

**WHETHER THE CURRENT REGULATORY FRAMEWORK IS ADEQUATE TO ADDRESS THE
CHALLENGES IN CLAIMS PROCEDURE IN PROPERTY INSURANCE**

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BS20B11/1099

**A DISSERTATION SUBMITTED TO THE SCHOOL OF LAW, IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE AWARD OF A DEGREE OF BACHELOR OF LAWS OF
UGANDA CHRISTIAN UNIVERSITY**

May, 2024



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DECLARATION

I **AGABA CHRISTMAS** do declare that this is my original work and to the best of my knowledge, it has never been submitted to any University by anybody else or institution for the award of a degree or its equivalent.

Signature.....

Date.....

APPROVAL

I certify that I have supervised and read through this work and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate in Scope and quality in fulfillment of the requirements for the award of a degree of Bachelor of laws, Uganda Christian University, Mukono

Name of Supervisor:

Mrs. DINAH MUKASA

SIGNATURE

.....

DATE

.....

DEDICATION.

I dedicate this work to my Parents, Mr. Ndyajunwa Herbert and Mrs Atukunda Grace who put all their effort to ensure that I pursue this degree in law; to my Uncle Mr. Muhumure Apollo and his wife Mrs Rukundo Gift for their unwavering support during my academic journey, to my supervisor Mrs Dinah Mukasa, to Asiimire racheal and all my friends who have helped me in this research, may God abundantly bless you.

ACKNOWLEDGEMENT

My sincere appreciation goes to the almighty God, for His compassion, blessings has enabled me to have the wisdom and interest to pursue the course I am undertaking and for the completion of this report. I would like to thank my supervisor **MRS. DINAH MUKASA** for her tireless efforts in ensuring that I get the best out Of my research and I would like to express my appreciation for the contribution and cooperation of all those who were able to be my respondents and the insurance companies that were used as my case study.

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4. The Insurance Complaints Bureau guidelines of 2022
5. The Insurance (Policyholders Compensation Fund)
6. The Guidelines on Claims Management for the Insurance industry 2012.
7. The Insurance Claims Guidelines 2021 (The Claims Process and Service Standard for Insurers
8. The UK Insurance Act of 2015 as amended
9. The Insurance Act Cap 487 Laws of Kenya
10. The Insurance Act of Philippines(The Republic Act No.10607)
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12. The Insurance Act of Philippines(The Republic Act No.10607)
13. California Code of Regulations
14. New York Codes, Rules and Regulations

LIST OF CASES

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Attorney General v NIKO Insurance Uganda Limited, (2013), HCCS NO 240 OF
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Prudential Insurance co V Inland Revenue Commissioner [1904] 2 KB

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ABSTRACT

With the constant growth of the economy, issues of insurance (claims settlements) are a growing concern and as such the law governing property insurance is one that needs to be considered.

This research sought to evaluate the adequacy of the Ugandan regulatory framework in addressing the challenges in the claims procedure regarding property insurance. In that regard, the study took a comparative analysis of different laws in other jurisdictions to identify the loopholes within the claims settlements operations under property insurance law in Uganda and make recommendations and proposals for reforms.

The research brought out a plethora of challenges such as fraud, unfair settlement practices, inadequate settlements, complex documentation, delay in claims settlements, disputes over coverage, and knowledge gaps among others.

The research paper recommends that the Regulatory bodies and insurance companies need to increase claims settlement limits for branches, provide platforms to explain the technical language used in the policy to customers that may not understand the language.

It proposes for the Amendment of the Property Insurance Laws to include timeframes within which claims must be settled. It further proposes for the provision of penalties in respect to the violation of the same.

CHAPTER ONE

1.1 Background

The history of insurance law is greatly linked to the practice of the medieval merchants. The records of the Chamber of Commerce of Florence have established as a matter of fact that insurance as it is known at present has its origins in the Medieval Italian merchants of the 14th century which spread their commerce over most of Europe.¹ Insurance among these merchants took a simple but basic form.² Groups of merchants would together agree that one of them would bear the loss of a particular voyage in consideration of a fee commonly known as the premium.³ They were enterprising traders from the thriving commercial cities of Northern Italy who introduced into England their custom of insuring their marine ventures. In recognition of these fallen merchants, Lombardy Street on London is actually named after them. It is where they established their international trading house.⁴

A contract of insurance is a contract under which one party in exchange for a premium agrees with another party to make a payment or provide a benefit to the policy holder or another person on the occurrence of a specified uncertain event which if it occurs, will be adverse to the interests of the other party.⁵ It is one whereby one party (insurer) promises in return for a money consideration (the premium) to the other (the insured) a sum of money or provide him with a corresponding benefit upon the occurrence of one or more specific events.⁶

Property insurance plays a vital role in safeguarding individuals and business against financial losses resulting from damage or destruction to their physical assets. In Uganda, like in many other countries, property insurance is a critical component of risk

¹Hodgin, R. Insurance Law, text and materials. 2nd (2002) p I. Published in Great Britain

² Ibid

³ Taylor, I, R The law of insurance. 2nd (1968) p. 2

⁴ Ibid

⁵ Section 2 of the Insurance Act 2007

⁶ Prudential Insurance co V Inland Revenue Commissioner [1904] 2 KB.

management strategies. It is worth noting that the effectiveness of property insurance is contingent upon the sustainability and vibrancy of the claims procedure. The insurance industry in Uganda was unregulated until 1978 when the Insurance Decree was passed which was later deemed ineffective in addressing the insurance challenges at the time. In April 1996, the insurance statute was enacted which among others established the Uganda Insurance Commission (UIC) (now the Insurance Regulatory Authority of Uganda) mandated to ensure effective administration, supervision, regulation and control of the insurance business in Uganda.⁷The insurance industry is currently governed by the Insurance Act and is regulated by the Insurance Regulatory Authority of Uganda (IRA) which is established under section 14 of the Insurance Act. The Authority set up a Complaints Bureau in 1998 as per section 15(f) of the Insurance Act to handle complaints against Insurance players because claims settlement is associated with a lot of challenges both on the part of the insured and the insurer. ⁸

In the year 2022/23, Insurance Regulatory Authority resolved over **201** complaints and settlement of claims estimated at a total of over 10 billion shillings of the **432** complaints that were received⁹. Of these complaints, 132 were concerned with property insurance policies.

As of 23rd April, 2024, **133** complaints have been received by the Complaints Bureau of the Insurance Regulatory Authority. Of these, 58 are property insurance complaints **18** have already been resolved and closed.

Of these complaints, most of them concerned delayed claims processing with **38** complaints, unfair settlement practices with **8** complaints, notification and communication with **6** complaints and inadequate settlements with **4** complaints. They have not received complaints on complex documentation and disputes over coverage regarding property Insurance as of 23rd April 2024.

⁷ Section 14 Insurance (Amendment) Act, 2011

⁸ www.insurance.gov.ug

⁹ IRA 2022 Annual Insurance Market Report at page 18

As a way of resolving such disputes, the Insurance Regulatory Authority has employed **Mediation**, most especially to complaints regarding inadequate settlements and unfair settlement practices. This has thus helped policyholders to have leveled ground other than having their claims declined in their entirety. Of the **132** property insurance complaints that were received by the complaints Bureau in 2022/23, **48** were resolved through mediation and the complainants have given feedback being grateful of the mediation services that were provided by the Bureau. In a survey conducted by the insurance regulatory Authority, a one **Ebiete Peter** applauded the Bureau for the mediation that was accorded to him in regards to the complaint he made against **Sanlam**¹⁰.

The Insurance Regulatory Authority has introduced the Interface Complaints Management system to monitor the period of time that the insurer shall take to respond to the policyholder's claim and complaint. Statistics indicate that **117 complaints** were filed through the interface of the complaints management system with IRA from January to June 2022. Over **80%** of them were resolved within the shortest period of time. The effect of the system was that while insurance companies were previously given a maximum of seven days to respond to a complaint, the days have been reduced hence this has improved efficiency. In a tracer study conducted by the Insurance Regulatory Authority on Customer satisfaction in respect to complaints handling regarding property insurance claims, **48%** of the Respondents had their issues resolved in less than two weeks, **22%** had their issues resolved between 2 and 3 weeks, **17%** had their complaints resolved in periods above a month while **13%** had their complaints pending at the time of the study and thus their issues had not been resolved.

The insurance players were urged to improve service quality especially in areas of claims payment and complaints management to increase insurance uptake. According to the Policyholders satisfaction Survey of 2023, the findings revealed that **32%** of the property insurance policyholders were not satisfied with claims handling while **48%** of policyholders were not satisfied with the complaints resolution. Of the 32% that were not

¹⁰ IRA 2022 Annual Insurance Market Report at page 18

satisfied with claims handling, a substantial percentage was concerned with delayed claims processing, inadequate settlements and unfair settlement practices. The policyholders' dissatisfaction was as a result of delayed and non-payment of claims, inflexible payment plans, and unexplained policy terms that lead to disputes over coverage, complex documentation that is required during claims handling¹¹. In a bid to reduce on such disputes, insurance companies have been advised to always highlight and explain the most important terms of the policy to their customers.

Table 4.1. Challenges faced by the insureds/policyholders in claims procedure regarding property Insurance.

CHALLENGES	RANK	FREQUENCY
1. Delayed claims processing	1	8
2. Complex documentation	5	5
3. Disputes over coverage	4	6
5. Inadequate settlements.	3	7
6. Unfair settlement practices.	2	7
No. of respondents was Eight (8)		

Table 4.1 illustrates the challenges faced by the insureds/policyholders ranked from the most frequent. According to the research findings on challenges faced by policyholders in claims procedure regarding property insurance, most respondents were in agreement that delayed claims processing is the most faced challenge as they make claims on their policies with a frequency of 8 being ranked number one as illustrated in **Table 4.1**.

Insured individuals often face delays in claims processing, leading to financial strain and frustration. The insurers at times make unnecessary investigations in order to frustrate the insureds. Delays can occur due to various factors such as incomplete documentation,

¹¹ Policyholders Satisfaction Survey, 2023.

investigation requirements or high claim volumes. Generally, an insurer must investigate once there is a valid reason that there is a claim to investigate. From the findings, the level of complaints over delayed claims payment/processing has been exponentially increasing over the years. From the report conducted by The Insurance Regulatory Authority, there has been an increase in cases of claims processing regarding property insurance from **108 complaints in 2022 to 188 complaints in 2023**. From the findings the authority has already received **38 complaints** regarding delayed claims processing of **58 complaints** that have been received as of April 2024 pertaining property insurance. Delayed claims payment complaints form a substantial number of the complaints that are received by the Complaints Bureau of the Insurance Regulatory Authority. The rise in delayed claims processing is attributed to delayed claim reporting and delay in claim documentation by the policyholders. However, it was reported that some insurers also prolong the claims management process by paying amounts due to clients in small installments¹². Policyholders also reported high costs associated with the claims process and ignorance about the claim handling process.¹³

“I filed my claim with all the documentation on 22nd of January 2024, they told me that I would receive my payment by 1st of February but up to today I have never received any single penny. I have been contacting them and their response has been that they are still investigating the validity of my claim. I have used my own money to repair my damaged home and I have forfeited the claim because I have little or no hopes that they will acknowledge my claim” narrates one of the policy holders who had taken out a standard homeowners policy later submitted his claim after the happening of the insured event. The above narration illustrates the problem of delayed claims processing in property insurance, its persistence and how it frustrates policyholders to the extent of forfeiting their claims

¹² Baseline Survey Report on the Insurance Industry in Uganda.

¹³ SUPRA

This was followed by unfair settlement practices that ranked as number 2 with a frequency of 7 out of all the 8 respondents as illustrated in **Table 4.1** above.

Under an insurance contract, both the insured policy holder and the insurer have an obligation to act in good faith. However, this is not always the case and insurance companies have an array of unfair claim settlement. Unfair claims settlement therefore refers to unjust behavior by insurers when handling claims by policyholders¹⁴.

Some of the unfair settlement practices that were gathered from the respondents in property insurance include failure by the insurance companies/insurers to adopt and implement reasonable standards for the prompt investigation of claims arising under their policies, not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. This is because in most cases, insurance companies always appoint their assessors who are not independent and impartial in carrying out the investigations and assessments.

“The investigations are not in good faith for example it is now about three to five months ever since I filed my claim but to get the assessment report from the assessors has been an impediment. Investigations take too long and I was not involved in the process so to know the progress of my claim “Narrates one of the respondents (policyholders) who had a renter’s insurance policy.

However, from the findings, it was revealed that insurance companies always need reasonable time to investigate and ascertain whether the cause of the damage falls squarely within the policy coverage. To reduce on this issue, the Complaints Bureau has at times appointed its own independent investigators to carry out investigations in order to align with the interests of policyholders.

Adequate and accurate documentation is paramount for a successful claim. Policyholders must provide the necessary documents and evidence, as failing to do so can result in

¹⁴<https://www.allcityadjusting.com/2023/08/27unfair-settlement-practices/>

delays, denials, or reductions in compensation¹⁵. However, policyholders find it challenging to gather and submit their required documentation for their claims especially if they are unfamiliar with insurance terminology or processes. Under the Insurance Regulatory Authority's Guide to Insurance Claim, the insurance provider will usually need legal documentation, police records, and witness statements among other things. From the field findings, it has been revealed that of the denied payments claims that are filed with the Insurance Regulatory Authority Complaints Bureau, the basis of denial is substantially lack of the required documentation. And of the **68 complaints** that were received on denied payments, 33 complainants have been able to file back with the required documentation. The insurance Regulatory Authority struck out **35 complaints** in the year 2022/23 where policyholders did not return with the requisite documentation. This represents a **51.5%** of waived claims. And thus remains a challenge faced by the policyholders (insureds) in property insurance.

According to Mr. Arnold Ainebyona, the Claims processor at Sanlam Insurance Company, they had **16** pending claims in 2023 due to lack of the required paperwork. Of these claims, 7 claims were to do with property insurance. This is because at the time of taking out the policy, it is always presumed that whatever the insured is disclosing is true due to the principle of utmost good faith, it is only when the policyholder makes a claim that it is revealed that they lack the required paper work.

Of these pending claims 4 were disposed off and 3 claims remain pending as of 29th April 2024.

Disputes over coverage. Policyholders may encounter disputes with insurers regarding the scope or interpretation of coverage under their insurance policies. An insurer may dispute a claim by an insured where an insurer believes that the loss or damage suffered by the insured is not covered by the policy. This could be as a result of so many intricacies which may include but not limited to policy exclusions, limitation or specific

¹⁵ Navigating the complexities of insurance claims by Mithali paresh

conditions that are not met.¹⁶From the findings, the complex language and terminologies used in insurance policies have been pointed out as causes of such disputes. The insurance Regulatory Authority has received over 35 disputes concerning the coverage of the policy in property insurance. Most of these disputes are in regard to exclusion clauses. It was reported that some of the companies in the country are said to be accepting premiums far lower than what is possible to cover a risk and this makes it difficult for them to pay claims in the event of an insured incident that leads to a claim.

Statistics from the Authority including returns, and information on claims outstanding and increasing number of complaints in 2023 however corroborate the policyholders' concerns. The industry non life (property insurance) average claims ratio reduced from **42.57%** in 2022 to **40.30%** in 2023.

Inadequate settlements. Policyholders may receive settlement offers from insurers that they perceive as insufficient to cover their losses and expenses. Disputes over valuation methods or depreciation calculations can further complicate the settlement process.

These underscore the importance of policyholder rights, consumer education, and regulatory oversight to ensure fair and efficient claims handling practices in the insurance industry. In 2023, the Complaints Bureau received **48** complaints regarding inadequate settlements. Of these complaints only **17** were property insurance complaints. 11 complaints were disposed off and closed while **6** are still pending. Some of these complaints are attributed to partial and non-independent assessments and investigations.

During the study, it was revealed that there are service related complaints that customers report to insurers. The claims manager at Sanlam revealed that whereas insurers enter into agreements with service providers to provide certain services to clients at a required standard, sometimes the service providers either refuse to serve customers or offer poor service to them. The result is customers complaining about the policy and eventually not

¹⁶ O.M.ATOYEBI, san "Making a Valid Insurance claim"

renewing it. As of 29th April 2024, they have received 2 complaints concerned with poor service delivery perpetuated by service providers most especially vehicle mechanics.

Insurance fraud, there has been an increase in the cases of fraud in the insurance industry and in property insurance motor vehicle insurance being the most affected. According to the Director of Research Planning, and Market Development, the value of detected fraud cases has grown from 5 billion Shillings in 2019 to 7 billion shillings. Of these cases, the value of 4 billion shillings relates to property insurance while 3 billion shillings relate to medical insurance.

A study by the auditing firm KPMG revealed that false claims had surpassed 61% between 2018 and 2021. Of these 45% concerned property insurance particularly motor vehicle related cases. It was also revealed that the most common fraud cases include staged vehicle theft, and staged vehicle accidents.

As of 1st May, 2024, the Anti-Fraud Unit has received **28** causes of fraud. Of these, 8 are property insurance claims regarding motor vehicle insurance. 5 cases have been investigated and completed while 3 remain pending. The unit expects more cases on fraud.

Knowledge gap. During the study finding, it has been revealed that one of the challenges that have stalled the insurance industry is illiteracy of policyholders and knowledge gap. Mr. Arnold Ainebyona, a claims processor at Sanlam Insurance Company revealed that of the 47 property Insurance complaints they received in 2023, 26 of them were as a result of illiteracy or knowledge gap. Of the 26 complaints, only 11 have been resolved and 15 are still pending. He revealed that it is a much overlooked challenge that has blackmailed the image of different companies. This he revealed is difficult to resolve since, it is always difficult to at consensus with the policyholder. As of 29th April 2024, they have received 9 complaints. Of these, 3 are property insurance complaints where it has been revealed that the only challenge is interpretation of policies

which is as a result of knowledge gap. One has been resolved and disposed off and 2 were still pending at the time of the study.

1.2 Statement of the problem

Making a claim by the insured in insurance is considered the one of the most sophisticated processes throughout the running of the insurance contract whereas being the back-borne of insurance as an industry. The policy-holder satisfaction survey that was conducted in November 2023 revealed that between 33% - 42% of the current property insurance policy holders are not satisfied with service delivery. The main complaints being in regard to claim settlement with the study revealing that some customers have been frustrated to the extent of abandoning claim that was due for clearing.¹⁷

Whereas the insured must pay in full the premium payable under the insurance contract on or before the date of inception of the policy or renewal of the policy¹⁸, there is no provision in the insurance Act entitling the insured to remedies in the event of late payment or an unreasonable refusal by insurers to pay insurance claims. The normal position is that where one party suffers loss because the other party has failed to meet its contractual obligations, the innocent party is entitled to damages for the loss suffered.¹⁹ However, the insurance contracts fall outside this rule. An insurer is not liable for any loss caused by its delay to pay a valid claim. This is based on the principle that the insurer's obligation is to prevent the loss occurring rather than to pay out a claim.²⁰ However, there has been introduction of the Enterprise Bill which makes it an implied term of every contract of insurance that following a claim, the insurer must pay sums due under an insurance policy within a reasonable time.²¹ Failure by the insurer to respond will entitle the insured to pursue the remedies available under contract law

¹⁷ The independent, September 27th, 2023

¹⁸ Section 63(1) of the Insurance Act of 2017

¹⁹ Hadley v Baxendale ((1854) EWHC J70

²⁰ Sprung v Royal Insurance (UK) Limited [1999] 1 Lloyd's Rep 111

²¹ Clause 13A of the Enterprise Bill UK

including damages and those remedies shall be separate to the insured's existing rights to recover sums due under the policy together with interest on those sums.²²

In practice, the technicalities in claims procedure are significantly more onerous for the insured than the insurer which require a review and reform of our Insurance legal framework to do away with many unfair aspects of the current legal framework²³, for example the law requires the insured to assess whether information would be relevant to the assessment of risk by a prudent underwriter, the test of materiality which underlies the rules on disclosure and misrepresentation, assesses the insured by reference to the professional knowledge of the insurer which is unfair, the insured can still be in breach even if their error was reasonable in the circumstances, intermediaries including brokers are generally treated as being agents of the insured. As such, the insured is held responsible for any failings on their part.²⁴

These unfair legal requirements put an onerous duty on the part of the policy holder²⁵. The process of filing a claim is very bureaucratic and involves a lot of paper work. Assessors take a long time to have a final report of the claim thus making it difficult for a policy holder to receive their indemnification even when they have the right paper work. This long process has frustrated customers/policy holders²⁶.

Insurance companies have also been found faulting agreements fraudulently in order to guard themselves from compensating sums of money especially when such an amount is perceived to be hefty. This happens in circumstances where insurance companies turn down a legitimate claim made by their clients²⁷. Even though the issue was amicably resolved in court, it poses to us the question on whether our insurance laws are sufficient to withstand the dynamics presented by the contemporary insurance industry and protect

²² Norton Rose Fulbright- November 2015 at page 20

²³ National insurance Corporation ltd v Kakungu sylvan civil Appeal no.040 of 2015

²⁴ The Motor Union Insurance co.ltd v A.K Damba 1963 1 EA 271

²⁵ SUPRA

²⁶ A report about Uganda's insurance sector by FSD Uganda, November 2016

²⁷ Attorney General v NIKO Insurance Uganda Limited, (2013), HCCS NO 240 OF 2012

the insureds against such challenges in claims procedure. Despite the relevance of this issue on the industry, no particular study has been carried out to this effect this study is therefore geared towards appraising the Insurance Laws in terms of their effectiveness and adequacy in addressing challenges faced in claims management or procedure and potentially identifying areas for reform and improvement.

There has been reported an increase in the cases of fraud cases in the industry which has led to significant losses to insurance companies. These cases have been reported to be as a result of collaboration between policyholders and insurance intermediaries which has thus hardened the tracking and cracking down of the same.

1.3 Research Questions

This study entails questions which formed a guide towards the attainment of the research objectives. The following questions guided the researcher.

1. Is the Ugandan legal framework adequate in regulating claims settlement challenges regarding property insurance in Uganda?
2. What are the measures that should be taken to improve claims procedure/settlement in Property insurance?

1.4 General Objective

The general objective of this study was to evaluate the adequacy of the current regulatory framework in addressing the challenges in claims procedure/settlement in property insurance

1.5 Research Objectives

In order to accomplish the above stated purpose, the following specific objectives guided this study;

1. To assess the effectiveness of the current regulatory framework in addressing challenges faced in claims procedure in property insurance.
2. To assess the level of compliance among insurers with existing regulatory requirements related to claims handling in property insurance.
3. To propose regulatory reforms based on the findings to better protect insureds against challenges in property insurance claims procedure.

1.6 Chapterization or Chapter Synopsis.

This research study consists of four chapters, with the following breakdown **chapter one**, deals with the introduction, background to the study, significance of the study, statement of the problem, scope of the study, research questions, and objectives of the study, literature review, methodology, and chapter breakdown. **Chapter two** will look at the existing regulatory framework and how it has addressed the challenges involved in making claims by the insureds. **Chapter three** focuses on making points of reference to property insurance laws in other jurisdictions **Chapter four** looks at the proposal for reforms and recommendations to cover the inadequacies within the existing legal framework.

1.7 Scope of the Study

This research paper is limited to the insurance industry in Uganda. It examines the challenges in claims procedure in insurance industry in Uganda. It also discusses the claims settlement operation, laws and institutions governing regulation in Uganda and ultimately recommendations to improve the claims settlement procedure in the industry.

1.8 Significance of the Study

Consumer or customer protection. Evaluating the effectiveness of the Regulatory framework is pertinent for ensuring that the insured parties are adequately protected against unfair practices, delays and disputes during claims process settlement. By

identifying the loopholes in the regulatory framework, policymakers can implement reforms to enhance consumer rights and promote fair treatment by insurers.

Market Stability and confidence. A robust and stringent regulatory framework fosters confidence in the insurance market by ensuring transparency, accountability and efficiency in claims handling. Policyholders and potential consumers are more likely to trust insurers and purchase insurance products if they believe their rights are protected and that they will receive fair treatment in the event of a claim.

Economic effect. In order to reduce the financial risks connected to property ownership, and operation of businesses, property insurance is essential. Delayed settlements or disputed claims can have vital economic disruptions to policyholders, leading to financial strain and ultimately business interruptions. Therefore, assessing the regulatory framework's adequacy will aid in determining the best course of action for reducing these effects and advancing economic stability.

Legal and Regulatory Reforms. Conclusions, recommendations and findings from the study can be used to create legal and regulatory reforms for the purpose of improving the claims procedure, enhancing consumer protection and streamline consumer protection in the insurance sector. The research can as well be used by policy makers to prioritize areas for regulatory intervention, optimize the claims system and fortify enforcement procedures in order to guarantee adherence to regulatory mandates. By highlighting the inadequacies in the existing regulatory framework, and the frailties with the institutionalized bodies, there shall be a clear view for reforms.

Academic and policy Debates. The study will contribute to academic discourse and policy debates surrounding insurance regulation, consumer rights and market dynamics. By providing empirical evidence and analysis, the research enriches discussions among scholars, policymakers, industry stakeholders, and consumer advocacy groups on ways to improve the regulatory landscape and address challenges in property insurance claims procedure.

Comparative studies of insurance regulation in different jurisdictions can offer valuable insights into best practices and lessons learned from other countries. By benchmarking Uganda's regulatory framework against international standards and experiences, the study can identify opportunities for aligning policies with global best practices and enhancing the competitiveness of the insurance market. The information from the findings of this research can be useful to the relevant regulatory bodies; the Insurance Regulatory Authority of Uganda in supervising the underwriting practice of insurance companies and ensuring that they adhere to recommended legal Requirements.

1.8 Methodology.

Methodology refers to a body of methods, rules and postulates employed by a discipline. It refers to a particular procedure or set of specific procedures or techniques used to identify, select, processes, and analyze information about a topic. In a research paper, the methodology section allows the reader to critically evaluate a study's overall validity and reliability.²⁸

This part attempts to define the methods and procedures that were followed in order to achieve the objectives of the study. This research was partly doctrinal and empirical. The primary source of information was through making interviews and questionnaires in which the researcher considered the study area and population, sampling, research instruments, data collection and analysis, and document analysis.

The study also substantially made use of the primary legal materials such as statutes, case law and Regulation. Further, it employed secondary sources of material including textbook and internal sources.

1.8.1 Study Area and Targeted Population

This study focused on Kampala because it's where most insurance companies and insurance regulatory institutions are situated. The study population was limited to

²⁸<https://libguides.wits.ac.za/c.php>

consumers of insurance products, insurance managers and administrators and insurance regulatory institutions.

1.8.2 Interviews

Interviewing is a research method that involves asking questions to collect data from individuals who have knowledge, experience or opinions on a particular topic or subject matter. It is a qualitative research method used to collect first hand or primary data. It involves asking one or more people about their opinions on a company, a product, or a topic. This method allows researchers to obtain detailed information that might not be available through other research methods.²⁹

While conducting this research, the targeted respondents were regulatory bodies, product consumers(policyholders) and insurers which were requested for appointments and issued with a copies of the interview guides so as to make them aware of the particular issues they were expected to respond to while conducting the interviews, data was recorded by writing. The interviewees provided immediate responses to queries.

Further, the researcher was able to seek and obtain clarification on specific issues and challenges faced by the insurance companies.

1.8.3 Sampling

Sampling is a technique of selecting individual members or a subset of the population to make statistical inferences from them and estimate the characteristics of the whole population.³⁰Sampling was used to select individuals who yielded information about a population of concern.

Different procedures were used for selecting a sample for purpose of data collection. Sampling is of two different kinds that is probability and Non probability sampling. Probability sampling is a technique in which a researcher selects a few criteria and

²⁹<https://www.studysmarter.co.uk>

³⁰<https://www.questionpro.com/blog/types-of-sampling-for-social-research>

chooses members of the population randomly. In this methodology, all the members have an equal opportunity to participate in the sample with this selection parameter.³¹

Under non probability sampling, the researcher randomly chooses members for research. This method is not a fixed or predefined selection process. This makes it difficult for all population elements to have equal opportunities to be included in a sample. Types of non probability sampling include convenience sampling and judgmental or purposive sampling. Convenience sampling depends on the ease of access to subjects. It is called convenience sampling because of the researcher's ease of carrying it out and getting in touch with the subjects. Under judgmental or purposive sampling, these subjects are selected purely considering the purpose of the study along with the understanding of the target audience.³²

This research thus employed judgment sampling because it was targeting a limited number of the population specifically those that have been or are engaged in the industry of insurance including policyholders and other insurance industry players.

1.8.5 Data Collection and Analysis

The data that was collected from insurance products consumers (policy holders), underwriters and administrators from the selected insurance companies using the above methods shall then be analyzed to support or refute research hypotheses and draw conclusions about the study's subject matter.

1.8.7 Limitation of the Study

The study focused on the insurance industry but did not cover the perspective of the general Public who are the direct users of insurances services. Their perspective ought to be considered as well. Some of the respondents took a lot of time to respond to the questionnaires, this in one way or the other delayed the study, Limitation in resources.

³¹ SUPRA

³²<https://www.questionpro.com/blog/types-of-sampling-for-social-research>

This constrained the researcher to heavily rely on phone calls and emails rather than face to face interactions which would have given the researcher first hand information. The research was mostly qualitative because of purposive or judgmental sampling technique that was used to select the respondents and therefore it was not easy to verify the claims from the respondents.

1.9 Literature review

Literature review is the visiting of scholarly materials related to the research topic to identify gaps and propose reforms related to the identified gaps from the pre-existing materials. Claims management plays an integral role in the development of insurance as an industry.

The claims management phase gives an opportune moment for delivery by the insurers and to favorably impress the policyholder and enhance their reputation for better performance.³³Crawford (2007) stated that claims are noted as the most critical channels and a defining link that shapes the overall perception of the customer towards their insurer.

The insurance industry is under constant pressure to improve customer service in claims handling while also making the process and its outcome more cost effective. In order to meet their obligations, insurers must have in place a prompt and efficient claims management.³⁴

According to (customer Satisfaction and Needs Assessment, 2006) a report about Uganda's Insurance Sector, conducted by Uganda Insurers Association, **84%** of the policyholders have never made an insurance claim, however the study did not reveal why all this substantial percentage of policyholders has not made claims in order to receive their indemnity.

³³ Bates and Atkins (2007)

³⁴ European Scientific Journal May 2017 edition Vol. 13 No.13 at page 359

The study further revealed that after an incident has occurred, the claim assessment takes a long time to have a final report of the claim, thus making it difficult for a customer to receive their indemnity when they have the right paper work. This long process is often frustrating. However, the study did not reveal the causes of delayed claim assessments.

A policy holder must notify an insurer in case of an incident. In the absence of specific provisions in the insurance policy specifying who to notify and who must do the notifying, notice must usually be given to the insurer or its authorized agents by the policyholder or its agents who can include the broker of a policyholder. However, unless the broker has express contractual authority to accept notifications on behalf of the insurer as agent, the notification must be passed up to the insurer³⁵. The law does not give options to the policyholder in circumstances where he/she is unable to give the required notice within the stipulated time due to circumstances beyond his/her reach.

The English Court of Appeal in the case of **Maccaferri v Zurich Insurance plc**³⁶ held that notice must be given within the time set out in the insurance policy. If the contract is silent on this, it would be prudent to give notice within reasonable time from the occurrence of the loss or event.

If such a condition is clear and is precedent to the insurer's liability, a failure to comply, however inadvertent or excusable will entitle the insurer to avoid liability.³⁷ Whereas the policy in most cases sets dates within which a policyholder is obliged to notify the insurer of the incident leading to his claim, it does not set timelines within which the insurer is obliged to fulfill his obligation by indemnifying the policyholder or the claimant.

³⁵ Rothschild Assurance plc v Collyear [1998]

³⁶ [2016] EWCA Civ I 302

³⁷ Cassel v Lancashire & Yorkshire Accident Insurance Company (1885) 1 T.L.R.495

Whereas the insured is required to pay premium as a condition precedent for the inception of the policy³⁸, there is no remedy to the insured/policyholder in cases of delayed payments by the insurer in regards to genuine claims.

³⁸ Section 64 of the Insurance Act 2017

CHAPTER TWO

EVALUATING UGANDA'S REGULATORY FRAMEWORK IN ADDRESSING THE CHALLENGES IDENTIFIED IN CHAPTER ONE.

2.0. Introduction

Insurance regulatory framework entails laws, rules, guidelines and regulations through which the Government controls the practice of insurance business in Uganda. Regulation of insurance in Uganda is mainly through various domestic legislations creating regulatory authorities/agencies to control the industry. These reflect both the need to address particular problems and streamline the flow and conduct of insurance and make it free from abuses, as well as ensure the widening of insurance markets. This chapter provides an insight into laws and regulations that govern and regulate the insurance industry in Uganda specifically property insurance and the challenges in claims procedure.

2.1 The Insurance Act No 5 of 2017

This Act was enacted to repeal the insurance Act, Cap 213, provide for the regulation of insurance business, to continue in existence of the Insurance Regulatory Authority of Uganda as the body responsible for the regulation of insurance business and to provide for related purposes³⁹.

Any person proposing to carry on insurance business shall apply to the Authority for a license and the application shall be considered by the Authority⁴⁰. While considering the application, the Authority shall satisfy itself as to the financial status and antecedents of the applicant, competence, and integrity of the proposed management and whether the

³⁹ Long title of the Insurance Act of 2017

⁴⁰ Section 41(1) of the Insurance Act of 2017

public interest would be served by granting the license⁴¹. These are to ascertain whether the applicant shall be in position to meet the insureds' demands in case of successful claims against the insurer. Licensing irons out the unprofessional way of handling customers' claims as one of the considerations to granting a license is the competence and integrity of the management.

Before granting a license to the applicant, the Regulatory Authority must first confirm to itself the precursor or antecedents of the applicant as regards to the business. This is to avoid scenarios of fraudulent operations and mysterious closure of insurance companies with unpaid or unfulfilled claims from policyholders. This is through setting minimum capital requirements for insurers. Under **Regulations 4(a) and 6**, the minimum paid up capital of an insurer engaged in non-life insurance business is six billion Uganda shillings and shall maintain a capital adequacy ratio of at least two hundred percent⁴².

A licensed direct insurer shall have such arrangements as it considers appropriate for the reinsurance of risks under insurance contracts that it has entered into in the course of its business as an insurer.⁴³ A reinsurance contract means an insurance contract under which one insurer, called the reinsurer, indemnifies or otherwise compensates, another insurer called the cedant, against losses on one or more contracts of insurance entered by the cedant⁴⁴. It is thus an arrangement whereby an insurer transfers all or part of a risk to another insurer to provide protection against the risk of first insurance. Reinsurance thus enables insurance companies to stay solvent by restricting their own losses. Sharing the risks with a reinsurer enables companies to honour the claims raised by people/policyholders without being worried about too many people raising claims at the same time⁴⁵.

⁴¹ Section 42 of the Insurance Act of 2017

⁴² The Insurance (Capital Adequacy and Prudential Requirements) Regulations, 2020

⁴³ Section 67 of the insurance Ac of 2017

⁴⁴ Section 2 of the Insurance Act of 2017

⁴⁵ <http://www.Canarahsbclife.com>

Under the Insurance Claims Guidelines of 2021, it is provided that to avoid delays, insurers should do cash calls to reinsurers immediately on receipt of the final adjuster's report. This shows the significance of reinsurance in insurance industry. This helps to solve the challenges of inadequate settlements by the insurers/ insurance companies because their risks are as well insured.

The Insurance Act under **Section 10** establishes **Insurance Regulatory Authority of Uganda (IRA)** which is mandated with the regulation of the Insurance industry in Uganda. The Insurance Act mandates the Insurance Regulatory Authority through **the Complaints Bureau** to receive and resolve insurance related complaints from the members of the public on the conduct of insurers and arbitrate, grant restitution to the complainant as may be possible⁴⁶.

One of the mandates of the Insurance Regulatory Authority among others is to protect the interests of policyholders or prospective policyholders⁴⁷. Under **section 48**, Insurers are required to maintain capital resources at levels adequate to support their insurance business taking into account the nature, scale, and complexity and the risk profile of the business⁴⁸. The minimum capital resource for insurers engaged in property insurance is six billion Uganda Shillings maintenance of capital adequacy ratio of at least two hundred percent⁴⁹.

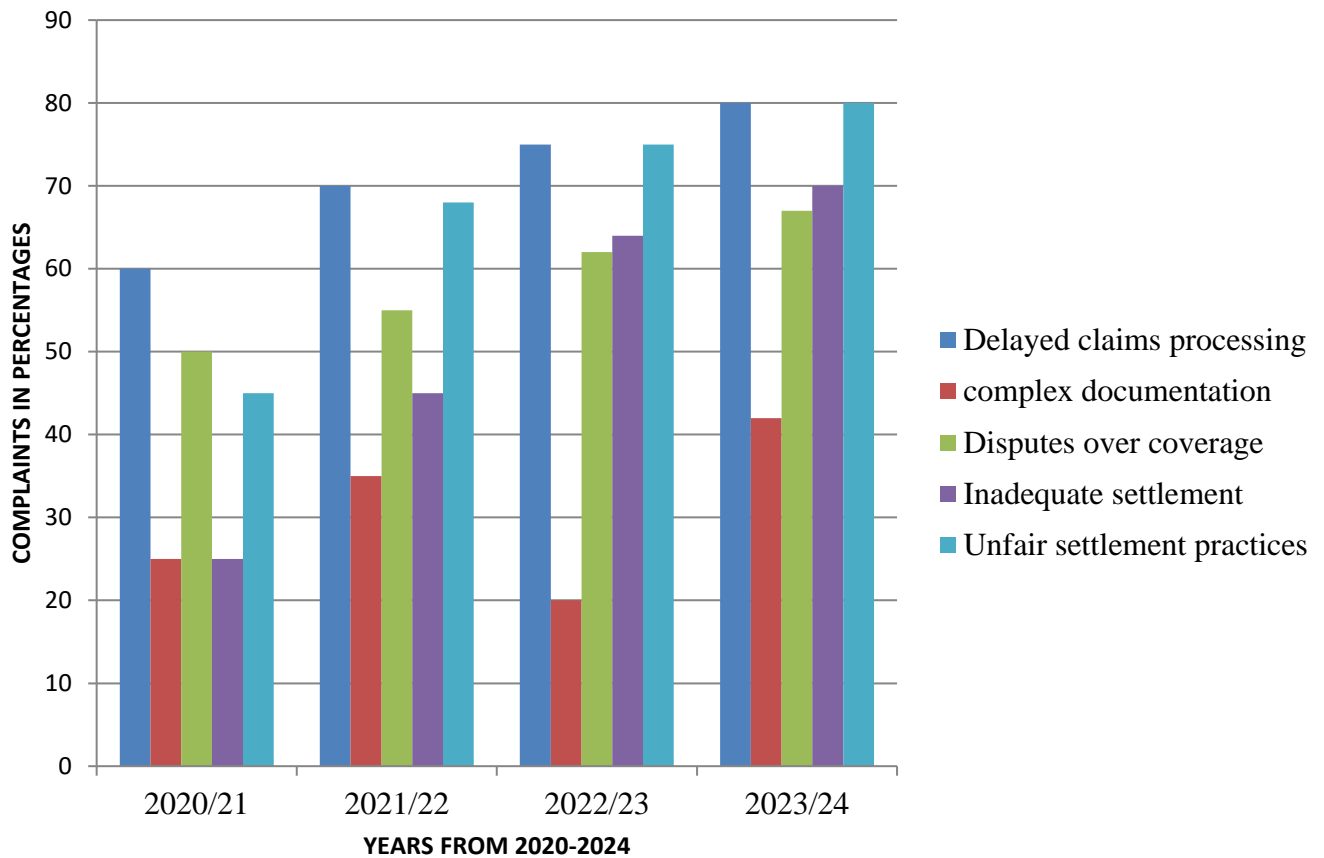
Figure 4.2. the frequency of complaints in property insurance expressed in percentages as received by the Insurance Regulatory Authority (IRA) as a regulatory body for the illustrated years.

⁴⁶ Section 12(1)(j) and (k) of the Insurance Act, 2017

⁴⁷ Section 11(1)(c) of the Insurance Act, 2017

⁴⁸ Insurance Act No.5 of 2017

⁴⁹ Regulation 4 The Insurance (Capital Adequacy and Prudential Requirements) Regulations, 2020



The Insurance Regulatory Authority has received complaints mostly on unfair settlement practices and delayed claims processing as illustrated under **figure 4.2**⁵⁰.

“There has been a persistent increase in complaints in property insurance pertaining unfair settlement practices and delayed claims processing from the previous years to the current year. And we hope that we are destined to receive more complaints in the following year. To us, this is a positive sign because it is a reflection of our ongoing sensitization of the masses to submit their complaints to the Authority” narrates one of the respondents from the Insurance Regulatory Authority (IRA)⁵¹.

⁵⁰ MRS. Magezi Gerin, 22nd April 2024

⁵¹ MRS. Magezi Gerin, 22nd April 2024

A claims manager at Goldstar Insurance Company in property insurance department (Name withheld for purposes of confidentiality) about the challenge of delayed claim processing and thus from the findings it is not conclusive that the delay in claim processing is only caused by insurers. She narrated thus; *some of the policyholders delay in reporting their claims, delay in making documentation for their claims and delay in submitting the investigation reports. Policyholders should bear in mind the fact that the sooner they report a claim and their documentation, the earlier they will be compensated, all other factors notwithstanding. However as an insurance company, we always advise policyholders to make their claims in time and with the required documentation.*

However, it should be noted that delayed claims settlement can be as a result of inadequate skilled personnel in various insurance companies to deal with the overwhelming level of claims. During the study, it was revealed that some insurance companies have numbers of claims managers which are not proportionate to the number of claims that are received. This hence leads to delay in the processing of such claims.

Disputes over coverage has also emerged as one of the complaints often received by the Insurance Regulatory Authority as illustrated in Figure4.2.

“The most sparking end to disputes over coverage is that most people that take out insurance policies are not acquainted with insurance terminologies for example we are dealing with a complaint from a policyholder whose policy had a franchise clause which limited the liability of the insurer to a loss only in excess of a certain amount and the policy holder did not know the significance of a franchise clause, we are thus imploring insurance companies to always explain some of these terminologies to their customers to reduce on such disputes over coverage” narrates one the Respondents from

the Insurance Regulatory Authority as a Regulatory Body regarding Insurance in Uganda⁵².

2.1. The Insurance Complaints Bureau Guidelines, 2022.

The objective of these guidelines was to provide for effective complaints handling process/ system which resolves issues raised by members of the public against an insurance player in a timely and cost effective way⁵³. The complaints can be brought by the policyholders against insurers⁵⁴.

On 13thSeptember, 2022, the Insurance Regulatory Authority launched a complaint management system (An interface of the complaints management system) to efficiently track and address grievances between insurers and the insuring public. According to the Insurance Regulatory Authority CEO, MR. Alhaj Kaddunabbi Ibrahim Lubega the online system enables the insuring public to lodge insurance-related complaints at their convenience, without necessarily having to travel to Insurance Regulatory Authority offices as it has been under manual system and it will enhance efficiency in complaints management. With the system, it was eluded that insurance service providers will be able to see a complaint lodged against them in real time and make it easy to track the period a complaint spends in the system without being resolved.

Guideline 31 of the Insurance Complaints Bureau guidelines of 2022 provides for the adoption and integration of ICT in the complaints management process through filing and service, exchange of documents regarding complaints.

Statistics indicate that **117 complaints** regarding property insurance were filed through the interface of the complaints management system with IRA from January to June 2022. Over **80%** of them were resolved within the shortest period of time. The effect of the system was that while insurance companies were previously given a maximum of

⁵² MRS. Magezi Gerin, 22nd April 2024

⁵³ Guideline number 4 of the insurance Complaints Bureau Guidelines, 2022.

⁵⁴ Guideline number 6 and 7 of the insurance Complaints Bureau Guidelines, 2022

seven days to respond to a complaint, the days are going to be reduced hence this will improve efficiency. In a tracer study conducted by the Insurance Regulatory Authority on Customer satisfaction in respect to complaints handling, **48%** of the Respondents had their issues resolved in less than two weeks, **22%** had their issues resolved between 2 and 3 weeks, **17%** had their complaints resolved in periods above a month while **13%** had their complaints pending at the time study and thus their issues had not been resolved. The Insurance Regulatory Authority through the complaints Bureau has substantially reduced on the challenges faced by the policyholder in claims procedure as illustrated by the above statistics.

Efficiency of the Insurance complaints Bureau.

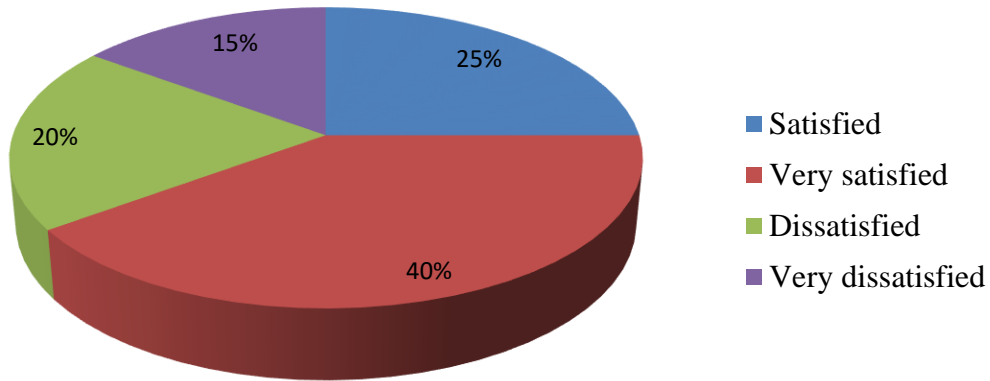
The complaints Bureau is customer centered, it was established purposely to entertain grievances of policyholders against insurance companies. Under Guideline 8⁵⁵, the nature of complaints that are entertained by the complaints Bureau include complaints that involve a disagreement concerning liability under policies issued, amount offered for settlement, breach of conduct by the licensee (insurer) and any other matter related to the actions of a licensee.

The Respondents that had lodged their complaints with the complaints bureau regarding property insurance policies were asked to rate their experience and how expedient their complaints were handled at the complaints desk. A four attributes scale was used to determine the efficiency of the complaints Bureau that is; very satisfied, satisfied, dissatisfied and very dissatisfied.

Figure.4.3. Showing customer satisfaction with the complaints Bureau regarding solution of complaints in property insurance.

⁵⁵ Insurance Complaints Bureau guidelines of 2022

Efficiency of the complaints Bureau



From the study it was revealed that 40% of the respondents were very satisfied, 25% were satisfied, 20% was dissatisfied and 15% were very dissatisfied with the operations of the complaints Bureau as illustrated in **Figure 4.3**.⁵⁶

Under an insurance contract, both the insured/policyholder and the insurer have an obligation to act in good faith.

However, this isn't always the case and insurance companies have an array of unfair claim settlement this is because Insurance policies rarely provide for claim payment timelines. Insurance companies have thus exploited this loophole to the detriment of the policyholders in the claims procedure thus unfair claims settlement which refer to unjust behavior by insurers when handling claims by policyholders⁵⁷.

This happens when the insurer unreasonably tries to delay, avoid or reduce the size of an insurance claim. Policyholders experience unfair or unethical settlement practices from insurers. These include placing emphasis on controlling claims severities, rather than paying each individual claimant the full amount deserved, without concern for the bottom

⁵⁶ Some of the policyholders that had submitted their complaints to the Bureau

⁵⁷<https://www.allcityadjusting.com/2023/08/27unfair-settlement-practices/>

line⁵⁸, and making payments due to clients in small installments⁵⁹. Failure to thoroughly investigate a policyholder's claim.

A report carried out by the Insurance Regulatory Authority indicates that there is a challenge of poorly assessed claims and bias by the loss assessors. Investigations are not carried out thoroughly while assessing claims. It was further found out that assessors are not independent and professional whilst handling these assessments. As a result, the Complaints Bureau has always been constrained to rely on biased reports which have led to delay in resolution of complaints because there has to be appointment of another independent assessor to carry out fresh investigations⁶⁰.

2.2 The Insurance Claims Guidelines of 2021

In a bid to reduce on the issues and complaints over these unfair claims settlement, the Insurance Regulatory Authority exercised its mandate as a Regulatory body and enacted The Insurance Claims Guidelines of 2021.

The Insurance Claims Guidelines 2021 (The Claims Process and Service Standard for Insurers) were meant to streamline issues concerning delayed payments/delayed acknowledgements of the policyholders' claims by the Insurance companies (insurers). The Insurance Claims Guidelines of 2021 thus provide timelines within which insurance companies are to pay claims made by the policyholders.

The **Guidelines under Paragraph 5C provide** for the Claims process and service standards⁶¹. The guidelines provide for the different timelines within which the Insurance Company (insurer) is expected to pay the insured's claim. Claims that range up to shs 10 Million shall be settled within a period of 10 days, claims that range from 10 Million to Shs 50 Million shall be settled within a period of 15 days and claims that range from

⁵⁸ Baseline Survey on the Insurance Industry in Uganda

⁵⁹ Baseline Survey Report on the Insurance Industry in Uganda.

⁶⁰ IRA 2022 Annual Insurance Market Report

⁶¹ Insurance Claims Guidelines of 2021

50Million and above shall be settled within a period of 20 working days after receipt of discharge voucher or upon receipt of cash call payment from reinsurers whichever occurs first.

Research by the Insurance Regulatory Authority indicates that there was an increase of **4.39%** in non life Gross claims paid by insurance companies from **Shs351, 612,302** that was paid in 2021 to **Shs367, 041,395** in 2022⁶².

Hence, there is a reflection on the significance of the Claims Guidelines of 2021 in streamlining the claims settlement procedure in property Insurance. However, the guidelines do not envisage a situation where the claim is disputed which thus requires investigation⁶³.It becomes abundantly clear that no specific time has been provided for an investigator and the insurer to conclude their investigations regarding a claim. Therefore, where there is a statutory period, that period will have to be observed and if there is none provided, then the claim must be discharged within a reasonable period⁶⁴.

What should be a reasonable period is a matter considered in the facts and circumstances of each case until the Regulator introduces Guidelines on claims investigations. In such circumstances the insurers exploit the insureds through delayed investigations, making non independent and biased assessments or investigations⁶⁵. Hence there is need to provide for the law to regulate investigations to reduce on the challenge of prolonged investigations in claims management.

In a bid to protect policyholders, the Insurance Regulatory Authority has proposed for the enactment of **The Insurance (Policyholders Compensation Fund) Regulations**. This is intended to operationalize Sections 138 and 139 of the Insurance Act for the protection of policyholders of an insolvent Insurance company that is unable to pay claims. The Regulations are still in the pipeline.

⁶² IRA 2022 Annual Insurance Market Report

⁶³ APA INSURANCE (U) LTD V MOIL (U) LTD APPLICATION NO.002 OF 2023

⁶⁴ QUADRA COMMODITIES SA V XL INSURANCE SE 431 (Comm.)

⁶⁵ IRA 2022 Annual Insurance Market Report

2.3 The Guidelines on Claims Management for the Insurance industry 2012.

These guidelines aimed at enhancing efficiency, transparency, disclosure of information to policyholders during claims processing and increase consumer satisfaction. The Insurance Regulatory Authority envisaged that an efficient claims management process would result into improved service delivery to the public which will in turn improve the industry.

The Guidelines require the insurer where further investigation is necessary to determine admissibility of the loss under the policy to notify the claimant of this requirement, explain and emphasize to the claimant the need to cooperate with the investigators and upon receipt of the investigation report, the insurer shall within seven days make an offer or communicate declinature and the reasons thereof⁶⁶. This is to keep the policyholder on notice regarding the progress of his/her claim.

Although the Guidelines were enacted to streamline the claims management procedure the view of policyholders has not changed from the fact that insurers do not provide them with utmost good faith claims conduct⁶⁷.

A report conducted in 2014 by the Insurance Regulatory Authority revealed that some insurance companies prey on the ignorance of the insured through wrongful denial of claims in the face of clear liability. It was revealed that insurers tend to employ delay tactics to ensure unfair rescission and claims processing practices. Some of these include improper rescissions, failure to pay claims on a timely manner, and failure to provide required information when denying a claim⁶⁸.

Hence this portrays that unfair claims processing practices still persist in the insurance industry as far as property insurance is concerned. As of 2023, research findings have

⁶⁶Clause 6.0 of the Guidelines on Claims Management 2012

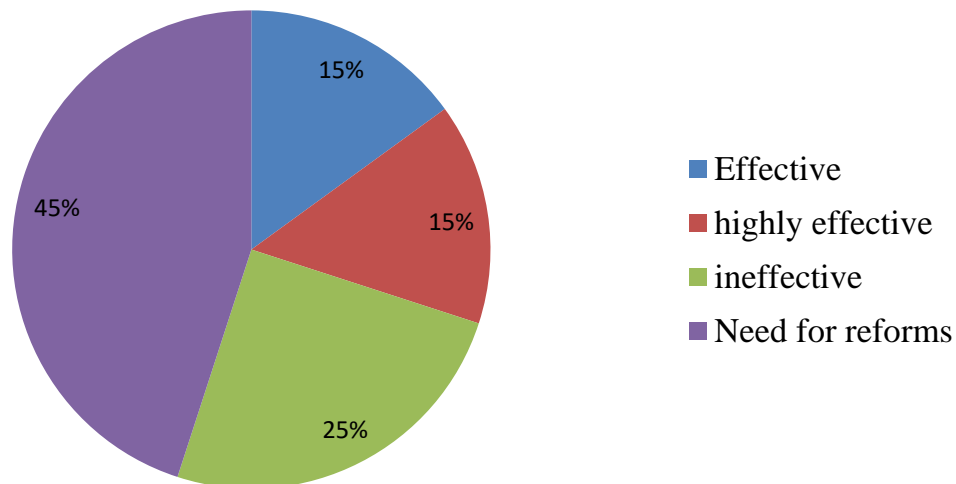
⁶⁷ Baseline Survey on the Insurance Industry in Uganda.

⁶⁸Baseline Survey on the Insurance Industry in Uganda

revealed that there is a persistent increase in the complaints regarding unfair settlement practices. The study shows that there was an increase of **5%** from the **75%** in 2022/23 to **80%** in 2023/24 as illustrated in **figure 4.2**.

Figure 4.4: How the various respondents rank the current legal framework in addressing the challenges in claims procedure in property insurance.

**EFFECTIVENESS OF THE CURRENT LEGAL FRAMEWORK
IN ADDRESSING THE CHALLENGES IN CLAIMS
PROCEDURE IN PROPERTY INSURANCE.**



As regards how the different respondents rate the current legal framework in addressing challenges faced in claims procedure in property insurance, **15%** said it is effective, **15%** highly effective and **25%** ineffective. However, a substantial part of the Respondents which is **45%** concluded that there is need for reforms in the legal framework⁶⁹.

Hence the available legal framework is not stringent enough to deal with challenges faced in claims procedure in property insurance.

⁶⁹ These included both insurers and insureds/policyholders

2.4 Anti-Fraud Unit.

The insurance anti-fraud Unit was created under the Insurance Regulatory Authority purposely to investigate any claims where fraud has been suspected. Speaking at the CEO's breakfast meeting in 2017, the Insurance Regulatory Authority CEO MR. Alhaj Kaddunabbi Ibrahim Lubega said that as a result of the increased number of fraudulent claims in the sector there was need to crack on the rising cases of fraud within the sector.

A total of 66 suspected Insurance fraud reports were received during the year 2020 across all segments, with 34 of those being property insurance cases to do with forgery and submission of fake documents, 18 cases were investigated and concluded during the period, 8 cases were still pending completion of investigations, 3 cases are pending before courts of law, 5 cases referred to the office of the DPP for legal guidance at the time of the study.⁷⁰

During the year 2022, a total of **15** suspected cases were reported at the anti-fraud unit, across all segments. Out of **15** fraud cases, **14** cases were investigated and concluded representing 93.3% conclusion. Of these cases, property insurance cases were 5, where Motor Vehicle related cases were **4** which were concerned with staged motor accidents and one cases concerning issuing false information.⁷¹

As of 1stMay, 2024, the Anti-Fraud Unit has received **28** causes of fraud. Of these, 8 are property insurance claims regarding motor vehicle insurance. 5 cases have been investigated and completed while 3 remain pending.⁷²

A study by the Insurance Regulatory Authority has revealed that the reasons for the penetration of fraud cases has been due to cooperation between the fraudsters and some Insurance intermediaries to defraud the system through forging insurance claim documents and inflating Motor garage bills.

⁷⁰Annual Insurance Market Report 2020 at page 28

⁷¹2022 Annual Insurance Market Report at page 43

⁷²MRS. Magezi Gerin 1st May 2024

According to Mrs. Doreen Nakubulwa, the Claims Manager at Britam Insurance Company, the company has received **6** suspected fraudulent claims as of 29th April 2024. Of these, **4** are for motor insurance particularly alleged staged vehicle theft, and staged vehicle accidents and **2** are to do with fire insurance. Of these **2** have been disposed off and one has been reported to the Insurance Fraud investigation Unit and three are still under investigation⁷³.

In order to crack down the levels of fraud there has been established systems and controls for detecting and identifying fraud appropriate to their exposures and vulnerability. The Claimants have been made aware of the consequences of submitting false statements in the claims filing phase and thus notifications have always been placed on their claim forms referring to the consequences of lodging fraudulent claims. There have been established databases where claims suspected to be fraudulent would be reported and the staff handling claims have been trained to scrutinize claim documents in order detect falsehood and possible fraud. Whereas there have been established mechanisms to detect and crack down fraud penetration in insurance, it was found out that some cases of fraud are committed by staff in collaboration with policyholders which has been an obstruction in doing away with insurance fraud.

⁷³Mrs. Doreen Nakubulwa, 29th April 2024

CHAPTER THREE

MAKING POINTS OF REFERENCE AND COMPARISON TO INSURANCE LAWS IN OTHER JURISDICTIONS.

3.0. Introduction.

Through benchmarking Property insurance laws from other Jurisdictions, the study shall find out some of the inefficiencies within the Ugandan property insurance laws. This will help in making recommendations and proposals for reforms thus improving and making the Property Insurance Laws more efficient. This will further help in the need to address challenges in the claims procedure in property Insurance in Uganda.

3.1. The UK Insurance Act of 2015 as amended

The normal position has been that where one party suffers loss because the other party has failed to meet their contractual obligations, the innocent party may claim for damages for the loss suffered⁷⁴. The English courts however, held on several occasions that insurance contracts fall outside this rule. This was based on the legal principle that the insurer's contractual obligation is to prevent loss occurring rather to pay out a claim⁷⁵.

However, the Commission's report on insurance law reform in July 2014 set out a number of reasons for changing the unfairness illustrated by the above rule as illustrated in the **sprung** case thus; the notion that an insurer's primary obligation under a contract of indemnity is to prevent the insured loss from occurring was declared not to be reflecting the commercial reality.

Insureds expect to have a contractual right to a payment in the event of a loss and the position unfairly favored the interests of the insurers and their failure to make timely payments risked prejudicing the very purpose for which insurance is purchased.

⁷⁴Hadley v Baxendale (1854) EWHC J70.

⁷⁵ Sprung v Royal Insurance(UK) limited [1999] 1 Lloyd's Rep 111

The Insurance Act of 2015 as amended did not provide a designated time within which a claim should be paid and penalties for non compliance. However, the Act was amended and **Clause 13A was inserted** which provides for implied terms about payment of claims.⁷⁶

Section 13A of the Insurance Act as amended provides for an implied term in every contract of insurance that if the insured makes a claim, the insurer must pay any sums due in respect of the claim. The remedies available for breach of the term are damages which are distinct from any right to enforce payment of the sums due and any right to interest on those sums⁷⁷.

The introduction of Clause 13A incentivized insurers to pay claims promptly and allows for damages to be paid to policy holders who have suffered losses as a result of late payment.

It is thus an implied term of every contract of insurance that following a claim, the insurer must pay sums due under an insurance policy within a reasonable time. Failure by the insurer to do so will entitle the insured to pursue remedies the remedies available under contract law including damages and those remedies shall be separate to the insured's existing rights to recover the sums due under the policy together with interest on those sums⁷⁸.The above provision makes it expedient for the claims process and indemnification of the insured by the insurer.

3.2. Laws of Kenya Insurance Act Cap 487

The Kenyan Insurance Act was amended by the Insurance (Amendment) Act No.11 of 2006 under **Section 27** which introduced a designated timeframe within which Insurance Companies are to settle policyholders' claims.

⁷⁶<https://www.nortonrosefullbright.com>

⁷⁷ Section 13A of the Insurance Act as amended.

⁷⁸ SUPRA

It is provided that where the Claimant has submitted all the relevant documents, every insurer shall in respect of claims arising out of policies of insurance issued by it admit or deny liability, determine the amount due, establish the identity of the Claimant and pay the claim, within ninety days of the date of the reporting of the claim or where the determination of liability is by a court, within ninety days of such determination.⁷⁹

However, if, for any reason, the insurer is unable to pay the claim within the period specified under the Act, they have an option to apply to the Commissioner for extension of time, and the Commissioner may grant extension for a period not exceeding thirty days⁸⁰. Where an assessment of claim has been carried out, a copy of the assessment report shall be made available to the claimant. This is to make the policyholder aware of the results of assessment in respect to his/her claim.

The Insurance Act of Kenya provides for a penalty equal to five per cent of the unpaid amount where the claim remains unpaid after the expiry of the prescribed time. And if an insurer fails to pay the amount of a claim and any penalty thereon the insurer shall be deemed to be unable to pay his debts and liable to be wound up.⁸¹ The effect of this provision is that it expedites the processing of claims by the insurers hence payments are made in time.

The **Insurance Act of Kenya Cap487** introduces claims settling agents who are persons that engage in the business of settling or negotiating insurance claims under policies issued by insurers whether in Kenya or outside Kenya.⁸² This enables policyholder/claimants who do not understand the bureaucracies in claims process to have their claims processed on their behalf.

⁷⁹ Section 203(1) of the Insurance Act of Kenya of 2020.

⁸⁰ Ibid.

⁸¹ Section 203(5) of the Insurance Act 2020 of Kenya

⁸² Section 2(b) of the Insurance Act of Kenya of 2020.

3.3. The Insurance Act of Philippines (The Republic Act No.10607)

The Republic Act precludes all insurance companies doing business in the Philippines from refusing without just cause, to pay or settle claims arising under coverages provided by their policies, or from engaging in unfair claim settlement practices.⁸³

Some of the acts by the insurance companies which constitute unfair claim settlement practices include but not limited to knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverage at issue, failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies, not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear and compelling policyholders to institute suits to recover amounts due under its policies by offering without justifiable reason substantially less than the amounts ultimately recovered in suits brought by them.⁸⁴

A company that shall be found liable of any of the unfair settlement practices or that it has not fulfilled its obligations shall have its license revoked after notice and an opportunity to be heard, and each instance of noncompliance may be treated as a separate violation of the Act.⁸⁵

There is a time limit within which insurers should be fulfilling the claims made by the policyholders. For example, the act obliges the insurer to pay the amount of any loss or damage for which he/she may be liable, under any policy property insurance policy, within thirty (30) days after proof of loss is received by the insurer and ascertainment of

⁸³ Section 247(a) of the Insurance Act of Philippines

⁸⁴ Ibid

⁸⁵ Section 247(c) of the Insurance Act of Philippines

the loss or damage is made either by agreement between the insured and the insurer or by arbitration.⁸⁶

However, in circumstances where such ascertainment is not had or made within sixty (60) days after such receipt by the insurer of the proof of loss, then the loss or damage shall be paid within ninety (90) days after such receipt. In circumstances where the insurer refuses or fails to pay the loss or damage within the time prescribed herein, the assured will be entitled to collect interest on the proceeds of the policy for the duration of the delay at the rate of twice the ceiling⁸⁷.

It shall be the duty of the Commissioner or the Court, as the case may be, to make a finding as to whether the payment of the claim of the insured has been unreasonably denied or withheld; and in the affirmative case, the insurance company shall be required to pay damages regarding expenses incurred by the insured person by reason of such unreasonable denial or withholding of payment plus interest of twice the ceiling of the amount of the claim due the insured, from the date following the time prescribed. It is as well provided that failure to pay any such claim within the time prescribed shall be considered prima-facie evidence of unreasonable delay in payment.⁸⁸

3.4. The Tanzanian Insurance Act of 2009.

The Act provides for the time limit for payment of claim. It is provided that every insurer shall pay claims within forty five days from the date of receipt of the executed discharge. However, where the insurer is unable to settle claims within that time, he may apply to the Commissioner for extension of time and an extra time of not more than forty five days within which the claim shall be settled maybe granted.⁸⁹

⁸⁶ Section 249 of the Insurance Act of Philippines

⁸⁷ Ibid

⁸⁸ Section 250 of the Insurance Act of Philippines

⁸⁹ Section 131(1) of the Insurance Act of 2009 (Tanzania)

Where an insurer fails without reasonable cause to settle the claim within forty five days or within the time extended by the Commissioner that claim shall be treated as a bad faith claim against the insurer.⁹⁰

A bad faith claim" means an insurer's delay in the processing of a legitimate claim beyond a time period consistent with normal industry practice or an insurer's delay in making payment to a claim beyond forty five days of the date of receipt of the executed discharge without consent of the Commissioner.⁹¹ There is a penalty of a fine not exceeding five million shillings on conviction for non compliance⁹²

All the above insurance laws in other jurisdictions provide a well stipulated time-frame within which insurance companies are obliged to acknowledge and pay the claims made by policyholders after they have met all the prerequisites. And provide for remedies to policyholders/claimants whose payments have been unreasonably withheld or delayed. This expedites the process of claims processing thus reduces on the level of delayed claims processing. However, this is not the case with the Ugandan insurance statutes.

This still leaves a gap which is still exploited by some insurance companies to practice unfair claim settlement practices under the guise of investigations.

Whereas different states have well stipulated timeframes within which an insurance company should settle a claim, they do not cater for situations when the company (insurer) disputes a claim. Some states merely require the investigation to be concluded in a reasonable time. However, some states provide specific period of time within which investigations should be carried out.

3.6 California Code of Regulations.

⁹⁰ Section 131(2) of the Insurance Act of 2009 (Tanzania)

⁹¹ Section 131(3) of the Insurance Act of 2009 (Tanzania)

⁹² Section 166(1) of the Insurance Act of 2009 (Tanzania)

In California every insurer is required upon the receipt of proof of claim, to immediately but in no event more than forty days later, accept or deny the claim in whole or in part. In California, the law gives insurers 40 days within which to investigate a claim. The 40 days begin to count when the insurer receives proof of claim⁹³.

3.7 New York Codes, Rules and Regulations

Under the New York Codes, Rules and Regulations, Insurance Companies have 15 days to acknowledge the receipt of the claim, and 15 days to start investigations and 15 days to decide on whether to accept or deny the claim.⁹⁴

The two laws provide for designated timeframe within which insurance companies are supposed to carry out their investigations and communicate their decisions to the claimant.

⁹³ California Code Regs.Tit.10(2695).7(b)

⁹⁴ Regulation 216.7 of New York Codes, Rules and Regulations.

CHAPTER FOUR

CONCLUSION

4.1. Summary

The study findings revealed that to a great extent, there exist in the legal framework of Uganda on the subject of insurance law most particularly property insurance, some of the required institutional framework both in law and man power to deal with the challenges faced in claims management. These include among others the Insurance Regulatory Authority established under **Section 10** of the Insurance Act which is mandated with the regulation of the Insurance industry in Uganda. .

The Insurance Act mandates the Insurance Regulatory Authority to receive and resolve insurance related complaints from the members of the public on the conduct of insurers and arbitrate, grant restitution to the complainant as may be possible. To further deal with challenges associated with claims procedure, the Insurance Regulatory Authority established the Complaints Bureau which entertains complaints made by policyholders against licensees.

The complaint bureau established under the Insurance Regulatory Authority acts as a court of first instance and it allows policyholders to submit their complaints and the bureau handles them. In case either of the parties is not satisfied with the decision of the Complaints Bureau, there has been introduced the Insurance Tribunal that entertains such disputes. According to the findings of the study there have been significant numbers of complaints that have been received by the complaints bureau of the Regulatory Authority.

The study findings reveal that there is a high growth rate of fraudulent claims in the insurance industry which thus led to the establishment of an Anti Fraud Unit by the Insurance Regulatory Authority to deal with and investigate allegations of fraudulent

claims. However, the study revealed that whereas the mechanisms for the resolution of the disputes were put in place, there is lack of man power to efficiently deal with such issues. This is because the magnitudes of complaints that are received are overwhelming and not proportionate to the available manpower.

A study by the auditing firm KPMG revealed that false claims had increased between 2018 and 2021. This portrayed the significance of the anti fraud unit that was introduced to deal with the fraud claims under the docket of insurance.

The findings of the study have also revealed that the laws governing insurance in Uganda are not central to claim settlement. This is in regards to timeframes within which payments should be made. However, the Insurance Regulatory Authority has issued guidelines to insurers i.e. **The Insurance Claims Guidelines 2021 (The Claims Process and Service Standard for Insurers)** to streamline issues concerning delayed payments/delayed acknowledgements of the policyholders' claims by the insurance companies (insurers). These provide for timelines within which a claim should be fulfilled. In addition there has been sensitization of policyholders on timely reporting and documentation of claims in order to enable their claims settled in time.

However, findings from the survey indicate that insurers have not done enough in terms of quality of advice for choice of product, servicing of policies, post sale and settlement of claims. A considerable gap exists in respect to the low level of awareness on existing insurance products, policyholder rights, and protection.

Policyholders expressed ignorance about the terms of the policies they hold. This has created false expectations which have worsened the existing public confidence deficit.

4.2 Recommendations

Despite the fact that, there has been a lot of institutionalization to improve on customer satisfaction, there is still room for improvement. The study has therefore come up with the following recommendations in line with the findings:

- Whereas the Complaints Bureau has been set up to receive and resolve customers' complaints, it's visibility is not significant among the general public. Therefore, there is a need to boost awareness and visibility of the complaints bureau and Insurance Regulatory Authority at large among the general public. This can be through publicizing of the complaints handling mechanisms (Complaints Bureau) and sensitization of the masses to always lodge their complaints with the bureau. The outcomes of complaints handled by the bureau should be compiled and publicized in order to give the public of the general view and create trust within the bureau. The Insurance Regulatory Authority should as well establish regional centers to effectively handle upcountry cases. Some of the respondents raised concerns over the need to travel all the way to Kampala from upcountry locations to have their complaints submitted with the complaints bureau which is an additional cost and thus expensive.
- Whereas the **Insurance Claims Guidelines** provide for timelines within which a claim should be paid, the guidelines do not envisage a situation where the claim is disputed which thus requires investigation. This has been exploited by the insurers under the guise of carrying out investigations to find out the genuineness of the claim. From the findings, some of the investigations take three years which does not favor the policyholders. Therefore, there is a need to provide for designated or statutory timeframes within which insurance companies should be carrying out their investigations in contested cases. The general application has been to conduct investigations within a reasonable period of time. However, this has been determined on case by case basis thus leaving room for exploitation. Hence the need to put in place a specific legislation that shall cover for timelines within which investigations should be carried out in circumstances where a claim is disputed.
- **There is a need to increase claims settlement limits for branch offices.** This would be to the benefit of the policyholder because it reduces on the lead time from the time of claim notification up to claim settlement. It would thus reduce on

the bureaucracy whereby the branch office has to first notify the head office to settle the claim on its behalf. The system of information interchange is usually slow, which makes policyholders wait unreasonably longer than they would have to wait if the processing for the claim was done at the branch office entirely.

This could be improved if the clients' information is kept electronically and is easily exchangeable between the branch offices in semi urban areas and the head office. However, an alternative approach would be maintaining the claim limits for branch but improving on the expediency of information processing to reduce on the period to ensure indemnification takes place quickly thus avoiding inconveniencing the policyholder who is in need of urgent indemnity.

- **There is need for insurance companies to provide service representatives to explain technical terms in policies to reduce on the challenge of knowledge gaps.** It has been revealed that some of the challenges are due to the knowledge gaps or the high levels of illiteracy regarding policyholders. The technical terms that are used in insurance policies which cannot be easily understood by lay person have been a hotspot for some of the challenges in claims process. There is thus a need for insurers to explain these terms to customers who may not understand the language on proposal forms. There is a tendency to take it for granted that customers thoroughly understand the policy form. A number of policyholders find language forms to be highly technical which would thus require sale representatives taking time to explain the technical language on the forms. Therefore, this can be done through insurance companies providing service representatives to explain the technical terms in the policies to the policyholders.
- **There is a need to provide for fraud as a statutory offence, and its penalties.** Whereas there is a policy in the industry that when an insider job of fraud is detected, the person involved is not only dismissed from work but also blacklisted by the industry, there is no prescribed punishment for policyholders who are found guilty of fraud than their policies being denied. This has led to persistent increase of fraud cases being penetrated by policyholders. However, making fraud as a

prescribed offence with its prescribed penalty would reduce on the increasing levels of fraud penetration by reducing on the rate of fraudulent claims made by the policyholders.

- **There is a need to decentralize Anti-Fraud Units.** Whereas there is established an Anti fraud Unit, it is only centralized thus making hard for insurance companies in semi-urban areas to report fraud cases. This has made the need to curb fraud cases futile and thus causing losses to the industry. There is thus a need to decentralize the anti fraud units to semi-urban areas in order to make it easy for insurance companies to refer their cases for investigation. This is intended to reduce on the rate of fraud penetration in the industry. Further, insurance companies should be encouraged to introduce fraud detection mechanisms. This would leave only sophisticated cases to be referred to the Unit and thus reduce on the burden and fraud penetration. This is intended to reduce on the rates of cases that are referred to the anti-fraud unit for investigation.
- **There is a need to prescribe for damages in form of interest against insurance companies that unreasonably delay to make payments to their policyholders.** During the study it was revealed that whereas there is a stipulated timeframe within which insurance companies should acknowledge policyholders' claims, there is no prescribed penalty against insurers that unreasonably delay to pay claims made by insureds/policyholders. It was revealed that some of the insurers deliberately delay their payments under the guise of investigations. This frustrates the policyholders and leads them to losses. However, there is no any form of mitigation to deter delayed claims processing by the insurers. By comparative analysis with most of the jurisdictions, it was revealed that other jurisdictions have statutory provisions to protect insurance consumers against unreasonable delayed settlements through compensation.

With the above recommendations, the claims process regarding property insurance shall be streamlined to cover the loopholes and demands of the modern property insurance trends

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