THE REPUBLIC OF UGANDA
IN THE INSURANCE APPEALS TRIBUNAL AT KAMPALA
APPLICATION No. 1 of 2025
(ARISING FROM THE DECISION OF THE INSURANCE REGULATORY AUTHORITY OF UGANDA VIDE; IRAB/COMP No. 58/03/24)

AAR INSURANCE SERVICES (U) LIMITED::APPLICANT

-VERSUS-

BARAHIRE NABOTH::RESPONDENT

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

DECISION

1.0 BRIEF FACTS OF THE APPEAL

1. The Respondent, a policyholder with the Applicant, underwent medical treatment in Israel and subsequently submitted a claim for reimbursement amounting to **USD 78,786**. The Applicant communicated to the Respondent via email on **12th December 2023**, indicating that he was entitled to a refund of **60%** of his chronic inpatient benefit. The Respondent rejected this position and maintained that he was entitled to **80%** due to long-standing membership. The IRA subsequently ruled in favor of the Respondent, relying on the doctrine of *promissory estoppel*, and directed the Applicant to pay **USD 47,271.6**, representing 60% of the incurred expenses. The Applicant appealed this decision to the Tribunal.

2.0 LEGAL REPRESENTATION

2. At the hearing, the Applicant was represented by Counsel Sarah Kisubi and Counsel Sharitah Nakuya, from Kalenge, Bwanika, Kisubi & Co Advocates, together with In-house Counsel Phoebe Desire Namujehe of Applicant. For the Respondent was Counsel Allan Waniala from S & L Advocates. The Respondent was absent.

3.0 APPLICANT'S SUBMISSIONS

3. In their written submissions before the Insurance Appeals Tribunal, counsel for the Applicant, AAR Insurance Services (U) Limited, presented arguments challenging the decision of the Insurance Regulatory Authority of Uganda (IRA) concerning the reimbursement of medical expenses incurred by the Respondent, Barahire Naboth.

4. Counsel for the Applicant stated that the Respondent, an AAR Gold cardholder, had undergone medical treatment in Israel and subsequently submitted a claim for reimbursement amounting to USD 78,786. The Applicant had initially informed the Respondent via email on 12th December 2023 that he was entitled to a refund of 60% of his overall chronic inpatient benefit. However, the Respondent

contested this, arguing that he expected an 80% refund due to his long-term membership.

5. Following further discussions, the Applicant clarified that the policy entitled the Respondent to a chronic inpatient benefit limit of UGX 40,000,000 and that only medical emergencies abroad within Asia qualified for a 60% refund. The Respondent rejected this explanation and insisted on his claim. The IRA subsequently ruled that the Applicant was bound by its email of 12th December 2023 under the doctrine of promissory estoppel, requiring it to pay USD 47,271.6, representing 60% of the Respondent's medical expenses.

4.0 Issue One: Whether the Applicant's Appeal is Time-Barred?

6. Counsel for the Applicant argued that the appeal was filed within the prescribed timeframe. They cited Regulation 9(3) of the Insurance Appeals Tribunal Regulations, 2019, which provides for a one-month appeal period. The decision of the IRA was made on 11th December 2024, meaning the deadline for appeal was 11th January 2025. However, the Applicant contended that the Christmas court vacation from 24th December to 15th January 2025, should be excluded from the computation of time, in line with Order 51 Rule 4 of the Civil Procedure Rules. Consequently, the appeal, filed on 15th January 2025, was within time.

5.0 Issue Two: Whether the Claim is Payable?

7. On the substantive issue, counsel submitted that the IRA erroneously applied the doctrine of promissory estoppel by treating the email of 12th December 2023 as a binding promise. They argued that an offer becomes a promise only upon unconditional acceptance, which was absent in this case. Instead, the Respondent had rejected the Applicant's initial offer and sought further negotiations, constituting a counter-offer. Citing **Hughes v. Metropolitan Rail Co. (1877)**, counsel asserted that a counter-offer negates the original offer, preventing the formation of a binding obligation.

8. Furthermore, counsel argued that the IRA failed to properly evaluate the evidence, as the policy explicitly limited the Respondent's chronic inpatient benefit to UGX 40,000,000. They maintained that the reference to "60%" in the Applicant's email referred to 60% of this benefit limit and not 60% of the medical bills incurred in Israel. They highlighted that the Complaints Bureau itself had found that the Respondent's case did not qualify as an emergency, thereby disqualifying him from the Rescue and Evacuation clause, which covered medical expenses abroad.

9. Counsel for the Applicant concluded that the IRA had misapplied the law and the facts of the case. They maintained that the doctrine of promissory estoppel was inapplicable due to the lack of a clear and unequivocal promise and that the policy terms had been misinterpreted. They contended that the Applicant was only liable for UGX 40,000,000, which had been offered as an ex gratia payment but was rejected by the Respondent. Accordingly, they prayed for the Tribunal to set aside the IRA's decision and uphold the Applicant's position.

6.0 RESPONDENT'S SUBMISSIONS

10. Counsel for the Respondent submitted that the appeal was time-barred, arguing that the Insurance Appeals Tribunal's procedures did not allow for the extension of time based on public holidays. They contended that Rule 9(3) of the Insurance Appeals Tribunal Regulations mandated the filing of an appeal within 30 days without exceptions. Citing Section 34(3) of the Interpretation Act, they emphasized that time extensions could only be granted where the law expressly allowed it, which was not the case in insurance matters. Additionally, they referred to the precedent set in ***Sitenda Sebalu v Sam K Njuba***, distinguishing it from the present case on the basis that the Insurance Appeals Tribunal regulations did not provide for time extensions. They concluded that the appeal had been filed out of time and urged the Tribunal to strike it out.

11. Regarding the issue of claim payment, Counsel argued that the principle of estoppel applied, as the Applicant had misrepresented its policy to the Respondent, leading him to believe that 60% of his medical expenses in Asia would be reimbursed. They pointed to internal email correspondence (AEX2) where the Applicant acknowledged this misrepresentation and contended that the Respondent had relied on this assurance to seek treatment in Israel. Furthermore, they highlighted witness testimony confirming that an authorized representative of the Applicant had permitted the Respondent's travel for treatment.

12. Counsel also refuted the Applicant's defense that the UGX 40,000,000 payment was a counteroffer, arguing that for a counteroffer to exist, there had to be an original offer that was rejected and replaced by a new offer. They maintained that the Respondent had never made such an offer but had merely sought reimbursement based on the Applicant's representations. Additionally, they pointed out that the Applicant's claim of an ex gratia payment contradicted its earlier acknowledgement of the Respondent's entitlement.

13. They further argued that the Applicant's attempt to downplay the term "Asia" in the policy was dishonest, as the misrepresentation had directly influenced the Respondent's actions. They referenced the Applicant's earlier refusal to pay based on territorial restrictions and noted that subsequent communications demonstrated the Applicant's awareness of the situation.

14. In conclusion, Counsel submitted that the Complaints Bureau had correctly applied the principle of estoppel and held the Applicant accountable for its representations. They urged the Tribunal to uphold the Complaints Bureau's decision and dismiss the appeal.

7.0 SUBMISSIONS IN REJOINDER

15. The Applicant, AAR Insurance Services (U) Limited, submitted a rejoinder to the Respondent's written submissions, highlighting key arguments regarding the timeliness of the appeal, the claim's validity, and the defense of the counter-offer.

16. Firstly, the Applicant argued that the appeal was not time-barred. They stated that while the Insurance Act and Tribunal regulations prescribe a deadline for appeals, they do not address scenarios where the deadline falls on weekends or during public holidays. They contended that Regulation 29 permits reliance on High Court procedures in such instances. The Applicant further submitted that Section 34(3) of the Interpretation Act, relied upon by the Respondent, was misapplied, as it pertains to applications for an extension of time rather than the automatic exclusion of non-working days. Additionally, the Applicant asserted that Regulation 11 does not account for situations where deadlines coincide with public holidays and festive closures, reinforcing that their appeal was filed within the prescribed timeframe.

17. Secondly, the Applicant rebutted the Respondent's claim of misrepresentation. They argued that the policy terms clearly outlined benefits and exclusions, particularly concerning treatment in Asia. The Applicant stated that during cross-examination, their witness confirmed that the Respondent's benefits were covered under the policy, and during re-examination, the witness clarified that an internal email cited by the Respondent did not constitute an offer to cover medical bills in Asia. Instead, it referenced the chronic inpatient benefit, which had been correctly applied in the Respondent's case. The Applicant emphasized that the Insurance Regulatory Authority (IRA) had already determined that the Respondent's treatment was not an emergency but a scheduled procedure for a chronic condition. The Applicant also pointed out that the Respondent relied on an email dated December 18, 2023, while ignoring a more relevant email from December 12, 2023, which explicitly stated that 60% of the chronic inpatient benefit would apply, rather than 60% of the total medical bills. Citing case law, the Applicant asserted that misrepresentation requires a false statement that induces a contractual agreement, which was not the case here. They maintained that the Respondent, as a party to the insurance contract, was presumed to have understood the policy terms before agreeing to them.

18. Lastly, the Applicant addressed the defense of promissory estoppel and counter-offer. They contended that the Respondent's assertion that an offer was made to cover treatment costs in Asia was unfounded. The Applicant clarified that an offer was made for 60% of the chronic inpatient benefit, which the Respondent ultimately rejected. They argued that since the Respondent had declined this offer, no agreement existed between the parties. The Applicant further disputed the Respondent's claim that a sum of USD 47,271.6 had been promised as a refund, explaining that the offer was specifically based on the chronic inpatient benefit limit under the policy. The Applicant maintained that their offer was made in good faith, and the Respondent's rejection demonstrated the absence of any binding commitment.

19. In conclusion, the Applicant reiterated their arguments, refuting the claims of misrepresentation and estoppel. They maintained that the policy terms were clear and that there was no misrepresentation regarding treatment in Asia. They emphasized that the Respondent had rejected all offers made by the Applicant,

demonstrating a lack of mutual agreement. Consequently, the Applicant prayed that the Tribunal dismiss the Respondent's claims and uphold their position.

8.0 THE DETERMINATION AND RESOLUTION BY THE TRIBUNAL

20. At scheduling the parties agreed to the issues as follows;

21. Issues for Determination

1. Whether the Applicant's appeal is time-barred?
2. Whether the claim is payable?
3. What remedies are available to the parties?

22. Issue 1: Whether the Applicant's appeal is time-barred?

23. The Tribunal has carefully considered both parties' submissions on this issue. Regulation 9(3) of the **Insurance Appeals Tribunal Regulations, 2019** provides that an appeal shall be filed within **30 days** from the date of the decision of the Insurance Regulatory Authority (IRA). The IRA's decision in this matter was rendered on **11th December 2024**, and the Applicant filed its appeal on **15th January 2025**. On the face of it, this period covers **thirty-five calendar days**, raising the issue of whether the appeal is time-barred.

24. This Tribunal notes that its rules of procedure do not make express provision for time reckoning, particularly with respect to public holidays or court vacations. However, **Regulation 29** of the Insurance Appeals Tribunal Regulations allows the Tribunal to apply the **Civil Procedure Rules (CPR)** where its own rules are silent.

25. Under **Order 51 Rule 4** of the Civil Procedure Rules, it is provided that:

26. *"The period between the 24th day of December in any year and the 15th day of January in the year following, both days inclusive, shall not be reckoned in the computation of time appointed or allowed by these Rules for amending, delivering or filing any pleading or for doing any other act."*

27. This position has been judicially recognized and affirmed. In **Herman Semakula v Ivan Asiimwe**, the **Supreme Court of Uganda** adopted the **Court of Appeal's** decision in **Byeitima & 2 Others v Asaba**, which, in interpreting **Rule 4 of the Court of Appeal Rules**, held that the **Christmas vacation (24th December to 15th January)** should be excluded when reckoning time for filing court documents. The Court of Appeal in that case directly applied **Order 51 Rule 4 CPR** and its definition of court vacation, stating:

28. *"The Christmas vacation from the 24th December to the 15th January is excluded when computing time for purposes of filing court pleadings or taking procedural steps under the Civil Procedure Rules."*

29. This Tribunal agrees with and is bound by these decisions. Applying this precedent to the matter before us, the effective number of days between the date of the IRA decision (11th December 2024) and the filing of the appeal (15th January 2025) excludes the Christmas vacation period. Therefore, only 13 working days are countable for purposes of time computation.

30. In line with the Supreme Court's guidance in *Semakula v Assimwe* and the Court of Appeal's ruling in *Byeitima v Asaba*, the Tribunal finds that the appeal was filed within time. Accordingly, the Respondent's preliminary objection on grounds of time-bar lacks merit and is hereby overruled.

31. Issue 2: Whether the claim is payable?

32. The key here is whether the Applicant (AAR) undertook to pay 60% of the total medical bill incurred by the Respondent in Israel, or merely 60% of the chronic inpatient benefit provided under the health insurance policy.

33. The Tribunal has examined the email correspondence dated 12th December 2023 exhibited as JExh-3 on pages 42-43 of the Trial Bundle in which the Applicant stated that the Respondent would be refunded 60% of the chronic inpatient benefit. The Tribunal also notes that the Respondent rejected this offer, seeking a higher percentage and further clarification.

34. It is a settled principle that promissory estoppel requires a clear, unambiguous promise which is relied upon to the detriment of the promise. In this case, the email of 12th December 2023 did not constitute such a promise of 60% of the total medical expenses. Instead, it specified 60% of the chronic inpatient benefit under the policy, which was limited to UGX 40,000,000. The Respondent's response disputing the offer amounted to a counter-offer, thereby negating the original terms.

35. From the reading of the pleadings and deliberations of counsel as well as the relevant witness testimonies, it appears that the Respondent sought a refund from AAR Insurance Uganda Limited in respect of medical treatment received in Israel, amounting to approximately USD 78,786 An email dated **12th December 2023** from AAR's Claims Officer, Victoria, informed the Respondent that their claim had been approved for **"***60% of your overall chronic inpatient benefit within Asia.***"**

36. The Respondent interpreted this to mean a reimbursement of *60% of the actual medical expenses incurred in Israel.* The Applicant, on the other hand, clarified during testimony and re-examination that the approval was for 60% of the chronic inpatient benefit cap.

9.0 ANALYSIS OF EVIDENCE AND SUBMISSIONS

37. We note that a related rule of insurance contract interpretation is the doctrine of reasonable expectations in instances where the terms of the insurance contract are ambiguous in application. The doctrine can be a component of contra

proferentem, entitling an insured to the coverage that she would reasonably expect when confronted by an ambiguous policy term, or the doctrine can function independently of contra proferentem by providing coverage in the face of unambiguous policy language to the contrary. This rule takes into account considerable promise and peril. ***See; Kenneth S. Abraham, A Theory of Insurance Policy Interpretation, 95 MICH. L. REV. 531, 531 (1996)***

38. The insured cannot claim anything more than what is covered by the insurance policy. The terms of the contract have to be construed strictly, without altering the nature of the contract as the same may affect the interests of the parties adversely. The clauses of an insurance policy have to be read as they are. Consequently, the terms of the insurance policy, that fix the responsibility of the insurance company must also be read strictly. The contract must be read as a whole and every attempt should be made to harmonise the terms thereof. ***See; Export Credit Guarantee Corporation. of India Ltd. v. Garg Sons International, (2014) 1 SCC 686.***

39. During the hearing, it was established through the witness Joanita Victoria Bukirwa (AW 1) that the Applicant was aware that the Respondent had a chronic condition.

40. The insurance policy "JEXH 1" defines a chronic disease to mean "a diagnosed chronic condition that is recognized as life-threatening which will require ongoing medication for a period longer than 3 months.

41. It was the Respondent's evidence that he underwent a procedure in Israel for the treatment of cancer. He testified that prior to his treatment; he informed the Applicant of the impending treatment and his case manager a one Gerald Nahamya had given this authorization. We agree with the Complaints Bureau that in the absence of evidence to the contrary, the Respondent had authorization to undertake the treatment subject to policy provisions.

42. We are also in agreement with the Bureau's finding that the Respondent's operation was not an emergency but was the scheduled medical treatment overseas on page 7 of the policy.

43. On cross-examination of and interpretation of the Email dated 12th December, 2023 which was exhibited as **"JEXh- 1"** on page 49 of the Trial Bundle, the wording used in the said email is critical i.e. "*Your refund claim has been approved for 60% of your overall chronic inpatient benefit within Asia.*"

44. In our evaluation, it is vital to point out that whereas the Applicant made a communication that could have captured the term 'Asia' hence leading to the crossroads of whether or not the Respondent was entitled to a claim under the rescue and evacuation in international emergency medical cover-up to the first 45 days of absence from the territory, which would apply for hospitalization with pre-authorisation from the insurer.

45. The second category in contention would be coverage under the inpatient benefit whose cover is to a limit of UGX 40,000,000 for chronic conditions.

46. From the analysis of facts before us, for the Respondent to have qualified under the two categories he ought to have obtained pre-authorisation from the insurer but in addition to that requirement to have qualified for international emergency medical cover within Asia the Respondent ought to have shown that it was an emergency. 'Emergency' within the context of the policy '*shall mean a sudden unexpected situation in which a Member requires immediate hospitalization and treatment to prevent a medical condition that arises from Accident, injury or sudden illness that could result in death or serious body impairment'.*

47. An indemnity limit is dependent on the type of cover provided. The use of the term "benefit" refers clearly to a predefined policy entitlement rather than the actual bill incurred. The word "benefit" does not denote actual cost but rather refers to a capped allowance under the insurance policy. This position is further clarified during Victoria's re-examination where she stated, "We meant 60% of 40 million that was allocated in the health plan." Hence, there was no commitment or offer made to reimburse 60% of the Respondent's actual medical bills. Even if the Applicant was mistaken, terming the Respondent's illness as an emergency would be flawed based on the criteria that an emergency arises from an unexpected situation.

48. The Respondent had undergone treatment as early as 23rd January 2023 when he requested for a travel letter from the insurer. By default, cancer is a chronic illness that requires treatment for a longer period usually longer than 3(three) months within the context of the policy.

49. We find that notwithstanding the wording of the email forming the basis of the dispute before us, insurance contract interpretation prioritizes the parties' intended meaning, with courts giving effect to the plain and ordinary meaning of unambiguous language. However, if ambiguities exist, courts may consider the context, purpose, and a business-like or commercially sensible interpretation to ascertain the parties' true intent. The insurance policy must be read as a whole to determine what the insurance company and the insured reasonably intended when they entered into the contract. The policy language that the parties agreed to will generally be read based on the wording's plain, ordinary and popular meaning. ***See; Civil Appeal No. 040 of 2015; National Insurance Corporation Ltd Versus Kakugu Sylvan***

50. Policy Provisions (Exhibit JEX1)

51. From the look of **Page 25** of the policy defines the "Chronic Inpatient Benefit" as UGX 40,000,000 and **Page 13** outlines exclusions for overseas treatment except in emergency cases occurring within 45 days of travel. The Respondent's treatment

in Israel did not qualify as an emergency but in the absence of any such pre-authorization from the insurer and therefore falls outside the scope of full overseas coverage.

52. Thus, UGX 40,000,000 is the maximum benefit applicable to the Respondent's case, and AAR's obligation was limited to this.

53. The Respondent testified that he interpreted the 12th December email to mean 60% of his actual treatment costs. He submitted bills totaling approximately USD 78,786 and expected a reimbursement of USD 47,000. He claims to have foregone alternative sources of funding in reliance on this understanding did not lead to any evidence to this effect.

54. In light of the decision of the IRA Complaints Bureau exhibited as JExh-2, the doctrine bars a party from going back on a promise if the other party relied on it to their detriment. *See:* ***Central London Property Trust Ltd v High Trees House Ltd [1947] KB 130.***

55. To succeed on estoppel, the Respondent must prove: A clear and unambiguous promise, reliance on the promise; and detriment suffered as a result. While the Respondent may have relied on his interpretation, the wording of the email does not meet the standard of a clear and unambiguous promise to pay 60% of the total bill. The promise, if any, is explicitly tied to the benefit cap. We find the email vague and confusing since the chronic limit is capped at Ugx.40,000,000 and the 60% alluded is specifically provided for bills incurred under the Rescue and Evacuation Clause for emergency treatment.

56. The Tribunal therefore finds that the IRA erred in holding the Applicant to this communication under the doctrine of promissory estoppel. The email of 12th December is as confusing as it is ambiguous. The absence of an unambiguous acceptance negates the establishment of a binding promise.

57. We now turn to the issue of misrepresentation. The Respondent testified that he interpreted the 12th December email to mean 60% of his actual treatment costs. The Respondent's Counsel then argued that this was a misrepresentation that was acknowledged by the Applicant through an internal email dated 18th December 2023 (AEX2), that its own policy misrepresented to the Respondent into believing that the Applicant would settle 60% of his bills in Asia.

58. In the email (AEX2) a one Jesca Nambalirwa stated that "*it was found that our policy recorded, that AARHU shall be settling 60% of bills from Asia, which was a misrepresentation of what we actually meant and what the client perceived while purchasing cover*"

59. The Applicant argues that the email dated 12th December 2023 specifically referred to 60% of the overall chronic inpatient limit benefit within Asia and that

this email was an internal communication which does not in any way constitute an acknowledgment of misrepresentation.

60. We perused the policy, and the benefits schedule states the limit for chronic illness to 40,000,000 whereas the 60% of bills from Asia are under the Rescue and Evacuation for international emergency medical cover. The Applicant while arguing that it offered to compensate 60% of the Respondent's chronic inpatient cover was ex gratia because the Respondent had not sought authorization.

61. It is the Tribunal's finding that the witness (AW 1) confirmed that they were aware of the Respondent's sickness before travel. We therefore have no reason to doubt that a one Nahamya had authorized the Respondent's travel. The Respondent stated that he was only required to provide proof of expenses and he duly submitted a refund form by email dated 12th September (JEX 10).

62. It was submitted by Counsel for the Respondent, that the Respondent believing that the Applicant would settle 60% of his bills in Asia led him to renew his policy as per that email (AEX2). The Applicant to that extent acknowledges the misrepresentation.

63. For the period between September and December 2023, the Applicant did not raise the issue of lack of authorization for the treatment including in the email dated 12th December 2023. The Applicant now seeks to rely on the offer of 60% being an 'ex-gratia' offer without having evidence that it objected to the Respondent's claim for lack of authorization. The Applicant's argument in the least is a baseless attempt to justify the 60% offer by classifying it as 'ex-gratia' as an afterthought.

64. The Tribunal finds that the email dated 12th December 2023 was careless and amounted to a negligent misstatement. The Respondent submitted bills totaling approximately USD78,786 and expected a reimbursement of USD 47,217 based on the email which communicated an approval.

65. A negligent misstatement is defined as an "inaccurate statement made honestly but carelessly usually in the form of advice given by a party with special skill/knowledge to a party that doesn't possess this skill or knowledge" (Willesee Bill, Law management 252, Curtin Handbook 2010).

66. Insurers have a duty to exercise reasonable care in their communications to avoid causing harm or misrepresentation. Insurance companies have a responsibility to ensure accurate internal communication and transparent claims processing to standards required to avoid negligent misrepresentation through misstatement such as in this case.

67. Regulation 43 of the Insurance (Licensing and Governance) Regulations 2020, requires the insurers to conduct business with integrity and with due skill, care

and diligence. Further still, Regulation 44(2)(c), (e) and (h) of the same Regulations require insurers to provide accurate and reliable information to policyholders.

68. We are in agreement with the IRA Complaints Bureau that by failing to provide accurate and reliable information to the Respondent to the highest professional standards, the Applicant was in breach of its duty of care to the Respondent.

69. We equally find the argument of on counter offer by the Applicant baseless and misguided.

70. Issue 3: What remedies are available to the parties?

71. The Applicant has demonstrated that the decision of the IRA erroneously arrived at the conclusion that the email dated 12th December 2023 was binding and the Applicant was estopped from reneging on its promise to pay.

72. The Tribunal has reviewed the insurance policy terms and conditions. It is not in dispute that the Respondent's chronic inpatient benefit limit was UGX 40,000,000, and that his treatment in Israel was for a chronic and non-emergency condition. The Rescue and Evacuation Clause, which would have covered treatment abroad, was only applicable in cases of emergency, a fact confirmed by both parties during proceedings.

73. The Tribunal therefore concludes that the Respondent is entitled to UGX 40,000,000 offered by the Applicant as per the chronic benefit limit.

74. General Damages

75. Having found that the Applicant liable for negligent misstatement, the natural and probable consequence of the Respondent's acts or omissions entitles the Respondent to general damages. The general rule is that such damages should be awarded at the discretion of the Court (Tribunal in this case) and are compensatory in nature in that they should restore some satisfaction, as far as money can do it, to the injured Plaintiff/party. ***See; Takiya Kashwahiri & A' nor vs. Kajungu Denis; CACA No. 85 of 2011.***

76. In assessing the quantum of damages, courts are namely guided by the value of the subject matter, and the economic inconvenience that a party may have been put through; ***See; Kibimba Rice Limited vs Umar Salim SCCA No. 17 of 1992***. Based on the surrender value claimed, the Appellant is awarded UGX1,000,000 as general damages. (***See; Decision of Hon. Musa Ssekaana J in Electricity Regulatory Authority v Watuwa Jimmy Cosmas (Civil Appeal 129 of 2018) [2019]***

77. The fact that this was a careless misstatement, we consider a sum of Ugx.20,000,000- (Twenty million shillings only) adequate compensation for the

breach of professional standard as stipulated in the Insurance (Licensing and Governance) Regulations 2020 misrepresentation and the inconvenience suffered by the Respondent as a result.

10.0 CONCLUSIONS AND FINAL ORDERS

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

1. The appeal partially succeeds.
2. The decision of the Insurance Regulatory Authority of Uganda dated 11th December 2024 is hereby set aside.
3. The Applicant, AAR Insurance Services (U) Limited, is liable to pay Ugx.40,000,000 (Forty Million Shillings Only) to the Respondent, as per the applicable chronic inpatient benefit limit.
4. The Respondent is awarded general damages of Ugx.20,000,000/- (Twenty Million Shillings Only)
5. Each party to bear its own costs.

It is so ordered.

DATED and DELIVERED at KAMPALA on the 27th day of May 2025.

Rita Namakiika Nangono
Chairperson - Insurance Appeals Tribunal

Solome Mayinja Luwaga
Member - Insurance Appeals Tribunal

John Bbale Mayanja (PhD)
Member-insurance Appeals Tribunal

Ms. Harriette Nabasirye Paminda Kasirye
Member-insurance Appeals Tribunal