IN THE COURT OF APPEAL OF TANZANIA

AT TANGA

(CORAM: MWAMBEGELE, J.A., MASHAKA, J.A. And RUMANYIKA, J.A.)

CIVIL APPEAL NO. 120 OF 2023

FRANCIS VICENT @ MAHIMBO .... APPELLANT

VERSUS

THE NATIONAL MICROFINANCE BANK PLC .... RESPONDENT

(Appeal from the decision of the High Court of Tanzania at Tanga)

(Mruma, J.)

dated the 16th day of November, 2020

in

Civil Appeal No. 3 of 2020

JUDGMENT OF THE COURT

29th April, & 8th May, 2024

MASHAKA, J.A.:

In August, 2016, the appellant Francis Vicent @ Mahimbo, a sole proprietor, sought to expand his working capital for a cereal business and retail shop, and was granted a loan facility by the respondent, National Microfinance Bank Plc (the NMB) to the tune of TZS. 50,000,000.00. He was required to service the loan in 24 months equal instalments of TZS. 2,569,283.00 and the payments were to begin after a one-month grace period. It was agreed that 0.75% of the loan amount per annum is life assurance premium to be paid before disbursement of

the loan to cover for death and permanent disability. Out of the required amount to be repaid, the appellant made payment of TZS. 25,690,830.00 as of July, 2017, however he failed to pay the balance of TZS 35,969,951.00.

The appellant contended that, his failure to repay the remaining instalments was caused by sickness which rendered him incapable to work without any support. The appellant claimed that he informed the respondent on 21st August, 2017 about his illness requesting to settle the outstanding loan amount from the insurance cover as per the loan agreement, but there was no reply from the respondent. He was adamant hence he wrote a reminder letter, still there was no reply, instead he was served with demand notices requiring him to pay the outstanding loan amount in full. The first demand notice was dated 21st August, 2017 and the second one dated 8th September, 2017.

The appellant was disturbed with the respondent's act of ignoring his request to settle the remaining sum of the loan with the amount under the insurance cover. He instituted Civil Case No. 17 of 2017 before the District Court of Tanga, against the respondent, for an order among others that; one, the respondent to secure the outstanding amount of loan TZS. 35,969,951.00 including interest if any through the insurance premium stated in the loan agreement; two, the respondent

be stopped from forcing him to pay the outstanding amount of the loan and; three, payment of damages of TZS. 30,000,000.00 being costs of economic and psychological hardships.

In her written statement of defence, the respondent admitted the existence of the loan agreement with the insurance clause. However, she averred that the insurance clause specifically covers death and permanent disability and mere sickness was not covered. In addition to that, the respondent contended that the appellant had failed to provide any proof of his permanent disability.

After full trial, the court held that the appellant had failed to prove the case on a balance of probabilities to prove permanent disability. The appellant's claims were dismissed and he was ordered to pay the outstanding balance of the loan within one year from the date of the decision. Dissatisfied, the appellant unsuccessful appealed to the High Court of Tanzania, at Tanga.

The High Court upheld the decision of the trial court on the ground that, the so-called medical reports tendered in court did not show the appellant's physical condition and the letter that described the appellant's permanent disability did not come from a hospital where he had undergone treatment, rather it came from the Regional Medical

Officer and was not supported by any medical report. Thus, concluding that there was no medical proof that the appellant had a permanent disability. On the issue of the insurance cover, the High Court concluded that there was no insurance policy document showing that an insurance contract was entered by the respondent and an insurance company.

Still undaunted, the appellant is before us in this appeal founded on four grounds:

> "1. *That the learned Judge at the Appellate Court erred in law for entertaining nonperformance of contractual obligation or duty bound to respondent.*
>
> 2. *That the learned Judge at the appellate court erred in law for impliedly maintaining the trial court's judgment/decisions that rests on the shoulders of grounds built upon incompetent testimony of incompetent witness.*
>
> 3. *That the learned Judge at the appellate court erred in law, in holding that, in absence of an insurance policy document between the respondent and the insurance company, the appellant cannot be heard claiming indemnity from the respondent's bank.*
>
> 4. *That the learned Judge at the appellate court erred in law for dismissing the said appeal in*

favour of the guilty respondent but to the detriment of innocent appellant".

At the hearing of the appeal, the appellant appeared in person unrepresented and the respondent did not enter appearance despite being duly served with the notice of hearing. As a result, at the request of the appellant, the Court proceeded with the hearing of the appeal in her absence in terms of rule 112 (2) of the Tanzania Court of Appeal Rules, 2019 (the Rules).

The appellant adopted the grounds of appeal and written submission filed earlier pursuant to rule 106(1) of the Rules. He had nothing useful to add. In support of the first and second grounds of appeal, the appellant argued that the High Court did not consider effectively the appellant's memorandum of appeal regarding the phrase 'permanent disability' hence in contravention of Order XX Rule 4 of the Civil Procedure Code, Cap 33 R.E. 2019 (the CPC) which requires a judgment to contain a concise statement of the case, points for determination, the decision thereon and reasons for such decision. It is his contention that, he was seriously sick and attended several hospitals including Bombo Regional Referral Hospital in Tanga and Shree Hindu Mandal Hospital in Dar es Salaam. Due to the sickness, he was permanently disabled and incapable of performing any significant gainful

activity, hence entitled to indemnification under the insurance clause in the loan agreement. He further, submitted that the respondent's witness was incompetent to testify on the disability of the appellant because she was not a medical expert but a bank officer from the loan department.

The appellant argued ground three that the first appellate court erred in law and in fact when it held that there was no insurance policy document between the respondent and an insurance company. He claimed that the documentary evidence which were admitted in evidence proved that he was permanently disabled hence entitled to indemnification.

On ground four, the appellant complains that the first appellate court erred in dismissing the appeal in favour of the respondent and at the detriment of the appellant and did not add more.

We have carefully gone through the arguments in support of the appeal and the written submission by the appellant. Commencing with ground one, the law relating to the content of a judgment is settled. Order XX Rule 4 of the CPC clearly states that a judgment shall contain a concise statement of the case, the points for determination, the decision thereon and the reason for such decision. This provision sufficiently provides clear guidelines to the court for what is expected in a

judgment. See: **Ali Abdallah Amour and Abdallah Ali Abdalla v. Al-Hussein Sefudin (Safi Stores)** [2004] T.L.R 313.

In the instant appeal, having gone through the record of appeal, the first appellate court was guided by the complaints raised in appellant's memorandum of appeal and the judgment was prepared within the requirements of the law and there was no any omission, as its decision contained a statement of the case, and the main issue was whether the appellant was entitled to indemnity upon being permanently disabled by sickness so as to order prayers pressed for by the appellant.

However, going further to the appellant's submissions, the centre of his complaint is based on the fact that the first appellate court did not consider the issue of permanent disability raised in the memorandum of appeal. At page 135 of the record of appeal, the first appellate court had discussed that permanent disability under insurance law is a technical term which connotes that because of a sickness or injury, a person is unable to work on his own or perform any activity for which he is suited to work. The first appellate court proceeded to hold that, after perusing exhibit P3 a letter written and signed by Dr. Violet G. Bakari for the Medical Officer In Charge of Tanga, does not disclose the hospital which attended the appellant and it was addressed to whom it may concern. The said letter detailed that due to the attendance of the appellant at an

unnamed hospital, he was weak and going on with treatment, care and support which would take a period of time to recover.

It is undisputed that the appellant willingly entered into a loan agreement with the respondent. It is settled that parties are bound by the agreements they freely enter into; this is the cardinal principle of the law of contract. See: **Simon Kichele Chacha v. Aveline M. Kilawe,** Civil Appeal No. 160 of 2018 [2021] TZCA 43 (26 February 2021) TanzLII. That being the position, we agree with the appellant that clause 7 (ii) of the loan agreement at page 13 of the record of appeal binds each party to the contract. The said clause reads:

> *"7. Fees and Charges*
>
> *The Borrower shall pay the Bank the following fees (which shall be debited to the Borrower's loan/current account with the Bank):*
>
> (ii) *A onetime credit life assurance premium of 0.75% per annum of the approved loan amount to cover for death and permanent disability (where applicable). Benefit payable under is limited up to the free cover limit currently at TZs 350M and above free cover limit only after medical underwriting."*

In the light of the above cited clause, for the appellant to benefit, the following conditions must be fulfilled, one, he has to prove that he is permanently disabled to work and two; such proof must be from a medical underwriting. The appellant in his testimony stated that in February, 2017 he became sick and went to Ngamiani Hospital for treatment. He was referred to Bombo Regional Referral Hospital where it was revealed that he had tuberculosis (TB) disease and later on diagnosed with kidney and liver problems. He was referred to Shree Hindu Mandal hospital in Dar es Salaam City and attended clinic. That evidence alone was not sufficient as clause 7(ii) of the loan agreement clearly stipulates a mandatory requirement of a medical underwriting. In such circumstances, it was expected that the appellant would submit a medical report/underwriting from either Bombo Regional Referral Hospital or Shree Hindu Mandal Hospital where he was diagnosed and undertook further treatment. To the contrary, the appellant tendered exhibits P3, P4 and P6 and upon our scrutiny, they fall short of being a medical underwriting which we shall shortly demonstrate. The documentary evidence from Shree Hindu Mandal Hospital are diagnostic test results and clinical notes (exhibit P4 and P6).

An underwriting is a term used for the process through which an institution or individual takes on a financial risk for a fee or at a

predetermined cost. The risk is generally taken in the case of loans. A medical underwriting contains all details about the patient's history, diagnostic test results, clinical findings, pre and post operative care, patient's progress and medication. In the so-called medical report tendered by the appellant it explained nothing. For avoidance of doubt, we shall quote the contents of exhibit P3 as follows:

"THE UNITED REPUBLIC OF TANZANIA, PRESIDENT'S OFFICE REGIONAL ADMINISTRATION AND LOCAL GOVERNMENTS

Tel: 2642997/2646683/84
Commissioner's Office,
Fax: 2647314 RMO,
Fax: 2647360 GIZ,

Regional,
Regional Medical Office,
P. O. Box 452,
TANGA

In reply Please Quote

Ref. No. RM/P/30/2 VOL. 22/240 *18/07/2017*

TO WHOM IT MAY CONCERN

REF: FRANCIS MAHIMBO MALE 51 YEARS 0404-0102005485

The above name patient is attending care and treatment clinic at our hospital.

The patient is weak and he is under treatment, care and support. It will take him some time to resume to his daily activities and be able to work.

Kindly assist him, and you can contract (sic) us for further progress.

Signed

Dr. Violet G. Bakari
For: MEDICAL OFFICER INCHARGE"

From the excerpt above, the question is, whether exhibit P3 qualifies to be a medical report/underwriting and does it prove that the appellant was permanently disabled envisaged under clause 7(ii) of the loan agreement. The term 'permanent disability' has been defined under the **Black's Law Dictionary, 8th Edition** at page 494 to mean:

> *"a disability that will **definitely** prevent a worker from performing some or all duties that he or she could do before an accident or illness"*
>
> [Emphasis added]

Taking into account the definition of the term permanent disability and exhibit P3, it is clear that the appellant was not permanently disabled as exhibit P3 clearly states that the appellant was weak and it would take some time to resume to his daily activities and be able to work. While being permanently disabled refers to definite incapacity. Additionally, exhibit P3, did not disclose what the appellant suffered, the period that he attended treatment and clinic visits and whether the impairment had substantially impacted the daily living of the appellant. The medical report was required to show how the disability prevented the appellant from engaging in gainful businesses and how it could

impact the appellant to perform the business he was doing, and how he was unable to adjust to any other business.

Be as it may, the exhibit P3 did not disclose from which hospital it originated and not known who is the receiver of the information. The office of Regional Medical Officer (RMO) from which the letter was authored is not a hospital. An RMO, is the medical officer in charge of a region and it is common knowledge that under the said office, there are several hospitals within the region. Further, it is interesting to note that exhibit P3 is dated 18/07/2017, while the appellant was still undergoing treatment at Shree Hindu Mandal hospital as gleaned at one of the diagnostic test results from the Department of Non – Invasive Cardiology, Color Doppler Echocardiography dated 03/08/2017. It was expected to see a medical underwriting appraising the appellant's health from the hospital he was attending for his treatment. Therefore, it was the duty of the appellant to disclose which hospital prepared exhibit P3, which he has failed to do so. We find this ground without merit and dismiss it.

Ground two, the appellant is faulting the competency of Fatuma Yusuf Mtangi (DW1). It is not in dispute that she was a bank officer from the loan department and her testimony was grounded on the conditions of a client who qualifies to have a permanent disability and

enjoy the relief from the respondent. At page 82 of the record of appeal, DW1 testified that the appellant's letter should have shown the historical background, medical analysis of the illness, percentage of permanent disability, and recommendation of the doctor approving the said disability. In our view, that was her opinion as the officer of the respondent on the qualification of a client to be categorized as permanently disabled to enjoy the exoneration from her bank and its loan department in the repayment of the balance of the loan through the insurance agreed on clause 7 (ii) of the loan agreement. We find this ground unmerited and dismissed.

On ground three, the appellant faulted the High Court in holding that, in absence of any insurance policy document between the respondent and the insurance company, the appellant cannot be heard claiming indemnity from the respondent's bank. This ground is interrelated with the proof of permanent disability. The finding of the first appellate court on this ground, in our considered view, is respectfully misconceived. There was no need of proof of the insurance policy between the respondent and the insurance company. What was required under clause 7(ii) of the loan agreement is proof of permanent disability through a medical underwriting. In that circumstance, the first

appellate court misconceived the fact of having an insurance cover for the appellant to be indemnified. This ground three has merit.

From the above analysis, the first appellate court was correct to deliver its decision in favour of the respondent, as the appellant had failed to prove the permanent disability protected under clause 7(ii) of the loan agreement which could have exonerated him from the liability. There is a famous saying that borrowing is easy, paying back is painful and the appellant has to endure the pain. It is worthy to note that, at page 74 of the record of appeal, during cross examination on 26/07/2019, the appellant had stated:

> *"I have no any disabled (sic) in my body but unhealthy body not be able to work any job. .... But right now I was ok as I look. I have not disabled (sic)".*

This is a clear confirmation that the appellant was not permanently disabled as he has tried to convince the lower courts and us. Thus, the appellant has an obligation to pay back the balance of the loan or face the consequences as agreed in the agreement. This concludes the fourth ground.

For the foregoing reasons, the appellant failed to prove that he was permanently disabled. We, therefore uphold the findings of the High

Court, to the extent explained. The appeal is dismissed in its entirety with costs.

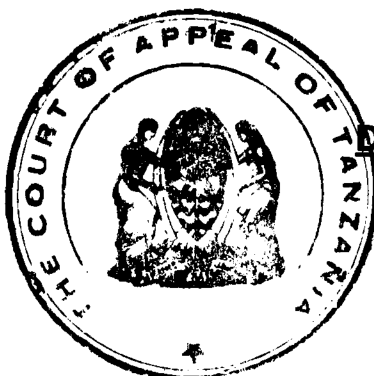
DATED at **TANGA** this 7th day of May, 2024.

J. C. M. MWAMBEGELE
JUSTICE OF APPEAL

L. L. MASHAKA
JUSTICE OF APPEAL

S. M. RUMANYIKA
JUSTICE OF APPEAL

The Judgment delivered this 8th day of May, 2024 in the presence of the Appellant in person and Ms. Elizabeth Ibrahim Chawinga, Branch Manager Madaraka Branch Tanga and Mr. Emmanuel Anael Pallangyo, Operation Manager for the Respondent is hereby certified as a true copy of the original.



G. H. HERBERT
DEPUTY REGISTRAR
COURT OF APPEAL