Complaints Bureau & Tribunal, Key Areas of Dispute, possible considerations during insurance Litigation

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Introduction

- Section 12(1) (j) and (k) of the Insurance Act, 2017 mandates the IRA to receive and resolve insurance related complaints and to receive complaints from members of the public on the conduct of a licensee and arbitrate and grant restitution to the complainant as may be possible.

- The Complaints Bureau was created to fulfil the above mandate and has been operational since 1998.

- One of the objectives of IRA as envisaged in section 11 (1) (c) is to protect the interests of policyholders or prospective policyholders.

Introduction continued

- Procedure of the Bureau is guided by The Insurance Complaints Bureau Guidelines, 2017 which came into force on 1st February 2017.

- The composition of the Bureau comprises: chairperson, deputy chairperson, secretary and any other person so designated. Currently, the Complaints Bureau comprises members from the Legal and Supervision Departments.

The Complaints Bureau

- To solve insurance complaints/cases which would have otherwise been a foundation of lengthy court processes.
- Provides prompt protection to policyholders/complainants.
- Builds confidence and improves image of insurance.

Overview of The Complaints Bureau Guidelines

- There are no Regulations in place for Complaints handling as this function is to be eventually performed by an ombudsman – S.135 of Act.

- The procedures for conduct of business of the Complaints Bureau are guided by The Insurance Complaints Bureau Guidelines, 2017. (Guidelines) but mandate is derived from Act.

- The Bureau is not bound by strict rules of evidence.

OBJECTIVE OF THE GUIDELINES

To provide for an effective complaint handling system to the Authority which;

(a) resolves issues raised by members of the public against an insurance player in a timely and cost effective way;

(b) may provide information that may lead to improvements in insurance service delivery; and

(c) improve the reputation of the Authority and strengthen the public confidence in insurance.

SCOPE OF THE GUIDELINES

- apply to every licensee or person regulated by the authority; and

- members of the public with any insurance related complaints / problem.

Who can lodge a complaint

- A prospect;
- A policyholder;
- A third party;
- An Insurance Broker;
- An Advocate on behalf of the insured, prospective or beneficiary, etc;
- Beneficiaries of an insurance Policy;
- Members of the industry licensed / registered with the Authority;
- Insurance service providers.

WHOM CAN THE COMPLAINT BE LODGED AGAINST

any party licensed or regulated by the authority such as;

- Insurers,
- Reinsurers
- Insurance Brokers,
- re insurance Brokers,
- Insurance Agents and Bancassurance Agents
- Health Management Organizations,
- Loss Assessors, Loss Adjusters etc.

Nature of complaints

Complaints may involve a disagreement concerning:

- liability under policies issued; (insurers deny coverage or benefits to the claimants)
- amount offered for settlement (Quantum) ;
- breach of conduct by the licensee;
- ambiguities in the Insurance Policy requiring interpretation;
- any other insurance matter related to the actions of a licensee.

COMPLAINTS OUTSIDE THE SCOPE

Guidelines do not apply where Complaints concern:

- activities other than those regulated activities under the Insurance Act No. 6 of 2017; or
- activities of any person for which the Authority has no legal regulatory responsibility,

The Authority may respond by:

- possibly explaining its position on the complaint; and, or where appropriate; or
- Referral or giving possible details of the Institution responsible for handling the matter

Lodging of the Complaint

A complaint may be lodged with the Authority at no charge/ cost/fee through;

- a written letter addressed to the Chief Executive Officer of the Authority;
- email to ira@ira.go.ug or any other designated email address of the Authority;
- the Complaints Bureau section on the Authority website i.e. www.ira.go.ug ;
- the toll free line 0800 124 124 or any other designated telephone number; or an
- oral statement that is reduced into writing by the Authority's officers in exceptional cases;
- by filling in and submitting the form issued by the Authority;
- physically delivered to the Authority's office at the front desk officer

Summary of the process flow from Lodgement of the complaint to conclusion

No.	Activity	Responsible person
1.	Complaint is received at the reception desk and forwarded to the CEO's office	Receptionist
2.	Complaint is forwarded to the Complaints Bureau for action	CEO
3.	Complaint is received and forwarded for registration	Manager Complaints and Litigation
4.	Complaint is registered and given a complaint number	Legal officers or legal intern
5.	Acknowledgement of receipt of the complaint, seeking a response from the licensee; and scheduling a meeting/hearing	Manager Complaints and Litigation, Legal officers or legal intern

Process flow cont'd

6.	Routine follow up of the complaint before the meeting to find out if the matter has been settled and whether the parties are ready for the hearing	Legal officers or legal intern
7.	Organising for the meeting	Legal officers or legal intern
8.	Attendance of the meetings/ hearings. In case fraud is suspected, the complaint is referred to the Insurance Anti-fraud desk for further investigations. The Bureau can also use the services of loss assessors, adjustors or any other expert to carry out independent investigations aimed at enabling the Bureau to arrive at a just conclusion of the complaint.	Members of the Complaints Bureau as per the composition (quorum is three members)
9.	Taking minutes of the meeting/ hearing	Legal officers or legal intern

Process flow cont'd

10.	Follow up of the parties after meeting till settlement of the complaint. If parties agreed to settle the matter, upon receipt of the confirmation of payment and or settlement, the complaint is closed.	Manager Complaints and Litigation, Legal officers or legal intern
11.	Writing of the decision of the Authority where parties fail to agree	Legal officers
12.	First Review of the decision before it is finalised	Members of the Complaints Bureau as per the composition
13.	Final review of the decision before it is finalised and sent out	Members of the Complaints Bureau as per the composition and the CEO.
14.	Licensee is followed up to comply with the decision where it is in the favour of the complainant	Manager Complaints and Litigation, Legal officers or legal intern
15.	Final letter is sent out closing the file upon conclusion of the complaint.	Legal officers or legal intern

Insurance Appeals Tribunal (Tribunal)

- Was established under the Insurance Act 2000 which was repealed by the Insurance Act 2017;
- Section 136 of the Insurance Act 2017 further provides for the Tribunal
- Any person aggrieved by the decision of the Insurance Regulatory Authority may within one month from the date the decision is communicated by the Authority , appeal to the Tribunal against the decision
- A party aggrieved by the decision of the Tribunal may within 30 days of the communication of the decision lodge a notice of Appeal with the High Court

Status : The Insurance Appeals Tribunal Regulations

- The Purpose of the Regulations is enable effective operation of the Tribunal
- By statutory Instrument 48 of 2019 the Minister made the said Regulations
- published in the Uganda Gazette on 5th July 2019
- not yet in effect because ;
- Section 137(8) of the Insurance Act 2017 provides for them being laid before the Parliament and this has not been done yet.

Issues to consider during Insurance Litigation

Cause of action

- At the outset of insurance litigation, one must conduct a careful evaluation of possible causes of action in light of the available facts on record in order to assess procedural and substantive strategies.
- When an insurance dispute turns on a clear-cut question of law and could appropriately be resolved on a motion to dismiss. For example, if an underlying claim for which coverage is sought alleges an occurrence that arose after the insurance policy at issue expired

Issues to consider during Insurance Litigation continued

Limitation period :

- Check whether the claim is within the limitation period .
- There is no statutory time for making a claim under the Insurance contract other than the usual six year limitation period applicable to all contractual claims.

- For any insurance-related claim to be viable, it must be brought within the applicable statute of limitations period, In determining whether a claim has been brought within the limitations period, courts address when the claim accrue

- However , some policies specify a time within which a claim must be made .

Issues to consider during Insurance Litigation continued

The dispute resolution clause and choice of law:

- consult the policy wording, to see what method of dispute resolution is provided for, and under which law.
- It is common for insurance contracts to contain arbitration clauses, which are strictly enforced. If an insurance contract requires arbitration, virtually every dispute related to or arising out of the contract will be resolved by an arbitration panel rather than a court of law.
- diligently comply with the procedural requirements of the arbitration process. Arbitration provisions in insurance contracts may set forth specific methods for invoking the right to arbitrate and selecting arbitrators.

Issues to consider continued

Interpretation:

- **Insurance policies** are interpreted in accordance with the general principles of contractual construction. An insurance policy provision will be deemed ambiguous if there is more than one credible interpretation. This ambiguity will be resolved by applying the following principles,
- **the natural meaning of words**: the starting point will be the natural meaning of the words used, although in an insurance context, words in a policy, specifically loss-causing events, can have multiple natural meanings;
- **a precedent:** the court will consider previous decisions to help decide an ambiguous provision
- **contra proferentem**: any ambiguity will be decided against the person who drafted the policy, which will usually be the insurer, Ambiguity has always been a useful, indeed often dispositive, weapon for **policyholders.**
- **business common sense** ; and **implied terms** where court may move away from the express terms

Issues to be considered

Provision of notice :Timeliness

- Typically, the insurance policy will specify how and when a notification should be made (in addition to what needs to be notified). Any notice requirements should be strictly complied with, so that cover cannot be denied. The insured must give the insurer the details of the loss, including the time and place, to enable the insurer to obtain sufficient evidence to meet the claim

- Notice of a loss or a claim must be given within the time specified by the policy itself, or upon the occurrence of the event giving rise to the loss or claim.

- Giving notice of circumstances, which may give rise to a loss or claim, must be done as soon as reasonably practical or possible. It is best to be prudent to avoid denial of coverage, although it can be difficult to predict whether a claim will emerge.

Issues to be considered .

Occurrence based policies versus claims based policies

- there are crucial differences between occurrence-based and claims-made policies. Policies written on a loss-occurring basis are triggered by the occurrence of bodily injury or relevant damage (as specified by the policy).
- Claims-made policies are triggered by notification of a claim or circumstance to the insurer. For this reason, compliance with notification provisions is essential to ensuring cover is provided under a claims-made policy.

Issues to consider continued

Confidentiality

- it is important to bear in mind that, unlike arbitration, litigation in the courts is public (unless there is very good reason for it not to be).

- **Mitigation:**

the party seeking to prove they have suffered a loss is under a duty to mitigate the said loss. If this is not done, then any compensation awarded may be reduced as a result.

- **Insurance coverage allocated across multiple insurance policies**

One insurer may pay the claim and then seek recovery from the other insurers; however, insurers will often include wording to exclude cover if there is more than one policy.

Issues to consider continued

- **Utmost good faith**: It is important that the policyholder at all times is truthful and does not conceal information since any falsehood discovered entitles the insurer to repudiate the claim.

- **Commercial relationships**: it is important to consider at the outset of a dispute whether litigation is the best course of action. It can irrevocably damage any continuing business relationship between parties, and so negotiation , arbitration or mediation may sometimes be a better way forward.