



**Insurance  
Regulatory  
Authority  
of Uganda**  
*Driving insurance growth*



• INSURANCE •  
**CASES DIGEST**  
**VOLUME 1, 2025**



*Driving  
Insurance  
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# Chief Executive Officer's Note

The establishment of the Insurance Regulatory Authority of Uganda (Authority) was a direct consequence of the Government's decision to implement the Liberalization policy, which transitioned its role from directly providing goods and services to overseeing and regulating them. Consequently, the Authority was instituted with the primary objective of **"promoting and facilitating the maintenance of a sound, effective, fair, transparent and stable insurance sector in Uganda."** One of its core functions is, effective regulation, supervision, monitoring, and control of the insurance sector. To fulfill its mandate effectively, the Authority established the Complaints Bureau, which has undertaken several initiatives, including the development and publication of the Insurance Cases Digest.

It is imperative to recognize that acquiring knowledge is an external process, particularly given the dynamic nature of the business environment, influenced by various political, economic, social, technological, regulatory and legal factors. Essentially, for a business entity or organisation to prosper, and become resilient; and attain global presence, its management and foundational structures must remain informed about ongoing developments in these areas, for planning, and ensuring seamless business operations.

The Insurance Cases Digest has been developed to inform readers about contemporary insurance issues. It aims to provide insights into the Authority's mandate execution, enhance understanding of competition and consumer protection law within the context of in-



surance, and contribute to the development of jurisprudence. Additionally, it serves as a quick reference for practitioners of insurance, competition, and consumer protection law.

I believe the Digest will furnish the Authority's stakeholders with insights into critical emerging issues in insurance knowledge and practice, information about the Authority's mandate. We hope that the information in this publication will bolster public confidence in the insurance industry; and clarify our role in promoting and safeguarding competition while protecting consumers of insurance from unfair and misleading market practices. The Digest will also support the Authority's awareness initiatives.

I commend the legal team for the effort, research and meticulous reviews that have gone into the development of this first ever Insurance Cases Digest in the Insurance Industry in Uganda. I am confident that every reader will derive maximum benefit from it.

Thank you.

***Driving Insurance Growth!  
For God and My Country!***



**Alhaj Kaddunabbi Ibrahim Lubega**

Chief Executive Officer

## Foreword

The Insurance Regulatory Authority of Uganda (“the Authority) was established under the Insurance Act, No. 6 of 2017, as Uganda’s insurance regulator and consumer watchdog.

The Authority actively carries out its mandate to promote and safeguard a competitive and fair insurance market, discourage unfair practices, and protect consumers from prejudicial conduct by insurance players. As a result, the Authority, through its Complaints Bureau, has made numerous decisions that have shaped insurance practice and regulation.

I am excited to introduce the first edition of the “Insurance Cases Digest,” a valuable and timely resource for professionals navigating the constantly changing landscape of insurance law. As the Director of Legal, I have seen first-hand the significant impact that in-depth legal knowledge can have on our industry. This digest highlights the importance of staying informed and proficient in an ever more complex field. Keeping up with legal precedents is essential for insurance professionals and practitioners.

This Digest is a carefully curated collection of landmark cases from the Courts of Judicature, the Insurance Appeals Tribunal and the Complaints Bureau decisions that have shaped the landscape of insurance law and practice.

Insurance law is more than just a set of statutes and regulations; it is a dynamic and complex tapestry woven from numerous legal



decisions and interpretations. It’s crucial for anyone involved in underwriting, interpreting, and enforcing insurance policies to understand the precedents set by key cases. This digest provides valuable insights into the legal reasoning and outcomes that influence our industry.

The editorial team at the Insurance Regulatory Authority of Uganda (IRA) made up of distinguished legal scholars and industry experts, has done an excellent job compiling and synthesising this wealth of information. Their commitment to excellence ensures that this digest serves as a valuable repository of knowledge and a catalyst for informed decision-making, particularly for insurance players.

I would like to thank the Authority and the editorial team for making this publication possible. Their expertise and hard work are evident on every page, I am certain that their contributions will benefit the insurance industry in Uganda and beyond for years to come.



**Francesca N. Kakooza**

Director Legal/Secretary to the Authority  
Insurance Regulatory Authority of Uganda

## Editorial Note

Welcome to the inaugural edition of the Insurance Cases Digest, a comprehensive compilation created to be an essential resource for insurance practitioners, academics, and students. This publication comes at a time when the insurance industry is confronting unprecedented challenges and transformations driven by technological advancements, regulatory changes, and evolving risk landscapes.

The cases featured in this digest address a wide range of issues, such as policyholder rights, insurer obligations, policy interpretation, and regulatory compliance.

Each case is carefully analysed to extract the main lessons and implications, providing readers with a clear understanding of the legal principles and practical guidance for real-world application.

Our expert editorial team has worked hard to present these cases in a manner that is both



accessible and deeply informative, ensuring that readers from various backgrounds can benefit from the insights provided.

We are also mindful of our industry's rapidly changing nature, and as such, we aim to keep this publication dynamic and responsive to new developments.

We are grateful to the Authority management, the editors whose expertise and dedication have been instrumental in bringing this digest to life. Special thanks go to all the legal officers in the Legal Department for summarising the cases.

We welcome feedback from our readers, as your insights and suggestions are invaluable to our ongoing efforts to improve and expand this resource.

Please feel free to contact us at **[complaintsbureau@ira.go.ug](mailto:complaintsbureau@ira.go.ug)**; **[legaldepartment@ira.go.ug](mailto:legaldepartment@ira.go.ug)** or **[ira@ira.go.ug](mailto:ira@ira.go.ug)** with any suggestions or comments.

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# COURT CASES

## I. LEADS INSURANCE LIMITED Vs. INSURANCE REGULATORY AUTHORITY OF UGANDA MISCELLANEOUS CAUSE NO. 1 OF 2013.

### Brief Facts:

1. The Appellant was aggrieved with the decision of the Authority to revoke its license and instituted a suit by way of Judicial review, seeking orders for declaration, certiorari and mandamus to compel the Authority to renew its licence for the year 2013 and prayed for costs of the suit.
2. The Appellant's contention was that the revocation did not comply with the relevant provisions of the law and breached the principles of natural justice in so far as they were not allowed to remedy the purported breach within the prescribed time, were not given a reason for revocation of their license and were not afforded a fair hearing.
3. The Respondent opposed the application and submitted that it did all it could to ensure that the accounts were de-frozen but in vain. That the reasons for revocation of the licence were set out in the respondent's letter dated 21<sup>st</sup> December 2012, that the revocation was in the public interest, and that the Respondent was within their mandate as a regulator of the insurance industry to revoke the license to protect the public.
4. After hearing the arguments of both parties, the trial Judge (Justice Eldad Mwangushya), ruled that the Appellant's application for judicial review did not establish any grounds for judicial review and dismissed it with costs.
5. The Appellant was dissatisfied with the decision of the High Court and appealed to the Court of Appeal on several grounds as below;
  - a) *The trial Judge erred in law when he held that no ground of judicial review had been established.*
  - b) *The learned trial Judge erred in law and fact when he failed to rule on whether the Respondent's notice of revocation complied with relevant law and subsequent process of revocation as contemplated by the said law.*
  - c) *The learned trial Judge erred in law and fact when he held that the Respondent's actions taken were within the law and there was a justification for the revocation of the license as the business of the Appellant was encumbered.*
  - d) *The trial Judge erred in law and fact when he held that the Respondent was justified in taking the action they did without affording the Appellant a right to be heard.*
  - e) *That the trial Judge erred in law and fact when he failed to establish whether the revocation of the Appellant's license was done in public interest.*
  - f) *The trial Judge erred in law when he held that no ground of judicial review had been established.*

## Judgment:

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1. The application for judicial review would be summarised as falling into three categories, namely: -
  - a) That the respondent's decision did not comply with Section 33 of the Insurance Act Cap. 213 (Now repealed).
  - b) That the decision was made in breach of the rules of natural justice and fair treatment.
  - c) That it was irrational for the respondent to condemn the appellant for the transgression of one of its shareholders.
2. It was apparent that the appellant's grievance was about the procedure taken by the respondent in revoking its license in contravention of Section 33 of the Insurance Act Cap. 213. Judicial review is simply a legal audit of the decision-making process and not the merits of the decision.
3. The notice period prescribed under the law to be given before revocation could be effected was not given to the appellant by the respondent. Such a complaint fell within the ambit of procedural impropriety.
4. The importance of giving the notice as required by the above provision was to give the Appellant a right to be heard, which is customised in natural justice of "***audi alteram partem***" (Listen to the other side).
5. When the respondent used the provisions of Regulation 9 of Insurance Regulations 2002, it circumvented issuing a written notice before suspension or revocation of the license. As such, Regulation 9 was a nullity to the extent to which it was inconsistent with Section 33 (2) of the Parent Act (Insurance Act Cap. 213), since it did not provide for immediate revocation.
6. The learned Justices of Court of Appeal agreed with the learned trial Judge and the Respondent that in the circumstances of this case, the intervention by the regulator when an insurance company is faced with operational challenges is not irrational. The respondent did what a sensible regulator would be expected to do. The decision was erroneous on account of the procedural shortcomings but not irrationality.
7. The Authority did not comply with the law before revoking the Appellant's licence of 2012. The appeal was allowed and the Ruling of the High Court was set aside.

## Commentary:

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- a) ***The Insurance Act Cap. 213 and the Insurance Regulations 2002 were repealed. The inconsistency which existed in these laws was removed in the Insurance Act, Cap. 191. Under the Insurance Act Cap. 191 and Insurance Regulations 2020, no licence can be revoked without notice to the licensee and granting a fair hearing.***
- b) ***According to the justices of Appeal, the decision to revoke was not irrational or wrong. The issue was with the failure by the respondent to follow the procedures laid down in the Insurance Act on revocation of a licence. Therefore, measures or interventions taken by a regulator to protect the public do not fall within "irrationality".***

- c) Where the law is clear on the procedure to be followed, the regulator should comply with this procedure to the letter to minimise litigation risk.
- d) The learned justices of appeal did not delve into whether revocation was done in public interest. This was mainly because this was a substantive issue that could not be handled in a judicial review application.

## **II. INSURANCE COMPANY OF EAST AFRICA Vs. KITAGENDA MUHAMMED CIVIL SUIT NO 301 OF 2012.**

### **Brief Facts:**

1. The Plaintiff stated that sometime in January 2012, the Defendant with the intention to induce the Plaintiff to pay him a commission, lodged a claim for commission in the Accounts Department of the Plaintiff fraudulently misrepresenting that he had solicited business from a client when this was not true. Secondly the Defendant fraudulently misrepresented to the Plaintiff that he was a licensed insurance agent for the year 2012 whereas not. Relying on that misrepresentation, the Plaintiff unknowingly paid the Defendant commission of US\$61,077.
2. By a written statement of defence, the Defendant denied all the allegations in the plaint and asserted that it was due to his good performance that he was elevated to a Unit Leader Agents. Secondly, it was the duty of the Plaintiff, as it had always been the case, to pay requisite fees for acquiring licences for the Defendant. These licences were always in custody of the Plaintiff.

### **Issues:**

- a) Whether the Defendant was paid a commission of US\$61,077 in respect of business concluded between the Plaintiff and the client?
- b) Whether there was any misrepresentation on the part of the Defendant to the Plaintiff?
- c) What remedies are available to the parties?

### **Judgment:**

1. The cause of action could not be founded on misrepresentation by the defendant that he was a licensed agent. The duty was on the plaintiff to establish whether the defendant was a licensed agent. Having dealt with the Defendant for a number of years, the Plaintiff could not move the court under a cause of action in misrepresentation.
2. The Plaintiff was forbidden by section 37 of the Insurance Act, Cap. 213 from paying a commission to an agent who was not licensed. Having paid commission in contravention of the Insurance Act, the Plaintiff could not turn around and seek refund of the commission paid and pray for declarations caused by its own contravention.

3. The action could not succeed without the court endorsing the Plaintiff's illegal act of paying the commission contrary to section 37 of the Insurance Act, Cap. 213. The suit was dismissed with no order as to costs.

### **Commentary:**

- a) *Under the Principal-Agent relationship, the agent acts on behalf of the insurer who is the principal. The principal remains with the duty to ensure that the agent who is acting on its behalf (with express and implied authority from the insurer) has a valid licence.*
- b) *The insurer should always ensure that all its agents have valid licenses before paying commission to them.*
- c) *Insurance agents should not claim commission for business they carried out without a valid insurance agent's licence.*
- d) *An insurer who pays commission to an unlicensed insurance intermediary should be fined for contravening the law under section 145(7) of the Insurance Act, Cap. 191.*
- e) *An insurance agent who carries out agency business without a valid licence contravenes section 81(1) of the Insurance Act Cap. 191 and is liable to a fine not exceeding two thousand currency points under section 81(6).*
- f) *The court ought to have recommended referral of these contraventions for punitive action/fining by the insurance regulator or criminal prosecution. The court, as a custodian of justice should not have permitted the defendant to retain commission it purportedly earned out of an illegality.*

## **III. ATTORNEY GENERAL Vs. NIKO INSURANCE UGANDA LTD HCCS NO 240 OF 2012**

### **Brief Facts:**

1. The Ministry of Local Government, acting on behalf of the Government of Uganda and M/s Amman Industrial Tools and Equipment Uganda Limited, entered into a contract where Amman Industrial Tools and Equipment Ltd agreed to supply the Plaintiff with 70,000 bicycles.
2. The Defendant issued a performance bond guaranteeing that it would pay 10% of the contract sum on receipt of the first written demand without cavil or argument should M/s Amman Industrial Tools and Equipment Ltd fail to perform its obligations under the contract.
3. The Ministry of Local Government paid 40% of the contract price to the contractor/supplier who failed to perform its part of the contract. The Ministry of Local Government wrote several letters to the Defendant pursuant to the provision of the performance bond making a demand for US\$489,650. The Defendant initially agreed to meet its contractual obligation but later argued that the performance bond was unenforceable because it was vitiated by fraud committed by M/s Amman Industrial Tools and Equipment Uganda Ltd and the Plaintiff's officials.

## Issues:

- a) Whether the officials of Government in collusion with Amman Industrial Tools and Equipment Ltd were fraudulent about the underlying procurement process and the contract concluded as a result.
- b) If so, whether the alleged fraud vitiated the performance bond?
- c) The remedies available to the parties.

## Judgment:

1. No clear fraud was established as alleged by the Defendant. It was not noted that the relationship between the Government officials and the Government is that of the principal/agent or employee/employer. It was clear that an act done with more authority than was given by the principal is not binding on the principal, except where a third party who has suffered because of the fraud had no notice of the limitations imposed on the agent.
2. The Plaintiff was entitled to the remedies sought in the plaint namely the payment of US\$489,650 under the performance bond dated 25th of November 2010 issued for the benefit of the Ministry of Local Government by the Defendant since no fraud was attributed to the Government.

## Commentary:

- a) **The wording of the performance bond in this matter was of an on-demand or first demand bond, and not a conditional bond by the use of the words**, “*And we undertake to pay you, upon your first written demand declaring the provider to be in default under the contract, without cavil or argument... without you needing to prove to show grounds or reasons for your demand or the sum specified therein*”.
- b) **The wording of the performance bonds issued by insurers should be very clear and unambiguous to distinguish on-demand bonds from conditional bonds. In this case, the wording was clear that this was a first demand or an on-demand performance bond.**
- c) **Fraud vitiates payment under a performance bond, including an on-demand or first demand bond.**

## IV. ISAAC KATONGOLE Vs. EXCEL INSURANCE COMPANY

### LTD HCCS NO 0176 OF 2012

#### **Brief Facts**

1. The Plaintiff filed this suit for a declaration that the Defendant breached the terms of a third-party insurance contract entered into under the auspices of the COMESA Yellow Card Protocol and for expenses, damages and costs incurred by Plaintiff due to the Defendant's breach of contract.
2. The facts are that the Plaintiff acquired a COMESA yellow card from the Defendant for its trailer registration number UAL 226 X/UAM 180 8Q. The Defendant is a member of the National Bureau of Uganda, which is authorised to issue COMESA yellow cards to its members.
3. The trailer got involved in an accident in Rwanda on 14 April 2011, injuring one Hadijah Mukakarisa. The Plaintiff's agents approached the National Bureau of Rwanda to settle the compensation claim arising from the accident. The National Bureau of Rwanda refused to honour the claim due to alleged errors in the yellow card issued to the Plaintiff. The Plaintiff settled the claim with the insured's representatives and sought compensation from the Defendant.

#### **Issues:**

- a) Whether the Plaintiff's suit is brought against the wrong party and is bad in law?
- b) Whether the High Court of Uganda is the appropriate forum to institute a suit and if not whether this suit is barred for want of jurisdiction?

#### **Judgment:**

1. The Yellow Card which was issued to the Plaintiff by the Defendant was invalid. The Plaintiff was, therefore, at liberty to sue all and any person he believed to have caused him damage. The Defendant was one such person, and the court overruled the Defendant's objections.
2. The court did not agree with the Defendant's Counsel that the cause of action of the Plaintiff was for indemnity and to be made against the National Bureau of Rwanda under the protocol for indemnity.

#### **Commentary:**

- a) ***According to the COMESA Protocol on the Establishment of a Third-Party Motor Vehicle Insurance Scheme, the National Bureau is defined as "a Government Designated Agency in each member state that shall be responsible for the management and control of the COMESA Yellow Card". In Uganda, it is Uganda Reinsurance Company Limited.***

- b) One of the duties of a national bureau is to act in the best interests of the issuing bureau in settling the claims against the holder/insured of a comesa yellow card.
- c) Where there are discrepancies in the yellow card, the National Bureau where the accident occurs is not bound to settle the claim. Recourse must be made to the insurer who issued the yellow card with support from the issuing national bureau.

## V. GOLDSTAR INSURANCE COMPANY LTD Vs. THE ATTORNEY GENERAL, SOUTHERN UNION INSURANCE BROKERS LTD & MULOWOOZA & BROS, CIVIL SUIT NO 132 OF 2010

### Brief Facts:

1. M/s Mulowooza and Bros Ltd, the operators and managers of the ship MV Kalangala, had taken out insurance cover for the ship which expired. There was an urgent need for insurance cover so that the MV Kalangala would be used to take Parliamentarians to the Ssese islands of Lake Victoria.
2. The second Defendant instructed the Plaintiff on behalf of the Ministry of works and transport to issue the insurance cover that was urgently needed. The Plaintiff obtained reinsurance and issued the insurance cover for a period of two weeks. Subsequently it became difficult to pay the Plaintiff the sums of money which it quoted. The second Defendant Southern Union Insurance Brokers (U) Ltd held out to be the agents of the Ministry of Works and Transport and duly instructed the Plaintiff and also informed the Plaintiff that the government was going to pay and provided the details of the Plaintiffs account to the Ministry of Works and Transport.

### Issue:

Whether the Defendants are liable to pay the Plaintiff the premiums which were due and owing.

### Judgment:

1. A third party can proceed against the agent or the principal or against both, especially in the circumstances of this case where instructions to provide the service were given by the agent.
2. As the owner of the vessel, the Government cannot escape liability because it is a beneficiary under the insurance policy. The consumer of the services who is the owner of MV Kalangala benefited from the procurement made on its behalf by the “agent”, and it can be directly pursued by third parties because it is the beneficiary of the services procured on its behalf.

3. The Plaintiff was awarded the sum of Uganda shillings 1,640,000/= as special damages and €22,409 as general damages for breach of contract to be paid by the first and second Defendants jointly and severally.

### **Commentary:**

- a) *Under the principal/agent relationship, the principal is bound by the acts of the agent.*
- b) *The principle of vicarious liability can operate in agent/principal relationships in case there is express authority.*
- c) *Authority of an agent can be derived from the instrument or inferred or implied from the circumstances.*
- d) *It was unprofessional for the insurance broker to holdout as having instructions for the Ministry of Works to act on its behalf to place cover. Insurance intermediaries should desist from breaching professional etiquette as required under the Insurance Act and the Insurance (Intermediaries) Regulations, 2021.*

## **VI. MICROCARE INSURANCE LTD Vs. INSURANCE REGULATORY AUTHORITY OF UGANDA CIVIL SUIT NO 684 OF 2015**

### **Brief Facts**

1. A preliminary objection was raised that the Plaintiff's suit was time-barred under Section 3 of the Limitation Act Cap 80 Laws of Uganda.
2. The Defendant refused to grant a licence to the Plaintiff to carry on insurance business, and the refusal to grant the licence in 2009 was the crux of the Plaintiff's cause of action.
3. The two years within which the Plaintiff should have instituted its suit had long passed when the suit was filed on 21st October, 2015. The Defendant's Counsel prayed that the suit should be struck out with costs to the Defendant.

### **Issue:**

- a) Whether the suit is time barred.

### **Judgment:**

1. The Plaintiff's action as disclosed in the plaint, could only be founded on tort and the cause of action arose in 2009. The claim for loss of income is a consequence of failure to operate a business and is not itself the cause of action but the consequence of the cause of action.
2. The Plaintiff's action, having been filed in 2015, is time-barred and accordingly rejected with costs under the provisions of law Order 7 rule 11 (d) of the Civil Procedure Rules.

### **Commentary:**

- a) ***IRA is a scheduled corporation under the Civil Procedure and Limitation (Miscellaneous Provisions) Act, Cap. 72 Laws of Uganda. The Act should be amended to provide for the Insurance Regulatory Authority of Uganda (IRA) since Uganda Insurance Commission was re-named IRA.***
- b) ***No action founded on tort shall be brought against a scheduled corporation, after the expiration of two years from the date on which the cause of action arose.***
- c) ***Timelines under the law should be strictly adhered to.***
- d) ***The denial of a licence should have been made a ground for judicial review since redress after exercise of administrative power is sought through judicial review.***
- e) ***Whereas this was good law then, following the enactment of the Insurance Appeals Tribunal Regulations and the constitution of this Tribunal, any decision of the Authority is appealable to the Insurance Appeals Tribunal under section 136(1) of the Insurance Act Cap. 191.***



INSURANCE REGULATORY  
AUTHORITY OF UGANDA

**COMPLAINTS  
BUREAU CASES**

## I. COMPLAINANT Vs.. SANLAM LIFE INSURANCE (UGANDA) LTD

### Brief Facts

1. The Complainant lodged this complaint on behalf of their client, seeking redress in a medical insurance claim of one of its employees.
2. The Complainant reported the claim to Sanlam Life and provided all the required claim documents for further action.
3. Sanlam Life declined the claim citing breach of the disclosure obligation relating to a pre-existing condition at enrolment for the cover.

### Issues

- a) Whether the Complainant's claim is payable.
- b) What remedies are available to the parties?

### Ruling:

1. The Authority reproduced the relevant Clause of the master policy and found that the insured's claim was payable.
2. The insurer appealed against the decision of the Authority.

On appeal, whilst upholding the decision of the Authority, the Tribunal held that;

- a) The Respondent had locus standi to lodge the claim on behalf of the insured and the beneficiary.
- b) The beneficiary under the insurance policy did not disclose the medical condition in issue because he was not informed, and was genuinely unaware of its existence until the objective tests were done.
- c) The Tribunal found that the claim was payable and ordered the appellant to pay the claim within 30 days.

### Commentary:

- a) **Life and health insurers should strengthen underwriting processes for specialised health conditions like premature deliveries.**
- b) **Proposal forms should be clear, concise and request for the right information.**

- c) **An insured or a beneficiary in an insurance contract is required to only disclose matters that are within his or her or their knowledge.**
- d) **An insurance broker can act on behalf of an insurer or an insured or insurance beneficiary (section 1 of the Insurance Act Cap. 191).**
- e) **When a broker is pursuing a claim on behalf of an insured or beneficiary, the broker should declare this and the claim or complaint should be in the name of the insured or beneficiary.**
- f) **Insurers should promptly settle payable claims.**

## **II. COMPLAINANT 1 & COMPLAINANT 2 Vs.. JUBILEE ALLIANZ INSURANCE & UAP OLD MUTUAL INSURANCE**

### **Brief Facts:**

1. A collision occurred along Masaka Road involving a vehicle, owned by the Complainant and another vehicle, belonging to the Complainant 2. The 1st Complainant's vehicle was comprehensively insured by Jubilee Allianz Insurance Company whereas the 2nd complainant's vehicle was insured by UAP Old Mutual Insurance. The accident was caused by the 1st Complainant whose insurer (Jubilee Allianz) agreed to compensate the 2nd complainant for the loss.
2. Due to the delay in payment of the third-party claim, the 2nd Complainant lodged a claim with its insurer UAP Old Mutual for indemnity. Jubilee Allianz was willing to pay UAP Old Mutual under subrogation according to the policy terms as long as UAP Old Mutual provided proof of payment of the 2nd Complainant's claim.
3. The Complainants strongly disputed the 15% depreciation rate which was applied to arrive at the payable claim amount to the 2nd Complainant. They also argued that Jubilee Allianz should pay the interest that accrued on the 2nd Complainant's loan with the bank due to its delay in payment of the claim.
4. This complaint was originally lodged by Complainant 1 against Jubilee Allianz but later on in the hearing, Complainant 2 and UAP Old Mutual were added as parties for the Authority to handle the whole matter comprehensively.

### **Issues:**

- a) Whether the calculation and application of depreciation value was accurate and fair?
- b) Whether the insurer is liable to pay interest on the compensation amount if there are any delays in settling the claim?
- c) What remedies are available to the parties?

### Ruling:

1. The 15% annual linear depreciation applied was not provided for in the policy document. After re-evaluating the depreciation rate, the Authority concluded that the applicable rate for this commercial vehicle should have been 13%.
2. The policy between the first Complainant and the first respondent did not extend cover to interest incurred due to financial obligations such as loans. Therefore, the first respondent was not liable under the insurance policy to pay interest accrued due to delayed settlement of the claim.
3. Once the insured has fulfilled their obligations under the insurance policy, the insurance company should promptly meet its obligations without unnecessary delays.
4. UAP Old Mutual was directed to re-compute the claim by considering a 13% depreciation to determine the pre-accident value and share the discharge voucher with the second complainant within three days and make payments within ten working days.

### Commentary:

- a) *The right of subrogation can only be exercised by an insurer after it has made payment to the insured or beneficiary.*
- b) *Motor comprehensive insurance policies should provide for the depreciation rate. Any ambiguities in an insurance policy are resolved in favour of the insured or beneficiary according to the contra proferentem rule of contract interpretation.*
- c) *Once the insured has fulfilled their obligations under the insurance contract, the insurer should also promptly settle its obligations except in cases of fraud or promptly communicate its decision to the claimant on whether the claim is payable or not.*
- d) *The purpose of an insurance contract is to provide indemnity to the insured in the event of a loss. Indemnity is not meant to give the insured an unnecessary benefit or to allow a claimant to profit from their loss, but to put them back in the position they were in before the loss.*
- e) *Insurers should comply with claim settlement guidelines issued by the Authority.*

## III. COMPLAINANT V SANLAM GENERAL INSURANCE COMPANY

### Brief facts

1. The Complainant lodged a complaint against the insurer for not honouring an insurance claim for damage caused by a power surge. The goods were insured under an all-risk asset insurance policy.

2. Claims were reported to the insurer through their insurance broker. The insurer repudiated the claim due to lack of insurable interest, insufficient evidence for equipment valuation, absence of a confirmed power surge and inconsistencies in the presented invoices. The Complainant sought a sum of UGX 282,020,000/=.

## Issues

- a) Whether the insurer unlawfully declined to honour the Complainant's claim?
- b) What remedies are available to the parties?

## Ruling:

1. There was no merit in the insurer's argument that the Complainant did not have insurable interest in the property insured because there was no dispute as to the ownership of the property. Additionally, insurable interest extends beyond mere ownership to lawful possession.
2. There was no merit in the argument that there was insufficient evidence for equipment valuation, purchase documents, and the insurer's request for these documents was odd and improper at the claims stage. The valuation concerns should have been addressed during the underwriting stage. The insurer could not dispute the valuation at the claims stage. (*Span International Ltd Vs. National Insurance Corporation HCCS No. 29 of 1999 [1997 – 2000] UCLR 404*).
3. The insuring clause in the policy covered internal short circuit, internal electrical fault or faulty wiring which the two assessors deputed by the insurer concluded as the likely causes of the damage. Arguments over the UMENE power surge became immaterial.
4. There were inconsistencies in presented invoices. The Authority appointed a new loss assessor and, in their report, indicated that the invoices were suspicious, lacked credibility, could not be authenticated and were fake. . On the basis of these inconsistencies, the Authority found that the claim was not payable.

## Commentary:

- a) **Insurable interest is not limited to only ownership. It extends to lawful possession.**
- b) **Where the insured provides all required information in the proposal form, and**
  - i. **the insurer does not inquire about the details of the property being insured;**
  - ii. **or request for more information, at the underwriting stage, the presumption is that the insurer is satisfied with the property and its value before issuing the policy. (*Span International Limited versus National Insurance Corporation HCCS NO. 29 of 1999; [1997-2000] UCLR 404*).**
- c) **Insurers should avoid underwriting at the claims stage.**

- d) ***It is the responsibility of the claimant to provide claim support documents. Where documents requested for by the insurer or loss assessor are not submitted, there is no basis for payment of the claim.***
- e) ***Complainants should desist from submitting fraudulent information to support claim settlement. Fraud is a criminal offence.***

## IV. COMPLAINANT Vs. SANLAM GENERAL INSURANCE COMPANY LTD

### Brief Facts

1. The Complainant engaged surveyors to provide professional advice before granting credit facilities. It was a prerequisite required of them to get professional indemnity insurance policy coverage. The surveyors were insured by the Respondent.
2. The valuation reports of the surveyors (insured) were later found to be erroneous. These errors led to defaults in the Complainant's work, promoting the complainant to attribute losses due to the professional negligence of the insured. The insured sought indemnity from the Respondent, who denied the claims citing reasons that the policy claim was time-barred and there was contributory negligence by the complainant.
3. Upon this, the Complainant lodged a complaint with the Insurance Regulatory Authority.

### Issues

- a) Whether the insured's claims are time-barred
- b) If not, did the insured breach their duty of care to the Complainant?
- c) Whether the bank is liable for contributory negligence?
- d) Whether the Complainant suffered a loss directly attributable to the professional negligence of the insured?
- e) Whether the claim is payable?
- f) What remedies are available to the parties?

### Ruling:

1. Some claims were lodged outside the extended discovery periods of the relevant policy renewals, and therefore time barred, whereas others were reported within the appropriate time frame, and thus not time barred.
2. The insured breached their duty of care by signing valuation reports without verifying the

contents, leading to erroneous property valuations which constituted professional negligence and a breach of the duty of care that the insured owed to the Complainant. The insured should have been diligent enough.

3. The bank is not liable for contributory negligence. The responsibility for due diligence had been outsourced to the insured, and the errors attributed to the bank were not significant enough to constitute contributory negligence.
4. The Complainant suffered a loss directly attributable to the insured's professional negligence by making incorrect property valuations. This led to the bank disbursing larger loan amounts than the actual property values warranted.
5. The insured's professional negligence resulted in a verifiable loss to the Complainant, making the claim valid under the policy terms. Therefore, The Respondent was directed to pay the adjusted loss amount to the Complainant, subject to policy limits and excess, within 30 days.

*On Appeal, while upholding the decision of the Authority, the Insurance Appeals Tribunal held that;*

- a) *The law does not restrict the right to lodge a complaint to only policyholders but also to third parties.*
- b) *The Authority decision was just, fair and legal*
- c) *The Appellant should pay the claim.*

### **Commentary:**

- a) ***The Insurance Act section 11(1)(j) and (k) and the Insurance Complaints Bureau Guidelines do not limit lodgement of complaints to only policyholders. Insurance beneficiaries and third parties can lodge complaints with the Authority. They are not limited by the privity of contract.***
- b) ***Claims made policies cover incidents/losses;***
  - i. ***That occur and are reported within the policy period***
  - ii. ***That occurred within the retroactive date but are reported within the policy period.***
  - iii. ***That are reported within the discovery period stipulated in the policy.***
- c) ***Discovery period means the extended time period following policy expiry during which the insured may discover and report a claim for losses which occurred during the policy period.***
- d) ***Occurrence policy provides coverage for incidents that take place during a policy period, regardless of when the claim is reported.***

## V. COMPLAINANT Vs. CIC GENERAL INSURANCE COMPANY LTD

### Brief Facts

1. The Complainant took out an All-Risks insurance coverage policy with the Respondent, which was running.
2. On the fateful night at an unknown time, persons broke into the offices of the complainant and stole a number of items, valued at UGX 73,600,000/=. The incident was reported to the Police Station and investigations confirmed that the theft had occurred as the thieves jumped over the perimeter wall fence and broke into the complainant's office.
3. the Complainant notified the Respondent of the said break-in and theft and informed them that the value of the lost assets is not in dispute; however, CIC repudiated the Complainant's claim for indemnity citing that there was no theft within the policy's definition, breached the geographical area clause, and material non-disclosure due to late or non-notification of change of ' office location.

### Issues

- a) Whether there was theft within the meaning of the Policy?
- b) Whether notification of change of location after the loss would entitle the Respondent to dis-honor the claim?
- c) What remedies are available to the parties?

### Ruling:

1. Minimal damage, like picking a lock or breaking a latch, can be considered a forcible entry. (**India Industrial Promotion & Investment Corporation of Orissa Ltd Vs.. New India Assurance Company Ltd Supreme Court of India**). The theft in this case met the policy's definition, satisfying the conditions of office breaking and actual forcible visible damage.
2. Failure to promptly notify the insurer of the location change was a material breach. The complainant breached the principle of utmost good faith in insurance contracts, as discussed in **Abillahi Kassimu Mandepe Vs.. Britam Insurance (Tanzania) Limited**, which mandates full disclosure of all material facts by the insured. Therefore, the claim was not payable.

### Commentary:

- a) **Policyholders must make full disclosure of all material facts within their knowledge that have a bearing or would have an effect on the risk insured or proposed to be insured.**

- b) **Non-disclosure of a material fact is a breach of the principle of utmost good faith, and where the non-disclosure is directly connected to the loss or claim, the claim will not be payable.**
- c) **The term “forcible entry” was expanded to include: entry obtained by picking a lock or forcing back a latch.**

## VI. COMPLAINANT Vs. LIBERTY GENERAL INSURANCE UGANDA LTD

### Brief Facts:

1. The Complainant lodged a complaint against Liberty General Insurance for failing to settle a claim amounting to UGX 198,820,646/. At a certain point in time, the Complainant sent a proposal to insure their assets to five insurance companies, with Liberty General emerging as the lowest bidder.
2. The Complainant then took out an Asset All Risks Policy with Liberty General Ins. During cover, a building housing the Complainant's office collapsed, damaging insured property. Liberty General repudiated the claim, citing an exclusion clause in the policy regarding the collapse or cracking of buildings.

### Issues:

- a) Whether the insurance claim is payable.
- b) What remedies, if any, are available to the parties?

### Ruling:

1. The exclusion clause in the policy excluded liability if the collapse or cracking of buildings caused the damage. It was established that the Complainant had sufficient notice of this exclusion clause before signing the policy. Despite raising concerns about specific clauses in the policy, the Complainant signed it after lengthy deliberations. The Complainant's officials signed the policy without rectifying their concerns, indicating acceptance of its terms. As per common law principles, a party is bound by the contract terms they sign.
2. The claim was not payable due to the exclusion clause.

### Commentary:

- a) **An exclusion clause in the insurance contract must be effectively communicated to the**

**policyholder. Effective communication by the insurer means that all exclusions in the policy must be included in the Key Facts Document at the point of sale; and explained to the prospective policyholder in a language that he or she understands. The Key Facts Document must be signed off by the prospective policyholder. (See Regulation 51 of the Insurance (Licensing and Governance) Regulations 2020.**

- b) **The Key Facts Document should form part of the insurance contract just like the proposal form/ application form.**

## **VII. COMPLAINANT Vs. ICEA LION GENERAL INSURANCE AND STATEWIDE INSURANCE COMPANY LTD**

### **Brief Facts:**

1. The Complainant filed a complaint against ICEA General Insurance and Statewide Insurance Company Ltd for failing to honour a claim arising from a work-related injury sustained during his employment. The Complainant's employer had a Group Accident/Workman's Compensation Insurance Cover, with Stewide Insurance Company Ltd and ICEA General Insurance.
2. The Complainant claimed to have suffered an injury while removing crates of soda from the conveyor while at work. He continued working even after sustaining injuries, but later retired. The Complainant lodged a claim for compensation with ICEA Lion General, but it was refused because they were not the insurers at the time of injury manifestation. Statewide Insurance Company Ltd also declined the claim, alleging that the date of injury on the claim form was altered and that no medical documents supported the claim.

### **Issues:**

- a) Which insurer is liable to settle the claim?
- b) What remedies are available to the parties?

### **Ruling:**

1. The critical determination was the exact date of manifestation of the injury, as it determines the responsible insurer. The date of manifestation refers to when the injury becomes obvious.
2. Despite Statewide's argument that treatment began at a certain point in time, the injury's connection with work was established sometime after treatment had begun. Statewide, being the insurer at the time of manifestation, was liable to settle the claim.
3. Statewide was directed to settle the claim within 15 days from the decision date and furnish proof of payment within the same timeframe.

## **Commentary:**

- a) **Notification of incidents or accidents-**
  - i. **Insurance beneficiaries should notify their Human Resource management whenever they experience an injury or incident which may lead to an insurance claim under the policy.**
  - ii. **The Human Resource management of the insured should immediately notify their insurer or broker so that the incident is registered by the insurer for onward management. This is intended to minimise declinature of claim due to late reporting.**
- b) **Manifestation of a scheduled disease is when the symptoms of the disease are clearly manifested in physiological or psychological signs or when it is first diagnosed by a medical practitioner.**
- c) **For physical injury, the date of occurrence is the date when the incident or accident occurs.**

## **VIII. COMPLAINANT Vs. CIC AFRICA LIFE ASSURANCE (U) LIMITED**

### **Brief Facts:**

1. The Complainant, extended a loan facility to a borrower. The complainant obtained an insurance cover, termed a Loan Guard Policy, from CIC Africa Assurance (U) Limited (the Respondent).
2. The insurance policy covered the outstanding loan balance in the event of the death or total permanent disability of the borrower or a guarantor. One of the shareholders, also the Borrower's director, and the loan's guarantor, was endorsed as the life assured under the policy.
3. Following the guarantor's death, the Complainant lodged a claim for the entire outstanding loan balance with the Respondent. The Respondent declined to pay the entire claim, offering only 30% of the assessed amount based on guarantor's shareholding in the Borrower company.

### **Issues:**

- a) Whether the complainant is entitled to payment of the entire insured loan balance of UGX 357,742,448/= from the Respondent.
- b) What remedies are available to the parties?

### Ruling:

1. The Complainant was entitled to payment of the entire insured loan balance UGX 357,742,448/= from the Respondent. The insurance policy clearly stated that upon the death of the life assured, the Respondent was obligated to pay the outstanding loan balance. The endorsement listing the guarantor as the life assured was not a mistake, and the argument by the Insurer that it was erroneous was deemed flawed.
2. The policy's intention was clear, and the Complainant should receive the total insured amount. The Respondent was directed to pay the Complainant the entire insured loan balance. Additionally, the Insurer was warned against unnecessary delays in settling claims, as prompt settlement of genuine claims is essential to maintain the integrity of the insurance industry.

### Commentary:

- a) *This is another case of ambiguous or vague policy wording just like many other similar cases.*
- b) *If the intention of the Insurer was to exclude coverage where a business relationship exists between the lender and the borrower, then this should have been a disclosure requirement by the policyholder at proposal stage.*
- c) *This should have also been included as an exclusion in the master policy document.*
- d) *Such an exclusion clause must be effectively communicated to the policyholder. Effective communication by the insurer means that all exclusions in the policy must be included in the Key Facts Document at the point of sale and explained to the prospective policyholder in a language that he or she understands. The Key Facts Document must be signed off by the policyholder.*
- e) *The Key Facts Document should form part of the insurance contract just like the proposal form/ application form.*
- f) *Introducing an exclusion at the claim stage may be seen as a ploy to avoid payment of a claim.*

## IX. COMPLAINANT Vs. MUA INSURANCE (UGANDA) LIMITED

### Brief Facts:

1. The Complainant filed a complaint against MUA Insurance (Uganda) Limited. The Complainant had taken out a Fidelity Guarantee Policy with MUA Insurance. At a certain point in time, the Complainant discovered a shortage in its stock at its warehouses and a theft incident at another warehouse.

2. Investigations revealed a total loss of approximately 75 metric tons due to a collusion between employees and casual labourers, with the warehouse manager implicated in fraudulent activities. The Complainant filed a claim for USD 100,000 under the policy, which MUA Insurance repudiated, citing insufficient evidence and policy breaches. The parties presented their arguments during hearings, focusing on whether the claim was payable under the policy and available remedies.

### **Issues:**

- a) Whether the Complainant's claim is payable as per the terms and conditions of the Fidelity Guarantee Policy.
- b) What remedies are available to the parties?

### **Ruling:**

1. The policy covers direct financial losses resulting from fraud or dishonesty by an insured employee that leads to personal financial gain for the employee.
2. The warehouse manager of the Complainant, admitted to fraudulent activities during a disciplinary hearing.
3. Despite the termination letter citing gross negligence, evidence showed the warehouse manager's involvement in fraudulent activities which justified the claim.
4. The loss due to employee dishonesty falls within the policy coverage, overriding arguments of unexplained shortages or losses.
5. The loss payable under the policy amounted to USD 37,810, as assessed by the loss assessor.
6. MUA Insurance was directed to issue a discharge voucher for payment within seven working days and pay the Complainant within twenty working days.
7. MUA Insurance was also instructed to submit the policy wording for review.

*On Appeal, the Insurance Appeals Tribunal held that;*

1. *In the absence of concrete evidence of fraud through a police investigation report, a court order or even in the least circumstances reports by independent assessors confirming the existence of the same, it would be erroneous to conclude that there was fraud and dishonesty without testimonies from the subject employees to establish the alleged facts.*
2. *Secondly, the reasons embedded in the termination letters of the employees/perpetrators were gross negligence as opposed to fraud and dishonesty.*
3. *Thirdly, the expert opinions of two independent assessors, M/s Claim Care and M/s Veri-Claims & Properties Ltd concluded that the employees were not liable for fraud and dishonesty. Most importantly, the report of the independent assessor had a verdict similar to that of the assessor appointed by the appellant, and both recommended that the insurance claim was not payable by the appellant. Whilst the reports from assessors confirm the existence*

*of financial loss occasioned to the respondent company, they don't qualify the loss to have directly arisen from continued acts of fraud and dishonesty by the respondent's employees.*

4. *The principle governing the enforcement of insurance policy contracts is precisely that for an insurance claim to be payable, it must be in the scope of the indemnity agreement and conditions enlisted therein.*
5. *For a fidelity guarantee policy to be enforced, the perils insured against must be described as fraud and dishonesty. The insured can only recover if he proves that the offence described in the policy has been committed.*
6. *The burden of proving fraud lies on the insured. In this case, the respondents were reluctant and failed to prove the employee's fraudulent acts. The employees were terminated for gross negligence and not fraud; therefore, there was no evidence implicating them as having knowingly participated in fraud against their employees.*
7. *The tribunal did not find either direct or circumstantial evidence to prove that the employee obtained financial gain/ advantage from the fraudulent actions. In the absence of vivid evidence, it was wrong to conclude that the respondent's employee had obtained personal gain. It is trite law that before coming to a decision, one ought to act on credible evidence and not indulge in conjecture, speculation, attractive or fanciful reasoning.*
8. *The decision of the Authority was reversed.*

### **Commentary:**

- (a) *The requirement to prove "dishonest personal financial gain by the insured employee involved in the fraud" in a fidelity guarantee policy is an unfair provision. This provision is very difficult, if not impossible to prove, and unrealistic.*
- (b) *The Authority needs to act on credible evidence adduced before it in the Complaints Bureau, and not hearsay or speculation.*
- (c) *The principle governing the enforcement of insurance policy contracts is precisely that for an insurance claim to be payable, it must be in the scope of the indemnity agreement and conditions enlisted there.*
- (d) *For a fidelity guarantee policy to be enforced, the perils insured against must be described as fraud and dishonesty. The insured can only recover if he proves that these perils as described in the policy have been committed.*

## X. COMPLAINANT Vs. NIC GENERAL INSURANCE COMPANY LTD

### Brief facts:

1. The Complainant filed a complaint against NIC General Insurance Company Ltd, the respondent, for failing to pay his insurance claim of UGX 6,778,000/=.
2. He had obtained comprehensive insurance policies for his vehicles. After an accident involving a truck, the Complainant lodged a claim with NIC General Insurance.
3. The insurer offered to settle the claim but also notified the Complainant of an outstanding premium balance of UGX 22,712,677/=. The insurer had previously sued the Complainant in court for outstanding premiums of UGX 22,712,677/=. The court held in favour of the Complainant.

### Issues:

- a) Whether there was a pending suit in court in respect to the subject matter before the Authority or whether the issues in the complaint can be severed from the matter in Court.
- b) Whether the Complainant was entitled to compensation in respect of his motor vehicle.
- c) What remedies are available to the parties?

### Ruling:

1. There was no pending suit between the parties in court at the time of the complaint. The matter before the Authority focused on unreasonable delay in paying a claim, distinct from the issues previously litigated in court regarding outstanding premiums.
2. The Authority found that the Complainant was entitled to compensation for the accident involving his motor vehicle.
3. The insurer's argument that the Complainant had not paid the premium for the policy was deemed contradictory, as the insurer had reviewed, processed, and offered a settlement for the claim.
4. The Authority ordered the insurer to compensate the Complainant the sum of UGX 6,778,000 within seven days and warned the insurer against further unprofessional conduct.

*On appeal by the complainant, the Insurance Appeals Tribunal held that;*

1. *Since the issue of limitation wasn't raised by the respondent before the Authority for consideration, it could not, therefore, be considered by the tribunal.*
2. *Alternatively, the letter of 23<sup>rd</sup> March, 2011, signed by the respondent's manager acknowledged the claim of UGX 6,778,000, although it was on condition that the insured accepted*

*the amount to be offset from an outstanding premium.*

3. *The respondent was ordered to pay the acknowledged amount whether there was an outstanding premium or whether it was disputed. The obligation to pay the acknowledged debt accrued when the letter was signed on 23<sup>rd</sup> March, 2011 by the respondent, and this part of the claim wasn't barred by limitation.*
4. *The computed sum of the claim was erroneous as it didn't include the towing charges of UGX 1,000,000 which ought to be covered by the policy. Therefore, the tribunal re-calculated the sum from UGX 6,778,000 to UGX 7,778,000.*
5. *NIC should pay to the Appellant UGX 7,778,000 with interest of 12% pa from 23rd March, 2011 until payment in full and the costs of the appeal.*

#### **Commentary:**

- a) *Insurers ought to conduct their business in a professional manner. (Regulation 43 of the Insurance (Licensing and Governance) Regulations 2020).*
- b) *Inordinate delay in payment of a claim after committing to pay, arm-twisting a policyholder at claims stage to pay debts which are in dispute are examples of unprofessional conduct.*
- c) *An undertaking by an insurer to pay a claim, and is communicated by letter is binding on the insurer except in exceptional circumstances like fraud on the part of the policyholder.*

## **XI. COMPLAINANT Vs. NIC LIFE ASSURANCE LTD**

#### **Brief facts:**

1. The Complainant was employed by NIC Life Assurance Company Ltd. His contract entitled him to commission payments based on premiums he brought in from clients.
2. The complainant convinced a client who signed up for life insurance. The Complainant claimed to have received only partial commission payments. He alleged that the insurer's actions, including delayed claim payments and regulatory issues, led to loss of the business and unpaid commissions, for which he sought redress from the Authority.

#### **Issues:**

- a) Whether the Complainant was entitled to UGX 55,000,000/= as his unpaid commission and compensation for loss of business.
- b) What remedies are available to the parties?

### Ruling:

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1. The Complainant did not possess a valid licence, which was a contravention of the Insurance Act.
2. The Complainant was not entitled to UGX 55,000,000/= as unpaid commission and compensation for loss of business.
3. The Complainant was fined UGX 500,000/= for carrying out insurance business without a valid license. Additionally, NIC Life Assurance Company Ltd was fined UGX 12,705,720/=, for paying commission to an unlicensed agent. These penalties served as a warning to both parties and other industry players, to emphasise compliance with regulatory standards.

### Commentary:

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- a) ***Under the Principal-Agent relationship, the agent acts on behalf of the insurer who is the principal. The principal remains with the duty to ensure that the agent who is acting on its behalf (with express and implied authority from the insurer) has a valid licence.***
- b) ***The insurer should always ensure that all its agents have valid licences before paying commission to them.***
- c) ***Insurance agents should not claim commission for business they carried out without a valid insurance agents' licence.***
- d) ***An insurer who pays commission to an unlicensed insurance intermediary should be fined for contravening the law under section 145(7) of the Insurance Act, Cap. 191.***
- e) ***An insurance agent who carries out agency business without a licence contravenes section 81(1) of the Insurance Act Cap. 191 and is liable to a fine not exceeding two thousand currency points under section 81(6).***
- f) ***The ruling is in line with the High court Judgement in the case of Insurance Company of East Africa Vs. Kitagenda Muhammed Civil suit No 301 of 2012.***

## XII. COMPLAINANT Vs. SANLAM LIFE INSURANCE (UGANDA) LIMITED

### Brief facts:

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1. The Complainant sought reimbursement for expenses incurred by his beneficiary, during a work trip.
2. The insurer alleged that the beneficiary underwent treatment without its prior authorisation. The insurer declined the claim, stating lack of pre-authorisation and categorising the treatment as elective rather than an emergency.

### **Issues:**

- a) Did the insurer grant approval for treatment outside the area of cover?
- b) Was the beneficiary's medical condition require immediate intervention?
- c) Whether the travel insurance for the trip absolves the insurer of its obligations under the group medical health insurance scheme?
- d) What remedies are available to the parties?

### **Ruling:**

1. The insurer failed to respond promptly to the Complainant's request for pre-authorisation, creating a reasonable expectation of approval for treatment outside the coverage area. The insurer's subsequent denial of the claim based on lack of pre-authorisation was deemed unjust and contrary to the principle of utmost good faith.
2. The treatment that was carried out was deemed necessary and not pre-planned, based on an independent medical specialist's opinion and clinical notes from the attending doctor. The insurer's assertion that the treatment was elective was unsupported by sufficient evidence.
3. The existence of travel insurance did not absolve the insurer of its obligations under the group medical health insurance scheme. The complainant's lack of awareness regarding the travel insurance and the circumstances of its acquisition precluded faulting them for pursuing the claim under the medical policy.
4. The insurer was directed to pay the claim within 14 days.

### **Commentary:**

- a) ***This was a case of ambiguous or vague policy wording. Sanlam lost this case partly because of the absence of the definition of "Medical Emergency".***
- b) ***The structure of Sanlam's response to the email claim notification from the claimant was an implied admission of the liability hence a pre-authorisation. Insurers need to be very careful when responding to clients to avoid indirect admission of unintended liability.***

### XIII. COMPLAINANT Vs. Jubilee LIFE INSURANCE LIMITED

#### Brief facts:

1. Jubilee Life Insurance Limited issued a Group Credit Life Assurance Policy to the Complainant to safeguard facilities extended to its clients.
2. The Complainant extended a loan facility of UGX 130,000,000/= to its client which was the Medical Centre then. The owner of the Medical Centre passed away, leaving an outstanding loan of UGX 127,559,401/=.
3. The Complainant lodged a claim with Jubilee Life Insurance Limited, but the insurer declined payment, citing misrepresentation of the borrower's health status and irregularities in facility disbursement.

#### Issues:

- a) Whether the deceased provided accurate health information in the 'Declaration of Good Health Form'.
- b) Was the Complainant bound by the 'Declaration of Good Health' form?
- c) Whether the 'Declaration of Good Health' form, introduced without regulatory approval and modifying policy terms, is valid and binding.
- d) Whether one of the employees of the Medical Centre had the legal authority to give instructions for the disbursement of funds, considering she was not the proprietor of the Medical Centre.
- e) What remedies are available to the parties?

#### Ruling:

1. The deceased may have concealed his actual health status when completing the health declaration form, but there's no evidence that the Complainant was aware of this information, thus not impacting the claim's validity.
2. The Complainant was bound by the Declaration of Good Health form, as both parties signed it. However, subsequent analysis revealed that the form's introduction as part of the proposal form violated regulatory approval requirements.
3. The introduction of the Declaration of Good Health form without regulatory approval rendered it invalid and non-binding. Misrepresentation by the borrower didn't affect benefits owed to the Complainant under the original policy.
4. Despite irregularities in the instructions for fund disbursement, they weren't significant enough

to invalidate the claim. Jubilee Life Insurance Limited was directed to pay the claim, subject to policy limits, within 30 days.

### **Commentary:**

- (a) **Jubilee Life lost this case on the basis of introduction of the “Declaration of Good Health Form” without approval by the IRA as required by section 65 of the Insurance Act 2017 and regulation 46 of the Insurance (Licencing and Governance) Regulations 2020.**
- (b) **It should be noted that use of “Declaration of Good Health Form” by life underwriters is best practice as it helps life insurers to collect necessary information for their underwriting decisions. However, introduction of such a form must be done in line with the law and regulations to ensure that such modifications in proposal forms are fair to the policyholders.**
- (c) **Additionally, such a form collects personal sensitive information from prospective policyholders, its introduction or changes to it must be done in line with the law and regulations.**

## **XIV. COMPLAINANT Vs. CIC GENERAL INSURANCE (U) LTD**

### **Brief Facts:**

1. The Complainant had a contractual agreement with CIC General Insurance (U) Ltd. The respondent, was appointed as the insurer's agent. The dispute arose over the interpretation of a Clause of the Agreement, pertaining to additional commission entitlement if the Complainant generated business worth UGX 1,000,000,000 for a certain the year
2. The Complainant alleged not to have received the additional commission despite generating business exceeding the stipulated amount. The primary discrepancy was regarding the premiums generated by one client, with the Insurer claiming the complainant was not entitled to commission from that business.

### **Issues:**

- a) Whether the Complainant is entitled to UGX 29,937,291/= as payment of 2.5% of the collected basic premiums for 2022?
- b) What remedies are available to the parties?

## Ruling:

1. The Complainant was not entitled to the claimed commission as it was revealed that he was not the ultimate beneficiary of the commissions. It was found that an unlicensed intermediary, was the beneficiary, and both parties were involved in an illegal arrangement.
2. The Insurer was fined UGX 162,492,269/=, equivalent to 20% premium received from the client, in accordance with Section 146(7) of the Insurance Act. The complainant was fined UGX 500,000/= and warned against engaging in actions that contravene the law.

*On appeal, the Insurance Appeals Tribunal held that;*

- 1) *There was an illegal payment made to unlicensed insurance brokers.*
- 2) *The Authority did not have any evidence confirming that the appellant had received premiums worth Ugx 812,462,343/= for it to levy the fine of 20% of Ugx 812,462,343. The fine was overturned and replaced with the fine of Ugx. 500,000/= for the insurer.*

## Commentary:

- (a) *The ruling of the Insurance Appeals Tribunal may encourage the vice of insurers dealing with unlicensed intermediaries since the fine was not punitive. Fines should be hefty enough to deter contravention of the law.*
- (b) *Insurers should desist from dealing with unlicensed intermediaries.*
- (c) *Intermediaries including agents have a duty to comply with the provisions of the Insurance Act and the Insurance (Intermediaries) regulations.*
- (d) *According to the agent-principal relationship, an insurance agent acts for and on behalf of the insurer, and not the insured. Requiring an insurance agent to present an appointment letter from the insured is illegal and contravenes the definition of an insurance agent espoused in section 1 of the Insurance Act Cap. 191. CIC General alluded that the agent had not been appointed by the client.*
- (e) *An Agency agreement is sufficient to confirm a valid, legal and binding relationship between an insurer and an insurance agent.*

## XV. COMPLAINANT Vs. GA INSURANCE COMPANY LTD

### Brief facts:

1. The Complainant filed a complaint against GA Insurance Company Ltd (the Insurer) for rejecting his claim under a Motor Comprehensive Policy after his car was involved in a road accident. The policy obligated the Insurer to compensate for loss or damage to the motor vehicle, excluding depreciation, wear and tear, mechanical or electrical breakdowns, failures, or breakages.
2. The accident occurred when the complainant's car caught fire, leading to a crash into a UNRA built-up wing wall of a culvert. Loss assessors concluded that the damage was due to fire and impact crash damage, with the suspected cause being an electrical short circuit within the dashboard.

### Issues:

- a) Whether the Complainant's claim is payable.
- b) What remedies are available to the parties?

### Ruling:

1. The Authority found that the exclusion clause in the policy regarding mechanical or electrical breakdowns did not extend to cover the damages resulting from the fire and subsequent crash. While acknowledging the exclusion clause, the Authority interpreted it restrictively against the Insurer and concluded that the damages fell within the primary risk insured against. Thus, the Complainant's claim was payable under the policy terms and conditions.
2. The Insurer was directed to issue a discharge voucher of UGX 25,201,700/= within three days of receiving the decision.

### Commentary:

- (a) ***Insurers need to clearly define the Electrical and Mechanical breakdown exclusion in the policy to avoid ambiguity and any further legal disputes. In this case, the first assessor concluded that the cause of loss was fire which was covered by the policy. The findings of the second assessor on the other hand were that the loss was due to an electrical short circuit within the wire harness.***
- (b) ***Insurance policies should be clear on what is covered and excluded, and the obligations of the parties. Ambiguous or vague provisions create misinterpretations, confusion, delays in settlement of claims, and defeats the intentions of the parties. In these circumstances, the contra proferentem rule is usually applied against the insurer.***

## XVI. COMPLAINANT Vs. MUA INSURANCE (UGANDA) LTD

### Brief Facts:

1. The Complainant filed a complaint against MUA Insurance (Uganda) Ltd (the Insurer) regarding two separate losses.
2. The Insurer appointed a company to inspect the consignments, concluding that the losses were due to out-of-range temperatures during transit.
3. The Insurer denied the claims, citing policy exclusions for losses due to mechanical and electronic breakdowns.
4. The Complainant filed a complaint seeking payment of both claims totalling to US\$ 38,560.

### Issues:

- a) Whether the Complainant's claim is payable.
- b) What remedies are available to the parties?

### Ruling:

1. The Authority found that the cause of loss, as determined by the surveyor's report, was exposure to out-of-range temperatures during transit. However, without temperature logs during transit, the exact cause of the exposure could not be determined.
2. The Complainant failed to provide evidence to support their claim and breached policy conditions, so the Authority concluded that the claim was not payable.
3. No remedies were granted to the Complainant.

### Commentary:

- (a) ***Insurance brokers owe a duty of care to their clients and prospective insureds to advise them appropriately on: the interpretation of the policy provisions and exclusions; obligations of the insured under the policy and consequences of non-observance, fairness of the policy terms and conditions; and suitability of the cover being taken up.***
- (b) ***Insurers should keep their insureds always updated on the levels of exhaustion of the sum insured so that they can pay additional premium in case the sum insured is depleted. This should be done by the insurance broker where the insured has a broker.***
- (c) ***Claimants should be cooperative during the claims process and submit all the required claim support documentation.***

## XVII. COMPLAINANT Vs. LIBERTY GENERAL INSURANCE CO. LTD

### Brief Facts:

1. The complainant's vehicle was involved in an accident, and the Complainant filed an insurance claim with Liberty General Insurance Uganda Limited (the Insurer).
2. The Insurer disputed the policy's validity, asserting it was a Motor Third Party Policy and no premium had been paid for the relevant period.
3. The Complainant lodged a complaint with the Insurance Regulatory Authority of Uganda seeking resolution of the dispute.

### Issues:

- a) Whether there was a valid insurance contract between the Complainant and the Insurer for the policy period in question.
- b) What remedies are available to the parties?

### Ruling:

1. The Complaints Bureau found no valid insurance contract between the Complainant and the Insurer for the policy period (2022-2023), as the policy was issued without upfront premium payment, rendering it void ab initio.
2. The Complainant was not entitled to any indemnity arising from such a policy. However, the Insurer was fined UGX 20,000,000/= for its unprofessional conduct, issuance of a backdated insurance sticker, and denial of issuing a comprehensive insurance policy.
3. The Insurer was also directed to rectify its practices, comply with the law, and report back on the steps taken within one month. Failure to remit the fine within 14 days would result in more stringent regulatory sanctions.

*On appeal, the Tribunal upheld the decision of the Authority and held as follows;*

1. The MTP Certificate of Insurance provided by the Appellant did not constitute a valid renewal of the insurance policy, as it lacked the distinctive features of an insurance policy.
2. Non-payment of premium, a condition precedent to a valid insurance contract, rendered the contract void, especially after the regulatory authority reinstated the requirement for premium payment before policy commencement.
3. As there was no valid insurance contract in place, the Appellant was not entitled to indemnity for the loss suffered. The tribunal declined to award punitive damages or costs to either party.

### **Commentary:**

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- (a) **Insurers should ensure full compliance with section 62 (1) of the insurance Act CAP 191 to avoid making policyholders believe they are on cover whereas not.**
- (b) **Insurers should do proper underwriting whenever there is a policy lapse before onboard-ing the client.**
- (c) **An Insurance contract only exists when there is an agreement between parties (offer and acceptance) which is followed by consideration (payment of premium). A contract of insurance is entered into once parties have agreed on the subject matter of insurance, terms and conditions of the proposed contract and one party pays consideration based on the agreed terms.**

## **XVIII. COMPLAINANT Vs. SANLAM GENERAL INSURANCE COMPANY LIMITED**

### **Brief Facts**

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1. The Complainant while in, Kampala found herself amidst a scuffle along the street caused by street vendors running away from Government agents.
2. The Complainant was pushed onto the transformer owned by another Government agent located in Kampala. The transformer had live wires, naked wires and or poor wiring that electrocuted the complainant's left arm and caused several injuries. She was rushed to Mulago Hospital where she was referred to Kiruddu Hospital for further case management.
3. The complainant sought compensation from Sanlam General who were Government agent insurers at the time of the accident. A demand of UGX 80,000,000/= being compensation for injuries suffered and UGX 10,000,000/= being instruction fees was made.
4. The Complainant lodged a complaint with the Authority having received no response from the insurers. Sanlam General issued a release of all claims amounting to UGX 8,000,000/=.
5. The justification was that the Complainant had fully healed and only had cosmetic injuries and that she had contributed to the injuries by failing to safeguard herself from such electrocution. The Complainant rejected the offer and parties were required to make written submissions.

### **Issues:**

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- a) Whether the injury suffered by the Complainant is covered in the policy
- b) Whether the Complainant is liable in contributory negligence for the injuries suffered.
- c) Whether the claim is payable.

### Ruling:

1. The injuries suffered are covered under the Insurance policy.
2. The insurer did not prove that the Complainant was a street vendor operating illegally. The Complainant was pushed onto the transformer, which was not her doing and was not foreseeable.
3. The test is whether a reasonable person of the same age as the Complainant would be able to foresee the harm she would likely suffer, and put measures to protect herself or prevent injury to herself.
4. No reasonable person of the age of 13 years or above could foresee that such danger could happen on a street where members of the public pass every day.
5. The Complainant was found not liable for contributory negligence, and the claim was found payable. Sanlam General was ordered to pay the claim according to the policy terms and conditions.

### Commentary:

- a) **General damages can only be awarded by court.**
- b) **A claim for future medical expenses is only tenable if medical evidence is adduced to confirm that the injured party would still need medical attention in the future as a result of the accident. In this case, the complainant had fully healed, and therefore not entitled to an award of future medical expenses.**

## XIX. COMPLAINANT LTD Vs. SANLAM GENERAL INSURANCE

### Brief Facts

1. The Complainant lodged this complaint against Sanlam General Insurance for failure to refund prorated premiums paid on a policy terminated by the insurer and for refusal to pay outstanding discharged claims.
2. The Complainant was issued several group motorcycle comprehensive insurance policies by Sanlam Insurance each covering numerous motorcycles.
3. Sanlam General issued a notice of cancellation for the master policy that had earlier been renewed and cancellation was to take effect 7 days after the notice. Parties agreed to extend the effective date of cancellation by 30 days.
4. The Complainant argued that before the policy was cancelled, they had lodged certain claims for which discharge vouchers had been issued, but no payments were made. The Complain-

ant claimed that the insurer repudiated about 38 claims on unreasonable grounds. In addition, the Complainant submitted other claims for events that had occurred before the effective date of cancellation.

5. Sanlam General argued that the policy had been cancelled due to poor performance and very high loss ratios, a poor risk management system by the complainant, fraud, and apparent complexity by the Complainant's staff. That they would only settle claims for which discharge vouchers were issued upon receipt of the outstanding premium payment.
6. The parties agreed on the amount of unpaid premium as of the policy's cancellation date and the amount of the undischarged claims. They did not agree on the amount of the premium to be refunded.

### **Issues:**

- a) Whether there is insurance coverage for policies where premium was outstanding
- b) Whether the insured is entitled to the payment for executed discharge vouchers
- c) Whether the insured is entitled to a pro-rata refund under the Insurance Policy, and if so, how much?

### **Ruling:**

1. Premium payment under the policies was arranged on a declaration or credit basis by their agreement. If an insurance company voluntarily agrees to provide cover on credit, the insured will be covered and is entitled to indemnity for claims under the policy.
2. The insured was found to be entitled to a refund of premium less all outstanding premiums due to the insurer.

### **Commentary:**

- (a) *The ruling that, "If an insurance company voluntarily agrees to provide cover on credit, the insured will be covered and is entitled to indemnity for claims under the policy" was premised on the provisions of the Insurance Act, Cap. 213 which was in force at the time the cover was taken. Section 34(3) of this Act provided that where an insurer allowed credit on premiums under a policy, any claims that arose from this policy would be payable by the insurer.*
- (b) *The Insurance Act Cap. 213 was repealed. Insurance Act, Cap. 191, now in force, requires that all premiums must be paid upfront before inception of the policy (Section 62).*
- (c) *Cancellation of policy can be initiated by any party in the contract (Insured or Insurer) and cancellation should follow the procedures stipulated in the insurance policy.*

## XX. COMPLAINANT LTD Vs. GOLDSTAR INSURANCE COMPANY LTD

### Brief Facts

1. The complainant lodged a complaint against Goldstar Insurance for failure to pay a claim.
2. The Complainant bought a goods-in-transit insurance policy covering rail and/ or Road risks to transport goods.
3. The Complainant subcontracted a company to provide the requisite services.
4. The truck was found abandoned and the consignment had been stolen/ was missing and the matter was reported
5. to Police for investigation.
6. Goldstar disputed the claim on the ground that the contract between the complainant and the transporter exculpates the transporter from any liability in case of loss hence affecting the insurer's right to claim from the transporter under subrogation.

### Issues:

- a) Whether Goldstar Insurance is liable to pay the claim
- b) What remedies are available to the parties?

### Ruling:

1. A claim of subrogation can only be made by an insurer who has paid a claim and in circumstances where such rights exist. The fact that the right of subrogation does not exist cannot in itself exculpate an insurer from liability under an insurance policy.
2. Goldstar was found liable to pay the claim

### Commentary:

- a) *The insurer should bring to the attention of the insured at the point of policy inception the implication of subrogation rights and always make sure that the contract signed by the insured has a subrogation clause.*
- b) *Insurers should desist from disputing claims on the ground that the insured does not have subrogation rights under the policy.*

## **XXI. COMPLAINANT Vs. UAP OLD MUTUAL GENERAL INSURANCE**

### **Brief Facts**

1. The Complainant, working for UAP Old Mutual claimed to have procured a client for UAP Old Mutual for four insurance policies which include; Plant and Machinery Insurance, Professional Indemnity Insurance, Contractors All Risks Insurance and Workers Compensation Insurance.
2. He alleged to have procured the business for the insured and prepared the insurance quotations. He lodged a complaint on non-payment of his commission for this business.
3. UAP Old Mutual denied the allegations and stated that the Complainant never procured the business as per their records and that a request for quotation did not in any way amount to an appointment. UAP Old Mutual further stated that the client procured the business directly from UAP Old Mutual.
4. Both parties agreed that the Complainant was a valid agent of UAP Old Mutual and duly licensed by the Authority to carry out the business of an insurance agent.

### **Issues:**

- a) Whether the Complainant is entitled to the commission as claimed.
- b) What are the remedies available to the parties.

### **Ruling:**

1. According to the definition of an insurance agent in the Insurance Act Cap 191, an agent can solicit applications for insurance, negotiate insurance coverage on behalf of the insurer, or perform other insurance-related functions that may be assigned to him or her by the insurer.
2. Mere performance of functions of an insurance nature that may be assigned to him/her by an insurer is enough.
3. The above-mentioned section does not talk about the attainment/ acquisition of an appointment letter first by an agent from a client before he/she solicits or negotiates an insurance arrangement for the insurer.
4. It is not proper and logical in this circumstance for UAP Old Mutual to ask for an appointment letter from its own agent for the business procured because the complainant is, in the first place, an agent of UAP Old Mutual with a duly signed agency agreement to procure business for UAP Old Mutual.
5. It was found that the agent actually solicited, negotiated, and prepared the insurance coverage for CCCC. What remained was the formality of signing the standard policy documents and paying premiums.

6. The agent is entitled to full commission on the two policy covers, the Contractors All Risk Insurance (CAR) and the Public Liability Insurance (P.I.).
7. Insurers should desist from using their huge bargaining powers to side-line agents out of business because this contravenes core insurance principles and ethics.

### **Commentary:**

- (a) *The law does not require an agent to get an appointment letter from the clients to become their agent.*
- (b) *The principal of an insurance agent is an insurance company and agents act on behalf of insurance companies. Therefore, having a valid contract and a valid license and performing duties as described under the insurance Act is sufficient to prove a legally binding relationship with the insurer.*
- (c) *Insurers should desist from taking advantage of the agents by illegally pushing them out of business as this contravenes core insurance principles and ethics.*
- (d) *Where an agent legally solicits business for an insurance company, he is duly entitled to his commission as provided for under the Act and the Regulations.*

## **XXII. COMPLAINANT Vs. AIG UGANDA LTD**

### **Brief Facts**

1. The Complainant lodged this complaint on behalf of another person at the time of her death.
2. Prior to her death, the deceased had been involved in an accident. A report was made to the employer, but he was never compensated with respect to the injuries resulting from the accident. UETCL had a group personal accident and worker's compensation policy with AIG.
3. AIG rejected the claim with no supporting documentation and informed the estate of the deceased that the claim was declined due to late submission.

### **Issues:**

- a) Whether the accident that occurred in 2014 to the late former employee of UETCL was a proximate cause to her death.
- b) What are the remedies available to the parties

### Ruling:

1. It was found that the chain of events starting from the accident progressively led to the death of UETCL's former employee, independently without the intervention of any other force started and working actively from a new and independent source.
2. The claim was not payable according to the policy which provided for payment of the principal sum where a covered injury resulted in the death of an insured person within 365 days after the date of the injury. The facts showed that the deceased suffered the accident in 2014, however the death occurred in 2016 which is two years after the injury which puts the present death claim outside the policy.
3. AIG advised considering an ex-gratia payment, considering it was not the complainant's fault that the insured (UETCL) did not notify the insurer of the 2014 accident and injury.

### Commentary:

***Notifications of a claim by the insured should be done within the stipulated time under the policy.***

## XXIII. COMPLAINANT Vs. SANLAM GENERAL INSURANCE COMPANY LTD

### Brief Facts

1. The Complainant had a fidelity guarantee cover with Sanlam Insurance that covered theft by their 281 employees. The complainant alleged that they lodged several claims with the insurer for theft of money by their employees, but it did not honor the claims.
2. In their response, Sanlam Insurance did not deny liability but stated that they needed supporting documentation in some claims to process them.
3. Additionally, Sanlam General relied on a clause in the policy, which stated that the implicated employees had guarantors who committed in writing to being liable in case of any fraudulent acts by the employees and that the claims should be apportioned, taking into consideration the guarantors.

### Issues:

- a) Whether Sanlam General is justified in relying on clause 10 of the policy to deduct the claim amounts

- b) What remedies are available to the parties

### **Ruling:**

1. It was held that the clause of the policy neither specified the proportion of amount which the insurer would pay and what portion would be recovered from the guarantors on a particular claim nor does it provide any formula/ method on how liability can be apportioned between the insurer and the guarantor which causes ambiguities on what the liability of the insurer on a particular claim would be.
2. The claim was payable and Sanlam General was directed to pay.

### **Commentary:**

- a) ***Insurance companies should draft policies by clearly spelling out the terms and conditions there under.***
- b) ***Such terms and conditions should be brought to the attention of the insured at policy inception.***

## **XXIV. COMPLAINANT Vs. LIBERTY GENERAL INSURANCE LTD**

### **Brief Facts**

1. The Complainant had a domestic package insurance policy with Liberty General. The property faced a leakage of water that escaped into the foundation of the residential house, causing damage to it.
2. The Complainant sought compensation from the insurer.
3. Liberty General denied liability on the grounds that there was a breach of contract due to non-disclosure.

### **Issues:**

- a) Whether the claim is payable?
- b) What remedies are available to the parties?

### Ruling:

1. It was held that the Complainant's conduct of constructing on top of NWSC water pipes without consent constitutes an offense. The loss is caused by an unlawful act, and thus, he cannot benefit from an illegality.
2. The claim is not payable as the insured breached the duty of utmost good faith owed to the insurer by not fully disclosing the presence of the water pipes and the previous leakages.

### Commentary:

- a) ***Where the insured breaches the duty of utmost good faith which he owes to the insurer by not fully disclosing any information he ought to know, the claim cannot be payable.***
- b) ***The Law hence the Authority cannot lend a hand to a man who finds his claim upon an illegal act.***

## XXV. COMPLAINANT Vs. UAP OLD MUTUAL GENERAL INSURANCE LTD

### Brief Facts

1. UAP Old Mutual General Insurance Limited agreed to provide the complainant with insurance cover under a Fire and Special Perils Insurance Policy. The sum insured under the policy amounted to an aggregate of USD 10,590,000, covering the building, plant and machinery, stock in trade, furniture, fixtures and fittings, house goods, furniture and personal effects and loss of profit.
2. During cover, a fire gutted the Complainant's property causing immense loss and damage. The appointed local loss adjusters engaged a forensic investigator to establish the cause of the fire. The report stated that a loose electric motor cover discovered at the scene suggested that it could have caused sparks that ignited the fire, and that the presence of dislocated butane gas pipes suggested that the fast growth of the fire could have been caused by a gas leak from the pipes.
3. The insured filed a claim with UAP Old Mutual for recovery of USD 9,639,769. However, UAP Old Mutual made a quantum adjustment through the local loss adjusters of USD 5,718,222 and they stated this was based on claim support documentation provided.
4. UAP Old Mutual notified its reinsurance brokers, which in turn informed the lead re-insures that proposed the appointment of an international loss adjuster to work with the local loss adjuster

## Issues:

- a) Whether there was breach of the PMO Warranty by the Complainant that warrants UAP Old Mutual to repudiate the claim?
- b) What is the effect of issuing a discharge voucher without prejudice?
- c) Whether UAP Old Mutual is in breach of any industrial regulations
- d) What remedies are available to the parties if any?

## Ruling:

1. It was found that the PMO warranty rendered the cover substantially useless and was so grossly unconscionable that it cannot be relied on by the insurer to deny a claim. UAP Old Mutual knew the kind of risk it was taking on, assessed the same and determined that it was within its risk appetite and could be *prima facie* fully covered. This renders the PMO warranty inconsequential and that there was no breach of the PMO warranty. UAP Old Mutual is not entitled to repudiate the claim.
2. UAP Old Mutual was in breach of *Regulation 51 of the Insurance (Licensing and Governance) Regulations, 2020* on issuance of a Key Features Statement (KFS) to the prospective policy holder before signing of the contract was not complied with. UAPOM dismissively suggested that this was merely a formality and that the policy contained all key facts.
3. The claim was found payable.

## Commentary:

- (a) ***Warranties have to be strictly complied with like conditions precedent to liability.*** *De Hahn v Hartley* (1786) 1 Term. Rep. 343
- (b) ***In case of breach of a warrant entitling the insurer to repudiate the claim, it matters not if the breach has no bearing or connection to the loss.***
- (c) ***Where parties contract on insurers written standard terms of business, the insurer should not be permitted to rely on a warranty, exception or definition of the risk if this could render the cover substantially useless from what the insured reasonably expected.***
- (d) ***The purpose of correspondences written “without prejudice” is to safeguard the position of the author who in that case would not necessarily be compromised by the contents of the document. The author reserves a right to invoke other defences available to him.***
- (e) ***Insurance companies should issue Key Features Statement to the prospective policyholders at the point of sale before issuance of cover.***
- (f) ***Claim processes by insurance companies should be in line with the claims Guidelines issued by the Authority.***

## **XXVI. COMPLAINANT Vs. SANLAM GENERAL INSURANCE COMPANY LTD**

### **Brief Facts**

1. The Complainant applied and received a loan facility from a company and offered his Motor Vehicle which was comprehensively insured by Sanlam Insurance as security.
2. In the course servicing the loan, the said security was involved in an accident and the complainant was asked to deliver it to a Garage in Kampala where he purportedly incurred towing charges. As a result of the accident, the company that offered the loan recalled the loan.
3. The loss adjuster's report indicated that the motor vehicle was being used for hire and reward contrary to the Motor Private insurance policy that excluded hire or reward. It was also confirmed that the accident occurred outside the geographical area contractually agreed upon.
4. The insurer repudiated the claim on grounds of breach of the geographical scope clause of the policy and use of the motor vehicle for hire and reward on contrast to the policy.
5. The policy was endorsed with a non-vitiating clause which treats the various parties as separate and distinct entities and protects the rights and interests of the parties who are not guilty of any fraud, misrepresentation and breach of condition/warranty.
6. The claim was considered based on the fact that the financier was not guilty of any misrepresentation. The insured had paid a claim amount to the company that offered the loan without the complainant's consent.
7. During the hearings it was resolved that the claim is not payable because the Complainant violated the terms and conditions of the contract. However, the claim was paid on the non-vitiating clause.

### **Issues:**

- a) Whether the Complainant is entitled to the towing charge expenses he incurred

### **Ruling:**

1. The insurance policy provided for a limit on the towing charges which was paid to the company that offered the loan as indicated in the signed discharged voucher. Sanlam Insurance performed its obligations according to the limitations of the company.
2. The brokers owed a duty of care to the Complainant. They were not authorized to advise the Complainant to tow his vehicle cross border which inflated his expenses and yet they were aware of the policy limitations.

## **Commentary:**

- (a) Once a contract is valid, it creates reciprocal rights and obligations between the parties. Where a document containing contractual terms is signed, then in the absence of fraud or misrepresentation the party is bound by its terms.
- (b) Insurance brokers do owe their clients as prospective insured person a duty of care.
- (c) A broker should act in the best interest of his principal and exercise skill and care.
- (d) The duty of skill arises not only out of the contract between them but also out of the broker's professional status.
- (e) A licensed broker should ensure that his employees meet high standards of ethics and integrity as required under the law.
- (f) Brokers should desist from any unprofessional conduct and ensure compliance while dealing with insurance policy holders/ beneficiaries.

## **XXVII. COMPLAINANT Vs. APA INSURANCE (U) LTD**

### **Brief Facts**

1. The Complainant took out a motor private comprehensive cover/policy and a COMESA policy which commenced for his motor vehicle with APA insurance. The Complainant's said vehicle got involved in an accident which resulted in total damage to the vehicle and being written off.
2. The Complainant immediately notified the Respondent through its brokers about the accident and submitted all relevant documents requested for by the Respondent.
3. The Respondent carried out a loss assessment on the motor vehicle. A preliminary report was made and the Complainant lodged a complaint with the Authority wherein a decision in favour of the Complainant.
4. The respondent successfully appealed the decision at the Insurance Appeals Tribunal which held that the Authority's decision was premature as it was based on a preliminary report and there was no formal rejection of the claim by the respondent.
5. The investigator/loss assessor's final report was drafted and the respondent formally rejected the claim based on the said report. The Complainant challenged the decision.

### **Issues:**

- a) Whether the claim is payable? and if so, whether APA Insurance Company Limited is justified in repudiating the claim?
- b) What are the available remedies to the parties?

## Ruling:

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1. It was held that the insurer verifying at claims stage information and subject matter provided by Complainant at the underwriting stage is not tenable. Underwriting is a standard process in the insurance industry and post claim underwriting arises out of poor underwriting. All material information must be obtained by the insurer at the time of underwriting and not at claims stage.
2. The assessor's failure to travel as requested and ordered by the Appeals Tribunal was quite absurd. The assessor resorted to use of the information he already had which we believe was intended to defeat the claim so as to form the basis of the repudiation by the respondent.
3. The respondent failed to refer the Authority to any facts disclosing fraud/ and or misrepresentation on the part of the Complainant in the assessor's report so as to justify the rejection.
4. The respondent's submissions that the insured could not justify and substantiate their claim due to lack of the required documents and information to be provided by the complainant is unjustified in law and claim was found payable.
5. The respondent alluded to misrepresentation of facts by the insured but failed to point the Authority to the misrepresented facts.

## Commentary:

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- (a) ***Investigation or loss adjustment/assessment of claims should be done promptly by the appointed loss assessor or adjustment.***
- (b) ***Insurers should not underwrite risks at the claims stage.***
- (c) ***Loss assessors/adjustors should desist from requesting for claim support documents in an un-ending manner.***
- (d) ***Repudiating claims on the ground of non-submission of documents which are not in possession or control of the complainant or which the complainant has failed to obtain (but has provided contact details of the person in possession to the loss assessor) should be avoided by the insurers.***

## XXVIII. COMPLAINANT Vs. EXCEL INSURANCE COMPANY LTD

### Brief Facts:

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1. The Complainant took out a Fire and Special perils policy with Excel Insurance Company Ltd to insure his building. While on cover, the building collapsed and according to him, this structural failure was due to earth movement of road making equipment near the building which was covered under the policy.

2. However, there was evidence to the effect that the collapse was due to pre-existing conditions such as poor workmanship among other factors which the complainant had not disclosed to the insurer at inception of the policy, hence risk was not covered under the policy.
3. The claim was held not to be viable.

### **Issues:**

- a) Whether the claim is payable.
- b) Remedies available.

### **Ruling:**

1. Contracts of insurance are contract uberrimae fidei (Utmost good faith). There is need to disclose all material facts by both parties.
2. As the law of evidence requires, one who alleges must prove with sufficient evidence as mere allegation is not evidence.
3. The loss causing the damage must be covered under the policy for the insurance company to pay the same.
4. Basing on general rules and principles relating to the interpretation of contracts, contractual provisions are supposed to be given their natural meaning.
5. Where the language used by the parties in the contract is clear, the Complaints Bureau like all courts will give effect to the same.
6. Contracts must be interpreted as a whole and not in isolation.
7. Unclear terms of a contract shall be construed against the maker (**Contra Preferentem rule**)
8. Excel was cautioned to start carrying out pre-inspection surveys of the insured property before taking on any risk.
9. The Bureau concluded that the risk was not covered under the policy, not even under the exclusion clause hence the claim was not payable.

### **Commentary:**

- (a) **Insurers should be more diligent when taking on big risks. Inspection or survey of the risks before cover should be carried out as a must. A Report should be there to show that the insurer inspected the risk and considered it before taking it on.**
- (b) **Loss assessors or loss adjusters should always ensure that they involve experts for technical losses or adjustments for which they are not skilled in like construction, medical, etc**

## **XXIX. COMPLAINANT Vs. ALLIANCE AFRICA GENERAL INSURANCE COMPANY LTD**

### **Brief facts:**

1. The Complainant lodged a complaint with IRA on the ground that the vehicle it insured got involved in an accident after it rammed into Alliance Africa insured vehicle, a trailer which had been parked at the roadside after its breakdown.
2. The Complainant alleged negligence on the part of ss's insured vehicle, having failed to display sufficient warning signs on the road to alert other road users about the breakdown. Alliance Africa also alleged contributory negligence on the part of the Complainant's insured vehicle on the ground that there was over speeding by the driver.

### **Issues:**

- a) Whether there was negligence on the part of Alliance Africa insured vehicle (trailer).
- b) Whether there was contributory negligence on the part of the Complainant's driver.
- c) Whether Alliance Africa is liable to make any compensation to QV.

### **Ruling:**

1. Negligence was defined as an omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate conduct of the human affairs, would do, or doing something which a prudent and reasonable man would not do.
2. Once one pleads negligence, he must set forth facts showing the same.
3. The party denying negligence has to show that circumstances were beyond their control to avoid any acts that might have led to the alleged negligence.
4. Contributory negligence was defined to mean negligence in not avoiding the consequences arising from the defendant's negligence, when the plaintiff has the means and opportunity to do so due to the plaintiff's failure to exercise such ordinary care, skill, diligence and skills he could not avoid consequences of the defendant's negligence.
5. The Complaints Bureau held the respondent liable for negligence and the complainant liable for contributory negligence

## **Commentary:**

- a) *Insurers through their Association may consider or explore whether the industry is ready for knock-for-knock agreements in Motor Vehicle insurance. This agreement, if it had existed, would have assisted in the quick resolution of the impasse between the two insurers, without the need to refer the dispute to the Authority.*

*A knock-for-knock agreement is an agreement where two insurers agree to each compensate their own policyholder in the event of an accident or other insured event irrespective of who is at fault.*

## **XXX. COMPLAINANT Vs. BRITAM INSURANCE COMPANY**

### **Brief facts**

1. The Complainant took out an All Risk Insurance Policy with Britam Insurance Co. Ltd, which covered material damage and 3<sup>rd</sup> party liability.
2. Under the policy, the exclusion clause removed coverage for vibrations because damages were foreseeable since the buildings were in a poor state.
3. In the due course, property losses for 3<sup>rd</sup> parties occurred and these were caused by vibrations. This was reported to Britam who refused to settle the claim on the ground that the risk that had happened was outside the policy.

### **Issues:**

- a) Whether the insurance claim is tenable
- b) What remedies are available to the parties

### **Ruling:**

1. The duty of the Complaints Bureau is not to rewrite insurance contracts between parties, but to just interpret them.
2. Parties to an insurance contract are bound by the terms of the contract unless someone pleads coercion, fraud or undue influence which must be proved. Hence once proved, the terms are not binding
3. Parties are obligated to perform their duties under an insurance contract.
4. Where the wording of an insurance clause is ambiguous, the contra preferentem principle shall be applied.

5. Once Exclusion clauses are not fairly drafted, they will be interpreted against the maker.
6. In conclusion, the Bureau held that there was a contract of insurance and that the same covered the risk that had occurred.

### **Commentary:**

- a) *Insurers should be careful to appoint licensed loss assessors or loss adjusters. In this case, at the time, the Authority discovered that the firm which was appointed to adjust the loss were not licensed loss adjusters.*
- b) *Loss assessors/Loss Adjustors once appointed to assess or adjust a loss are under the duty to be independent, thorough in their investigations and professional.*
- c) *Policy provisions should be very clear and unambiguous. In this case, the wording “excluding all property within proximity to the road and road reserve” was held to be vague and ambiguous.*

## **XXXI. COMPLAINANT Vs. OLD MUTUAL LIFE ASSURANCE COMPANY LTD**

### **Brief Facts:**

1. The Complainant had a SOMESA policy with Old Mutual Life Insurance. She lodged a complaint against Old Mutual Life on the ground that her policy had been lapsed without any communication to that effect.
2. Three (3) payments were missed which led to policy lapse. No formal communication of this lapsation was given to the complainant yet Old Mutual Life continued receiving her premiums. Premium statements issued by Old Mutual Life indicated that her policy was active and she was still on cover, hence she continued to pay premium.

### **Issues:**

- a) Whether the lapsation of the Complainant's policy by Old Mutual Life was justified and lawful.
- b) Whether the Complainant is entitled to benefits.
- c) Remedies available to the parties

## Ruling:

1. The principle of waiver by conduct was relied on by the Authority to hold that Old Mutual Life had lost its right to lapse the policy when they continued to receive premium yet they claimed the policy had lapsed.
2. Insurers have a duty to conduct business in a fair and transparent manner hence lapsing of the policy without communication to the complainant was held to be unfair.
3. The Complainant was held to be entitled to benefits since she had paid the arrears.
4. The Authority exercised its mandate under S.11(1)(b) (formerly section 12 (1)(b) of the Insurance Act Cap. 191 and Guideline 16 of the Insurance Complaints Bureau Guidelines 2022 to direct Old Mutual Life to amend its policies to include provisions on lapse warnings, sending lapse notices.
5. Old Mutual Life was also warned against receiving or picking premium, and putting it on a suspense account without the consent or knowledge of the customer/policyholder after the policy has lapsed.

## Commentary:

- (a) *Insurers should be very keen and careful when capturing customer details from their prospective insureds at the proposal stage. Prospective insureds or policyholders should always be requested to confirm and re-confirm their details. In this case, the customer's email address was captured wrongly, which affected receipt of notifications from Old Mutual Life.*
- (b) *At Least 2 lapse warnings should be sent to a policyholder before the Lapse Notice is issued. One lapse warning should be written either by SMS or email, and another through phone call. Phone calls should be recorded.*
- (c) *Communication of lapse through a Lapse Notice should form part of all life insurance policies. This communication should be written and sent to the policyholder.*
- (d) *A Lapse Notice should be clear and easily understood by the customer. It should indicate that no more premiums should be deposited by the customer unless a commitment is made to reinstate the policy. The insurer should, also on the other hand not receive or pick these premiums without receipt of the commitment.*
- (e) *Instructions to cancel standing orders and direct debits should be effected by banks immediately. Banks, especially those under bancassurance need to be held accountable for delays in cancelling these auto deductions.*
- (f) *Insurers should not be held accountable for delays and failure to act on direct debits or standing orders (effecting or cancellation) by banks, except in cases of bancassurance.*

## **XXXII. COMPLAINANT Vs. ICEA LIFE INSURANCE COMPANY LTD**

### **Brief Facts:**

1. The Complainant lodged this complaint against ICEA Insurance on the ground that the policy was mis-sold to her by their agent. When she got involved in an accident, she defaulted on paying premium for 3 months which made her policy lapse. She requested ICEAS Insurance for her savings but the request was rejected on the ground that the policy had lapsed due to that non-payment.

### **Issues:**

- a) Whether there was mis-selling/ misrepresentation on the part of ICEA Insurance.
- b) Remedies available

### **Ruling:**

1. There was mis-selling of the policy by ICEA Insurance.
2. Insurance companies and their agents should act with utmost good faith from the point of sale of the policy up to its expiry.
3. Both parties are supposed to disclose relevant information to each other.
4. Insurers should act fairly towards customers
5. Insurers are supposed to ensure that their agents act with integrity, due care, skill and due diligence.
6. The Authority also noted that by one signing an acknowledgement form, it is not enough that she has understood the policy. That there should be written or recorded proof that the customer has understood the policy.

### **Commentary:**

- (a) ***Insurers have a duty, while conducting business to ensure that their employees, agents act with integrity, due skill, care and diligence; have due regard to the needs and interests of their customers and prospective customers; that they treat customers fairly and that the information given to customers is accurate, clear, fair and not misleading. (Refer to Regulations 43 and 44 of the Insurance (Licensing and Governance) Regulations, 2020).***
- (b) ***Illiterate customers should be protected through the use of the certificate of translation in all the documents that are sent or given to the complainant.***

- (c) **Insurers should treat customers fairly and not take advantage of their vulnerabilities.** *Signing an acknowledgment form is not enough evidence that the customer has understood, especially in the case of one who can append a signature but does not read the English language. The insurer's customer service should reach out to all its customers and receive written or recorded verbal proof from the customer that they understood the policy they purchased.*
- (d) **It is incumbent upon the insurer, during the cooling off period, to call the customers and follow up to confirm if the customer understood the terms and conditions of the policy.** *Follow ups or phone calls should be recorded.*

### **XXXIII. COMPLAINANT Vs. SANLAM GENERAL INSURANCE COMPANY LTD**

#### **Brief Facts:**

1. The Complainant took a Goods in Transit Policy from Sanlam General Insurance Company Ltd. At all times during the subsistence of the policy, Sanlam was charging and receiving premium from the Complainant basing on the declarations that were always made upon arrival of goods at the Complainant's warehouse. When a loss occurred, Sanlam denied liability basing on a clause in the policy which was to the effect that,  
*"Total premium to be charged per declaration subject to no prior losses on the day of submission of cover instructions".*

#### **Issues:**

- a) Whether Sanlam General Insurance Company Ltd is justified in relying on the Clause in the policy schedule to wit; total premium to be charged per declaration subject to no prior losses on the day of submission of cover instructions, to reject payment of the claim?
- b) What remedies are available to the parties if any?

#### **Ruling:**

1. Insurance contracts like all the other contracts must be understood in their primary, natural, ordinary and popular sense.
2. The contra proferentem rule was defined as one where courts interpret a contract strictly against the drafter.
3. The Doctrine of estoppel by conduct was discussed as a principle whereby, a party who has by his declaration, act or omission intentionally caused the other to believe a thing to be true and to act upon such belief, cannot be allowed to deny the truthfulness of that thing.

4. Variation of a contract can only be done by a subsequent written agreement.
5. The Clause relied on by Sanlam to deny the claim was ambiguous as it defeated the intention of the policy.

### **Commentary:**

- (a) ***Insurers should ensure that all the clauses, terms, conditions and warranties in an insurance policy are clear and unequivocal to avoid being caught by the contra-proferentem rule.***
- (b) ***Insurers should be very mindful or careful about the conduct, acts and omissions of their staff or employees or agents. Conduct, acts or omissions by an insurer, its agents or authorised officers that divert from the policy requirements, conditions, warranties or terms can be enforced against the insurer. In this case the insurer would be estopped from pleading reliance on the policy provisions.***
- (c) ***At renewal of the policy, insurers and policyholders should re-visit and review the key provisions in the policy and agree on them afresh. This will rule out cases of non-compliance with policy provisions or defences based on previous conduct.***
- (d) ***Time within which declarations should be made for GIT and Marine policies should be clear in the policy.***

## **XXXIV. COMPLAINANT Vs. OLD MUTUAL LIFE ASSURANCE**

### **Brief facts**

1. The Complainant bought a policy from Old Mutual Life Insurance (Now then called UAP Life Insurance) which lapsed due to non-payment of premium for 3 months. Before lapsation, Old Mutual Life did not send any lapse warnings nor did it give notice of lapsation to the complainant. However, the company continued to make premium deductions and put them on its suspense account without the complainant's knowledge or consent.
2. Additionally, premium statements indicating that her policy was active were sent to her by Old Mutual Life giving her an impression that her policy was active.

### **Issues:**

- a) Whether the lapsation of the Complainant's policy by Old Mutual Life was justified and lawful.
- b) Whether Old Mutual Life is entitled to any interest.
- c) Remedies available to the parties

### Ruling:

- a) By the fact that the policy had lapsed but deduction of premium went on by Old Mutual, it was estopped from relying on Clause 3.2 of the policy to lapse the same without notice to the complainant, and also not enjoy the benefits accruing from the policy.
- b) Insurers have a duty to conduct business with integrity, due skill, care and diligence to observe good business practices and transparency.
- c) That it was also wrong for Old Mutual Life to put the customer's money on a suspense account without her knowledge.

### Commentary:

- a) ***After lapse of the policy, the insurer should not receive premiums from a policyholder and put them on the suspense account without the knowledge and consent of the policyholder.***
- b) ***Insurers who receive premiums after policy lapse will be estopped from claiming that the policy is inactive and no benefits are payable except premiums received after policy lapse.***
- c) ***At least 2 lapse warnings should be sent to a policyholder before the Lapse Notice is issued. One lapse warning should be written either by SMS or email, and another through phone call. Phone calls should be recorded.***
- d) ***Communication of lapse through a Lapse Notice should form part of all life insurance policies. This communication should be written and sent to the policyholder.***
- e) ***A Lapse Notice should be clear and easily understood by the customer. It should indicate that no more premiums should be deposited by the customer unless a commitment is made to reinstate the policy. The insurer should, also on the other hand not receive or pick these premiums without receipt of the commitment.***
- f) ***Instructions to cancel standing orders and direct debits should be effected by banks immediately. Banks, especially those under bancassurance need to be held accountable for delays in cancelling these auto deductions.***
- g) ***Insurers should not be held accountable for delays and failure to act on direct debits or standing orders (effecting or cancellation) by banks, except in cases of bancassurance.***

## **FREQUENTLY ASKED QUESTIONS ABOUT THE IRA COMPLAINANT BUREAU AND THE COMPLAINTS BUREAU MANAGEMENT SYSTEM.**

### **1. What is the Complaints Bureau?**

The Complaints Bureau was set up under the Insurance Act Cap 191, to help the public resolve insurance-related complaints. It is part of the Insurance Regulatory Authority of Uganda (IRA) and is mandated to receive, investigate, and settle disputes involving licensed insurance companies. Its goal is to protect policyholders and promote a fair and efficient insurance market. The Bureau works fairly, quickly, and without unnecessary legal procedures, helping parties reach a resolution while ensuring consumer rights are upheld.

### **2. Who can lodge a complaint?**

Any affected person including the following persons, can lodge a complaint;

- a) A prospect
- b) A policyholder
- c) An Administrator of an estate/ authorized person
- d) Beneficiaries of an insurance policy
- e) A broker
- f) An Advocate on behalf of the insured, prospective or beneficiary
- g) Members of the industry licensed by the Authority
- h) Insurance services providers

### **3. Against whom can the complaint be lodged?**

A complaint may be lodged with the authority against any party licensed, authorized, or regulated by the authority. This includes insurers, reinsurers, insurance brokers, reinsurance brokers, health management organi-

zations, loss assessors, loss adjustors, bancassurance agents, and insurance agents.

### **4. Nature of the complaint.**

Complaints may involve a disagreement concerning;

- a) Liability under policies issued
- b) Amount offered for settlement
- c) Breach of conduct by licensee
- d) Any other matter related to the actions of a licensee.

### **5. What is the Complaints Bureau Management system?**

The Complaints Bureau system is an online platform managed by the Insurance Regulatory Authority of Uganda where persons can submit complaints related to insurance claims, disputes, or service issues. It ensures that complaints are handled efficiently and in accordance with regulatory standards.

### **6. How do I access the complaints bureau system?**

- a) The complaints management system is accessible on <https://iracomplaints.go.ug/wp-login.php>
- b) The Insurance Regulatory Authority of Uganda website [www.ира.оу.рф](http://wwwира.оу.рф), then look for the icon with e-services and click on "make a complaint"

### **7. How do I log into the complaints bureau management system?**

**Step One:** Click on the link below: <https://iracomplaints.go.ug/wp-login.php>

**Step Two:** Click on "Register" to create an account.

**Step Three:** Fill in the required information, and click on “Register” at the bottom.

**Step four:** Click Log in and fill in your user-name or email address and the created password, and click “Log in”

**Step Five:** Click “*Make a complaint*” to fill out a complaint by filling in all the required information, click on “*Add file*” to attach a document and submit the complaint.

**Step Six:** After filing the complaint, check for continuous updates or send communication through the notification box under Reports icon > click on General Reports icon, then click on the complaint lodged and on “view-details.”

## 8. What are my responsibilities when filing a complaint?

You are responsible for providing accurate information, attaching necessary documentation, and responding promptly to any requests from the bureau during the hearing process.

## 9. I am experiencing technical issues with the system. What should I do?

For any technical issues, please contact our support team at [ira@ira.go.ug](mailto:ira@ira.go.ug); or [legaldepartment@ira.go.ug](mailto:legaldepartment@ira.go.ug) or our toll-free line at 0800-124-124. They will assist you with troubleshooting or guide you on how to proceed.

## 10. Will my insurer know that I filed a complaint?

Yes, to conduct a fair adjudication, the bureau may need to communicate with the insurer and share details of your complaint. However, this is done confidentially and only to the extent necessary to resolve the matter.

## 11. What is the complaint process?

- a) Upon receipt of your complaint through the system, your complaint is assigned to an officer to handle the same, who

asks the insurer to respond to your complaint within five working days while attaching the necessary documents.

- b) The Bureau shall within 14 working days from the date of lodging your complaint schedule a hearing and upon the first hearing where the complaint if in its opinion warrants an inquiry request for better particulars if the information availed information is insufficient, cause an investigation into a particular matter or issue any directive to the parties in the interim.
- c) During the complaint hearing, the bureau shall first hear the complainant's case and their witnesses, if any, followed by a response by the party complained about and their witnesses, if any.
- d) Every party has the right to cross-examine the other party or their witnesses, and the complaints bureau may question any party.
- e) The bureau always encourages the parties to resolve the dispute amicably. Where parties fail to agree, the Bureau makes a ruling after hearing and receiving submissions from the parties.
- f) Once the parties agree, the bureau makes the necessary recommendations to enable settlement and closure of the complaint.

## 12. What if I am unsatisfied with the bureau's decision?

If you are unsatisfied, you may lodge an appeal with the Insurance Appeals Tribunal within 30 days of the date a written decision from the complaint's bureau is issued.



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