IN THE INSURANCE APPEALS TRIBUNAL AT KAMPALA
APPLICATION NO. 11 & 13 OF 2025
(ARISING FROM INSURANCE REGULATORY AUTHORITY COMPLAINT NO. IRAB COMP.141/06/2024)

ESEZA MUWANGA NAJJOMBWE::APPLICANT

VERSUS

1. **OLD MUTUAL LIFE ASSURANCE UGANDA LTD**
2. **HOUSING FINANCE BANK (U) LTD::RESPONDENTS**

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 FACTS

1. This consolidated decision in Application Nos. 11 and 13 of 2025 arises from the decision of the Insurance Regulatory Authority of Uganda (IRA) in Complaint Reference No. IRAB/COMP/03/03/24, filed by the Applicant, Ms. Eseza Muwanga Najjombwe, against Old Mutual Life Assurance Uganda Ltd (the 1st Respondent) and Housing Finance Bank Uganda Ltd (the 2nd Respondent). The complaint concerns the wrongful denial of her Total Permanent Disability (TPD) insurance claim under a Group Credit Life Assurance Policy.

2. The Applicant, a software engineer by profession, secured a mortgage facility from the 2nd Respondent in September 2022 to the tune of UGX 295,000,000, for the purpose of purchasing a residential home. As a mandatory condition for mortgage approval, the 2nd Respondent required her to obtain a Group Credit Life Assurance Policy, which she did from the 1st Respondent. The loan was approved on 13th September 2022, and a Key Features Document (KFD) was issued on the same day by the 2nd Respondent's loan officer. This KFD expressly stated that Total Permanent Disability arising from either natural or accidental causes was covered under the policy. On 14th September 2022, the Applicant was asked to sign a pre-insurance declaration form, and her account was debited for the premium of UGX 6,800,000.

3. The Applicant continued to make repayments on her mortgage and to discharge her legal duties until April 2024, when she was diagnosed with Bipolar Affective Disorder by Dr. Hafsa Lukwata, a Consultant Psychiatrist. Her medical condition caused her to suffer extreme symptoms of paranoia, disorganization, agitation, and

impairment of her judgment and mental function, leading to job loss and incapacity to carry on any gainful employment. Medical records from AAR Medical Centre and JOMEC confirmed that she had to be placed under prolonged psychiatric care and multiple medications to control her condition. The Applicant's consultant psychiatrist concluded in a detailed medical report that she was permanently unable to work.

4. On this basis, the Applicant submitted a TPD claim to the 1st Respondent through the 2nd Respondent. However, the claim was rejected because the condition was excluded from cover, being a mental illness of natural origin. The 1st Respondent further claimed the condition was pre-existing, despite the Applicant having no prior diagnosis or treatment for any mental health condition at the time of insurance uptake. The denial of the claim was communicated without allowing the Applicant to submit a final medical report or additional documentation, contrary to standard insurance practices and procedural fairness.

5. Following the rejection, the Applicant filed a complaint with the IRA. The Authority reviewed the complaint and found that the 1st Respondent, Old Mutual Life Assurance Uganda Ltd, had failed in its regulatory obligations under Regulation 59(3) of the Insurance (Licensing and Governance) Regulations, 2020, by not reviewing, correcting, or withdrawing the misleading Key Features Document issued to the Applicant. It also found that the 2nd Respondent, as the intermediary and distributing bank, misrepresented the scope of the policy and did not clarify that mental illnesses of natural origin were excluded under the master policy. Consequently, the IRA imposed regulatory sanctions and administrative fines on the Respondents. However, it declined to uphold the Applicant's claim, citing a lack of a medical report from Butabika Hospital.

6. The Applicant contests this finding, asserting that her diagnosis and treatment were conducted by a licensed Consultant Psychiatrist and that there is no statutory or policy requirement that a mental illness must be certified by Butabika Hospital alone. She further argues that both Respondents acted in bad faith and misled her at the time of policy acquisition. She relied on the representations in the KFD, which expressly stated that TPD from natural causes was covered. At no point was she provided with the master policy terms to verify exclusions, and she was never given adequate disclosure of the scope of coverage or the pre-existing condition clause. Moreover, she contends that she had never been diagnosed or treated for any psychiatric condition before 2024, and the Respondents' claim of non-disclosure was baseless.

7. She now seeks a decision reversing the IRA's refusal to allow her claim and a declaration that both Respondents are liable under the insurance contract. She also seeks compensation for the outstanding loan balance, consequential loss, and damages for breach of statutory duty, misrepresentation, and mental anguish suffered due to the wrongful denial of her rightful claim.

2.0. REPRESENTATION

8. At the hearing of this appeal, the parties were represented by Counsel Rebecca Nakiranda for the Applicant from Nakiranda & Co. Advocates. Present in Court was the Applicant, Ms. Eseza Muwanga, together with Ms. Esther Muwanga Nanyonga, who also appeared as a witness. The Applicants' second witness, Dr. Hillary Kuteesa, of Nakasero Hospital, was present via Zoom.

9. The 1st Respondent was represented by Counsel Martin Kakuru, appearing together with Cyntha Kwendu from Ligomarc Advocates. Mr. Akena Joshua, the Chief of Operations and a witness in the matter, was present on behalf of the 1st Respondent.

10. The 2nd Respondent was represented by Counsel Africano Bigirwaruhanga from the internal legal department of the 2nd Respondent. He informed the Tribunal that the 2nd Respondent's witness was unavailable and, given that the hearing was concluding, they would rely on the testimony recorded by the Insurance Regulatory Authority (IRA), which forms part of the trial proceedings in this appeal.

3.0 ISSUES FOR DETERMINATION

11. The Tribunal identifies the following issues for determination arising from the above grounds of appeal:
    1) Whether the Respondents breached the insurance contract?
    2) Whether the Respondent breached statutory obligations warranting penalties imposed?
    3) What remedies are available to the parties?

12. **SUBMISSIONS FOR THE APPLICANT**

13. In the submissions made by Counsel for the Applicant, it was argued that the claim under the Group Credit Life Assurance Policy was validly made. The Applicant was said to suffer from Bipolar Affective Disorder, a condition which, according to her counsel, amounted to Total Permanent Disability (TPD) within the meaning of the insurance contract. It was contended that the nature and severity of the condition rendered the Applicant incapable of undertaking any gainful employment, thus satisfying the policy's threshold for TPD.

14. The Applicant's counsel further submitted that she was not required to prove that the disability resulted from an accident. They contended that the insurance policy did not expressly restrict coverage to accidental disabilities and that, to the extent the policy language was ambiguous, such ambiguity ought to be interpreted against the drafter under the doctrine of contra proferentem. They submitted that the insurance company, having drafted the policy, could not now rely on unclear terms to defeat a valid claim.

15. It was also submitted that the Respondent was estopped from denying coverage on the basis that the Applicant was issued a Mortgage Protection Certificate. This document expressly referenced coverage for death or disability without qualifying the type or cause of disability, and the Applicant relied on that representation. Counsel contended that it would be inequitable for the insurer to now limit cover only to accident-related disabilities, having failed to make this clear from the outset.

16. The Applicant also alleged a regulatory breach by the 1st Respondent under ***Regulation 59(2) of the Insurance (Licensing and Governance) Regulations, 2017***. It was argued that the insurer failed to ensure that the 2nd Respondent, the master policyholder, provided the Applicant with a clear summary of the key policy terms. This omission deprived the Applicant of an opportunity to understand any exclusions or limitations, such as the purported requirement that the disability be accidental in origin.

17. Further, the Applicant took issue with the Respondent's basis for denying the claim, particularly the emphasis on the absence of an assessment from Butabika Hospital. It was submitted that the Applicant's refusal to be assessed at that facility did not invalidate the diagnosis of Bipolar Affective Disorder made by Dr. Kuteesa, a qualified psychiatrist. The insistence on a single assessment source was described as unreasonable and discriminatory, particularly given that the Applicant had already obtained a valid medical opinion from a licensed mental health professional.

18. Lastly, the Applicant called for upholding the decision of the Insurance Regulatory Authority, which had disallowed the Respondent's rejection of the claim and imposed a fine of UGX 5,000,000 for breach of statutory duties. The Tribunal was urged to maintain this position as a matter of justice and regulatory enforcement.

19. **SUBMISSIONS FOR THE RESPONDENT**

20. In response, Counsel for the 1st Respondent submitted that the claim was rightly denied because the insured risk under the policy did not materialize. It was argued that ***Clause 4(1)(ii) of the Master Policy*** limited coverage to Total Permanent Disability caused solely and directly by an accident resulting in bodily injury. Since Bipolar Affective Disorder is a psychiatric condition of natural origin, it did not result from an accident and thus did not fall within the scope of cover. In support, reference was made to ***Prudential Insurance Co v Inland Revenue Commissioner [1984] 2 K 658 and NIC v Kakagu Sylvan (Civil Appeal No. 040 of 2013),*** which affirmed that liability under an insurance policy arises only when the specific insured peril occurs.

21. It was further argued that the claim was premature because the Applicant was not in default on her mortgage obligations. Under cross-examination, the Applicant conceded that the mortgaged property continued to generate rental income and that loan repayments remained current. The Respondent submitted that the

insurance policy was intended to cover loan default arising from disability, and since no such default occurred, the risk had not crystallized.

22. The 1st Respondent also alleged material non-disclosure and misrepresentation on the part of the Applicant. It was submitted that she breached the principle of utmost good faith by failing to disclose a prior diagnosis of Bipolar Disorder made on 10th July 2019. The Respondent relied on inconsistencies between documents, including Exhibit PE12 (Proof of Disability Form) and PE13 (email correspondence), to show that the Applicant had manipulated dates concerning her diagnosis. Citing ***Drake Insurance v Provident Insurance Plc*** **[2003] EWHC 109 (Comm) and** ***APA Insurance (U) Ltd v Moil (1) Ltd,*** as well as Justice Musota's holding in ***NIC v Kakage*** **(2016) UGHCCD 136**, they argued that non-disclosure of material facts rendered the claim void ab initio. Contradictions between the Applicant's own testimony and that of her witnesses, including her sister and psychiatrist, were presented as further evidence of concealment.

23. In addition, the 1st Respondent submitted that the Applicant frustrated an independent medical review by Dr. Akimana, a senior psychiatrist at Butabika Hospital. Although she initially agreed to the review, her lawyers later wrote to the Insurance Authority requesting that Dr. Akimana's assessment be disregarded. This was interpreted as a deliberate obstruction of the independent evaluation process, which was essential to providing the Authority with an objective basis for assessing the claim.

24. The Respondent also contested the claim on the grounds that there was no proof of Total Permanent Disability. They argued that even if psychiatric conditions were covered under the policy, which they were not, the Applicant had not met the criteria for TPD as defined in both the insurance contract and the ***Mental Health Act, Cap. 308, Section 59(3)***, which requires a declaration by the Mental Health Board or a Court that the person is incapable of managing her affairs. The Respondent pointed to evidence that the Applicant had voluntarily resigned from employment, managed her own bank accounts, supervised rental properties, rejected assessment by a national referral hospital, and continued to service her mortgage. All these actions, in their view, contradicted the claim of permanent disability.

25. In addressing the Applicant's reliance on estoppel and contra proferentem, the 1st Respondent submitted that these doctrines could not override the express terms of the insurance contract. ***Section 91 of the Evidence Act*** was cited to support the proposition that extrinsic evidence, such as the Mortgage Protection Certificate, cannot be used to vary or contradict the written terms of the Master Policy. It was argued that the certificate was merely a summary and did not override the detailed contractual provisions in the policy itself.

26. Lastly, on the issue of the regulatory fine, the 1st Respondent denied any breach of statutory obligations. They contended that under Regulation 59(2), the duty to disclose key policy terms to the insured fell on the 2nd Respondent, who was the master policyholder. The insurer claimed to have become aware of the Key Features Document only after the complaint was filed and, therefore, should not be penalized for its absence or content. Accordingly, the fine of UGX 5,000,000 was said to have been wrongfully imposed.

4.0 DECISION

27. Having carefully considered the submissions of Counsel for the Applicant and the Respondents, the pleadings, documentary evidence, and relevant legal authorities cited, the Tribunal now proceeds to determine the remaining issues raised in the appeal.

28. **ISSUE 1 - Whether the Respondents breached the insurance contract?**

a) Failure to honor the scope of cover represented and notified to the Applicant

29. This Tribunal has examined the totality of the evidence, including the documentary exhibits and oral testimonies adduced by the parties and their respective witnesses, and is persuaded that the Applicant's condition qualifies as Total Permanent Disability (TPD) within the meaning and intent of the operative insurance contract.

30. The point of contradiction is between the Master Policy and the Key Features Document (KFD***). Clause 4(1)(ii) of the Master Policy*** defines TPD in restrictive terms, confining its ambit to disability that arises "solely and directly from an accident resulting in bodily injury." In contrast, the KFD, a consumer-facing document provided to the Applicant at the inception of the policy, expressly extends coverage to TPD arising from both accidental and natural causes.

31. The Applicant gave credible testimony to the effect that she relied upon the KFD in forming her understanding of the policy's coverage and only became aware of the limiting language of the Master Policy upon the rejection of her claim. This assertion was corroborated by Mr. Joshua Akena, a witness for the Respondent, who admitted under cross-examination that the KFD is issued to prospective policyholders at the point of onboarding, typically by the distributing bank, to delineate the scope of coverage. He candidly conceded that there may exist inconsistencies between the KFD and the Master Policy, but maintained that such incongruities do not necessarily render the policy void or unenforceable.

32. It was the Applicant's evidence that she signed the Key Features Document and was given a Mortgage Protection Certificate (AExh.10). It was provided in the certificate that the insurance certificate was issued under the Group Mortgage Protection Master Policy. However, Counsel for the Applicant contended that while the mortgage certificate referenced the master policy No.010/021/1/0210723, the

master policy on record (AExh.10) is master policy number No.010/003/1/0030722. This discrepancy was not explained, and no evidence was provided by the Respondents to provide context for the discrepancy.

33. On the strength of this evidence, we find that the Key Features Document formed an integral part of the insurance contract by way of incorporation by reference since neither party denies this. This principle of contractual construction, namely, that ancillary documents expressly referred to in a principal agreement are deemed to be incorporated and thus binding upon the parties, is well established in law. The decision in *Lucy Kabege v NIKO Insurance* is instructive in this regard, where the Court held that once incorporation by reference occurs, the incorporated terms assume equal force and effect as the principal terms of the policy and must be read conjunctively therewith.

34. In the present case, the Respondent agree to the existence of the Key Features Document, and the 1st Respondent, Mr. Joshua Akena, agreed that indeed the KFD formed part of the contract. Therefore, the KFD and the Master Policy must be read harmoniously as forming a composite insurance arrangement. The principle that a document incorporated by reference acquires contractual force applies with equal vigour in the realm of insurance law, particularly here the incorporated document defines the contours of coverage in a manner more expansive.

35. The Respondent's witness, Mr. Akena, in his testimony confirms several key facts: that the bank provided the KFD to customers; that the bank was not the insurer's agent but a direct client; that the KFD was not authored by the insurer but used to explain policy coverage; that the insurer accepted premiums and acknowledged the Applicant as a covered life assured; and that coverage included death, mental illness, and critical illness.

36. It is the Tribunal's finding that the KFD had the distinctive features of the contract of insurance, i.e. the subject matter of the insurance, the period of the insurance, the date of the commencement of the policy, the details of the peril which was insured against and also a list of exemptions specifying the circumstances in which the insurers would not be liable.

37. Where ambiguity exists in an insurance contract, the contra proferentem rule applies to favor the insured. In the present case, the Applicant was led to reasonably believe, based on the KFD, that disabilities arising from natural causes, including psychiatric illness, were covered. Courts of law, for example, in ***General Accident Insurance v. Umerji*** **[1973] EA 362 and** ***NIKO Insurance Tanzania Ltd v. Serina Pius*** have held that ambiguities must be construed against the insurer. The Tribunal adopts this approach.

38. Accordingly, the Tribunal holds that the Key Features Document in this case was contractually binding upon the parties, and that the coverage representation therein, which encompasses both accidental and natural causes of disability, prevails in resolving any ambiguity as to the scope of TPD coverage. Further still, the Tribunal is satisfied that the KFD did not incorporate terms other than those on its face. The Applicant testified that she did not receive the insurance master policy in question and was, therefore, not aware of the terms and conditions. Consequently, the Respondents cannot hold the Applicant liable for what the Applicant was not aware of at the time of the insurance contract.

39. It is the Tribunal's finding, therefore, that the Master Policy was effectively overridden by the KFD, which was the only document given to the Applicant and the same was incorporated into the contract. We have therefore applied the contra proferentem rule to resolve any ambiguity in the Applicant's favor.

b) Breach of Duty of Utmost Good Faith

40. On the issue of whether the Applicant was in breach of the duty of good faith. It was the 1st Respondent's submission that the Applicant failed to disclose that she had been diagnosed with bipolar disorder as early as 10th July 2019, as per the proof of disability form (PExh.12), which subsequently altered records alleging a diagnosis in April 2024. It was argued that the fact that the Applicant had already received treatment for a condition she had prior to acquisition of the policy showed that she was not acting in good faith.

41. The Applicant's doctor, Dr. Hillary Kuteesa (AW.3), a licensed psychiatrist, testified that in 2024, he diagnosed the Applicant with Bipolar Affective Disorder, which he described as chronic, permanent, and significantly impairing her ability to function in any form of gainful employment. He testified that he attended to the Applicant in 2024 and at Nakasero Hospital for psychiatric symptoms she had recently developed. The doctor testified that during the consultation, he obtained her medical history and interviewed both her and her sister Esther Muwanga Nanyonga (RW.2). That the sister had told him that in July 2019, the Applicant exhibited similar symptoms, including fatigue and difficulty sleeping, but the family managed them with over-the-counter antibiotics without seeking professional care. At that time, there was no diagnosis or recognition of any mental illness.

42. The Doctor stated in his witness statement that to support the diagnosis and assess the degree of impairment, he administered the World Health Organization Disability Assessment Schedule, a recognized international tool used to evaluate functional disability resulting from mental health conditions. It was his finding that the Applicant suffered significant impairments in concentration, learning, task performance, and interpersonal relationships, and he prepared the medical report and attached the assessment tools used in the diagnosis (AEx 11) with a conclusion that, due to Bipolar Affective Disorder, the Applicant was medically incapacitated and unable to return to her employment because she could not concentrate.

43. The Tribunal finds on the balance of probabilities that, as per the evidence of Dr. Kuteesa Hillary, Bipolar Active Disorder evolved gradually and manifested through observable psychiatric symptoms, which only a professional could evaluate and confirm. The Tribunal is in agreement with the Complaint's Bureau's finding using the case of **Durand v Industrial Comm'n 224 Ill 2d 53, 862 N.E.2d 918 (Ш.2006),** wherein the court held that 'the appropriate manifestation date was when the petitioner's carpal tunnel syndrome was confirmed with a diagnostic study and that confirmation was on 19th April 2024. The Tribunal therefore find that the Applicant was not in breach of the duty to act in good faith.

c) Improper Conduct in Medical Assessment

44. The Applicant's attending physician, Dr. Hillary Kuteesa, a licensed psychiatrist with over twelve years' experience in the public and private health sector, submitted a detailed psychiatric report that the Applicant suffered from Major Depressive Disorder (Severe) with suicidal ideation and had lost occupational functioning. The Respondent, however, discredited the doctor's assessment for having contradictions and noted that it was industry practice to have a medical assessment from an independent doctor from a specialized institution or hospital.

45. The Insurance Regulatory Authority sought an independent assessment from Dr. Akimana. The Assessment was conducted at Butabika National Referral Mental Hospital. Although the Applicant submitted to the examination, she later, through her lawyer by way of email dated 4th February 2025, stated that she did not want to be associated with Butabika Hospital and requested the immediate removal and permanent destruction of all records related to her at Butabika.

46. The email from the Applicant's lawyer was forwarded to Dr. Akimana, and he responded in an email dated 27th February 2025 as follows: 'Thank you for reaching out. Following my assessment of Ms. Eseza Muwanga Najjombwe, I had a discussion with her regarding the next steps. Given her expressed concerns and preferences, I advised that the necessary services be sought elsewhere to better support her needs. I trust this approach will ensure the best possible outcome for all parties involved. Please let me know if any further clarification is required.

47. The Tribunal is in agreement with the IRA Complaints Bureau that by declining to fulfil the necessary next steps for the release of the medical report, the complainant created a situation where the Authority lacked the essential medical evidence to establish whether her condition falls within the scope of Total Permanent Disability.

48. The Tribunal finds that while the Applicant has a right to determine the medical institutions she is associated with, an independent reassessment was necessary to facilitate a fair determination of her mental state for purposes of ascertainment of Total Permanent Disability.

49. At the hearing, the Applicant was asked by the Tribunal if she was willing to give consent for the release of the report by the Dr. Akimana, and she confirmed that she would give the consent. However, given the fact that the said Dr. Akimana dropped the engagement and advised the Applicant to seek services elsewhere, this is not an option at this point.

50. The Tribunal finds that, given that Dr. Akimana's engagement was rescinded by the Doctor, there is a need for engagement of another independent medical practitioner from a credible institution. The Tribunal instructs the Insurance Regulatory Authority to identify and engage another independent doctor for a medical re-assessment to establish whether the Applicant's condition falls within the scope of TPD.

51. **Issue Two - Whether the Respondents breached statutory duties under the Insurance Regulations?**

52. The Tribunal previously found that both Respondents had breached regulatory duties under the ***Insurance (Licensing and Governance) Regulations, 2020*** **and the** ***Insurance (Bancassurance) Regulations, 2017,*** particularly **Regulations 59(2)** and **59(3)**. The oral testimonies presented during the hearing confirm and reinforce those findings.

53. Regarding misrepresentation and inadequate disclosure by the 2nd Respondent (the bank), the Applicant, Ms. Eseza Najjombwe, testified that the only document she signed at the time of contracting was the Key Features Document (KFD), which she understood to be a summary of the relevant insurance policy. She was never provided with the full Master Policy at the time of entering the contract and only saw it upon claim rejection. This was confirmed during cross-examination, when she stated: "I didn't request a copy. It was given when I made my claim… They shared this policy as proof."

54. Further, during re-examination, the Applicant confirmed: "I signed a KFD… It contained the key facts of the document, exclusions, and different terms for doing medical exams for certain loans." Dr. Hillary Kuteesa corroborated this in his testimony, noting that the Applicant's medical history and diagnosis were consistent with her disclosure and claim. Additionally, Mr. Joshua Akena, the representative of the 1st Respondent (Old Mutual), admitted during cross-examination that although the insurer issued the policy to the bank, the KFD was authored and issued by the bank, and that: "Yes, the Key Features Document forms part of the policy arrangements." This implies that any inaccuracies or misrepresentations in the KFD were attributable to the 2nd Respondent, and by extension, to the 1st Respondent, who remained aware of and benefited from the issuance of such documents in the onboarding process.

55. As to the supervisory lapse by the 1st Respondent (the insurer), while the 1st Respondent argued that the bank was a direct client and not its agent, it was established in evidence that the bank acted as the bancassurance intermediary, a role regulated under the ***Insurance (Bancassurance) Regulations, 2017***, making it bound by fiduciary and regulatory duties toward the insured. The insurer issued a certificate of insurance directly to the Applicant and admitted to receiving premiums on her behalf. Moreover, Mr. Akena acknowledged that the insurer did not cancel the policy despite inconsistencies between what the bank represented in the KFD and what the Master Policy stated. He stated: "We don't cancel the policy… As long as the bank continues to issue loans, the policy is there." This constitutes a failure by the insurer to enforce regulatory standards of transparency, contrary to **Regulation 59(3)**, which places a duty on insurers to ensure that a summary of key terms and conditions is provided to the insured accurately and understandably.

56. Therefore, the issuance of a misleading KFD by the 2nd Respondent and the failure of the 1st Respondent to detect, correct, or prevent such misrepresentation constitute regulatory breaches and violations of the duty of utmost good faith.

57. Any penalty imposed by an administrative or judicial body must be lawful and proportionate to the circumstances. In this case, the Tribunal is satisfied that the fines imposed were moderate, proportionate, and justified in view of the conduct of the Respondents and the significant consumer prejudice suffered by the Applicant. The fines served a corrective and deterrent purpose without being excessive or punitive.

58. Accordingly, the Tribunal upholds the Authority's decision to impose fines on the Respondents and finds no legal basis to interfere with the amounts imposed.

59. **Issue 3 - What remedies are available to the parties?**

60. In view of the findings on the preceding issues, the Tribunal finds that the Key Features Document in this case was contractually binding upon the parties, and that the coverage representation therein encompassed both accidental and natural causes of disability, prevails in resolving any ambiguity as to the scope of TPD coverage.

5.0 CONCLUSION AND FINAL ORDERS

61. In conclusion, the Tribunal makes the following orders:
    1) The Tribunal hereby declares that the Applicant qualifies for *Total Permanent Disability* under the Key Features Document issued by the Respondents.

    2) The Insurance Regulatory Authority is hereby instructed to identify and engage an independent doctor from a credible medical institution for a medical re-assessment of the Applicant to establish whether the Applicant's

condition falls within the scope of TPD within 30 days from the date of the decision.

3) The Applicant is directed to avail herself for the re-assessment and give all necessary consents needed to facilitate the release of the medical report.

4) The Tribunal finds that the Respondents are not entitled to any relief. Their respective failures were material, unjustified, and resulted in financial and emotional prejudice to the Applicant.

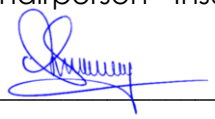
5) The Applicant is awarded costs of this appeal.

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

Delivered and dated at Kampala on the 1st day of October 2025.

Rita Namakiika Nangono

Chairperson - Insurance Appeals Tribunal

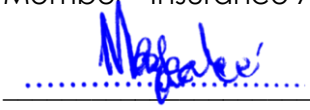


Solome Mayinja Luwaga

Member - Insurance Appeals Tribunal

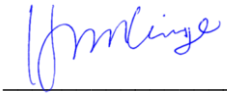
George Steven Okotha

Member - Insurance Appeals Tribunal



John Bbale Mayanja (PhD)

Member - Insurance Appeals Tribunal



Harriette Nabasirye Paminda Kasirye

Member - Insurance Appeals Tribunal