

**IN THE HIGH COURT OF PUNJAB AND HARYANA
AT CHANDIGARH**

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2023:PHHC:052559

CWP-30101-2022

Date of Decision:16.03.2023

The Oriental Insurance Company Limited

.....Petitioner

Versus

Permanent Lok Adalat and others

.....Respondents

CORAM: HON'BLE MR. JUSTICE VINOD S. BHARDWAJ.

**Present: Mr. Radhe Shyam Sharma, Advocate,
for the petitioner.**

VINOD S. BHARDWAJ , J.(Oral)

The instant petition has been filed seeking quashing of the impugned award/order dated 21.04.2022 (Annexure P-1) passed by Permanent Lok Adalat (Public Utility Services), Gurugram, whereby the application filed by respondent No.2-claimant under Section 22-C of the Legal Services Authorities Act, 1987 has been partly allowed and the petitioner-Insurance Company has been directed to pay an amount of Rs.60,000/- along with simple interest @ 6% per annum from the date of filing of the application till its realization along with Rs.5500/- as litigation expenses.

Briefly summarized, the facts of the present case are that husband of the respondent No.2-claimant had availed a Mediclaim policy bearing No.215301/48/2016/3895 for the period from 17.03.2016 to midnight of 16.03.2017 in the name of Amichand. The premium for the said

policy was duly paid. The respondent No.2-applicant and her husband Amichand were insured under the said policy bearing No. MA-ID-5022909716. However, on 09.01.2017, respondent No.2 fell on the floor in the washroom and sustained injuries. She was accordingly admitted in the Paras Hospital on 10.01.2017. Since respondent No.2 as well as her husband Amichand were insured under the same policy, a claim for cashless treatment was submitted by them with the petitioner-Insurance Company. The same was, however, rejected vide email/communication dated 12.01.2017. Hence, respondent No.2 had to spend the sum of Rs.60,000/- on her treatment from their own sources. It was also pointed out that as a result of injuries sustained during fall in the bathroom, there was a minute blockage apart from several minor injuries sustained by her. This was the first claim submitted by respondent No.2 and even the same was denied despite there being no outstanding bonus/premium to be deposited.

Aggrieved of the repudiation of the claim, an application under Section 22-C of the Legal Services Authorities Act, 1987 was submitted by respondent No.2 before the Permanent Lok Adalat (Public Utility Services), Gurugram.

On notice, reply to the application was submitted by the petitioner-Insurance Company raising various objections regarding maintainability, jurisdiction and concealment of the true and material facts. It was contended on merits that respondent No.2 was well aware of the terms & conditions of the Mediclaim policy, however, the complete facts were not disclosed. It was further claimed that respondent No.2 is seeking claim pertaining to a pre-existing disease which is barred under the Mediclaim Insurance Policy and the said aspect is evident from the discharge summary

issued by Paras Hospital, Gurugram. It has also been stated in the discharge summary that the patient was admitted under neurology for further evaluation and management and further that the claim of respondent No.2 about sustaining injuries by falling on the floor of the washroom was false, frivolous and concocted.

Efforts for reconciliation and amicable resolution of the issue were initiated by the Permanent Lok Adalat (Public Utility Services), between the parties but they failed to arrive at an amicable settlement. Consequently, adjudication of the dispute under Section 22-C(8) of the Legal Services Authorities Act, 1987 was undertaken. Upon consideration of the evidence brought before the Permanent Lok Adalat and evaluation of the same, the Permanent Lok Adalat partly allowed the application of respondent No.2 and directed the petitioner-Insurance Company to release the amounts noticed above.

Aggrieved thereof, the present petition has been filed.

Learned counsel appearing on behalf of the petitioner-Insurance Company contends that the award passed by the Permanent Lok Adalat is liable to be set aside as it failed to consider that there was a non-disclosure of the medical condition by the respondent No.2-applicant and also for the reason that the hospital in question was not recognized for cashless claims. He refers to discharge summary of the respondent No.2 as per which the diagnosis mentioned is as under:-

“DIAGNOSIS:

- ACUTE STROKE - RIGHT ACA INFARCT

ADMITTING COMPLAINT/CHIEF COMPLAINTS

-Sudden Weakness in both lower limbs x 2 days (L>R).

-Headache since morning on 10/01/2017.

-Dizziness since morning on 10/01/2017.

-Urinary incontinence x 2 days.”

He further contends that the benefit of cashless treatment could be extended to an applicant only if the treatment is taken at a network hospital and that too with prior approval of the Insurance Company.

I have heard learned counsel appearing on behalf of the petitioner and have gone through the documents appended along with the present petition.

The discharge summary appended by the petitioner (Annexure P-3) also records the following:-

“HISTORY OF PRESENT ILLNESS: *Patient was apparently asymptomatic 2 days back when she developed sudden weakness in both lower limbs, headache, dizziness and urinary incontinence. Patient was unable to stand without support and patient gives history of fall. Patient was admitted under Neurology for further evaluation and management.*

“PAST MEDICAL HISTORY:

- No history of chronic disease.*
- No history of LOC/Seizure.*
- History of kidney stone.”*

A perusal of the same shows that there is no history of any chronic disease, common artery disease or any prior medical history of ailment qua the present claims for which the respondent No.2 was admitted to the hospital. Rather, it is recorded that there is no history of any chronic disease or seizure. It further records that there was a sudden stroke. It has been specifically recorded in the said discharge summary that the patient was asymptomatic and was unable to stand without support. Further, there was a diagnosis of an acute stroke. It was thus a case of an emergency

admission. The petitioner-Insurance Company has nowhere taken this plea that the Cashless Mediclaim benefit will not be admissible to an insured for emergency medical treatment. The very object of seeking Mediclaim policy is to cover up for an emergent exigency and the stand adopted by the petitioner-Insurance Company for denial of the benefit is clearly misconceived.

The specific stand of the petitioner-Insurance Company is that there was non-disclosure of the pre-existing disease by the respondent, however, for the reasons best known to them, they chose not to append the policy documents and/or the disclosure made by respondent No.2 at the time of submission of the policy form. The details regarding the health conditions required to be disclosed and purportedly not disclosed or concealed are also not forthcoming.

Notwithstanding the fact that the policy form has not been brought on record by the petitioner-Insurance Company, there is also no evidence to substantiate that respondent No.2 was aware of any pre-existing disease and had concealed the same. A non-disclosure clause comes into operation only when a person/applicant is aware of existence of a medical condition and conceals the same despite on asking of the Insurance Company. In the event, the insured was not aware of any medical condition, there is no obligation to make any such disclosure. The Insurance Company is well within its right to seek medical examination of a person before acceptance of the proposal and issuance of a Mediclaim policy and it was at no point of time precluded from subjecting an insured to a medical treatment prior to issuance of a medical policy. The Insurance Company having opted to not subject the respondent No.2 to undergo any such tests and issued the

policy, clearly shows that it had taken into consideration all the disclosures made and was willing to underwrite the risks.

The claim made by the petitioner about non-disclosure of chronic disease or pre-existing disease is thus unsubstantiated and is not supported from the documents brought on record. No such documents were furnished by the petitioner despite availing two opportunities. The same being in possession of the petitioner, an adverse inference thus flows against the petitioner for such non-disclosure.

For denying any claim under the provisions of Section 45 of the Insurance Act, 1938, the non-disclosure has to be material. In order to attract a “Non-disclosure or concealment” clause, there is an inherent requirement of the insured being aware of the medical condition and also of her obligation to inform the same before she can be attributed non-disclosure. The said burden lay on the Insurance Company which could have been reasonably discharged by placing the requisite proof or documents. However, the same were not produced despite opportunities. The non-production of the documents by the Insurance Company leaves no option but to allow an inference against the Company and not against the insured.

The same leads to the next issue as to whether the award suffers from any illegality/impropriety or gross non-application of evidence available on file.

Section 22-D of the Legal Services Authorities Act, 1987 entails that the Permanent Lok Adalat (Public Utility Services) is governed by the principles of equity, objectivity, fairness, principles of natural justice and other principles of justice. A discretion so exercised by the Permanent Lok Adalat (Public Utility Services) would not ordinarily be held to be bad

merely because any other view is also a possible view. Unless the view adopted by the Permanent Lok Adalat (Public Utility Services) is held to be perverse, illegal, improper and unsustainable on the basis of the documents available on record, such discretion is not to be ordinarily interfered with by the High Court in exercise of its writ jurisdiction. The Permanent Lok Adalat (Public Utility Services), while allowing the application of respondent No.2, had observed as under:-

“7. After perusing the pleadings of the parties and documents placed on file and arguments advanced by counsel for both the parties, it reveals that husband of the applicant namely Ami Chand had taken medi-claim policy for the period 17.3.2016 to 16.3.2017 from the respondent covering her husband, the applicant Santosh Kumari being wife as per copy Annexure-A and Annexure A1. The abovesaid policy was continuing and the applicant was paying premium and policy for consecutive year 2017-2018 which is not disputed by the respondent. The applicant alleged that on 9.1.2017 she fell down in the washroom and got injury and admitted in Paras Hospital on 10.1.2017. The amount of Rs.60,000/- was spent on her treatment as per copy Annexure A4.4, in the Paras Hospital, Gurgaon. The applicant submitted her claim before the respondent but the respondent rejected the claim of applicant vide email/letter dated 12.1.2017 (Annexure B).

8. On the other hand, the respondent alleged that the claim of the applicant was rejected as per (Annexure A3.1) as per terms and conditions of medi-claim policy (Annexure R2) as the applicant was having pre-existing disease which is clearly mentioned in the discharge summary (Annexure R1/A6.1 to A6.4) issued by Paras Hospital, Gurgaon. It is also alleged by the respondent that as per clause 4.1 of the condition of the policy (Annexure R2) it was clearly mentioned that any ailment/disease/injuries/health condition which are pre-existing

(treated/untreated, declared/not declared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person upto 3 years of this policy being in force continuously. For the purpose of applying this condition, the date of inception of the first indemnity based health policy taken, shall be considered provided the renewals and have been continuous and without any break in period, subject to portability condition.

9. *Now the dispute remained only on the point that whether the applicant was having pre-existing disease or not? The applicant claimed that on 9.1.2017 she fell down on the floor in the washroom and admitted in the hospital on 10.1.2017 and respondent relied upon only on discharge summary (Annexure R1) wherein it was mentioned that the applicant “diagnosis acute stroke, right ACA Infearct, admitting complaints/chief complaints sudden weakness in both lower limbs, headache, dizziness, urinary incontinence, patient was apparently asymptomatic 2 days back when she developed sudden weakness in both lower limits stand without support and patient gives history of fall, patient was admitted under neurology for further evaluation and management, in the past medical history it was mentioned that no history of chronic disease, no history of LOC/seizure and history of kidney stone”.*

10. *In document Annexure A3.1, the claim of applicant was rejected as mentioned 'suspected PED' according to policy terms and conditions cashless claim cannot be extended. There is no document produced by the respondent except the discharge summary disclosing suspected PED. The arguments advanced by learned counsel for the respondent that the applicant is having pre-existing disease as the same was suggested in the discharge summary, is not sustainable as there is no other documents on file produced by the respondent that the applicant was having pre-existing disease. Only admission*

by the doctor, does not mean that the applicant was having pre-existing disease prior taking medi-claim policy from the respondent since 2016 to 2018. When the applicant is aged about 75 years old and had taken medi-claim policy from the respondent then the respondent has to prove medical record of the applicant before issuing the policy or taking payment of policy premium. Now the respondent cannot say that disease suffered by the applicant, is not covered under the policy as there is no doctor's report on the file, produced by the respondent to prove that repudiation of claim was genuine, rather it is proved on file by the applicant that repudiation of the claim of the applicant is unjustified and not genuine. The deficiency in service on part of respondent has been proved on file.

11. In *Star Health & Allied Insurance Company Limited Chandigarh Versus The Chairman, Permanent Lok Adalat Gurgaon and another*, CWP No.3356 of 2014 decided on 02.04.2014, it was held by Hon'ble High Court of Punjab and Haryana, Chandigarh as under:-

“5. Having heard learned counsel for the petitioner appellant, we are of the considered view that no interference of this Court would be warranted in the view taken by the learned Single Judge as well as the Lok Adalat. The law is well settled with regard to the exclusion clauses in standard forms of contracts. When the bargaining powers of the parties is unequal and a consumer has no real freedom to contract, then such a power may be considered unfair. The principle deducible from various precedents is that the Courts would not enforce and when called upon to do so, strike down such an unfair and unreasonable clause in a contract, entered into between parties who are not equal in bargaining power. For instance, the above principle would apply where the inequality of bargaining power is the result of the great disparity in the economic strength of the contracting parties. It would also

apply where a man has no choice, or rather no meaningful choice, but to give his assent to a contract or to sign on the dotted line in a prescribed or standard form or to accept a set of rules as part of the contract, however unfair, unreasonable and unconscionable a clause in that contract or form or rules may be. The types of contract to which the principle formulated above applies to terms which are so unfair and unreasonable that they shock the conscience of the Court. They are opposed to public policy and require to be adjudged void. In that regard we may place reliance on the judgment of Hon'ble the Supreme Court rendered in the case of Central Inland Water Transport Corporation Ltd. v. Brojo Nath Ganguly, AIR 1986 SC 1571". There is no document on file produced by the respondents that insurer had knowledge of disease or that she was suffering from the disease prior to taking the policy from respondent No.1."

Learned counsel appearing on behalf of the petitioner-Insurance Company has failed to demonstrate or to refer to any material on the basis whereof it can be said that the findings recorded by the Permanent Lok Adalat (Public Utility Services), Gurugram suffer from any illegality, impropriety, irrationality or non-appreciation of the evidence available on record. The conclusion drawn by the Permanent Lok Adalat (Public Utility Services) cannot be said to be unreasonable. Consequently, I find no infirmity in the impugned award/order dated 21.04.2022 (Annexure P-1) passed by Permanent Lok Adalat (Public Utility Services), Gurugram.

The present writ petition is accordingly dismissed in *limine*.

March 16, 2023
seema

(VINOD S. BHARDWAJ)
JUDGE

Whether speaking/reasoned: Yes/No

Whether Reportable: Yes/No