

IN THE HIGH COURT OF JUDICATURE AT PATNA
Civil Writ Jurisdiction Case No.19515 of 2016

Star Health and Allied Insurance Co. Ltd. Regd. & Corporate Office -1, New Tank Stree, Valluvar Kottam High Road, Nungambakkam, Chennai-34, through its Senior Manager, Star Health and Allied Insurance Co. Ltd. Grand Plaza, 3rd Floor, Dak Bunglow Chauraha, Fraser Road, Patna.

... .. Petitioner/s

Versus

1. The Secretary, Insurance Ombudsman, State Of Bihar And Jharkhand Arcade, 1st Floor, bazar Samiti road, Bahadurpur, Patna-16
2. Rajesh Kumar Palsania S/o Late Bhagirath Mal C/o Shree Dadiji Stores, Mohalla - Jai Ram Bazar, P.O. - Khagaul, District - Patna.

... .. Respondent/s

Appearance :

For the Petitioner/s : Mr.Ashok Kumar,Advocate
For the Respondent no. 2: Mr. Abhay Kumar Singh, Advocate

CORAM: HONOURABLE MR. JUSTICE RAJEEV RANJAN PRASAD
ORAL ORDER

4 20-08-2019 Petitioner in the present case is aggrieved by and dissatisfied with the judgment and award dated 24.10.2016 passed by Insurance Ombudsman in Complaint Reference No. PAT-G-044-1617-0095 as contained in Annexure '3' to the writ application by which the petitioner Insurance Company has been directed to settle the claim without further delay and pay compensation of Rs. 50,000/- towards monetary compensation against the arbitrary cancellation of the policy.

Learned counsel for the petitioner submits that the facts of the case are not in dispute. The Assured had obtained a mediclaim individual policy from the petitioner based on his proposal and declaration dated 27.03.2014 / 28.03.2014



(Annexure 'P/4'), however, lapsed due to non-payment of renewal premium in time. The Assured filled up a declaration form on 28.03.2014 declaring normal condition of his health 'good'. He declared that he was not suffering from any of the diseases mentioned in the proposal form. Based on the declaration of the good health, the Insurance Company agreed to issue the policy, later on the policy lapsed due to non-payment of premium within grace period of 30 days. The respondent, however, got the policy revived after 32 days for the period 02.05.2015 to the midnight of 01.05.2016. The Assured raised a claim for the expenses incurred by him in course of his treatment in Medanta Hospital. In course of processing of his claim seeking reimbursement of hospitalisation expenses for treatment of chronic kidney disease. The Insurance Company found that the USG report dated 15.03.2013 was showing medical renal disease and serum creatinine report dated 14.05.2013 showed 3.75 mg/dl. The Insurance Company therefore repudiated the claim of the Assured vide letter dated 28.01.2016 as contained in Annexure '4' to the counter affidavit.

Being aggrieved by the repudiation of claim when the Assured moved before the Insurance Ombudsman by filing a complaint, the Insurance Ombudsman allowed the complaint.



It is the contention of learned counsel for the petitioner that the Insurance Ombudsman could not appreciate that contract of insurance is unlike other contracts and it is based on principles of *uberrimae fidei* i.e. utmost good faith. It is submitted that from the materials available on the record it is quite clear that petitioner was fully aware of the material facts relating to his health that he was suffering from renal disease but for purpose the policy he concealed material facts relating to his health and declared that he was in good health. It is submitted that had the true and correct facts been disclosed to the Insurance Company, the Insurance Company could have taken a decision thereon and there were possibilities of refusal to issue/renew or revive the policy.

Learned counsel has relied upon the judgment of the Hon'ble Supreme Court in the case of **Mithoolal Nayak Vs. Life Insurance Corporation of India** reported in **AIR 1962 SC 814** and in the case of **Satwant Kaur Sandhu Veresus new India Assurance Company Limited** reported in **(2009) 8 SCC 316** to submit that although Section 45 of the Insurance Act, 1938 applies only in a case of life insurance policy but the Hon'ble Supreme Court has categorically held that the principle of *uberrimae fidei* i.e. utmost faith equally applies in case of a



mediclaim policy. It is submitted that the order passed by the Insurance Ombudsman simply takes note of the submission of the Insurance Company that there was a break in the insurance policy of 32 days and non disclosure of the health conditions while seeking revival of the policy would prove fatal but the Insurance Ombudsman has not dealt with the said argument and has proceeded to consider the case as if the policy was a continuing policy without any break and proceeded to consider as to whether the disease for which the claim has been filed was contacted during the breaking period even the said issue has not been considered later on in the impugned award. The Insurance Ombudsman has taken a view that there was no concealment of information by the insured and has directed for payment of compensation after holding that the cancellation of the policy by the Insurance Company was arbitrary.

It is submitted that the impugned award is liable to be set aside as in no case the Insurance Ombudsman could have taken a view as has been taken in the present case.

On the other hand, Mr. Abhay Kumar Singh, learned counsel representing private respondent submits that the Insurance Ombudsman has come to a conclusion that if the disease has not been contacted within the discontinued period of



32 days, there is no reason as to why the claim in question may be repudiated. He has submitted that the respondent had not filled up the declaration present at Annexure 'P/4'. Learned counsel has relied upon the judgment of the National Consumer Disputes Redressal Commission, New Delhi in Revision Petition No. 2097 of 2017 (**Reliance Life Insurance Company Ltd. & Anr. Versus Tarun Kumar Sudhir Haldar**) and in Revision Petition No. 2175 of 2014 (**The New India Assurance Company Ltd. Vs. Rakesh Kumar**).

Having heard learned counsel for the petitioner and the private respondent, this Court is of the considered opinion that the Insurance Ombudsman could not appreciate that contract of insurance is based on principles of utmost good faith. A person who is called upon to disclose certain informations relating to his health at the time of issuance of policy, renewal or revival of the same must disclose the true and correct facts, failing which he would be liable for the consequences in terms of his own declaration.

In this case, it is not an issue as to whether the private respondent had contacted the disease prior to issuance of the policy or during the discontinued period of the policy. What is relevant for the case is the fact that when the respondent was



called upon to disclose the status of his health for purpose of the policy, he answered all the columns in Annexure 'P/4' dated 28.03.2014 in negative giving a declaration that he was not suffering from any renal disease whereas in course of processing of his claim the Insurance Company came to know that he was suffering from a renal disease and the same was within his knowledge at least since 2013.

So far as the case of **Mithoolal Nayak** (supra) is concerned, that was in respect of a life insurance policy. The Hon'ble Supreme Court was discussing Section 45 of the Insurance Act, 1938. The present case is that of a mediclaim policy. In the case of **Satwant Kaur Sandhu** (supra) the Hon'ble Supreme Court was considering the case of a mediclaim policy. In the said case the husband of the appellant before the Hon'ble Supreme Court had obtained the mediclaim policy for the period 07.05.1990 to 06.05.1991. During continuance of the policy on 11.09.1990 he suddenly fell ill and was admitted in a hospital at Ludhiana. Later on he was shifted to Madras Institute of Nephrology where his condition deteriorated leading to his death on 26.12.1990. The appellant informed the Insurance Company about the death of her husband and raised a claim for Rs. 23,270.80/- for



reimbursement of the expenses. At this stage, the Insurance Company found from the Madras Institute of Nephrology that the deceased was a known case of a “chronic renal failure/diabetic nephropathy”, and was on regular haemodialysis at his place. He felt severe breathlessness and developed sudden cardiac arrest leading to his death. The Insurance Company obtained a certificate to this effect from the hospital and repudiated the claim. On a challenge made to the repudiation, the learned District Consumer Forum allowed the claim with interest thereon but the Insurance Company challenged the judgment of the District Consumer Forum before the State Commission where the appeal of the Insurance Company was allowed. When the complainant moved before the National Commission, the revision of the complainant was also dismissed. The complainant moved before the Hon’ble Supreme Court in appeal being aggrieved by the order of the State Commission and the National Commission. After considering the facts and circumstances of the case the Hon’ble Supreme Court in its judgment in paragraph 18 to 25 recorded as under:-

“18. A mediclaim policy is a non-life insurance policy meant to assure the policy-holder in respect of certain expenses pertaining to injury, accidents or hospitalisations. Nonetheless, it is a contract of insurance falling in the category of contract *uberrimae fidei*, meaning a contract of



utmost good faith on the part of the assured. Thus, it needs little emphasis that when an information on a specific aspect is asked for in the proposal form, an assured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. It is not for the proposer to determine whether the information sought for is material for the purpose of the policy or not. Of course, the obligation to disclose extends only to facts which are known to the applicant and not to what he ought to have known. The obligation to disclose necessarily depends upon the knowledge one possesses. His opinion of the materiality of that knowledge is of no moment. (See *Joel v. Law Union & Crown Insurance Co.*¹.
19. In *United India Insurance Co. Ltd. v. M.K.J. Corpn.*² this Court has observed that it is a fundamental principle of insurance law that utmost faith must be observed by the contracting parties. Good faith forbids either party from non-disclosure of the facts which the party privately knows, to draw the other into a bargain, from his ignorance of that fact and his believing the contrary. (Also see *Modern Insulators Ltd. v. Oriental Insurance Co. Ltd.*³)
20. *MacGillivray on Insurance Law* (10th Edn.) has summarised the assured's duty to disclose as under:

“... the assured must disclose to the insurer all facts material to an insurer's appraisal of the risk which are known or deemed to be known by the assured but neither known nor deemed to be known by the insurer. Breach of this duty by the assured entitles the insurer to avoid the contract of insurance so long as he can show that the non-disclosure induced the making of the contract on the relevant terms.”

21. Over three centuries ago, in *Carter v. Boehm*⁴, Lord

1.(1908) 2 KB 863 (CA)

2. (1996) 6 SCC 428

3. (2000) 2 SCC 734

4. (1558-1774) ALL ER Re 183 : (1766) Burr 1905



Mansfield had succinctly summarised the principles necessitating a duty of disclosure by the assured, in the following words: (All ER pp. 184 H-185 I)

Insurance is a contract of speculation. The special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the assured only; the underwriter trusts his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge to mislead the underwriter into a belief that the circumstance does not exist. The keeping back of such circumstance is a fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention, yet still the underwriter is deceived, and the policy is void; because the *risque* run is really different from the *risque* understood and intended to be run at the time of the agreement.... The policy would be equally void against the underwriter if he concealed.... Good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from his ignorance of the fact, and his believing the contrary.

Having said so, as noted above, the next question for consideration would be as to whether the factum of the said illness was a “material” fact for the purpose of a mediclaim policy and its non-disclosure was tantamount to suppression of material facts enabling the Insurance Company to repudiate its liability under the policy.

22. The term “material fact” is not defined in the Act and, therefore, it has been understood and explained by the courts in general terms to mean as any fact which would influence the judgment of a prudent insurer in fixing the premium or



determining whether he would like to accept the risk. Any fact which goes to the root of the contract of insurance and has a bearing on the risk involved would be “material”.

23. As stated in *Pollock and Mulla's Indian Contract and Specific Relief Acts*:

“any fact the knowledge or ignorance of which would materially influence an insurer in making the contract or in estimating the degree and character of risks in fixing the rate of premium is a material fact.”

24. In this regard, it would be apposite to make a reference to Regulation 2(1)(d) of the Insurance Regulatory and Development Authority (Protection of Policy-holders' Interests) Regulations, 2002, which explains the meaning of term “material”. The Regulation reads thus:

“2. *Definitions*.—In these Regulations, unless the context otherwise requires,—

(a)-(c) * * *

(d) ‘proposal form’ means a form to be filled in by the proposer for insurance, for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to accept or decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, terms and conditions of a cover to be granted;

Explanation.—‘Material’ for the purpose of these Regulations shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the insurer.”

Thus, the Regulation also defines the word “material” to mean and include all “important”, “essential” and “relevant”



information in the context of guiding the insurer to decide whether to undertake the risk or not.

25. The upshot of the entire discussion is that in a contract of insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not to accept the risk is a “material fact”. If the proposer has knowledge of such fact, he is obliged to disclose it particularly while answering questions in the proposal form. Needless to emphasise that any inaccurate answer will entitle the insurer to repudiate his liability because there is clear presumption that any information sought for in the proposal form is material for the purpose of entering into a contract of insurance.”

The two judgments placed before this Court on behalf of the respondent would not be applicable in the facts and circumstances of the case, inasmuch as, in the case of **Rakesh Kumar** (supra) the mediclaim policy was taken on 31.05.2011 and it was renewed in the next year from 31.05.2012 to 30.05.2013. During subsistence of the policy the complainant suffered severe chest pain and had been admitted to the hospital. No material could be produced to demonstrate that the complainant was suffering from hyper tension and Diabetes Mellitus from a date prior to the commencement of the mediclaim policy. That was not a case of a policy issued on the



basis of a declaration of good health at the time when in fact the policy holder was suffering from a disease. No proof was there and the material placed before the forum being totally vague, the National Commission came to the conclusion that the same would not carry any evidentiary value.

In another case of **Tarun Kumar Sudhir Haldhar** (supra) the life Assured Smt. Rekha Haldhar obtained a policy by filling a proposal form on 12.07.2010. She died on 24.06.2011 due to diabetic Ketoacidosis. The claim was repudiated. But on a challenge made to the same, the District Consumer Forum allowed the complaint and directed the Insurance Company to pay the amount of Rs. 1,25,500/- with compensation for physical and mental trauma was assessed at Rs. 5000/- and Rs. 3000/- respectively. An appeal preferred against the order of the District Consumer Forum was dismissed on the ground of delay. It was contended before the National Commission that the Life Assured had not given correct answer to the questions put to her in paragraph 29 and 30 of the proposal form where she was required to give information with regard to her past suffered or presently suffering medical ailments. The National Commission after going through the records found that he petitioner had not filed copy of the



application for condonation of delay which was moved before the State Commission and as such the Commission was unable to consider whether the delay in filing the appeal deserves condonation. Thereafter the National Commission went into the merit of the case and after going through the claim Form-B Medical Attendant Certificate, it was found that the same contained a categorical answer to the question number 7. The date of diagnosis of the disease was mentioned as 22.06.2011, meaning thereby that on the date of proposal the Life Assured had not been diagnosed of the said disease. It is in the aforementioned background the National Commission concluded that the disease was complained for the first time by the deceased Life Assured on 22.06.2011 which is much after the date of the proposal.

Both the judgments of the National Commission on which reliance has been placed by learned counsel for the private respondent would not help him to persuade this Court to take a different view of the matter.

In ultimate analysis this Court finds that the respondent while giving a declaration of good health vide Annexure 'P/4' had not disclosed the material fact relating to his health. Learned counsel for the respondent has raised an issue



with regard to the filling up of declaration of good health as according to him, the declaration shown in the enclosed form (Annexure 'P/4') were not filled up by the respondents rather it was filled up by the agent of the Insurance Company and therefore, it cannot be said to be binding on him. This Court understands that law is well settled on this issue. An agent while filling up the proposal form acts as an agent of the Insured/Assured and not of the Insurance Company. This being the position, from the materials available on the record, this Court finds that the Insurance Company has brought sufficient materials to take a view that the Insurance Ombudsman has not considered the issues raised herein, in accordance with law.

The writ application is, thus, allowed, the impugned order is set-aside and the matter is remitted to the Insurance Ombudsman for a fresh consideration after calling for all relevant records from the Insurance Company.

The observations of this Court have been made only in the context of the present case and the Insurance Ombudsman shall taken an independent view of the matter based on all materials on record in the light of the laws laid down by the Hon'ble Supreme Court in the case of **Satwant Kaur**(Supra) and such other judgments which may be brought to it's notice



by the respective parties.

This writ application is allowed to the extent indicated
hereinabove.

(Rajeev Ranjan Prasad, J)

avin/vats- AFR

U			
---	--	--	--

