THE REPUBLIC OF UGANDA
IN THE INSURANCE APPEALS TRIBUNAL AT KAMPALA
APPLICATION No. 05 OF 2024
(ARISING OUT OF IRAB/COMP.20/20/2023)

SANLAM LIFE INSURANCE (UGANDA) LIMITED ::APPLICANT

-VERSUS-

NICHOLAS LUTAKOME:::RESPONDENT

(Appeal arising from the decision of the Insurance Regulatory Authority dated and delivered on 13th March 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. BRIEF BACKGOUND

1. The Respondent, a former Chief Executive Officer (CEO) of the Applicant, Sanlam Insurance (Uganda) Limited, was a beneficiary, along with his dependents, under a group medical and health insurance scheme provided by the Applicant. Upon resigning as CEO effective 15th March 2022, the Respondent and his dependents are purported to have remained beneficiaries under the insurance policy until 31st December 2022.

2. In September 2022, while on a work assignment in Turkey, the Respondent's wife, Josephine Nakyanzi Katabazi, experienced severe pain, leading to an emergency medical intervention that required surgery. On the 27th day of September 2022, the Respondent sought pre-authorization from the Applicant for the surgery, but the request was delayed. Despite the delayed response, the surgery proceeded on 29th September 2022, costing the Respondent UGX 24,069,372, which he later claimed for reimbursement.

3. The Applicant rejected the claim on the grounds that there was no prior authorization and that the surgery was not deemed an emergency. The Respondent filed a complaint with the Insurance Regulatory Authority (IRA), which, on the 13th day of March 2024, ruled in his favor, holding that the claim was payable under the policy.

4. The Applicant Sanlam Insurance, dissatisfied with the decision, appealed to the Tribunal, arguing that the Respondent was no longer eligible under the policy at the time of the claim and had failed to obtain the required pre-authorization for surgery conducted outside the insurance coverage territory hence this appeal.

2.0. GROUNDS OF APPEAL/ISSUES FOR DETERMINATION

2.1. The IRA Complaint Bureau erred in law and fact when it held that there was pre-authorization of the surgical operation of the Respondent's dependent in Turkey without assessing whether there was express written approval from the Applicant prior to the surgery.

2.2. The IRA Complaints Bureau erred in law and fact when it held that the Respondent had the locus standi to bring the Complaint on his wife/dependant's behalf.

2.3. The IRA Complaints Bureau erred in law and fact when it failed to evaluate evidence on record and failed to consider the fact that the insured had long ended his employment relationship with the insurer thereby disentitling him and/or his dependants for claiming under the policy which had already terminated.

2.4. The IRA Complaints Bureau erred in law and fact when it failed to evaluate evidence on record and arrived at a wrong conclusion that the Respondent's dependant, Josephine Lutakome's medical condition for which the surgery was performed in Turkey constituted a medical emergency requiring immediate surgical intervention.

2.5. The IRA Complaints Bureau erred in law and fact when it failed to evaluate evidence on record and arrived at a wrong decision that the claim payable under the policy beyond the area of the policy's cover/jurisdiction without assessing whether there was a Special Written Approval for such extension of territory beyond East Africa.

2.6. The IRA Complaints Bureau erred in law and fact when, having noted that the pre-authorization for coverage beyond the area of cover under the policy was at the sole discretion of the Applicant, it went on to make contradictory findings that whittle away the discretion reserved under Clause 2.6 of the policy.

2.7. The IRA Complaints Bureau erred in law and fact when it failed to consider the Applicant's position and policy provisions that the failure by the Respondent to provide full medical details notably, the failure to provide the referral notes, names of the referring medical personnel, and failure to produce receipts and invoices from the primary care managers/facility would make the claim wholly unpayable.

3.0. THE AGREED ISSUES FOR DETERMINATION BY THE TRIBUNAL

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

1. *Whether the Respondent had locus standi to file a complaint before Insurance Regulatory Authority?*
2. *Whether the Respondent's claim is payable?*
3. *What remedies are available to the parties?*

3.1 REPRESENTATION AND APPEARANCE

6. At the hearing the Applicant was represented by Counsel Horace Nuwasasira and Joel Mucunguzi of M/s Signum Advocates while the Respondent was initially self-represented and appeared together with his wife Josephine Lutakome but later on instructed Counsel Kaweesi Paul, Mugisha Jennifer Ruth and Nangendo Rose from Libra Advocates to represent him through the proceedings.

EVIDENCE AND SUBMISSIONS

APPLICANT'S EVIDENCE SUBMISSION IN SUPPORT OF THE APPLICATION

7. In its submissions, the Applicant argued that the Respondent's resignation and eligibility for insurance claims were the major points of contention. That the Respondent, having resigned as CEO on 15th March 2022, was no longer eligible to be a member of the Sancare Medical Insurance Plan. Counsel alleged that Clause 4.1 of the Sancare Medical Insurance Master Policy clearly states that only employees are eligible for membership. Therefore, the Respondent and his dependants were not entitled to make claims after his resignation. Counsel noted that this was confirmed during cross-examination of RW1 and RW2.

8. Further that there is need for strict interpretation of insurance policies. It was Counsel's submission that insurance policies must be interpreted strictly according to their terms. The Applicant cited ***Scorpion Holdings Limited vs. Lion Assurance Company Limited***, which emphasizes that extrinsic evidence, whether oral or written, should not alter the terms agreed upon at underwriting and that by this Tribunal allowing such evidence would jeopardize the insurer by obligating them to cover unanticipated risks.

9. Third that there was no valid policy amendment of Clause 4.1 of the Sancare Medical Insurance Master Policy that therefore the argument that an email dated 1st March 2022 (R.Exh 1) amended Clause 4.1 of the Sancare Medical Insurance Master Policy was dismissed as unfounded and contrary to the amendment procedures required by law. Counsel cited ***Section 65(2) of the Insurance Act*** which mandates that any amendment to a policy must be approved by the Insurance Regulatory Authority (IRA), and there was no such approval in this case.

10. The Applicant Company also submitted that there was a fraudulent use of the insurance card by the Respondent and his dependants who continued to use the medical insurance card after his resignation, which counsel argues amounts to fraudulent intent, especially as the Respondent had already resigned and ceased to be a member of the plan.

11. Further that there was a failure to seek pre-authorization of the surgery and that pursuant to Clause 14.6 of the policy preauthorization is required for specific medical procedures, including surgeries. That therefore the Respondent having failed to seek such preauthorization before his dependent's surgery in Turkey, violated the policy terms. The Respondent's claim that an email from the insurer dated 30th September 2022 amounted to pre-authorization was rejected, as the email merely requested documentation.

12. It was also argued by the Applicant that there was no special written approval for treatment outside jurisdiction. That subject to Clause 2.6 of the policy coverage is limited to East Africa, unless the insurer grants special written approval. That the Respondent did not seek or receive such approval for his dependant's surgery in Turkey and thus the email referenced by the Respondent did not provide this approval, and the Applicant argued that the email had been misinterpreted.

13. The Respondent's claim that his dependant's surgery was a medical emergency was contested by the Applicant. The Applicant submitted that the surgery was elective, as confirmed by Dr. Susan Obore (J. Exh 10), and not an emergency as alleged by the Respondent. It was further argued that the Respondent and his witness presented inconsistent evidence, particularly regarding the interpretation of the master policy. While the Respondent initially acknowledged the policy's existence, he later sought to disregard its terms when making his claim, undermining his credibility. That the Sancare Medical Insurance Master Policy, exhibited as J. Exh 3, should be accepted as truthful based on the principle from ***Administrator General vs. Bwanika James,*** where a document admitted during a scheduling conference is presumed truthful unless its contents suggest otherwise.

14. The Applicant submits that the Respondent's evidence is riddled with major contradictions central to the case, as defined in ***Ojara Samuel vs. Bwomi Sezi***. These inconsistencies undermine the credibility of the Respondent's claims. This is because the Respondent's evidence (RW2) indicated that medical treatment occurred in Gayrettepe Florence Nightingale hospital, but contradictory evidence was tendered from Urolojinstabul, leading to doubts about the authenticity of the treatment claim. Further that, the Respondent's dependent continues to use the disputed medical policy despite RW1's claim that it had expired, raising concerns of potential fraudulent renewal.

15. All in all, the Applicant asserted that the medical claim is not valid because the treatment was not pre-authorized by the insurer, nor was any special written approval granted for treatment beyond the policy's jurisdiction. The surgery for Mrs. Josephine Lutakome was not a medical emergency, and the Respondent's failure to provide crucial medical documents disentitles him from the insurance claim. The Applicant requests costs based on ***Regulations 8(d) and 26(d) of the Insurance Appeals Tribunal Regulations, 2019***, arguing that the Respondent's actions led to unnecessary legal proceedings. The policy does not cover the circumstances of the claim. The Applicant therefore prayed that this Tribunal reverses the decision of the IRA's Complaints Bureau and dismiss Complaint No. 20/20/2023 and that the Respondent should bear the costs of the proceedings.

4.0. RESPONDENT'S SUBMISSIONS

16. In response to the preliminary objection on locus standi by the Applicant, the Respondent argued that he had locus standi to lodge a complaint before the IRA Complaints Bureau pursuant to ***Guideline 6*** *of the* ***Insurance Complaints Bureau Guidelines, 2022 (as amended)***, which allows beneficiaries of an insurance policy to lodge a complaint. That therefore as the principal member of the Sancare Medical Insurance Plan, the Respondent was a beneficiary along with his dependa nts, including his wife. Therefore, he had the right to file a claim for reimbursement related to the treatment of his wife. That the Applicant's objection, claiming only the Respondent's wife could lodge the complaint, is misguided and should be rejected. It was claimed that the Respondent's wife, Mrs. Josephine Lutakome, underwent surgery in Turkey, which is undisputed. The key issue was whether the medical claim met the policy's requirements for reimbursement.

17. The Applicant rejected the claim for lack of pre-authorization and because the surgery was not deemed an emergency. However, the Respondent argued that ***Clause 2.6 of the Master Policy (JEX 3)*** requires special written approval for treatment outside the East African Community (EAC), but does not specify how or when this approval should be sought. The Respondent testified that he contacted **Mr. Partison Ndyamuhaki** on 27th day of September 2022, informed him about the surgery, and received verbal pre-authorization. He also followed up with a written email on the

same day, as seen in **JEX 12**. That Mr. Ndyamuhaki responded on **30th September 2022**, asking the Respondent to complete the claims form and provide all necessary medical reports, indicating that the Applicant did not reject the claim outright.

18. The Respondent submitted that his email of 27th September 2022 constituted a formal request for the special written approval, and **Mr. Ndyamuhaki's response** dated 30th September 2022 constituted the Applicant's approval for treatment outside the EAC. The policy does not specify that approval must be granted before treatment or that it must follow a specific format. Since the Applicant did not clearly decline the request, the approval should be deemed granted. Further that if there is any ambiguity in the policy, it must be resolved in favor of the Respondent under the **contra proferentem rule**, which requires interpreting unclear contract terms against the party that drafted them (the Applicant).

19. Whereas the Applicant contended that the surgery was not an emergency, thus disqualifying it from reimbursement under **Clause 14** of the policy. The Respondent countered that while the Applicant disputed the emergency nature of the surgery, the lack of clear guidance in the policy on what constitutes an emergency means the Tribunal should favor the Respondent's claim. The Respondent complied with the Applicant's requests by submitting the necessary medical documents and claim forms and that therefore, the special written approval was implicitly granted, and the claim is payable under the terms of the **Sancare Medical Insurance Policy**.

20. The Respondent argued that his claim meets the conditions set out in the policy for reimbursement. Any ambiguity in the policy should be interpreted in favor of the Respondent, and the claim should be honored. That the Applicant wrongly interpreted Clause 14.6 of the Master Policy, which does not restrict refunds for treatment outside the East African Community (EAC) to emergency cases. It merely states that in emergencies, pre-authorization should be obtained within 24 hours of admission. Counsel argued that the Applicant granted verbal pre-authorization on 27th September 2022 and reaffirmed this via an email on 30th September 2022, even though the surgery occurred on 29th September 2022. The request for additional medical documentation by the Applicant implies that pre-authorization was effectively given.

21. Counsel further argued that the Respondent's wife suffered from a worsening uterine prolapse, which was managed through surgery in Turkey. Although uterine prolapse is not inherently life-threatening, there was a risk of kidney failure, as testified by medical experts, making it an emergency. That since the Applicant had extended the Respondent's medical cover until 31st December 2022 despite his resignation in March 2022. By continuing to provide medical cover, the Applicant waived its right to deny the claim, per the doctrines of waiver by estoppel and affirmation, which

are discussed in detail, supported by case law and legal principles from insurance law texts.

22. Further that the Applicant did not present evidence to contradict the Turkish medical expert's findings or challenge the validity of the medical documents provided by the Respondent. Therefore, the Respondent's claim for UGX 24,069,372 should be paid, and general damages, interest, and costs should be awarded due to the delay and refusal of payment by the Applicant.

5.0. APPLICANT'S SUBMISSIONS IN REJOINDER

23. In rejoinder to the submissions of the Respondent the Applicant argued that the emails dated 27th September 2022 and 30th September 2022, exhibited in the Joint Trial Bundle, do not constitute preauthorization or special written approval under the insurance policy. The email of 27th September was a mere notification of the Respondent's wife's condition and lacked any attachments or language indicating approval. Moreover, the Respondent, who had been the CEO of the Applicant, knew the procedure for obtaining such approvals, making it unreasonable to interpret the emails as fulfilling those requirements.
24. The Applicant contends that it was within its discretion to reject the claim as the surgery did not qualify as a medical emergency under Clause 2.6 of the insurance policy. The timeline of events where the Respondent's wife fell ill on the 26th day of September, the Applicant was notified on 27 September, and surgery took place on 29th September does not suggest an urgent, life-threatening condition. Additionally, there were inconsistencies in the medical documents, such as the referral from a different hospital than the one where the surgery took place, which raised doubts about the legitimacy of the claim.

25. The Applicant challenges the Respondent's argument that waivers of preauthorization or special written approval were granted via alleged communications with Applicant's representatives, Mr. Partison Ndyamuhaki and Mr. Julius Magabe. The Applicant emphasizes that neither individual had the authority to bind the company to such waivers. The Respondent, being a former CEO of the Applicant, should have known that decisions of this magnitude required board approval and that the reliance on informal communications was flawed.

26. The Applicant submits that the doctrines of waiver and estoppel, as invoked by the Respondent, do not apply in this case. Insurance policies are governed by specific legal frameworks, including the Insurance Act and the Insurance (Licensing and Governance) Regulations, which regulate any amendments to policies. Therefore, the Respondent's reliance on these doctrines, without following proper legal

procedures, constitutes an illegal amendment to the insurance policy. Moreover, the Respondent's attempt to use these equitable doctrines without evidence of a valid policy or addendum cannot override the existing legal provisions.

27. The Applicant asserts that the Respondent's failure to provide complete medical documents, including those from two other medical facilities visited, further weakens his claim. This lack of documentation raises questions about the nature of the treatment and whether it qualified for coverage under the insurance policy. The absence of such critical information prevents the proper assessment of the claim and suggests potential fraud.

28. The Applicant cites ***Section 65(2) of the Insurance Act and Regulation 47(1) of the Insurance (Licensing and Governance) Regulations*** to support its position that any amendments to insurance policies require approval from the Insurance Regulatory Authority. The doctrines of waiver and estoppel cannot be applied in a way that circumvents these legal requirements, particularly in a regulated industry like insurance. In conclusion, the Applicant reiterated its initial prayers, including: A declaration that the insurance claim is not payable, confirmation that there was no preauthorization or special written approval for the medical treatment, a finding that the surgery was not a medical emergency, reversal of the Insurance Regulatory Authority's Complaints Bureau decision and dismissal of Complaint No. 20/20/2023 and an order for the Respondent to pay the costs of the proceedings.

THE DECISION

29. Having perused the submissions put across by both counsel for the parties and the record of proceedings before the IRA, we find as follows;

Whether the Respondent had locus standi to file a complaint before Insurance Regulatory Authority?

30. In its application, the Applicant raised a preliminary objection that the Respondent Mr. Nicholas Lutakome had no right to bring a complaint against the Applicant.

31. The Applicant did not submit on this issue in its written submission but the Respondent did. We shall resolve it since it was agreed at the hearing that it would be the first issue to be handled.

32. The Respondent citing ***Guideline 6*** *of the* ***Insurance Complaints Bureau Guidelines, 2022 (as amended)*** submitted that beneficiaries of an insurance policy could lodge a complaint. As a principal member of the Sancare Medical Insurance Plan, the Respondent was a beneficiary along with his dependants, including his wife. He therefore had the right to file a claim for reimbursement related to the treatment of his wife.

33. It is our finding that the Respondent in the instant case was the principal beneficial of the medical insurance policy as a chief executive officer. His wife was a beneficiary as his wife. Under **Guideline 6 of the Complaints Bureau Guidelines**, any affected person including a third party and beneficiary of an insurance policy can lodge a complaint before the IRA.

34. The Respondent has the locus to claim as he was the principal beneficiary under the medical insurance policy and we resolve this issue in the affirmative.

Whether the Respondent's claim is payable?

35. Will categorize this issue into 2 sub issues as below;

a) Whether the Respondent was a beneficiary of the medical insurance policy?

36. Clause 8.1 of the Master Insurance Policy **(J. Exh3) provides** that ***a member who is an employee and who ceases to be an employee during a benefit year shall cease to be a member from the last day of employment. In such case all rights of the member to medical benefits in terms of the medical insurance plan shall cease from the last day of employment exept for claims in respect of services rendered prior to the last day of cover of the member in terms of the Master Policy. Any additional notice period between the Employer and the member shall not extend the policy cover of the member.***

37. It is not disputed that the Respondent had indeed resigned from the Applicant Company and his last day of employment was 15th March 2022. And according to the Applicant's argument he was not eligible to be a member of the scheme in accordance with the above clause. It was the Applicant's prayer that the policy be strictly applied.

38. However the Respondent testified that he sent an email to the Applicant on the 1st of March, 2022 at 12.39 **(REX.1)** addressed to Julius Mugabe requested and we quote ".....In order to support my transition, I would like to request the company to support my family on medical insurance for the current period running up to 31st December 2022 ....."

39. The said Julius Mugabe on behalf of the Applicant responded through an email dated 1st March, 2022 at 15:56 that ***'SPA is happy to offer support for the current medical insurance cover to continue running up to December, 2022.....'***

40. The Respondent further testified that the said Julius Magabe who was the Regional Manager was not a Board Member but he was his direct supervisor. He stated that Julius was in copy of his resignation letter and that was why he addressed the request for the benefit to him.

41. It is our considered view that Mr. Mugabe's email did not amend the master policy as argued by the Applicant. Rather his acceptance had the effect of waiving the position between the parties as stipulated in Clause 8.1 of the Master Policy.

42. **Waiver** is where one party voluntarily agrees to a request by the other not to insist on the precise performance method outlined in the contract. In these circumstances, it may be said that that party has waived its right to insist on performance in that way.

43. For an act, statement, or other conduct, to be construed in law as a waiver, it must be shown that there was ***mutual agreement*** to alter or otherwise affect the legal relationship of the parties. *BIRD v. HILDAGE* (1947) 2 All ER 7.

44. *It is an agreement to release or not to assert a right. If an agent with authority to make such agreement on behalf of his principal agrees to waive his principal's rights then the principal will be bound, but he will be bound DA WSONS' BANK LTD. v. JAPAN C077'ON TRADING CO. LTD.* (1935) A.I.R. PC 79.
45. Upon applying the same to the instant case, we find no difficulty in holding that Mr. Mugabe on behalf of the Applicant waived the terms of the master policy as there was a clear mutual agreement through email between him and the Respondent. The Respondent has proved that he was eligible to benefit from the policy based on the waiver.

b) Whether the Applicant pre-authorised for treatment outside the area of cover
46. The Applicant rejected the claim on the grounds that there was no pre-authorization and that the medical condition for which treatment was sought was not an emergency.

47. Clause 2.6 on Geographical limits of the Master Policy provides that '***the policy is issued and only valid within the Republic of Uganda; (herein referred to as the jurisdiction); area of cover (hereinafter referred to as the territorial scope within East Africa) includes Kenya, Tanzania, Uganda, Burundi and Rwanda whilst cover may be extended at the sole discretion of the insurer on special written approval for treatment outside the area of cover'***

48. In effect the above clause implied that there was a possibility that the policy would be operational outside the territorial limits of East Africa on the special approval of the insurer. The Applicant alleges that treatment in Turkey was outside the jurisdiction as per the Master Policy.

49. Pre-authorization is defined as the prior written approval of the insurer, which is required for all hospital admissions, scans, dental, and optical treatment. To determine these issues, it is important to analysis the email correspondences between the parties. On 27th September 2022 **(JEX 12)**, the Respondent wrote to the Applicant informing it that his wife had a medical emergency that required a surgery. After 3(three) days on the 30th day of September, 2022, the Applicant in response thereto wrote back stating that the Respondent should share the relevant documentation.

50. The fact that the Applicant took 3 days to respond to the Respondent's request left the Respondent's wife no option but to proceed with treatment and it would be very unfair to fault her for tardiness of the Applicant.

51. Further still, we find that the Applicant's email response created a reasonable expectation for the Respondent to the effect that there was no objection as to treatment outside the coverage area. This is based on the representations made by the Applicant that was focused on the relevant documentation rather than the place of surgery. In the subject email, no objection was made by the Applicant. No representations were made to the Respondent as to any reservations about the place of performance of the subject procedures.

52. Therefore, this for the Respondent is therefore estopped from claiming that it did not pre-authorize treatment in accordance with ***Section 114 of the Evidence Act* Cap 8** which is to the effect 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'.*

53. The representation may be an express statement or implied by spoken words, by written words, or by conduct. However, the representation must be sufficiently clear and unambiguous. Silence can even give rise to an estoppel by representation if the "representor" knows that the "representee" has adopted a false assumption and fails to correct the mistake in circumstances where it would be unconscionable not to do so.

54. Further still, the request for documentation could only be obtained after thorough investigations of the Respondent's medical status. The IRA in its decision found that it is unclear how the insurer determined that Josephine's medical condition was not an emergency based solely on the email requesting pre-authorization without a

comprehensive review of her medical records and that this seemingly arbitrary determination and the delay in responding to the pre-authorization was strange and absurd. The question as to whether the pre-authorization had been overtaken by events since the surgery was performed before the response from the Applicant.

55. This brings into question whether indeed there was a medical emergency that necessitated a quick response from the Applicant. Upon perusal of the decision of the IRA we are inclined to be in consonance with their finding that the documents requested by the insurer, which included the theatre report, post-theatre case, and original receipts for all payments made were documents which could only be obtained following the conclusion of the surgery.

56. At the hearing, the Respondent exhibited a copy of the laboratory report in Turkish and English version dated 26th September, 2022 and copy of the discharge report dated 29th September, 2022, a copy of the Medical Report on medical procedure performed on Ms. Josephine Lutakome dated 22nd August, 2023 from Dr. Obore Suzan and another from Dr. Andabati Gonzaga.

57. In the cross examination of Dr. Isaac Musuubo who was presented as a witness confirmed that the Applicant would refund a Medical claim for management sought outside the territory of coverage; if there is clearly documented chain of referral along which pre-authorization is sought, assented and approved and the condition for which care was sought qualified as an emergency. Aside making mere assumptions that this was not a medical emergency, no concrete evidence was led by the Applicant to disprove the nature of treatment undertaken by the Respondent's wife.

58. On the contrary, the Respondent led evidence to the effect that the attending Gynecologist diagnosed a severe cystocele, a bladder prolapse that could obstruct the urinary tract. He deemed it necessary to asses bladder function through urodynamic testing, which was normal. Dr. Obore concluded in her report that Mrs. Lutakome's decision to seek medical care was justified, given the severity of her symptoms. She added that the attending doctor at the time recommended surgery as the only viable option, and Mrs. Lutakome agreed because it had been recommended in the past by other healthcare professionals.

59. The position of the law is that as a general rule, the burden of proof lies on the Party who asserts the affirmative of the issue or question in dispute. When that Party adduces evidence sufficient to raise a presumption of what he asserts is true, he is

said to shift the burden of proof that is, his/her allegation is presumed to be true unless his opponent adduces evidence to rebut the presumption. ***Court of Appeal Civil Appeal No. 85/2011Takiya Kaswahiri versus Kajungu Dennis at page 85.***

60. We therefore find that the Respondent's claim is payable.

Remedies

61. We have had the benefit of perusing the evidence and submissions by counsel for both parties on record and the decision of the IRA and as far as remedies are concerned following the resolution of the issues/grounds hereinabove. The appeal is therefore disallowed and the decision of the IRA is accordingly upheld.

8.0. CONCLUSION AND FINAL ORDERS

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

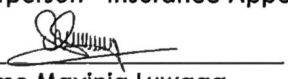
1) This appeal is disallowed.

2) Each party to bear its costs.

63. 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 21st day of October 2024.

Rita Namakiika Nangono
Chairperson - Insurance Appeals Tribunal



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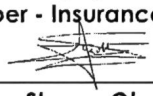
Member - Insurance Appeals Tribunal



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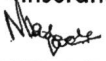
Member - Insurance Appeals Tribunal



Dr. John Bbale Mayanja

Ms. Harriette Nabasirye Paminda Kasirye
Member-Insurance Appeals Tribunal