THE REPUBLIC OF UGANDA
THE INSURANCE APPEALS TRIBUNAL AT KAMPALA
APPLICATION No. 03 of 2024
(ARISING OUT OF IRAB/COMP No. 32/03/23)

JUBILEE LIFE INSURANCE LIMITED::APPLICANT

-VERSUS-

MANGO FUND INC::RESPONDENT

(**Appeal arising from the decision of the Insurance Regulatory Authority datedand delivered on 2nd February 2024)**

CORAM; MRS. RITA NAMAKIIKA NANGONO - CHAIRPERSON
MR. GEORGE STEVEN OKOTHA- MEMBER
MRS. SOLOME MAYINJA LUWAGA – MEMBER
DR. JOHN BBALE MAYANJA – MEMBER
MS. HARRIETTE NABASIRYE PAMINDA KASIRYE –MEMBER

DECISION

1.0. THE BRIEF BACKGROUND

1. The Respondent, a licensed non-deposit taking microfinance institution in Uganda, provides credit facilities to small and medium-sized enterprises. To protect its loan offerings, the Respondent secured a Group Credit Life Assurance Policy from Jubilee Life to cover its clients' loans.

2. On 2nd September 2022, the Respondent extended a loan of UGX 130,000,000 to Morris Okwir, who operated under the name Lubangaber Community Medical Centre. Unfortunately, Okwir passed away on 6th November 2022, leaving an unpaid loan balance of UGX 127,559,401. According to his death certificate, Okwir died due to Tuberculosis Pneumonia.

3. The Respondent submitted a claim for the remaining loan balance, but the Applicant, after reviewing the claim, declined to settle it. The refusal was based on the Borrower's failure to disclose the illness that led to his death, which had been diagnosed 3(three) years prior. Additionally, the Borrower had misrepresented his health condition in the declaration of good health, falsely stating that he was in perfect health despite having pre-existing conditions.

4. Subsequently, on 3rd March 2023, the Respondent filed a complaint with the Insurance Regulatory Authority (IRA). The IRA's Complaints Bureau ruled that the claim should be paid, subject to the policy limits, and directed the Applicant to make payment within 30 days. The Applicant was notified of it's right to appeal the

IRA Complaints Bureau decision to the Insurance Appeals Tribunal within 30 days of receiving the ruling.

2.0. GROUNDS OF APPEAL/ISSUES OF DETERMINATION

i. The IRA Complaints Bureau erred in law and in fact when it failed to consider the valid and enforceable arbitration agreement between the Applicant and the Respondent which ousted the Complaints Bureau's jurisdiction to hear and determine the dispute between the Applicant and the Respondent.

ii. The IRA Complaints Bureau erred in law and in fact when it failed to consider the critical illness claims exclusion as justification for the Applicant to exclude payment of the claim in respect of a loan disbursed to a person with Human Immunodeficiency Virus (HIV).

iii. The IRA Complaints Bureau erred in law and fact when it failed to properly apply the insurance law principles of utmost good faith and holding that the Respondent had no obligation to verify the borrower's health status.

iv. The IRA Complaint's Bureau erred in law and fact when it failed to properly evaluate the evidence relating to fraudulent loan transaction underlying the claim.

3.0 THE AGREED ISSUES FOR DETERMINATION BY THE TRIBUNAL

5. The Parties agreed on two issues for determination by the Tribunal.

i. Whether the Respondent's claim is payable and;

ii. What remedies are available to the parties?

4.0. REPRESENTATION AND APPEARANCE

6. At the hearing, the Applicant was represented jointly by Counsel Patson Arinaitwe, Horace Nuwasasira and Joel Mucunguzi of M/s Sigum Advocates while the Respondent was represented by Counsel Arthur Mwebesa from A. Mwebesa & Co Advocates.

EVIDENCE AND SUBMISSIONS

APPLICANT'S EVIDENCE SUBMISSION IN SUPPORT OF THE APPLICATION

7. The Applicant contends that the Complaints Bureau committed significant errors in its assessment of the claim. First that the appeal is based on the fact that, despite the Bureau finding that the Life Assured had fraudulently misrepresented their health status, it still ruled the claim payable, which was a grave misjudgement.

8. The Applicant further argues that the Bureau neglected the Respondent's deceptive conduct both during the inception of the policy and at the time of the claim. Additionally, that the Bureau erroneously categorized the declaration of good health as an amendment to the policy and misinterpreted the legal consequences of such an amendment.

9. That the life assured breached the duty of utmost good faith by not disclosing a critical pre-existing condition (HIV/AIDS). The Bureau acknowledged in its decision that the borrower likely concealed their true health status when completing the health declaration form. That this conclusion was supported by medical reports from Nsambya and Lira University Hospitals, which confirmed the Deceased had been diagnosed with HIV/AIDS long before taking out the loan. Expert testimony from Dr. Maurice Ego highlighted that the deceased was under tuberculosis treatment and had severe immunosuppression due to non-adherence to antiretroviral medication. Despite this, the deceased falsely declared they were in good health. Counsel for the Applicant submitted that this was fraudulent misrepresentation.

10. The Applicant cited ***MacGillivray on Insurance Law*** and the case of ***Nakisenyi Hanifah &Nabatanzi Shadia vs. Insurance Company of East Africa Ltd.***, Counsel for the Applicant argued that the misrepresentation met the criteria for actionable fraud:the statement was false, made dishonestly, and induced the recipient to enter into the contract. The deceased knew of their condition and concealed it, violating the policy's exclusions for persons with critical illnesses like HIV/AIDS. By declaring they were in good health, the deceased misled the Applicant, which qualifies as fraudulent misrepresentation and allows the Applicant to invoke the doctrine of estoppel by conduct under ***Section 114 of the Evidence Act***.
11. The Applicant asserts that the Bureau's conclusion that the claim was payable, despite the clear evidence of concealment of vital information, was untenable. The Bureau's decision failed to prioritize the life assured's duty to ensure that the insurer could recoup any loan payments from them in the event of non-payment.
12. The Applicant further maintained that the Credit/Mortgage Life Application form used by the Respondent was not an amendment to the policy text or format but rather due diligence measures akin to Know Your Customer (KYC) documentation. Counsel relied on ***Section 65 of the Insurance Act*** which requires the approval of the Insurance Regulatory Authority (IRA) for policy amendments, but the form was not an amendment to the policy. That instead, it was a standard requirement for disclosing health status, particularly as the policy excluded certain critical illnesses, such as HIV/AIDS. Requiring such disclosures aligns with the duty of utmost good faith, a principle central to the insurance contract, as demonstrated in ***Carter vs. Boehm*** **and** ***Hajji Kavuma vs. First Insurance Company Ltd.***
13. The Applicant further emphasized that this duty existed even before the introduction of the form and should be upheld to prevent insurance fraud. The requirement for disclosure was not an additional burden but one already implicit in the exclusions under the policy. Allowing a Life Assured to conceal a critical illness would undermine the policy's purpose.
14. On the arguments that the declaration was an Amendment**,** the Applicant contended that even if the declaration of good health were considered an amendment, the penalty for not seeking IRA approval is not invalidation of the amendment. That subject to ***Section 65(2) of the Insurance Act and Regulation 46 of the Insurance (Licensing and Governance) Regulations, 2020,*** the penalty for failing to seek approval is a directive from the IRA and, potentially, a fine under ***Section 121(2) of the Insurance Act***. The Bureau's decision to treat the unapproved

amendment as invalid was thus incorrect, as the Act prescribes a fine, not invalidation, as the penalty for non-compliance.

15. In summary, the Applicant prayed that this Honourable Tribunal be pleased to correct the Bureau's errors by acknowledging the fraudulent misrepresentation, recognizing the declaration of good health as a due diligence measure rather than an amendment, and applying the correct legal penalties if it were found to be an amendment.

5.0. THE RESPONDENT'S REPLY IN OPPOSITION TO THE APPEAL

16. Although, the Respondent failed to file its submissions in opposition of the Applicant's submissions, we note that the Respondent filed a reply in opposition of the Appeal, wherein it emphasized that the argument by the Applicant that there was an arbitration clause in the Insurance Contract which therefore legally excluded the IRA Complaints Bureau from handling the parties complaint from which this appeal arises, was a mere afterthought and that being the draftsman of the contract, the Applicant could not be seen to approbate and reprobate. We shall refer to the said reply in opposition of the Appeal as and when necessary.

6.0. THE DETERMINATION AND RESOLUTION BY THE TRIBUNAL

17. Before we delve into the determination of the preliminary issues raised by the Applicant, as to; *Whether the IRA Complaints Bureau erred in law and in fact when it failed to consider the valid andenforceable arbitration agreement between the Applicant and the Respondent which ousted the Complaints Bureau' jurisdiction to hear and determine the dispute between them***.**

18. An arbitration clause typically limits the parties' rights to litigate in court by mandating that the disputes be resolved through arbitration instead. However, it has been established through judicial precedent that parties may waive their arbitration rights through conduct, such as initiating litigation without invoking the arbitration agreement, thus rendering the arbitration clause inoperative. (**see** Justice Mubiru Stephen in the case of ***AC Yafeng ConstructionCo. Ltd vs Living World Assembly Ltd & 2 Ors HCCS No. 739 of 2021***, while relying onthe case of ***Broken Hill City Council vs. Unique Urban Built Pty Ltd [2018] NSWSC 825*****)**

19. In the current case, the Group Life Credit Assurance Policy issued to the Respondent, provided under clause 13 that "*Should any difference arise between the company and the Assured touching the meaning of this policy or as to the right, obligations or liability of either party or parties under this policy, the same shall be referred to Arbitration in accordance with the provisions of the Arbitration Act or any statutory modification or re-enactment for the time being in force.*"

20. The above notwithstanding the IRA is mandated under sections 12(j),12(k) of the Insurance Act 2017, to receive and resolve insurance related complaints, and to receive complaints from members of the public on the conduct of a person licensed under the Act and arbitrate and grant restitution to the complainant as may be possible. The Authority is further mandated under section 135 (2) and (3)

to perform the functions of the Ombudsman.

21. Further still, on October 2021 the IRA issued a Circular amending the dispute resolution clause in all insurance and health management contracts as follows;

"Dispute Resolution Clause – Any dispute/compliant between the parties to the insurance or health management contract <u>may</u> be resolved amicably between the parties without the intervention of a third party and/or the dispute/complaint <u>may</u> be escalated to the Insurance Regulatory Authority of Uganda or Omudsman in accordance with the Insurance Act and Regulations before resorting to the other mediation, arbitration, litigation or any form of dispute resolution.

19. The same circular in accordance with section 65 and 121 directed the players to modify the dispute resolution clauses in all existing (old and new) insurance and health management contracts in line with the above wording by 1st November 2021.

20. In conclusion the IRA Complaints Bureau had jurisdiction over the matter.

Resolution of Issue One - whether the Respondent's claim is payable?

21. We have carefully considered the Applicants grounds of appeal, the testimony of the witnesses as well as the documentary evidence admitted in the joint trial bundle. We have also considered the authorities cited by the parties.

22. The principle of **utmost good faith** (**uberrimae fides)** is a foundational concept in law requiring both the insured and insurer to act with honesty and transparency. Both parties are required to disclose all material facts that would influence the insurer's decision to underwrite the policy. The principal mandates that the insured must disclose all material facts relevant to the risk being insured, while the insurer must provide all clear and complete information about policy terms. The principle ensures fairness and trust promoting ethical dealings in insurance contracts.

23. In a group credit life insurance application, material information typically includes medical history, health status, family history such as genetic predisposition to certain illnesses, life style habits such as smoking and previous insurance claims. This information is crucial as it influences the insurer's risk assessment and any insurance professional is assumed to be knowledgeable on the disclosure requirements.

24. The Applicant contends that the Assured fraudulently concealed material information that was critical to decision whether or not to provide insurance cover, and that the IRA Complaints Bureau erred in ruling that the claim was payable despite their finding that there was concealment of information.

25. As pointed out by the IRA Complaints Bureau, we are cognizant of the fact that in a group credit life insurance policy the insured is the lender whereas the life assured is the borrower. **IRA** Complaints Bureau argued that in such cases it

becomes a challenge to extend the duty of good faith and full disclosure to the policy holder as they are not an agent of the life assured. The Tribunal disagrees with the statement. The policy was placed through an Insurance Broker whose duty was to professionally guide both the insurer and assured on the requirements of the policy. There is evidence on record that communication between the insurer and assured was through the broker, including the instruction to complete the Declaration of good health by the life assured. The Broker had the responsibility to explain the importance of the declaration of good health form, and its impact on the benefits if the assured life was not truthful, before it was signed by the assured life and the insured. It is also our conviction that, having read and understood the impact of failure to disclose the true health status of the assured life, the General Manager of the Respondent, being the beneficiary of the policy, was duty bound to carry out due diligence regarding the health status of the assured before signing the health declaration form. It is her evidence on cross examination that she was just a, witness, but as agued by Counsel for the Applicant there is no space for witnessing on the declaration form. In her position as General manager, and representing the assured, she was obligated to fulfil the responsibilities inherent to their position. In this particular case she was expected to do proper due diligence and not simply sign as a witness as she alleges, considering that the terms and conditions of the policy were explained by the Broker.

26. The authors Raoul and Colinvaux in their book **The Law of Insurance** 4th Edition (Pg.297 to 300), discuss the role and liability of insurance brokers. The learned authors make it clear that insurance brokers do owe their clients as prospective insured personsa duty of care. They write (at Page 297)

27. "…***Duty of assureds agent***

28. ***Insurance brokers are agents who make it their business to procure contracts of insurance for those who employ them. Having undertaken to obtain insurance an insurance broker must exercise proper care and skill in carrying out the assured's instructions, and he cannot excuse himself from accepting a policy that gives insufficient cover by saying that the assured ought to have examined it. As the assured's agent, he should make inquiries as to material facts and will be liable to the assured for breach of duty if he (the broker) fails, through his lack of care in this matter, to disclose such facts as are material (e.g. claims history) with the result that the policy is avoided by the insurers…"***

29. The insurance broker therefore is under a duty to act carefully and also to exercise proper care and skill when carrying out the assured's instructions or be liable in damages and possibly for the assured's loss as would be an underwriter. Agents owe a duty of care, loyalty and full disclosure to principals.

30. The authors of Halsbury's Laws of England 4th edition (Para 381) state that *where a person employs an insurance broker as opposed to going directly to an insurer then the ordinary law of agency will also apply to that relationship.*

31. In considering whether there was fraudulent concealment of material information on the part of the assured, we have examined the evidence on record. The medical reports from Nsambya and Lira University Hospitals confirm that the deceased had been diagnosed with HIV/AIDS and was receiving treatment for tuberculosis at the time of applying for the loan. The report from St. Francis Hospital Nsambya included histopathology results which reflected that the deceased was HIV and so did the report from Murchison Bay Hospital which indicated that Morris was undergoing Antiretroviral therapy (ART). From the above evidence it is in no doubt that the deceased Morris Okwir was infected with HIV. This evidence is collaborated with expert evidence by Dr. Maurice Ego (AW3). During cross examination, AW3 confirmed that he is a qualified medical doctor with specific training in HIV management. He confirmed that the deceased's condition was advanced, with severe immune suppression due to non-adherence to anti-retroviral treatment. His opinion was based on the medical reports from which AW3 cited specific information about Morris's CD4 count, weight loss, and persistent cough. He also explained the visible features, such as wasting syndrome, which are consistent with advanced HIV and low CD4 counts to clarify why he could infer the assured's condition from his appearance. AW3 further stated that according to the medical records availed the assured was already on medication for HIV in 2015. There is no doubt therefore that the assured was aware of his health status, which he ought to have disclosed at the time of applying for the loan.

32. We find that, the deceased, by declaring he was in perfect health, deliberately omitted to disclose his pre-existing condition of HIV/AIDS, a fact critical to the assessment of the risk insured. In the 3rd Schedule of the policy under exclusions claims arising from failure to follow medical advice, acquired immune deficiency syndrome (AIDS), or related illness and any pre-existing conditions are excluded. The Tribunal is persuaded by the documentary evidence from the medical facilities and the expert evidence, to concur with Counsel for the Applicant that the deceased was not eligible for cover at the time of obtaining the loan.

33. Under a special provision in the policy "**If in the opinion of the company there is any special hazard in respect of a member, a special restriction may be imposed or an extra premium charged in respect of the member as the company may in its absolute discretion think fit. If the evidence of health is not to the satisfaction of the company, the sum assured may be modified or, the premium increased, or the risk declined, in respect to the said member as the company may in its absolute discretion think fit".**

34. **Halsbury's Laws England** further points out in paragraph 351 on page 209b that;

35. "**For material facts, the basic test hinges on whether the mind of a prudent insurer would be affected, either in deciding whether to take the risk at all or in fixing the premium, by knowledge of a particular fact if it had been disclosed. Therefore, the fact must be one affecting the risk. If it has no bearing on the risk it need not be disclosed, and if it would do no more than cause the insurers to make inquiries, delaying the issue of the insurances, it is not material**

if the result of the inquiries would have no effect on a prudent insurer. Whether a fact is material will depend on the circumstances, as proved in evidence, of the particular case. It is for the court to rule as a matter of law whether a particular fact is capable of being material, and to give directions as to the test to be applied."

36. In the matter before the Tribunal much as the loan amount was within the free cover limit, a specific request for the life assured to declare his health status was made through the broker in a letter dated July 15th 2022(A Exh. 13). Evidence was admitted of the declaration signed by both the assured life and the assured, and it is evident that material information about the health status of the assured was concealed.

37. The respondent in the course of carrying out due diligence had a duty to establish that their client was eligible for a loan and that would make him eligible to be insured under the policy. AW1, the Chief Operations Officer of the Applicant testified that due diligence under the group policy is carried out by the Respondent and this testimony was not rebutted by the respondent. He further testified that the terms of the policy were explained to the Insurance Broker and his testimony was not rebutted. The broker has a duty to explain the terms and conditions to the parties to ensure full disclosure of material facts in order to ensure their claims are not rejected when they do occur.

38. In the case of **Carter vs Boehm (1766)97ER 1162, lord Mansfield** eloquently articulated the principal of utmost good faith when he stated ***"If the facts are concealed in any way, whether fraudulent or not, then the risk taken by the insurer may be different from the risk they intended to take in which case the policy would be void. This was seen as a natural consequence of an imbalance of knowledge under which the insured (usually) has knowledge of most of the key information which should form the basis for a risk assessment by the insurer"***

39. In ***National Insurance Corporation Ltd v. Kakugu Sylvan,*** material facts are defined as those significantly influencing the underwriting process. The test therefore is, did it materially affect the Applicant's decision to accept the risk. In the current case, considering the Applicant specifically requested for information on the current health status of the life assured, an honest response would have influenced the decision to either load premium or not provide cover at all.

40. Where there has been a failure to disclose material information or where there has been a misrepresentation, the insurer can avoid the insurance contract or deny liability and reject the insured's claim. The disclosure need only have an impact on the formation of the prudent insurer's opinion and on his decision-making process or that the undisclosed fact could be one which a prudent insurer would want to know or take into account during his decision-making process.

41. It is on record that the loan to the assured was made on 2nd September 2022, and he passed on the 6th November 2022, just over two months after loan disbursement. This fact, collaborated with the evidence of AW3 and documentary

evidence from the medical facilities, prove the assured life was aware of his health status but deliberately concealed it.

42. AW1, during cross examination contended that the Respondent, who is the lender has a duty to carry out due diligence on its clients, to ensure they are eligible for loans (KYC) as required of all banking and money lending institutions. It is our considered view that the free cover limit did not absolve the lender of the duty to carry out proper due diligence. The insurer in this type of policy relies entirely on the lender /assured to disclose all material facts that are relied on to determine whether or not to take the risk as well as to determine the requisite premium.

43. The Tribunal has noted several irregularities in the entire loan transaction. The loan disbursement orders were made by the assured's wife who purported to be a director of the health centre but later, evidence adduced shows she was never a director, and no evidence was adduced to clarify her role in the Lubangaber Community Health Centre. On 12th August 2022, before the loan was approved Adyao Everline Eromu, Morris Okwir's wife through a letter she signed as a director requested the loan to be paid to Acan Anna's account (AExh. 23) which the Respondent promptly adhered to. It is questionable why she would give the payment instructions instead of the loan applicant. It is not normal or accepted practice for a financial institution to adhere to instructions from a person other than the applicant for the facility, whereas according to evidence of the General Manager of the respondent (RW1) the facility was granted to a sole proprietor.

44. We further note that the loan agreement was signed by Morris Okwir/T/A Lubangaber Community Medical Centre, as a Director and Everline Adyao as a Guarantor, yet the schedule of assured lives included Morris Okwir's wife as a Director of Lubangaber Community Medical Centre. Soon after the death of Morris Okwir, Everline asked Jubilee to alter the schedule of the lives assured to reflect only one Director, Morris Okwir, and herself a Guarantor.

45. It is also noted that whereas the supplier of the medical equipment was SINCO Medical Supplies, the account given for transfer of funds was a personal account of one, Acan Anna. The Respondent (RW1) contends that Acan was the authorised coordinator of SINCO, but no evidence is brought to confirm Acan's connection to SINCO, and the evidence on record is that Everline sued Acan for failure to deliver the equipment, instead of SINCO, the supposed supplier (AExh.19). The invoice for the medical equipment does not bear postal norphysical address of the Nairobi Head office nor the Uganda coordination office (A Exh.23 and 24). These inconsistencies makes one wonder whether any due diligence was done before approving and disbursing the loan.

46. A thorough due diligence process helps mitigate risk and protect the interests of an institution. The key considerations include credit worthiness, legal compliance, reviewing organizational documents, identifying potential risks associated with the borrower and ensuring all necessary documents are accurate. In view of the above irregularities and inconsistencies, it would appear there was no due diligence done, or the expected vigilance was not exercised.

47. Under clause 4 of the loan agreement the Borrower agreed that the loan would be secured by a chattel mortgage over all the existing and newly purchased medical equipment (reason why the respondent would have taken more interest in who the supplier of equipment was), a certificate of title and development for the land located on plot 19, Bululu Road, Kaberamaido, Personal guarantees from directors and postdated cheques (A Exh.25). No evidence was adduced of any attempts to actualize the securities.

48. Based on the above observations and findings and analysis, we are inclined to agree with Counsel for the Applicant on the precedent cited in the case of ***Nakisenyi Hanifah & Nabatanzi Shadia vs. Insurance Company of East Africa Ltd***. that the misrepresentation met the criteria for actionable fraud: the statement was false, made dishonestly, and induced the recipient to enter into the contract. The deceased knew of their condition and concealed it. By declaring they were in good health, the deceased misled the Applicant, which qualifies as fraudulent misrepresentation.

49. In the case of HIH Casualty and General Insurance Ltd vs Chase Manhattan Bank (2003) UKHL, Eix I.J regarding non-disclosure and fraud, held that non-disclosure in the insurance context was referred to as concealment, and the doctrine has sometimes been viewed and explained as constructive fraud.

50. This Tribunal therefore finds that the deceased's failure to disclose his HIV/AIDS status constituted fraudulent misrepresentation. The false statement was made dishonestly, and the insurer relied on it when issuing the policy, meeting the legal requirements for actionable fraud. The Tribunal finds that the Complaints Bureau erred in ruling that the claim was payable despite the clear evidence of misrepresentation. The deceased breached the duty of utmost good faith by not disclosing his critical pre-existing condition. The Bureau's decision to prioritize the payment of the claim over the material misrepresentation was a misjudgment and disregarded the insurer's right to avoid liability due to the fraudulent misrepresentation.

51. It is well-established that fraudulent misrepresentation by the assured allows the insurer to avoid the policy entirely, as illustrated in **Carter vs. Boehm**.

52. *Furthermore was the Applicant was entitled to rely on the doctrine of estoppel byconduct due to the deceased's misrepresentation.*

53. ***Section 114 of the Evidence Act* Cap 6** provides that '***when one person has, by his or her declaration, act or omission, intentionally caused or permitted another person to believe a thing to be true and to act upon that belief, neither he or she nor his or her representative shall be allowed, in any suit or proceeding between himself or herself and that person or his or her representative, to deny the truth of that thing'.***

54. The legislation was considered in the case of **Pan African Insurance Company (U) Ltd v International Air Transport Association HCCS No. 667 of 2003** by Lameck Mukasa J who had this to say, "***The doctrine of estoppel by conduct prevents a party against whom it is set up from denying the truth of the matter. The principle is that where a party has by his declaration, act or omission intentionally caused the other to believe a thing to be true and to act upon such belief he cannot be allowed to deny the truthfulness of that thing."***

55. In the instant case RW1 confirmed during cross examination that she signed the declaration of good health on behalf of the Respondent, without objection when it was presented by the Broker.

56. The Tribunal concurs with the Applicant's submission that the doctrine of estoppel by conduct is applicable in this case. The deceased, by falsely declaring that he was in good health, induced the Applicant to issue the policy under the assumption that he did not have a critical illness. The Applicant relied on this misrepresentation, and as such, the doctrine of estoppel prevents the Respondent from claiming the policy benefits derived from that misrepresentation.

57. The form containing the declaration of good health, and agreement to forego benefits if the declaration was found to be false, was introduced to the Insured through the Broker by email. The broker was requested to share the form with the Insured to include as part of their various loan paperwork. As per the testimony of AW1, the intention was to provide further guidance on due diligence/KYC. We have scrutinized the Group Master Policy (A Exh.15) and in our view the effect of the declaration was not to amend the policy

58. On the legal consequences of failing to seek IRA approval for amendments, we find that even if the declaration of good health were considered an amendment, the Tribunal agrees with the Applicant's position that the failure to seek IRA approval does not invalidate the amendment. Under ***Section 65(2) of the Insurance Act*** *and* ***Regulation 46 of the Insurance (Licensing and Governance) Regulations, 2020***, the penalty for non-compliance is a directive from the IRA or a

fine, not invalidation of the amendment. Therefore, the Bureau's decision to invalidate the form was legally flawed. Therefore the Tribunal finds in favour of the Applicant on this issue.

Remedies

59. Considering the facts and circumstances of this case and the authorities reviewed above, we would therefore allow the appeal.

Conclusion

60. In light of the above findings, the Tribunal rules as follows:

1. The deceased's failure to disclose his pre-existing health condition constituted fraudulent misrepresentation.
2. The Complaints Bureau erred in directing the Applicant to settle the claim despite the evidence of misrepresentation.
3. The declaration of good health was not an amendment to the policy but part of the due diligence process.
4. Even if the declaration were an amendment, the Bureau's decision to invalidate it due to non-approval was incorrect as the penalty is prescribed.

7.0. CONCLUSION AND FINAL ORDERS

61. In conclusion, the Tribunal makes the following orders:

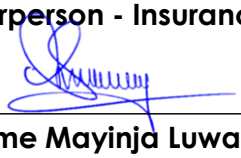
1) This appeal is allowed.

2) Each party bear its own costs.

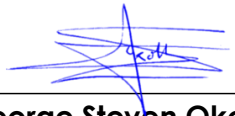
62. Any party dissatisfied with this decision may appeal to the High Court within 30(Thirty)days from the date of this Decision.

DATED and DELIVERED at KAMPALA on the_____day of November, 2024.

Rita Namakiika Nangono
Chairperson - Insurance Appeals Tribunal



Solome Mayinja Luwaga
Member - Insurance Appeals Tribunal



George Steven Okotha
Member - Insurance Appeals Tribunal

John Bbale Mayanja(PhD)
Member - Insurance Appeals Tribunal

Harriette Nabasirye Paminda Kasirye
Member-Insurance Appeals Tribunal