoned as a ground for the dismissal of respondent's defence but relied upon for purposes of considering an appropriate costs order which applicant submitted should be in her favour, whatever the outcome would be. As far as the merits are concerned, applicant points out that the issue in this matter is whether the respondent complied with PPRs when it repudiated applicant's policy. Applicant submits that the respondent did not provide it with sufficient reasons for the repudiation. Further that the medical questions posed to her over the telephone when she applied for cover did not include specific questions relating to the conditions she is alleged to have failed to disclose. Besides, she had disclosed to respondent that she suffered stress, anxiety, panic disorder, depression, agoraphobia as well as sensory-neural hearing loss in writing in respect of a previous application for insurance cover during 2012. In any event, those conditions are immaterial to physical injury. Applicant submits that her requests for further details relating to the reasons for the respondent fell on deaf ears. Even though a list of authorities was attached by applicant and reference made to decided cases with copies thereof provided, the heads of argument did not direct my attention to those parts of the judgment/s on which reliance was placed.

Respondent's submissions

[39] As indicated earlier in relation to respondent's condonation application that a point was raised that there was no proper service of the application on the respondent. That there was no compliance with Rule 4 of the Uniform Rules of this Court. This, the respondent submits also has a bearing on its condonation application in that it would be prejudicial to it in that the starting date for the time period within which it was required to file its reply would be difficult to determine.

[40] Regarding the merits, respondent submits that there was compliance with Rule 17.6 of PPRs. Namely that the applicant was provided with sufficient reasons for the repudiation which reasons enabled her to challenge or contest the decision before the Ombud for Long-Term Insurance as well as in respect of this matter. It is further argued that Rule 17.6 only provides a procedural regime and does not require a court to "*look through*" the reasons provided by the insurer. Furthermore, that there is also no duty on the insurer to fossick around its records to unearth information which should have been disclosed to it. In this regard the court was referred to the matter of Regent Insurance Company Ltd v King's Property Development (Pty) Ltd t/a King's Prop 2015 (3) SA 85 SCA. In this matter it was held that the law does not place a duty on an insurer to make inquiries, that the insurer was not required to "*fossick*" around its records to unearth bits of information that had been disclosed to it in he past. It was suggested that this was inconsistent with the duty of disclosure. It was argued on behalf of the respondent that applicant does not seem to be taking issue with the details provided on the repudiation letter, but rather why the respondent did not have the recourse to information she provided in respect of her previous applications.

[41] It was argued that it would have been different had applicant referred to her previous applications for cover when she was questioned about her medical history or conditions.

Discussion

[42] Respondent points out, correctly so in my view, that the applicant does not seem to be impugning the details provided for the repudiation of her policy with the respondent or the language used. But rather questions why respondent did not access information provided by her in respect of her previous applications for cover.

[43] The question therefore is whether the respondent complied with Rule 17.6.3(a) of the PPRs in relation to the repudiation letter. The following is recorded in the said letter dated 1 July 2022:

‘**RE: SALARY PROTECTION: INJURY ONLY – THE PAYMENTS HAS BEEN STOPPED.**

This letter serves to inform you that we have assessed the medical evidence in connection with the claim on the policy number listed above. Your Salary Protection: injury only claim payout has been stopped as detailed below.

As previously stated in the Salary Protection: Injury only Approval Letter dated 11 March 2022.

It is important to note that your claim is subjected to continuous and periodic reviews.

According to medical information received and assessed, it is noted that you were treated for **Anxiety and Depression**.

In addition to this it is noted that you had a previous claim for loss of hearing and we refer to the Medical form that you signed on 6 May 2009. It is noted, that because of your hearing loss, you experienced “sound direction loss, loss of balance” and you state that you could “not safely drive a vehicle or fluently converse with other persons”. The total deafness is confirmed by Dr Ritters in his report dated 29 April 2009 who states that this condition is a sensory neural hearing loss, and it will not improve. He states that it is permanent with total hearing loss. Renee Version, an Audiologist confirms this.

A report by Dr JJ Swartz dated 22 October 2009 refers to you being unable to work due to issues with your hearing apparatus, Depression and problems with communication.

Dr Swartz further confirms that you had notable Depression and that you were in the care of Mrs Linda Grobler, a psychologist. The treatment was *Serlife, Urbanol and Ativan*.’

[44] In my view, the repudiation letter is compliant with the provisions of Rule 17.6.3(a) of the PPRs. Therein, the applicant is informed in plain language of the reasons for the decision to repudiate her policy in sufficient detail. Hence the applicant does not assail the contents of the letter as it were. She complains that the information she allegedly did not disclose was disclosed previously, a few years previously and respondent should have same in its data reserves. That she did not disclose the medical conditions as demonstrated in the repudiation letter is not in dispute. Applicant suggests two reasons why she did not disclose the said information. Firstly, she says she answered the questions as she understood them. And did so honestly. The second reason she suggests that she had disclosed the information in respect of her previous applications and questions why the respondent did not access the information. Let us examine these reasons, *vis-à-vis* what was required of the applicant. This must be viewed against the backdrop of the history provided by the applicant regarding her previous applications, some of which were declined due to medical reasons. This in circumstances where it is also common cause that in respect of the policy concerned, she was no longer dealing with respondent’s consultants by the name of Ms Mnuna. She also does not suggest that she was. During the telephonic interview, her interviewer made it clear that because they were dealing with a new policy, a new assessment was going to be done. During the interview she was informed that the product is directly distributed by Frank Financial Services. The questions posed appear to be clear and straight forward. For example, according to the transcript of the interview with Fahima, she was cautioned to think of everything associated with her health and not only those conditions that were mentioned in previous questions. Later, the interviewer asked if there is any other illness or symptoms, activity or occupational risk that she has not mentioned? Her answer was NO. It is also noteworthy that during the interview she was informed that she qualifies for the cover she was applying for. As well as the fact that the medical and risk assessment questions she answered formed the basis of the agreement. That she will be sent her policy documentation. Clearly therefore, a deal was clinched there and then. The assessment took place there and then, based on her answers to questions posed to her. This seems to have been the case with her previous applications as well. The materially or otherwise of the undisclosed conditions to the cover sought by applicant i.e. against disability as a result of an

injury, is raised "*by the way*" not prominently as a basis for the relief sought. Besides, on the papers, I am unable to determine whether or not the non-disclosed medical conditions were material to the cover sought or not. There is no prayer that the court should declare them as being immaterial to the cover. The respondent was not provided with proper opportunity to refute whatever reasons may have been advanced to show that they were material, if they were. I am inclined to agree with the respondent that there was no reason for it to double check or verify information provided to it by the applicant, unless of course applicant had referred them to information she provided in respect of her previous applications. Besides, it was made very clear that the cove she qualifies for is based on the telephonic assessment of the medical as well as other information she provided during that telephone interview.

[45] I am not persuaded that the applicant has made out a case for the relief she seeks.

Costs

[46] Applicant submitted that the respondent should be ordered to pay the costs of this application irrespective of the outcome thereof. This in view of the fact that it failed to consider mediation and or failed to comply with Rule 41A(2). By so doing, leaving the applicant no other option but to approach this court for relief. There is a dispute regarding service of papers initiating the proceedings on the respondent. In addition, the return of service reflects that service was effected electronically on 25 October 2023 (including the notice in terms of Rule 41A). The notice of motion which does not contain the Rule 41A notice bears the stamp of the Sheriff, Port Elizabeth West of the 25 October 2023. The notice in terms of Rule 41A filed separately two days after the notice of motion does not bear the Sheriff's date stamp. It is not clear whether the respondent was served with a notice in terms of Rule 41A. Respondent also makes the point that mediation would not have resolved the matter as attempts to do so by the applicant before the Ombud failed. In my view, there is no reason why costs should not follow the result.

<u>Order</u>

[47] 1. Respondent's application for condonation of the late filing of its answering affidavit is condoned.

2. The application is dismissed with costs.

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N G BESHE

JUDGE OF THE HIGH COURT

<u>APPEARANCES</u>

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