TANZANIA INSURANCE OMBUDSMAN

HIGHLIGHTS ON COMPLAINTS HANDLING

Foreword:

The Ombudsman Insurance Regulations, GN 411of 2013 require that complaints which have been established to be viable should be resolved by way of mediation, reconciliation and arbitration. Ordinarily, a complaint is admitted for consideration where it meets the viability criteria set out under regulation 13(1) of GN 411 and the manner to determine the complaint is as specified under Reg. 15 read together with Regulations 16 and 17 respectively. Presently, the Ombudsman is obliged to determine all viable complaints within sixty (60) days from their date of admission.

The process of reconciliation and/or mediation is an interactive one. In order to resolve one dispute, it may take three to four separate meetings between the Ombudsman and the parties before a dispute is settled. The first meeting of the Ombudsman and the complainant is to determine the nature and validity of the complaint. There follows series of consultative meetings and exchange of documents with the insurance registrant and the complainant before a consensus is reached. See regulation 17(1).

The first challenge we have had to deal with was to decide what happens when the sixty days specified under the law expire before a dispute has been finally determined.

Indeed, the law does not provide for extension of the period where no successful reconciliation or mediation/arbitration is realized. One of the principles for the determination of disputes is anchored in equity and it is our considered opinion that, once a complaint is established to be viable, and the facts constituting the complaint require that arbitration proceedings be conducted, justice will demand that the same be handled prudently to its conclusion. By necessary implication, disputes that are the subject matter of arbitration may take a longer period for their determination than what has been provided for under the regulations and the controlling factor being that justice must prevail over expediency. In any event, the Ombudsman has not conducted any arbitration proceedings and it is only a matter of time before we can state for sure the exact time needed for the conduct of such proceedings.

In the following paragraphs, we will consider a series of the complaints resolved by the Ombudsman, which depict the nature of disputes and the ensuing practices within the insurance market in Tanzania.

1. Delays in Claims Settlement as a result of Failure by an Insurer to adhere to Rules of Procedure - Insurance Registrants “Challenging” Court decisions.

The dispute filed by one complainant indicated that he had demanded payment for bodily injuries which arose out of a motor

vehicle accident. This was a third party claim against the insurer who had issued cover for the motor vehicle which caused the accident. The driver of the motor vehicle was put on trial and was convicted and had paid the fine. The insurance company, having been served with all relevant documents including the certified copy of the court proceedings and judgment, declined liability to pay the claim on the grounds *that the court record was faulty.* The insurer interpreted police records as against statements by the various witnesses to prove that the convicted driver was not to blame for the accident. The insurer was therefore refusing to pay the claim on the basis of what it claimed was a faulty court record.

Upon reconciliation proceedings between the Ombudsman and the registrant, the following facts were established-

i. The driver of the offending motor vehicle had been convicted and had paid the fine;
ii. No appeal had been preferred by either the driver or anyone else to challenge the court record
iii. The insurance registrant was not a party to the court proceedings and thus had *no locus* to challenge the court decision.

It transpired further that the said CEO was not aware of the fact that all court decisions are binding unless quashed by a higher court of competent jurisdiction. The decision taken by the registrant to try and impugn the court record in the absence of appellate

proceedings was not only unethical but also unacceptable. The claim was subsequently paid.

As a matter for observation, the existing conflict between practice of finding of fault and strict liability under the insurance legislation is yet to be resolved. If the insurance industry and in particular the registrants are keen on making insurance a competitive agent for national savings development investment, they are advised to reduce undue reliance on legal technicalities as are referred to above.

One of the main tasks of the Insurance Ombudsman is to put in place, vital foundations for the evolvement of a sound and credible system for dispute resolution within the insurance industry, thereby contributing effectively towards consumer protection and sustainable consumer confidence. The instances referred to below in paragraphs (ii) to (v) relate to the existing malpractices within the industry. These have to be fought at all costs.

2. Delays in Claims Settlement as a result of the use of Restrictive Endorsements on Insurance Cover Notes

It is not uncommon to come across the following endorsements on

Motor Vehicle Cover Notes issued by some insurance registrants and respective intermediaries: "**in case of accident do not accept liability".** And this is without mentioning the numerous exemption clauses incorporated in insurance policies which limit liability and

delay the prompt payment of compensation to victims of road accidents. On the face of it, the practice may have been coined to enable insurance managers to exert hands on strategy when dealing with policy holders. At most, drivers at fault have been encouraged to disclaim liability when they could have simply given an explanation detailing the manner in which the accident occurred. As a result, there are a good number of drivers who, for a long period, have denied causing the accident and later, after the court proceedings have delayed for a year or two, change course and decide to enter a plea of guilty to the charges. This restrictive practice has caused not only caused unnecessary delays in the disposal of cases arising out of road accidents but also severe inconvenience to victims of such accidents. A good example can be taken from a road accident claimed nine (9) lives and caused severe bodily injuries to over 25 passengers including damage to the vehicles involved.

> On 4th of May 2013 at around 17:00 hrs. along Iringa – Mbeya highway a Scania lorry tried to overtake a passenger bus forcing the said bus to collide with another oncoming lorry. In that accident, nine (9) people were killed on the spot while twenty five (25) others sustained severe bodily injuries. In addition, both vehicles badly damaged.

During the police investigations in respect of who caused the accident, the driver of Scania lorry which had tried to overtake the passenger bus denied to have been at fault notwithstanding

overwhelming evidence from some of the survivors of the accident. After a period of three (3) months of court appearances, the said driver subsequently pleaded guilty to the various charges filed against him.

3. (i) Insurance Registrants versus Systemic Fraud, underwriting malpractices, etc.

The complainant was the owner of a passenger bus plying between Dar es Salaam and the southern regions. The said bus was reported to have been gutted by fire in Kilwa and was reduced to ashes allegedly while travelling from Dar es Salaam. When the policy holder filed his claim for total loss, the insurer disclaimed liability on the grounds of non-payment of premiums.

In the course of the reconciliation proceedings, it transpired that the proprietors of the ill-feted bus claimed to have purchased insurance cover from an agent whose records could not be verified and that premium was not remitted to the insurer. Further, it was shown that the complainant had devised a system of backdating cover assisted by some of the registrant's employees who actively insisted on prompt payment of the claim. Reports filed by the loss assessors who were appointed to investigate the accident were not conclusive in respect to actual scene of the fire. Assessors tracked and viewed the burned bus long after it had been moved from the alleged scene of the fire. Further, there were no claims filed by

passengers who were on board the ill-feted bus and especially those who might have suffered loss of property as a result of the said fire.

At the reconciliation proceedings, the complainant produced no receipts to support his insurance claims. He made frantic efforts to show that his passenger bus was fully covered at the time of the inferno but without a single receipt to support his claim. Under the foregoing circumstances, the Ombudsman had no alternative but to uphold the insurer's decision to repudiate the claim.

(ii) Alleged theft of Motor Vehicle

This was a dispute in respect to disclaim of liability by insurer upon refusal to pay for loss of motor vehicle. Going by the copies of documents produced by the complainant, i.e. the Cover Note issued to the complainant, it was endorsed that the contract was direct business, meaning that money had been paid directly and receipted by the insurance registrant**.** Following the alleged theft and filing of claim, it then transpired that in fact no premium had been paid notwithstanding frantic efforts by the complainant to show that he ought to be paid.

At the reconciliation table, the insured was unable to produce premium receipt, not even when the cover note was stamped and endorsed as premium having been paid. To complement these fraudulent efforts, an employee of the insurance registrant tried to

show that the cover note which had been endorsed “direct business” had been purchased through an agent!!.

In the upshot, the Insurance Ombudsman upheld the Registrant's decision to disclaim liability.

(iii) Absence of Due diligence on part of insurance registrant.

A claim for total loss arising out of a road accident was filed against the insurer. Facts availed to the Ombudsman indicated that the m/vehicle had been under third party policy cover for the previous year. And a month after expiration of the third party policy, the motor vehicle was uplifted to comprehensive cover. The records showed that the business was transacted through an insurance broker. During the canvassing of the comprehensive policy, crucial underwriting practices were overlooked either through laxity, connivance and/or compromise. No pictures taken at inception of cover. The broker received the respective premium and cover was issued. The complainant subsequently sustained an accident which allegedly occurred on 24/12/2013 at 09.00 pm. The said motor vehicle was damaged beyond repair and the owner filed claimed for total loss. At first, the insurer approved payment for total loss but the insured rejected the offer on the ground that it did not match the sum insured.

The refusal by the insured prompted the insurance company to scrutinize and investigate the accident afresh in respect to how and when the accident could have happened; a matter which caused delay in effecting the disputed payments. Due to the said delay, the complainant filed with the Ombudsman.

During the reconciliation proceedings and by relying on the photographs submitted by the complainant, it became clear that the claim cannot be paid. Unwittingly, the insured presented to his broker, pictures of the accident taken through his i pad in an effort to show the degree of damage sustained and to hasten payment. Upon scrutiny, the photographs showed that the car had sustained the said accident on 17/11/2013 at 1:59 p.m. when there was no cover. The Ombudsman upheld the decision by the registrant to repudiate the claim.

(iv) Misuse of Premium Warrants

This was a case relating to inception of cover through premium warrants. The complainant working through an insurance broker, negotiated for payment of premium by installments. Although cover note and Commissioner's sticker were issued, the complainant did not pay a coin until the expiration of eighty two (82) days when it was reported that the motor vehicle in dispute had sustained an accident. The specific date of accident and the actual scene of the accident were unknown and could not be verified and the driver at time of accident was undisclosed. The Police report regarding the scene of the accident was alleged to have been prepared and issued

at the insistence of the complainant. Since the complainant could not challenge any of the issues identified above, and on the balance of probabilities, the Ombudsman upheld the insurer's decision to disclaim liability.

4. (i) Insurance Charlatans or Fraudster ("Vishoka")

The insurance sector just like the other utility departments has not been immune to imposters who parade as professionals and masterminds in their own right. The Ombudsman had the opportunity to deal with a claim filed by complainant who was acting as an administrator of the estate of a deceased person, a victim of a motor vehicle accident. At the beginning, the "administrator" complained to the Ombudsman that the insurance registrant was delaying the payments for no apparent good reasons. Upon admission of the complaint, the Ombudsman called on the registrant to give reasons for the inordinate delay in effecting the payments. In the course of the reconciliation proceedings, the registrant informed the Ombudsman that it was making a close review of the relationship between the so-called administrator and the dependents of the deceased.

The Ombudsman instructed the insurance registrant to facilitate a meeting between his Office and the relatives of the deceased in order to verify the identity of the man parading as the administrator. At the first meeting between the Ombudsman and

the wife and children of the deceased, the family strongly denied to know or to be familiar with the administrator of the estate of the deceased. However, the family could not explain when and how the man had managed to process the court papers in respect to the estate of the deceased. At the second meeting, the Ombudsman met with administrator and challenged him on the denials by the family of the deceased.

Later, at a tripartite meeting between the Ombudsman, the administrator and the wife of the deceased, the wife and children changed course and claimed to be very familiar and known to the administrator. For fear that the deceased family might have been threatened or otherwise pressurized into the positions they had adopted, the Ombudsman directed the registrant to pay directly to the wife of the deceased.

4. (ii) Complainants filing Exorbitantly huge Amounts but which cannot be substantiated

This was a dispute whereby the complainant had sustained very serious bodily injuries arising out of collision of two motor vehicles. The complainant originally claimed Tanzania Shillings eighty five (85,000,000/=) million as compensation which the registrant readily rejected but offered TZS thirteen (13,000,000/=) million.

The Ombudsman convened a meeting with the insurance registrant and reviewed the basis of the offer taking into account that the victim complainant could no longer conduct his businesses as usual, as he could no longer make use of his right hand which was permanently disfigured. The quantum of payment was revised upwards to TZS twenty (20,000,000/=) million. He was paid and signed the respective discharge voucher in satisfaction of the claim.

Incidentally, having been paid, the victim complainant, wrote to the Commissioner of Insurance, complaining of allegedly low quantum and wanted the same to be revised and the Ombudsman was upraised on the issue.

It is the Ombudsman settled view that once a dispute has been reconciled and payment is effected, the complainant may not be allowed to re-open the dispute. The principle being that there must be an end to complaints.

(iii) Cocktail/Mix of insurance and other private businesses

The complainant operates a fleet of buses and has good business relations with the insurance registrant. His passenger buses ply between upcountry stations and Dar es Salaam and some of these buses have sustained serious road accidents. The complainant also operates own garage where buses that meet with accidents are repaired.

In this dispute it transpired that the complainant would pay lump sum as insurance cover for specific passenger buses. For instance he would pay comprehensive cover for three or four buses at a time. And in case there occurred an accident, the complainant would report the incident as required and raise claim for payment. There was information that the insurer would promise to pay the said claims but when he honored any claim it was done belatedly. The complaint not willing to have his transport business stalled, approached the bank for a loan facility on the understanding that when the insurer pays up his liabilities, he would then offset the bank loan.

It so happened that the insurer defaulted on the agreements and since the bank pressed for repayments, the complainant filed with the Ombudsman asserting that the insurer had refused to honor his claims for damaged passenger buses.

Upon reconciliation meetings between the parties, the registrant agreed to pay the outstanding claims. It may be observed that while the parties were engaged in good business, this was a clear case of malpractice, whereby insurance premiums are channeled to fund private business in disregard of prudential regulations. It may not be denied that insurance registrants who engage in such activities end up paying for new spares in clear disregard of the principle of indemnity. Apart from mixing up commercial activities with insurance products, the complainants in this class dictate the final

costs of the repair charges, much to the disadvantage of the insuring public.