NORTON ROSE FULBRIGHT

The Big Read Book Series Volume 23

Norton Rose Fulbright South Africa's review of insurance judgments of Uganda (2002-2023)

April 2025

Introduction

Dearest Reader

Welcome to Norton Rose Fulbright's The Big Read Book Series.

This is Volume 23 of the series – A review of insurance judgments of Uganda (2002-2023).

Like our Zimbabwe, Kenya, and Botswana editions, the cases discussed in this edition are binding in Uganda but not in South Africa. The findings in a number of the judgments do not match South African law and the case law should not be relied on in South Africa. The judgments make interesting reading, nonetheless.

An online version of this publication is available through our Financial Institutions Legal Snapshot blog at https://www.financialinstitutionslegalsnapshot.com/ with links to the judgments. You can also keep up with developments in insurance law including South African judgments and instructive judgments from other countries by subscribing to our blog.

You can access the previous volumes in the series, here.

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Uganda Insurance Law

The insurance industry in Uganda has a robust regulatory framework comprising Acts of Parliament, regulations, circulars, and guidelines. This comprehensive framework governs licensing, amalgamations and transfers, consumer protection, insolvency and winding up, dispute resolution, among many other key aspects. The sector comprises insurers and re-insurers and is managed by brokers, surveyors, agents, and actuaries.

Historical context

The primary point of reference in Uganda is the Insurance Act, Cap 191 Laws of Uganda (the 'Act'). The Act has undergone several developments and fresh enactments. The Act, upon its commencement on 30 March 2018, repealed the 1996 Insurance Act, Cap. 213, and provided for the regulation of insurance business in Uganda; the continued or saved existence of the Insurance Regulatory Authority of Uganda (the 'IRA') as the body responsible for regulating insurance businesses in Uganda, and provided for related purposes.

The Regulatory Space

The Act empowers the IRA as the regulator overseeing the activities of Uganda's insurance industry. The Act also empowers the IRA in consultation with the Minister of Finance, Planning and Economic Development to make regulations.

At present, a host of regulations have been passed to operationalise the Act. These include the Insurance (Minimum and Maximum) Regulations, 2023 (as amended), the Insurance (Oil and Gas Business) Regulations, 2022, the Bancassurance Regulations, 2017, the Insurance Appeals Tribunal Regulations, 2019, the Motor Vehicle Insurance (Third Party Risks) Regulations, SI 214-1, the Insurance Regulations 2002, the Investment Regulations of Paid-Up Capital & Insurance Funds, the Capital Adequacy & Prudential Requirements, Regulations, 2020, the Insurance Training College Regulations, 2020, the Licensing and Governance, Regulations, 2020, the Insurance (Index Contracts) Regulations 2020, the Insurance (Fees) Regulations, 2020, the Insurance (Intermediaries) Regulations, 2021, the Insurance (Mobile Insurance) Regulations, 2020 and the Insurance (Reinsurance) Regulations, 2020. In addition to the regulations, the IRA has in the exercise of its mandate, issued guidelines and circulars.

The Parliament of Uganda also passed the Marine Insurance Act Cap. 192, the Motor Vehicle (Third Party Risks) Act Cap. 193 and the Workers Compensation Act Cap 233 to govern specific aspects of insurance. Other laws that complement the industry's existing framework include the Companies Act, Cap. 106, the Financial Institutions Act, Cap. 57, the Competition Act, 2024 and the Insolvency Act, Cap. 108.

Context of the dispute resolution procedure

In 2024, the IRA issued internal dispute guidelines to aid the effective and quick conclusion of clients' complaints by the licensees before they are escalated to the Authority. In the same vein, the IRA established the Insurance Complaints Bureau (the 'Complaints Bureau') to receive and resolve insurance-related complaints from the general public. Persons aggrieved by the decision of the Complaints Bureau may, under the Act, pursue an appeal before the Insurance Appeals Tribunal (the 'Appeals Tribunal'). A party aggrieved by the decision of the Appeals Tribunal may proceed to the High Court of Uganda for further redress.

That notwithstanding, the IRA has, through its regulatory mandate, directed licensees to entrench a provision in their respective dispute resolution clauses that offers the parties the latitude to explore the settlement of disputes first, amongst themselves, before the same is forwarded to the IRA per the Act and regulations and before the parties resort to other avenues such as mediation, arbitration or litigation.

On the whole, Uganda's insurance industry is one of the most highly regulated, managed and supervised sectors in Uganda.

VS Hydro Uganda Limited and Three Others v Rwenzori Hydro (Pty) Limited and Three Others (2023)

(Court of Appeal Civil Application No. 155 of 2023)

Keywords
construction / advance payment bond / performance guarantees

The parties entered into a construction agreement to build a number of hydropower projects. The applicant construction company obtained, from a bank, advance payment guarantees and performance guarantees to secure loan facilities, advance payments, and the performance of its contractual obligations to the first to third respondents (the beneficiaries of the guarantees).

A dispute arose under the construction agreement, relating to whether the works had been completed, and the respondents called on the guarantees. The applicant sought to interdict the call and payment under the guarantees, pending determination of the contractual dispute under the construction agreement.

The trial court granted a temporary interdict in respect of the performance bonds only. The court accepted the applicant's assertion that the works had been completed, and that the projects had become operational.

The trial court did not interdict payment under the advance payment bonds, which guaranteed repayment of loans that the first respondent had advanced to the applicant.

There are limited reasons to deny a call on an advance payment bond. In this case, the applicants had relied on the fraud and unconscionable conduct exception. The trial court however stated that:

> "To prove that a demand under a performance guarantee is fraudulent, the applicant for an injunction must show that the beneficiary knows that the demand is fraudulent, or that the circumstances around the demand are such that the only reasonable inference is that the demand is fraudulent."

It was not shown that the respondents could not have honestly believed in the validity of their demands under the guarantees.

The court found no reason to grant an interim injunction preventing the bank from paying under the advance payment bond.

The application was dismissed.

Salini Construttori SPA v Jubilee Insurance Company of Uganda Ltd (2019)

(High Court Civil Suit No 109 of 2016) 2019 UGCommC 27 (14 February 2019)

Keywords
variation of policy / interpretation

The plaintiff, Salini Construttori SPA, contracted to construct a power plant in Njeru, Uganda. To execute that contract, it had to procure material. It ordered around 5000 metric tons of reinforcing steel bars, to be shipped from Turkey to Uganda. The defendant insurer provided marine insurance for the duration of the journey, under an All Risks policy.

The cargo was loaded in Turkey but did not reach Uganda. The ship developed mechanical problems and was forced to dock in Guinea. The cargo was unloaded, and the iron bars degraded.

The plaintiff claimed under the policy.

The insurer presented a policy wording which had been altered since initially agreed, arguing that the parties had agreed to vary the policy. The court found that the parties had required the regulatory authority's permission of make the change, and since it had not been sought or granted, the new version of the policy presented by the insurer containing new exclusions did not apply.

The insurer nevertheless denied liability on the basis that that the ship was over 30 years old, on the basis of the age limitation clause in the policy. As the plaintiff had not informed the insurer of this fact, the insurer was unable to determine whether to grant coverage or to charge an additional premium. Further, the cargo had been condemned and destroyed for unclear reasons. The insurer alleged that the plaintiff should have taken steps to mitigate its loss.

The court found that the plaintiff was expected to notify the insurer if the age of the vessel is over 30 years. However, the plaintiff could only do so if they were aware of that age at the time the insurance questionnaire was filled in. In this case, the plaintiff had written "unknown" in relation to the age of the vessel, and this had been accepted by the insurer. Using a vessel over 30 years old would not nullify the insurance – the policy allowed for an adjustment of premium if new information regarding the risk came to light.

To mitigate its losses, the plaintiff filed an application with the court in Guinea, seeking an order of inspection of the cargo – that court granted the application, and appointed local inspectors to determine the extent of the cargo's degradation. It was found that the cargo was unfit for its intended purpose, and the court in Guinea ordered that the dock be cleared of the cargo. The plaintiff and insurer also sent representatives to conduct a joint survey of the cargo, and it was agreed that the goods were degraded beyond use. The plaintiff had therefore attempted to mitigate its loss.

The court accordingly ordered the insurer to indemnify the insured for the loss.

The plaintiff sought general damages for breach of contract based on the inconvenience and loss the plaintiff had suffered. The court noted that the award of general damages is in the discretion of the court, however the precedent in this regard is not consistent. The court, for example in *Tight Securities Ltd v Chartis Uganda Insurance Company Ltd and Another; Kabege v Niko Insurance (Uganda) Ltd and in Mugisha v Chartis (U) Ltd; and Mirembe Wire Products Ltd v Goldstar Insurance Company* (discussed below) awarded general damages for breach of contract. However, in *Sameer Agriculture Livestock Ltd Anor v CCL Logistics(U) Ltd* (also discussed below) the court did not allow a claim for general damages for breach of contract.

The court in this case agreed that the plaintiff had to incur losses due to the insurer's failure to pay the claim, including legal expenses, and expenses relating to the delivery of samples. Further, alternative steel had to be sourced, and the plaintiff had incurred penalties for late delivery. The court found that the plaintiff should have been indemnified as soon as it notified the insurer of the loss and awarded general damages.

Goldstar Insurance Ltd v Uganda Revenue Authority (2019)

(High Court Civil Appeal No 26 of 2016) 2019 UGCommC 3 (20 February 2019)

Keywords
contingency reserves / tax / deductions

The Uganda Revenue Authority conducted a corporate tax compliance audit on the appellant, an insurer. The Revenue Authority stated that the insurer had inaccurately dealt with the tax treatment of its contingency reserves.

The Income Tax Act allows a deduction of the amount kept in reserve for unexpired risks. The Revenue Authority stated that contingency reserves do not fall under this section and are therefore not allowable deductions. This conclusion was reached after it corresponded with the Insurance Regulatory Authority to confirm how these reserves are treated in financial statements. The Insurance Regulator stated that contingency reserves are intended to cover fluctuations in securities and variations in statistical estimates.

The insurer argued that the contribution it makes to its contingency reserves is a statutory requirement. Section 47(2)(c) of the Insurance Act requires an annual transfer to contingency reserves equal to 2% of the gross premium income, or 15% of the net profits, whichever is the greater, until the reserves accumulate to an amount stipulated by the Act.

The Revenue Authority maintained that the reserves are not deductible. It argued that the fact that the annual movement in this type of reserve is included in the statement of changes in equity, and not the income statement (since it does not meet the criteria for income in international accounting standards) supported its decision.

The insurer argued that expenditures and losses incurred in the production of gross income, is deductible. Since section 47 of the Insurance Act compels them to set aside sums of money as contingency reserves, the amount can be equated to expenditure and therefore be deducted from their gross income in computing tax payable.

The court found that although the Insurance Act imposes restrictions on the money held in reserve by the insurer, which did not mean that the amount ceased to belong

to the insurer. The money held in reserve had not been lost by the insurer. It could even be invested for profit. An investment cannot be allowed as a deduction. The insurer collected and received contingency reserves as premium for its client's insurance. The amount remained at the insurer's disposal for its benefit. The purpose for which the contingency reserve could be used was for the insurance business's payment of liabilities envisaged in the normal business of an insurer.

The court stated that the majority of reserves are set aside after tax, because these are retained earnings which arise out of the profitable operations of the insurer. If an insurer makes a loss, no reserves (which are meant to come out of the profits and set aside for the purpose of strengthening the company) are set aside for that year. The reserves are portions of profit and are earned through the insurer's normal operations and are then set aside for any particular purpose. That is why a reserve is an asset.

One can only deduct sums of money that are used in the production of income. In this case, contingency reserves were not used in the production of income but were part of the income itself.

Therefore, the court held that contingency reserves are not allowable deductions for insurers.

Hajji Kavuma v First Insurance Company Ltd (2018)

(High Court Civil Suit No 442 of 2013) 2018 UGCommC 65 (7 May 2018)

Keywords
motor vehicle accident, utmost good faith

The plaintiff sued his insurer under a motor vehicle policy.

The plaintiff purchased a Mercedes Benz in 2011. At the time of purchase, various additions and changes to the car had been made by the previous owner. The plaintiff made further changes to the car. This resulted in what is described as an upgrade of the car from a G300 series to a G55 series.

The vehicle was involved in an accident and was damaged beyond repair. The plaintiff claimed under the policy.

The insurer rejected the claim and sought to avoid the policy for fraud, non-disclosure or misrepresentation. The plaintiff conceded that he had not provided information about the upgrades. This affected the risk because, according to the insurer's witness, at least one of the upgrades was not proper. For example, the change to the dashboard did not suit the type of engine installed when the original engine was replaced. The insurer also alleged that the plaintiff had deliberately caused the accident and that the claim was therefore fraudulent.

In Uganda, contracts of insurance are seen as contracts of utmost good faith. The misrepresentation of the vehicle's type affected its valuation and should have been disclosed to the insurer.

The court held that the non-disclosure of the adjustments made to the vehicle was material. The fact that the insurer did not specifically ask for this information did not assist the plaintiff, since he clearly knew about the history of the vehicle and nevertheless concealed this information. There was insufficient evidence to prove fraud, but the non-disclosure was sufficient to be dismissive of the case.

The insurer was entitled to avoid the policy. The plaintiff's claim failed.

Obita v DFCU Bank (2018)

(High Court Miscellaneous Application No 425 of 2017) 2018 UGCommC 45 (6 August 2018)

Keywords
loan / credit insurance

A bank sued the applicant for repayment of a loan. The bank applied for summary judgment, alleging that the applicant had no possible defence. The applicant applied to court to be allowed to defend the matter at a trial, stating that the loan was subject to an insurance clause, under which the bank was obliged to obtain comprehensive insurance on the borrower's behalf in return for a non-refundable insurance fee.

The court found that whether the outstanding loan was to be settled by indemnity from the insurance company was a possible defence and should be interrogated during a full trial. Therefore, the court granted the applicant leave to defend the case.

Walusaga v Barclays Bank of Uganda Limited (2017)

(High Court Miscellaneous Application No. 966 of 2016) [2017] UGCommC 49 (28 March 2017)

Keywords
loan / credit insurance

A bank sued the applicant for repayment of a loan. The bank applied for summary judgment, alleging that the applicant had no possible defence. The applicant applied to court to be allowed to defend the matter at trial, stating that the loan was subject to an insurance clause, under which the bank could obtain insurance in regard to the loan. Premium would be advanced from part of the loan amount.

The borrower therefore alleged that the bank could only proceed against the insurer for the outstanding amount.

The court stated that the borrower was not a party to the insurance contract and the policy did not bring the borrower within the ambit of being a beneficiary of the policy. The court was only provided with the loan agreement. Neither party produced the insurance contract. The loan agreement obligated the borrower to pay the loan. The court therefore held that there was no triable defence and found in favour of the bank.

Microcare Insurance Ltd v Insurance Regulatory Authority of Uganda (2017)

(High Court Civil Suit No 684 of 2015) 2017 UGCommC 47 (12 May 2017)

Keywords
time bar claim against a regulator

The Insurance Regulatory Authority of Uganda refused to grant a licence to the plaintiff in 2009 and petitioned to have the plaintiff wound up. The plaintiff sued the Regulator, alleging that its actions caused the plaintiff reputational damage, loss of business, and loss of income.

The Regulator alleged that the claim was time-barred. The Regulator is a "scheduled corporation" under the Civil Procedure and Limitation (Miscellaneous Provisions) Act, which provides that "no action founded on tort shall be brought against a scheduled corporation, after the expiration of two years from the date on which the cause of action arose". The claim was brought in 2015.

The plaintiff argued that its claims were not founded only on malfeasance in public office and breach of statutory duty but also on loss of business, loss of income, and loss of earnings. Therefore, the plaintiff alleged that its causes of action were distinct and that the events giving rise to these causes of action arose at different times.

The court held that the plaintiff's claim as pleaded could only be founded on tort and that the cause of action arose in 2009. The claim for loss of income was a consequence of failure to operate a business and was not itself the cause of action but the consequence of the cause of action.

The claim was therefore time-barred and dismissed.

National Housing Construction Co Ltd v Lion Assurance Company Ltd (2017)

(High Court Civil Suit No 239 of 2013) 2017 UGCommC 14 (17 February 2017)

Keywords
advance payment guarantee / payment "under the contract"

In July 2011, the plaintiff entered into a construction contract with NH-MKP Builders. The builders were contracted to construct over 300 apartment blocks. The plaintiff undertook to pay 20% of the contract price to the builders against receipt of an advance payment guarantee.

The advance payment guarantee was issued by Leads Insurance Company and was set to expire on 22 December 2012 – before the plaintiff received full repayment of the advance payment. The plaintiff wrote to the builders in November 2012, requesting that they renew the advance payment guarantee. In response to the request, the builders took out another advance payment guarantee with the defendant, Lion Assurance Company Ltd.

The plaintiff called on the guarantee, but the defendant insurer denied liability, advising the plaintiff to pursue payment from the builders.

The plaintiff argued that the defendant was obliged, under the advance payment guarantee, to unconditionally pay the sum on demand. The defendant argued that no advance payment was made by the plaintiff after it was issued. The guarantee was meant to secure payments made subsequent to its existence and was not intended to secure obligations that were already in place.

The court had to consider whether the plaintiff advanced any money against the guarantee issued by the defendant, and whether the defendant was liable if no money was advanced under the guarantee.

The court found that securing the advance payment guarantee was a condition precedent to the plaintiff's obligation to make the advance payment to the builder.

Although the terms of the guarantee stated that it was unconditional, there was also a clause providing that the guarantee was to remain valid and in effect from the date of the advance payment "under the contract" until 26 December 2013. The court interpreted this to mean that an advance payment had to have been made under the advance payment guarantee with the defendant, and not under any previous advance payments.

As there were no advance payments made after the guarantee was issued, the court dismissed the plaintiff's claim.

National Insurance Corporation Ltd v Kakugu (2016)

(High Court Civil Appeal No 40 of 2015) 2016 UGHCCD 136 (8 November 2016)

Keywords
motor vehicle insurance

The respondent took out comprehensive insurance with the appellant for three motorcycles. One motorcycle was stolen in 2008, and the other two were hijacked in 2010. On both occasions, the respondent reported the incidents to the police and informed the insurer by letter. The respondent demanded compensation for the loss, but the insurer rejected the claim and denied liability, alleging that the respondent had breached the conditions of the policy due to non-disclosure and misrepresentation. The insurer alleged that the identity of the driver at the time of the hijacking was not disclosed.

The court held that the terms in the schedule relating to the use of the vehicles and which drivers were covered were "deliberately confusing" and ambiguous, and therefore these terms were construed against the insurer.

The insurer did not provide sufficient evidence in relation to its allegations of connivance in the theft by the insured or its employees, or the assertion that the insured had entered into a hire-purchase agreement for two of the motorcycles.

The insurer therefore did not prove its allegations of misrepresentation, non-disclosure and breach of the policy and was ordered to pay the claim.

Insurance Company of East Africa v Kitagenda (2016)

(High Court Civil Suit No 301 of 2012) 2016 UGCommC 212 (16 December 2016)

Keywords
broker / broker licence / payment of commission / illegality

The plaintiff insurer sued the defendant for repayment of commission paid to him in relation to business written in 2012.

The defendant had been the insurer's agent since 2004. In 2012, the insurer paid him around US$61 000 commission on the basis that he had solicited business from a new client.

The insurer subsequently learned that the client had applied for the insurance directly and that the defendant was not involved in soliciting the business. Further, the defendant was not a licensed insurance agent for the years 2011 and 2012, during which the relevant client applied for the cover.

The agent alleged that it was the insurer's duty to pay the fees for his agent licence, and that the insurer had always kept the licence in its custody.

Even though this may have been practice between the parties, in terms of the Insurance Act, the agent himself had the duty to obtain his licence.

The court accepted that the defendant carried on the business of an agent without a licence, from 2011 to 2012 in contravention of the Insurance Act.

Section 37 of the Act states that an insurer is not allowed to pay commission to an unlicenced intermediary. Therefore, both parties had contravened the Act.

The court did not accept the insurer's argument that the defendant had misrepresented to them that he was licenced. The court stated that it is a duty of an insurance company to ensure that it deals only with licenced persons. Having dealt with the defendant for a number of years, the court stated that the plaintiff could not rely on misrepresentation. The plaintiff ought to have known about the status of the agent's licence.

A plaintiff cannot rely on his own illegality to found a cause of action.

The court therefore found the action for refund of commission (and any counterclaim by the agent for outstanding payment) unenforceable, because what both parties did was prohibited by statute.

Nakisenyi Anor v Insurance Company of East Africa (U) Ltd (2016)

(High Court Civil Suit No 652 of 2013) 2016 UGCommC 38 (16 March 2016)

Keywords
life assurance / medical examination / imposter fraud / evidence

The plaintiffs sued the insurer after it rejected their claim under a life insurance policy.

The policy was negotiated with the insurer and the life insured between February and March 2013. The life insured passed away in April 2013 but the insurer rejected the beneficiaries' claim, alleging fraud and misrepresentation on the part of the life insured.

The insurer alleged that the life insured concealed her health conditions, refused to undergo personal medical examinations and fraudulently caused another person to undergo the medical examinations necessary to support her insurance proposals.

The death certificate stated that the life insured died of respiratory failure due to Pneumocystis Pneumonia (PCP) and immunosuppression.

The insurer alleged that the life insured died from an HIV-related illness and that the medical examinations which supported the insurance proposal was for a person who was found to be HIV-negative. Therefore, the insurer concluded that the person who took the medical examination was not the life insured.

The insurer's witness, a medical doctor, had signed the medical examination form but had not conducted the examination himself. He testified that the medical examination documents usually arrive with a separate sealed letter that includes a photograph of the person to be examined. In this case, the letter with the photograph had not been received, and the receptionist merely phoned the insurer to confirm what tests were to be done. This witness testified that it was normal for the tests to be carried out without waiting for the letter or photograph. He signed the medical examination form based on the assessment by the examining doctor and the findings from the lab.

The court noted that none of the insurer's witnesses had interacted with the life insured or the alleged imposter. The examining doctor and the receptionist were not called as witnesses and therefore the evidence of the insurer's witness amounted to hearsay. The plaintiffs called as their witness the defendant's commission agent, who testified that he accompanied the life insured to the medical exam and that he took the second letter (with the photograph) to the examination himself. The court accepted the evidence of this witness, who was found to be consistent during cross-examination.

The insurer's claim that an imposter underwent the medical exam was not sufficiently evidenced. The only other evidence presented relating to the fraud was that the cause of death appeared to be related to HIV/AIDS, and this was inconsistent with the result of the medical examination. This assumption was not borne out by the evidence of another witness for the plaintiff, a medical doctor, who stated that the cause of death may have been incorrectly recorded, since it was not possible to diagnose PCP and immunosuppression without lab tests, which were not done on the life insured. The insurer was not able to prove fraud on the part of the life assured.

The insurer was ordered to pay the claim.

Leads Insurance Company v Attorney General (2016)

(High Court Civil Suit No 56 of 2015) 2016 UGHCCD 31 (30 March 2016)

Keywords
confiscation of property / insurance licence

The insurer sued the attorney general for return of title deeds, and for related loss of income.

The attorney general's agents seized documents (including the title deeds of a number of properties owned by the insurer) during an investigation of the insurer's shareholders. The insurer was not the subject of the investigation and was not charged with any criminal activities. Despite demand from the insurer, the title deeds were not returned.

The insurer applied to court to order that the title deeds be returned. The court ordered that duplicate certificates be released to the Uganda Insurance Authority, and that the deeds remain with the Insurance regulator during the investigation.

The insurer needed the title deeds to renew its insurance licence, as it related to the valuation of its assets. The attorney general did not comply with the court order and the insurer's licence was not renewed.

The insurer applied to court to enforce the earlier order, and to charge the attorney general with contempt of court. It also claimed for loss of income as well as general and special damages occasioned by withholding its title deeds.

The court awarded general damages for the inconvenience associated with not being able to secure its licence. The court also awarded punitive damages, since the defendant acted "unconstitutionally and recklessly" by ignoring an order of court. The court noted that government agencies should be aware of the consequences of crippling businesses because of their shareholders' conduct.

However, the claim for loss of income was not allowed. The insurer attempted to prove the amount of income lost by referring to income of previous years. However, the court stated that special damages are meant to deal with exactly computable financial losses. Relying on previous earnings was speculative and unrelated to the suit. While the evidence seemed credible on the surface, it fell short of proving any loss of income in the relevant year, since the insurer did not operate for lack of a licence.

The court also ordered that the title deeds be released to the insurer.

Housing Finance Bank Ltd and Liberty Life Assurance Uganda Ltd v Igeme Nabeta (2015)

(HCCS 228 of 2012) 2015 UGCommC 102
(7 September 2015)

Keywords
credit insurance / group scheme / salary loan

The defendant defaulted on loan repayments due to the first plaintiff, a bank. The first plaintiff claimed from its insurer, who indemnified the loss. The first plaintiff assigned its rights in the claim against the defendant to the insurer. The insurer then proceeded against the defendant for repayment of the amount.

The court found that subrogation could not apply because the loan was a "salary loan" for a member of parliament. The defendant lost his job due to a petition to court relating to his election. This was a foreseen risk, and the first plaintiff was insured against this risk. The insurance formed part of a group scheme under which members of parliament contributed to the premium. In the circumstances, the defendant could not be considered a third party who may be sued in tort or for breach of contract.

The plaintiffs' claim was dismissed.

Scorpion Holdings Ltd v Lion Assurance Co Ltd (2015)

(High Court Civil Suit No 221 of 2013) 2015 UGCommC 50
(3 March 2015)

Keywords
plant and machinery insurance / fire damage

The plaintiff took out insurance on machinery with the defendant insurer. The plaintiff lodged a claim for damage by fire to the insured machinery. The insurer rejected the claim, alleging that the claim was fraudulent.

Reports by two assessors, contracted by the insurer, were presented by the plaintiff. Both reports noted that the plaintiff had complied with the conditions of the policy.

The defendant alleged that the plaintiff did not disclose its financial standing and that some banks had security interests in the logbooks of the insured equipment. The court found that these disclosures were immaterial to the policy and were not required under the policy.

The insurer alleged that the cost of the equipment was lower than that claimed, but the court did not accept this argument. The court noted that the value of the machinery was determined during the conclusion of the policy terms, and that the agreement between the parties as to the value would be upheld. Further, it was upon the agreed value that the premium was calculated.

The insurer alleged that the insured knew of a threat to the safety of the machinery, since a disgruntled employee had apparently said that he would take revenge on the insured. However, no evidence was led to substantiate this claim. The insurer was unable to prove fraud in the claim.

The insurer was ordered to pay the insured's claim.

Odongo v M/S Standard Chartered Bank (U) Ltd (2015)

HCT-00-CC-MA-0905-2014

Keywords
salary loan / credit insurance

A bank sued the applicant for repayment of a salary loan. The applicant alleged that the loan was insured, alternatively that the bank breached the loan agreement by failing to take out an insurance policy to secure the loan.

The bank evidenced that it had insured the loan, but that cover was limited to non-payment due to death, total permanent disability, retrenchment, abscondence, and age range.

The applicant argued that his employer had made him redundant, and that amounted to retrenchment. The applicant's explanation was that his employer made it difficult for him to continue working because they transferred him to another country, which forced him to resign.

The court stated that the applicant had chosen to resign, and this was not classified as a retrenchment. The policy would therefore not cover his loan, and he was ordered to repay the bank.

Tight Securities Ltd v Chartis Uganda Insurance Company Ltd and Another (2015)

(High Court Civil Appeal No 16 of 2014) 2015 UGCommC 135 (13 November 2015)

Keywords
subrogation / limitation of liability / exemption of liability

The second respondent, a coffee company, contracted with the applicant for security services. A burglary occurred and the second respondent suffered a loss. The second respondent's insurer (the first respondent) indemnified part of the loss.

The respondents then claimed against the applicant for recovery, alleging that its employee had connived in the theft and that the applicant was liable for the loss.

The applicant paid 2.5 million shillings to the respondents, that being the limit of liability in the security/guarding contract. However, the first respondent's claim was for 5.7 million shillings plus US$7 000, and 4.5 million shillings for the second respondent.

The court found that the security company fundamentally breached the contract through the actions of its employee who colluded with the thieves.

The breach resulted in the court holding that the exemption from liability clause could not apply. However, the limitation of liability (to 2.5 million shillings) was still applicable, despite the breach.

The court noted that enforcing limitation of liability clauses is determined in light of the contract as a whole, in order to determine where the parties have apportioned risk. A breach of contract does not necessarily nullify a limitation of liability clause, especially if the agreement clearly contemplates a breach and apportions the loss. This is especially so if the parties have equal bargaining power, like the parties in this case. Further, the contract further transferred risk by requiring the respondent to procure insurance for theft.

The insurer was entitled to subrogation of the second respondent's claim, but only up to the limit of 2.5 million shillings. As the appellant had already paid that amount to the second respondent, nothing further was recoverable under the special damages claim.

Despite the limitations clause though, the court also allowed a general damages claim for breach of contract and awarded the second respondent 4.5 million shillings in general damages.

Sameer Agriculture Livestock Ltd Anor v CCL Logistics(U) Ltd (2015)

(High Court Civil Suit No 401 of 2010) 2015 UGCommC 157 (7 May 2015)

Keywords
subrogation / general damages

The first plaintiff contracted with the defendant to transport powdered milk. The first plaintiff insured the transport of the goods with the second plaintiff. The goods were stolen during the journey.

The insurer compensated the first plaintiff, and then sued the defendant under its right of subrogation. The court allowed the insurer's claim, as it had indemnified the insured. However, the court did not allow the claim for general damages against the defendant for breach of contract, because it stated that the insurer had no claim in this regard – the insurer indemnified the first plaintiff under a contract of insurance and was entitled only to recovery of the amount paid to the insured. The insurer did not suffer any inconvenience for what they were legally bound to do under the insurance contract.

The court stated further that the first plaintiff, since it had subrogated its rights to the insurer, was not entitled to recover general damages either, since it should be "sufficiently satisfied" with the compensation it received from the insurer.

Goldstar Insurance Company Ltd v Attorney General 2 Ors (2014)

(High Court Civil Suit No 132 of 2010) 2014 UGCommC 116 (22 August 2014)

Keyword
payment of premium / agents and principal

The plaintiff insurance company sued the attorney general in its representative capacity for the government's Works and Transport Ministry, in respect of outstanding premium.

The third party operated a vessel owned by the Ministry of Works and Transport. The vessel required insurance for the third party to operate it under its contract with the Ministry.

The second defendant is an insurance broker, acting for the first defendant. It approached the plaintiff to insure the vessel. The plaintiff undertook the risk and in turn took out a policy of reinsurance. The plaintiff issued a cover note under which the first defendant was required to pay premium of €22 000 and 1.6 million shillings.

The plaintiff made demands for payment of the premium. The second defendant made an acknowledgment, with a promise to pay the outstanding premium. However, the premium was never paid.

The first and second defendant pleaded bare denials and did not attend the hearing. The third party admitted the facts presented by the plaintiff.

The court found that the Ministry was responsible for insuring the vessel, and that the second defendant acted as the Ministry's agents in procuring the insurance on the Ministry's express instructions. The Ministry had to pay the premium, which it failed to do.

The court noted that, in the ordinary course, failure to pay premium would mean that the insured is unable to recover indemnity on the occurrence of a loss event. However, no insurable loss occurred during the term of the policy. Nevertheless, the court found that the vessel could not lawfully be operated by the third party without insurance. The insurance was procured, and the vessel was operated.

The court found the first and second defendant jointly and severally liable for payment of the premium. This is because the claimant can claim against either the agent or principal, and it is left to the agent to recover from the principal if necessary.

Kabege v Niko Insurance (Uganda) Ltd (2014)

(HCT00CCCS 319 of 2012) 2014 UGCommC 65 (29 May 2014)

Keywords
professional indemnity insurance

The plaintiff, a real estate surveyor, was contracted by a bank to value a property. The valuation was accepted by the bank as confirmation of the value of property used as security for a loan it intended to advance to a third party. The third party defaulted on the loan. When the bank attempted to recover the security, it was found that the valuation of the land in the plaintiff's valuation report was for a neighbouring property, not owned by the third party. The loan was therefore advanced on the wrong information. The bank therefore sued the plaintiff.

The plaintiff sought indemnity from its insurer, the defendant.

The insurer rejected the claim on the basis of fraud, alleging that the employee who had handled the valuation was known as a speculator with no technical knowledge in valuation, that he was known to give false information based on the wrong plots in his reports, and that he did not have a valid surveyor's certificate, which is a requirement of the Surveyors Registration Act. Therefore, the claim was based on a fraudulent practice and misrepresentation, rather than on professional error or unintended negligence.

The court noted that fraud must be strictly proved by the party alleging it and that the standard of proof is higher than on a balance of probabilities (but not as heavy as requiring proof beyond a reasonable doubt). The insurer did not have sufficient evidence to prove fraud.

The court also accepted the insured's evidence that the cover was extended to include cover for fraud or dishonesty. The insurer argued that extra premium for the extension was not set out in the schedules and that the insured was therefore not entitled to the extension. The court held that the policy was ambiguous in this regard and interpreted it against the insurer in accordance with the *contra proferentum* rule.

The court ordered the insurer to pay the plaintiff's claim.

The court also awarded the plaintiff 10 million shillings in general damages, for the insurer's reluctance to fulfil its obligations under the policy, which resulted in inconvenience and loss of time to the plaintiff.

Longway Suitcase Manufacturing Co Ltd v UAP Insurance (U) Ltd (2014)

(HCT00CCCS 417 of 2010) 2014 UGCommC 146
(3 October 2014)

Keywords
fire insurance / consensus on the subject of insurance/ literacy of the insured

The plaintiff insured sued the insurer for loss that resulted from a fire at the plaintiff's factory. The insurer rejected the claim, alleging that the fire was caused by the plaintiff in an act of arson.

The defendant was unable to prove arson, and the court expressed its displeasure at the insurer's attempts to keep the reports of its assessor's away from the plaintiff.

In relation to objections raised about the safety of the premises and the value of the property, the court noted that the insurer had inspected the premises before issuing the policy and had not raised any objections to issues already present at the time of inspection.

However, after the cross-examination of the plaintiff's managing director, who was responsible for procuring the insurance, the court concluded that no valid contract of insurance had ever been concluded, despite the parties having stated to the court that they were in agreement that a valid policy had been concluded. The court noted that the plaintiff's managing director had to provide testimony through a translator, since he did not speak or read English. This conclusion is supported by the definitions in the Illiterates Protection Act. His testimony evidenced that he did not know what was contained in the contract of insurance.

Since there was no valid contract, the court ordered the insurer to refund premiums paid and dismissed the plaintiff's claim.

Nshimwe Co Advocates v Microcare Insurance Ltd and Insurance Regulatory Authority of Uganda (2014)

(Miscellaneous Cause No 17 of 2014) 2014 UGHCCD 81 (17 June 2014)

Keywords
insurance regulator / garnishee order / money held in trust

The plaintiffs were awarded judgment against an insurer, the first defendant. The insurer failed to pay the judgment debt. The plaintiff therefore applied to court to issue a garnishee order against the Insurance Regulatory Authority, since the regulator held money of the insurer, which the plaintiff alleged was held "in trust".

The regulator stated that the money was not held in trust, but was part of a statutory fund, to be used only in terms of the Insurance Act. The money held by the regulator, seen as a security deposit, forms part of the assets of the insurer. This was not denied.

The court stated that the security deposit is not a statutory fund but is held for the insurer. The court noted that the Insurance Act itself allows up to 50% of the amount held as security deposit by the regulator to be used to settle losses arising from liabilities to claimants (but the amount withdrawn must be replaced by the insurer within ninety days). The amount claimed in this case was far less than 50% of the funds held by the regulator as security deposit for the insurer.

The court therefore allowed the application for the garnishee order against the regulator.

Katongole v Excel Insurance Company Ltd (2014)

(HCCS 176 of 2012) 2014 UGCommC 117 (22 August 2014)

Keywords
jurisdiction / Yellow Card Protocol

The plaintiff sued the insurer for breach of a third-party insurance contract entered into under the COMESA Yellow Card Protocol. The Protocol is a regional system of insurance, and the Yellow Cards are recognised as policies of insurance. The policies provide compulsory minimum motor insurance, required by member countries.

The plaintiff acquired a Yellow Card from the defendant, an insurer in Uganda. The insured motor vehicle was in an accident in Rwanda. When the plaintiff approached the insurance authority for compensation in Rwanda, the claim was refused, due to alleged errors in the Yellow Card.

The defendant stated that it was the wrong party to the suit – and that the Rwandan Yellow Card authority should have been sued instead. The court had to decide whether the case could proceed.

The plaintiff argued that its claim was based on the incorrect Yellow Card issued by the defendant, which resulted in the Rwandan authority not handling its claim for compensation. The Rwandan authority wrote to the defendant asking it to explain the discrepancies in the Yellow Card it issued, but the defendant did not respond. The Rwandan authority was not in a position to proceed with the claim. Therefore, the plaintiff's claim against the defendant was for breach of the insurance policy, and not for damages (or indemnity) arising out of the accident.

The court accepted that the plaintiff did have a cause of action against the defendant, based on breach of contract, and dismissed the defendant's preliminary objection to the suit.

Bakwanye Trading Co. Ltd v Bollore Africa Logistics Uganda Ltd (2013)

HCT-00-CC-CS-393-2012

Keywords
time bar / joinder

The plaintiff contracted with the defendant for the delivery of cocoa. The defendant was unable to deliver the goods, due to a robbery. The plaintiff sued the defendant and the court allowed the claim.

The defendant tried to join its insurer as a third party to the claim. The court did not allow the claim against the insurer, because the policy stipulated that any loss must be reported within 16 days of the event causing the loss. This was not done, and therefore the defendant was time-barred from claiming against the insurer.

Attorney General v NIKO Insurance Uganda Ltd (2013)

(HCCS 240 of 2012) 2013 UGCommC 179 (25 October 2013)

Keywords
performance bond / fraud

The Ministry of Local Government contracted with a tool and equipment company for the supply of 70 000 bicycles. The defendant insurer issued a performance bond, guaranteeing that it would pay 10% of the contract sum, on receipt of a written demand from the plaintiff, without objection, should the supplier fail to perform its obligations under the contract.

The supplier defaulted on its obligations and the plaintiff made the written demand to the insurer. The insurer initially agreed to meet the obligation but then argued that the bond was unenforceable because it was vitiated by fraud committed by the supplier and the plaintiff's officials. The allegation of fraud was based on an investigation report of the Public Procurement and Disposal of Public Assets Authority, in which it recommended disciplinary action against a number of government officials.

In reviewing the evidence, the court found that the defendant advanced an unproved allegation that a fraud was intended against the defendant. The allegation of collusion or fraud was an inference drawn from the proceedings in the criminal trial against the officials. No evidence was led to show that the intention of the award of the contract to the supplier was calculated by officials of the Ministry of Local Government to make a demand on the bond.

The plaintiff's case was that the supplier failed in its contractual obligations and the government was therefore entitled to call on the defendant to make good the amount guaranteed. The government was also entitled to insist on performance of the contract with the supplier. Nevertheless, the defendant is not concerned with the underlying dispute between the government and the supplier.

The insurer's argument that the officials had been found by the Anti-Corruption Court to have a case to answer, on the charges advanced by the Public Procurement Authority, was not sufficient to avert liability. Having a case to meet merely means that a prima facie case against the officials had been established, and that they had to defend themselves. Until they were heard and judgment passed, it could not be assumed that they would be convicted.

Therefore, the plaintiff's claim succeeded and the insurer was ordered to pay the amount demanded under the performance bond.

Mawadri v Brit Syndicates Anor (2013)

(HCT00CCCS 376 of 2009) 2013 UGCommC 14 (28 January 2013)

Keywords
event insurance / cancellation vs "no-show"

The plaintiff, a music events promoter, sued its insurer for US$500 000 for losses sustained as a result of the cancellation and postponement of a music event she had promoted and insured.

The plaintiff organised a concert featuring the musical artist, Akon.

The concert, scheduled for 2 May 2008, was postponed because Akon was allegedly suffering from strep throat at the time. The event was subsequently held on 9 May 2008. The plaintiff claimed from the insurer for losses suffered as a result of the postponement.

The insurer rejected the claim, arguing that the policy did not cover losses arising from an artist failing to appear. The plaintiff completed part A of the insurance proposal form, which dealt with cancellation, abandonment, postponement or interruption of the event. Part B, which deal with cancellation due to non-appearance, was left completely blank apart from the plaintiff's signature and address. The insurer alleged that part B was not completed because the non-appearance of the artist was considered to be remote. Further, non-appearance of the artist was a specific exclusion. The insurer offered an extension to cover non-appearance of the artist but required details relating to the artist in order for this extension to be considered and accepted. The plaintiff did not provide this information.

The court noted that the broker is the insured's agent. The broker did inform the plaintiff that further information was required in order for the no-show extension to apply. The plaintiff failed to provide the required information.

When the premium quotation was provided to the plaintiff, it was made clear that it was for the events cancellation policy only.

The insurer's decision to reject the claim was therefore upheld.

There was also the issue of late notification of the claim, which the plaintiff alleged its broker was liable for. The court found that the broker was dilatory in submitting the claim to the insurer, in breach of its duties to the insured. Damages for this breach of duty were awarded against the broker, in the sum of US$5 000. The court noted that this award was made because although the broker breached its duty, no claim would have been payable by the insurer even if the claim had been submitted on time.

Mugisha v Chartis (U) Ltd (2013)

(HCT00CCCS 190 of 2009) 2013 UGCommC 7
(22 January 2013)

Keywords
motor vehicle policy / fraud

The plaintiff sued his insurer under a motor vehicle and personal injury policy. He was involved in an accident in which the vehicle was destroyed. He also suffered bodily injury as a result of the accident.

The defendant rejected the claim on the basis that the car was set on fire deliberately, and therefore that the claim was fraudulent.

The court noted that although the events surrounding the accident were suspicious, fraud must be strictly proved by the insurer, and this was not done.

The court therefore allowed the plaintiff's claim for loss of the vehicle and medical expenses for bodily injury.

The court did not allow the claim for consequential loss, noting that insurance contracts are usually contracts of indemnity that do not cover consequential loss, unless specifically included.

The court did allow the claim for general damages, resulting from the inconvenience suffered due to the insurer's refusal to honour the claim.

Sebowa v Paramount Insurance Co Ltd (2013)

(HCT00CCCS 10 of 2011) 2013 UGCommC 76
(26 April 2013).pdf

Keywords
motor vehicle insurance

The plaintiff sued his insurer under a motor vehicle policy, after his vehicle was damaged in an accident. The insurer rejected the claim on the grounds that premium had not been fully paid and that the plaintiff had breached the policy.

The court stated that the insured is obliged to pay the premium and cannot wait to see whether the event insured against occurs before tendering the premium and then demanding indemnity. The burden of proof to evidence payment of premium was on the plaintiff, and he failed to produce proof in this regard.

The failure to report the accident promptly denied the insurer the opportunity to assess the damages on the spot. Further, the plaintiff had dismantled parts of the vehicle before it could be assessed. This was a breach of the policy condition that obliged the plaintiff to prevent further damage to the vehicle.

The plaintiff had also claimed from the third party involved in the accident, without informing the insurer. The insured cannot claim from both the insurer and the third party.

The plaintiff's claim was dismissed.

Adotu v National Insurance Corporation (2013)

(Civil Suit No 717 of 1995) 2013 UGHCCD 13
(1 February 2013)

Keywords
retirement benefits / incorrect defendant / currency reform

The plaintiff sued the insurer under his retirement benefit scheme when he worked for the Uganda Cement Industry. By the time the case was filed, the employer was no longer in existence – the company had been sold and it was alleged that all matters relating to employee benefits had been handed over to the insurer.

The insurer alleged that it had discharged its obligations to the employee (including an amount of around 13 000 Ugandan shillings due to the plaintiff) and also argued that it had no direct contract with the plaintiff.

The court stated that the contract was executed between the defendant and the plaintiff's employers who administered it according to the terms agreed between them. The plaintiff should have approached the employer (or its successors, who would be liable for its obligations). For example, if he had failed to pay contributions, the insurer would not have gone directly to him but would have approached his employer for payment of premium. Further, if the policy was not being properly managed, the plaintiff would have a remedy against the employer. The employers were accountable to the plaintiff for queries about what was paid on his behalf to the defendant and anything due to him.

The court therefore held that the plaintiff had no action against the defendant insurer.

The court went on to consider what amount could have been payable to the plaintiff in the event that its decision was wrong. The plaintiff alleged that the surrender value paid to him, 13 000 shillings, was "chicken feed". The court noted that this was due to the Currency Reform Statute that provided for the removal of two zeroes (to convert the old currency into the new currency). After the cutoff date stated in the Currency Reform Statute, the new currency would be used, "however painful the effect of the reform may be". Therefore, the court noted that the amount calculated for the plaintiff's surrender value entitlement was correct.

The plaintiff's case was therefore dismissed.

Tight Security v Goldstar Insurance Co Ltd (2012)

(HCT00CCCS 665 of 2002) 2012 UGCommC 34 (26 April 2012)

Keywords
multiple claims / expert reports

The plaintiff sued the defendant for multiple claims under multiple policies it had with the insurer. Most of the claims were for theft and robbery, and one was for workmen's compensation. The defendant rejected the claims for a number of reasons, including non-payment of premium, breach of policies, and that some of the losses did not fall within the scope of cover.

In a previous hearing, the parties agreed to have the dispute referred to two agreed upon experts, who were then appointed by the court. The accounting expert reconciled the amounts paid and owed by the parties to each other (including claims already paid by the insurer, and premium paid by the insured), and the insurance expert determined which claims were still payable by the insurer.

The plaintiff disputed some of the findings in the expert reports. The court however noted that these issues should have been raised earlier, on receipt of the interim reports. The court upheld the expert reports and ordered the insurer to pay the amounts determined by the experts.

Liberty Construction v Attorney General (2012)

(HCT00CCMA 24 of 2012)

Keywords
guarantee / on-demand bond

The respondent made a written demand to the applicant's insurer, for a sum guaranteed in a performance bond. The insurer then claimed against the counter-guarantee made by the applicant in favour of the insurer.

The applicant alleged that it completed 99% of the works, and that the respondent breached the construction contract by invading the site and confiscating equipment. The applicant instituted action against the respondent for breach of contract and applied to court to restrain the respondent from insisting on payment of the bond, and for the bond to be recalled until determination of its appeal.

The applicant alleged that its business would be wiped out if it paid the counter-guarantee. Payment of the counter-guarantee would therefore lead to irreparable loss.

The respondent alleged that the bond was an on-demand guarantee and could not be interfered with. Further, the insurer was not joined to the proceedings, and therefore that the claim was brought against the wrong party.

The court noted that the applicant had not made a specific application for stay of execution of the lower court's order. This was because the respondent had already taken steps to enforce the order by demanding payment of the bond. The applicant stated that it required the court to restrain

the respondent from insisting on receiving the money to be paid out of the bond.

The court held that the bond was an on-demand bond, and it was independent of the underlying construction contract.

Allegations of fraud and bad faith were not properly pleaded or proved.

The court held that it could not uphold the status quo of the bond, as requested by the applicant, because the status quo had changed once the bond was called on. The applicant would have had to join the insurer to restrain it from paying the bond. The court could not order the respondent to not receive the money.

The applicant's claim was dismissed.

Aon Uganda Limited v Uganda Revenue Authority (2008)

(HCT00CCOS 04 of 2008)

Keywords
broker services / insurance services / VAT exemption

The applicant, an insurance broker, applied to court to challenge an assessment of the revenue authority, which had held it liable for Value Added Tax (VAT) on its services. It was requested to pay over 4 billion shillings, as backpay for unpaid VAT.

The broker alleged that its services fell within a VAT exemption, since "insurance services" are exempt. The VAT Act does not define insurance services, and therefore the court had regard to other statutes, industry practice, and the practices of foreign jurisdictions to determine its scope. The VAT Amendment Bill that was before Parliament at the time included brokerage services in the definition of insurance services.

Based on the evidence and interpretation of statutes, the court found that brokerage services do fall within the definition of insurance services and are exempt from VAT.

X-Tel (U) Ltd and Insurance Company of East Africa (U) Ltd v Security 2000 Limited (2007)

(HCT00CCCS-163-2004)

Keywords
subrogation / cash in transit

The second plaintiff insurer brought this suit in its name and the name of the first plaintiff, under the doctrine of subrogation. The claim was for recovery of around 11 million shillings, the amount paid as indemnity by the second defendant to the first defendant, for an insured loss allegedly caused by the defendant.

The defendant, a security company, was hired by the plaintiff to transport money to the bank. The defendant picked up 43 million shillings from the first plaintiff, but the money disappeared. The first plaintiff claimed from its insurer and was paid 11 million shillings.

The defendant challenged the validity of the insurance policy, but the court found that a valid contract of insurance existed. The defendant then alleged that the policy did not cover cash in transit. The insurer argued that once the validity of the policy was affirmed, the defendant as a third party had no right to question the propriety of the indemnification under the policy. The court did not deal with this assertion. Instead, it found that the policy did cover cash in transit.

The court ordered the defendant to pay the insurer the sum it paid under the policy.

Kenkom Limited v Saracen Uganda Limited (2007)

(HCT00CCCS-0134-2003)

Keywords
subrogation / cash in transit

The insurer brought a claim (in the name of the plaintiff) against the defendant for money lost during the performance of cash in transit security services.

The defendant argued that in stealing the plaintiff's money, its employees were not acting in the scope of their employment, and therefore it should not be held vicariously liable for the loss. Further, since the insured had not signed the insurance policy, no valid insurance existed and therefore subrogation could not apply.

The court found that the policy was signed by the insurer and that it was not necessary for the insured to sign the policy for it to be valid.

Regarding vicarious liability, the court stated that liability for losses caused by acts or omissions of employees does not require that those acts be specifically authorised by the employer. What is important is that those acts or omissions from which liability arises must be committed while the employees are acting in the course and scope of their employment. The defendant's employees in this case were required by the defendant to offer cash in transit services to the plaintiff. They went to pick up the cash and drove to the bank, as they were meant to do. To this extent they were acting in the course and scope of their employment. While they were so acting, they omitted to deliver the cash box and stole the money. Therefore, though unauthorised, the theft was committed in the course and scope of the employees' employment.

The insurer's subrogated claim therefore succeeded.

Kirasha v United Assurance Co. Ltd (2006)

(HCT00CCCS-0861-2004)

Keywords
motor vehicle insurance / evidence

The plaintiff insured its motor vehicle and goods in transit with the defendant insurer. Two months after taking out the policies, the plaintiff's vehicle was involved in an accident. It was alleged that the vehicle caught fire and the goods inside it were destroyed, along with the vehicle.

The insurer rejected the claim. It argued that the value of the vehicle and the value of the goods were misrepresented.

Evidence proved that the plaintiff's vehicle had burnt in a fire. The plaintiff alleged that when the goods were loaded, they went to the defendant's head office for an inspection. The employee of the defendant who was alleged to have checked the goods was not called as a witness for the defence. The defendant's argument that there were no goods in the vehicle or that the value of the goods was overstated was not corroborated by any eyewitnesses or other evidence. The defendant only investigated the claim by inspecting the damaged vehicle and its declared cargo, 24 days after the accident. No explanation was given for this delay, which the court said was "inordinate and inexcusable".

The defendant tried to prove, through similar fact evidence, that the plaintiff was a fraudster. The insurer approached other insurers to confirm whether other vehicles had been burnt in similar circumstances. The court stated that this evidence was irrelevant. Further, the previous insurer confirmed to the court that the plaintiff's previous claim was genuine. The court noted that the nature of the plaintiff's business entails this specific risk.

The court found that the plaintiff discharged its burden of proof in proving the existence of the policies and the loss. The defendant did not adduce sufficient evidence to avert the claim and the court ordered the defendant to pay the claim.

Aqua Plumbing (U) Ltd v United Assurance Co Ltd (2004)

Civil Suit No. 431 of 2002

Keywords
motor vehicle insurance / expiry of policy / payment of premium

The plaintiff sued the insurer under a motor vehicle policy. The plaintiff's vehicle was involved in an accident, and it claimed indemnity from the insurer. The insurer rejected the claim, alleging that there was no cover in place.

The plaintiff took out motor vehicle insurance with the defendant from March 2000 to March 2001. When the policy expired, the parties negotiated a renewal. The accident occurred in November 2001 and the vehicle was written off. The plaintiff paid the premium on the policy only after this accident occurred.

The court accepted the evidence that the plaintiff had not renewed its comprehensive insurance on the vehicle immediately on expiry, but attempted to do so only after the accident had occurred. Therefore, at the time of the accident, there was no valid insurance in place.

The plaintiff's claim failed.

Mirembe Wire Products Ltd v Goldstar Insurance Company (2003)

Civil Suit No. 54 of 2002

Keywords
goods in transit / insurance policy / cover note / incorporation of terms

The plaintiff sued its insurer for the value of goods lost in transit, which it had insured. The defendant rejected the claim, alleging that the plaintiff had breached the terms of the policy.

The insurer argued that the relevant cover note referred to an insurance policy containing additional terms, which were breached. The plaintiff stated that the cover note did not incorporate any terms other than those on the face of it.

The court held that it would be "reading too much into the cover note to say that mere reference in it to the above insurance policy is an automatic importation into it of terms other than those on the face of it". Therefore, the court was satisfied that the cover note did not incorporate any outside terms.

The plaintiff alleged that it did not breach any term of the cover note, which was the only document it received and knew of in relation to the insurance. The court accepted that the plaintiff had not received the additional terms referred to, as alleged by the insurer. Since the plaintiff was not aware of those terms, he was not bound by them.

The plaintiff's claim was upheld. The court also awarded the plaintiff general damages for the inconvenience suffered as a result of the defendant's refusal to honour its claim.

Zaidi t/a Mbarara Silk House v United Assurance Co. Ltd and Byamukama (2003)

(HCT05CVCS-0039-2001)

Keywords
burglary / insurance policy / evidence

The plaintiff insured its merchandise with the defendant. A burglary occurred, and the plaintiff claimed against for indemnity. The claim was rejected.

In considering the claim, the court noted that neither of the parties tendered the insurance policy as evidence. In the absence of the policy, it was unclear what the terms of the agreement were, especially in regard to what the indemnity amount was. The breaches of the policy alleged by the insurer could therefore not be proved either.

In the absence of relevant evidence, the court dismissed the plaintiff's claim.

Suffish International Food Processors (U) Ltd and Panworld Insurance Company v EgyptAir Corporation t/a EgyptAir Uganda (2002)

Civil Appeal No. 15 of 2001

Keywords
subrogation

The first appellant contracted with the respondent for the transport of fresh fish from Uganda to Brussels. On arrival at its destination, the consignment was found to be unfit for entry into the European Economic Community and was destroyed. The first appellant's insurer indemnified it for the loss. This case was brought in the name of the first appellant and the second appellant (the insurer), under the doctrine of subrogation.

The first appeal court accepted the respondent's argument that the existence of a valid contract of insurance between the two appellants had not been proved. The doctrine of subrogation can only be invoked on the basis of a binding, operative contract of indemnity.

The appellants had produced a marine certificate of insurance and testimony of a witness to prove the agreement between them. The court noted that the marine certificate covered a period after the consignment had arrived in Brussels.

While the court accepted that an insurance policy need not be strictly set out in a single policy document, it noted that the policy terms need to be proved. Since this was not done by the appellant, the court could not assess the insurance relationship and the conditions of cover. The respondent might have had certain defences, based on the contract, but the contract was never put into evidence. For example, express waivers of subrogation rights, or aspects of the policy that are illegal, could have been relied on by the respondent.

The respondent's earlier admission of liability to the first appellant, and the first and second appellants' actions that evidenced a binding contract of insurance between them, was not sufficient – the respondent was still entitled to know the details of insurance upon which the claim against it was based. The first appellant also had the option to recover against the respondent on the basis of negligence, and did not do so.

The appellant's claim was dismissed.

Norton Rose Fulbright South Africa Inc with Shonubi Musoke & Co.
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