Satwant Kaur Sandhu vs New India Assurance Company Ltd on 10 July, 2009

Equivalent citations: 2009 AIR SCW 7213, 2010 (2) AIR JHAR R 91, 2010 (1) ALL LJ 805, 2010 (1) AIR BOM R 453, 2010 (1) AIR KANT HCR 245, (2009) 4 CIVILCOURTC 503, (2009) 7 MAD LJ 1103, (2009) 4 RECCRIR 546, 2009 (8) SCC 316, (2009) 9 SCALE 488, (2009) 3 UC 1718, (2009) 4 ALL WC 3285, (2009) 4 RECCIVR 692, (2009) 2 WLC(SC)CVL 290, (2010) 1 ACJ 265, (2009) 4 CIVLJ 656, (2013) 3 CPR 664, (2010) 1 ALLMR 974 (SC), (2010) 1 ICC 9, (2009) 80 ALLINDCAS 31 (SC), (2009) 76 ALL LR 645, (2009) 4 CPJ 8, (2010) 1 BOM CR 427

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Bench: R.M. Lodha, D.K. Jain

REPORTABLE

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 2776 OF 2002

SATWANT KAUR SANDHU -- APPELLANT (S)

VERSUS

NEW INDIA ASSURANCE COMPANY LTD. -- RESPONDENT (S)

JUDGMENT

D.K. JAIN, J.:

1. This appeal, by special leave, is directed against the judgment and order dated 8th December, 2000 passed by the National Consumer Disputes Redressal Commission, ("the National Commission" for short) in Revision Petition No.322 of 1999 whereby the Commission has affirmed the order passed by the State Consumer Disputes

Redressal Commission, New Delhi (for short "the State Commission"), rejecting appellant -

complainant's claim against the respondent - Insurance Company for compensation on account of deficiency in service for not processing her claim under a mediclaim policy.

2. Succinctly put, the material facts giving rise to the present appeal are as follows:

On 7th May, 1990 appellant's husband, late Shri Pritpal Singh Sandhu, 48 years old and an advocate by profession, after completing necessary formalities insured himself under a mediclaim policy provided by the respondent. The policy was for a period from 7th May, 1990 to 6th May, 1991. The annual premium of Rs.1500/- was also paid by him. On 11th September, 1990, Pritpal Singh suddenly fell ill and was admitted in Dayanand Medical College and Hospital, Ludhiana. On 7th December, 1990 he was shifted to Madras Institute of Nephrology also known as, Vijaya Health Centre, Chennai where his condition deteriorated, ultimately leading to his death on 26th December, 1990. The appellant informed the respondent about the death of her husband on 17th January, 1991. On 29th April, 1991 she filed a claim for Rs.23,217.80 for reimbursement of the expenses incurred on hospitalization.

3. The respondent - Insurance Company made inquiries from Madras Institute of Nephrology (Vijaya Health Centre) and obtained a certificate dated 6th May, 1992, (Annex.P-6) stating that the deceased was a known case of "Chronic Renal Failure/Diabetic Nephropathy"; was on regular haemodialysis at his place and after admission on 7th December, 1990 with severe breathlessness developed sudden cardiac arrest on 26th December, 1990 leading to his death. The certificate also stated that the insured was a known diabetic for the last 16 years. Thereupon, the respondent vide letter dated 30th August, 1993 informed the appellant that her claim had been repudiated. Being aggrieved, the appellant filed Consumer Complaint Case No. 48 of 1996 before the Consumer Dispute Redressal Forum No.IV at Bunkar Vihar Nand Nagri, New Delhi ("District Forum" for short) with the prayer that the Insurance Company should be directed to pay the claim amount of Rs.23,217.80 along with interest @ 24% per annum and compensation for agony as also the litigation expenses.

4. Before the District Forum, the stand of the respondent was that the claim preferred by the appellant had been repudiated on the basis of the report supplied by Vijaya Health Centre, Chennai where appellant's husband had died. In the written statement filed by the respondent before the District Forum, it was stated that while filling up the proposal form, against queries No.10 and 11, the insured had stated that he was in sound health and had not undergone any treatment or operation in the last 12 months, whereas the medical report revealed that he was a known case of "Chronic Renal Failure/Diabetic Nephropathy" being diabetic for the last 16 years. It was also added that the opinion of two independent doctors was obtained to affirm that the claim could not be honoured as material facts relating to the health of the insured were concealed at the time of taking out the policy.

5. The District Forum vide its order dated 20th May, 1997, refuted the opinion of the independent doctors on the ground that they had never personally treated the deceased. The Forum noted that report of Vijaya Hospital was not supported by any circumstantial evidence and was, therefore, unreliable. The policy was repudiated on 30th August, 1993 i.e. almost 2 years and 8 months after the death of the deceased. Preferring to rely on the letter written by the elder brother of the deceased, Col. Gurcharanjit Singh on 21st June, 1993 to the Asstt. Manager, New India Assurance Co. stating that deceased became unwell some time in September/October, 1990 and thereafter his condition deteriorated fast resulting ultimately in his death, the District Forum concluded that the Insurance Company was guilty of deficiency in service because repudiation was not based on full material information and that there was inordinate delay in deciding the claim under the policy. The District Forum accordingly directed the respondent to pay the claimed amount with interest at 12% per annum from 1st April, 1991 i.e., 3 months after the death of the insured till the date of actual payment. The respondent was also required to pay Rs.1000/- as cost of litigation.

6. Aggrieved, the respondent - Insurance Company preferred appeal before the State Commission. The State Commission vide its order dated 31st December, 1998, allowed the appeal and set aside the order of the District Forum. The relevant part of the order reads as under:

> "Death of the insured occurred within seven months of taking the mediclaim policy and Section 45 of the Insurance Act is not even remotely attracted. We are of the considered view that repudiation of the claim was on a consideration of the aforesaid record of the Madras Institute of Nephrology and, therefore answer to col. 10 of the proposal form amounted to mis-representation and suppression of material facts regarding health made by the policy holder. No case of deficiency in service has been established."

7. Being aggrieved by the order of the State Commission, the appellant filed Revision Petition before the National Commission. As noted earlier, the National Commission has dismissed the Revision Petition, by a short order, which reads thus:

> "It is a case of concurrent finding of fact recorded both by the District Forum and the State Commission. We do not find any reason to interfere with the order passed by the State Commission. The Revision Petition is dismissed."

8. Mr. D.S. Lambat, learned counsel appearing for the appellant contended that the National Commission has grossly erred in upholding the State Commission's order on the premise of "concurrent finding of fact" by the Fora below when both the Forums had arrived at different findings regarding suppression of material facts about the state of health of the insured. It was, thus, urged that the National Commission misled itself in passing an order which did not bear consonance with the factual position on record. Learned counsel also submitted that the State Commission had erred in relying on inadmissible and unproved contents of a document viz. certificate dated 6th May, 1992, to reverse a logical and cogent finding by the District Forum. Lastly, it was contended that the National Commission acted illegally in dismissing appellant's Revision Petition without assigning any reason and appreciating the fact that the claim was repudiated after 30 months, which,

according to the counsel, by itself amounted to deficiency of service by the respondent.

9. Per Contra, learned counsel for the respondent submitted that the repudiation of claim was fully justified because at the time of submission of the proposal form, the respondent had made a false declaration that he was possessing sound health and had not undergone any treatment in the last 12 years and taking the facts disclosed as correct the policy was issued. It was urged that a mediclaim policy is issued solely on the basis of the facts disclosed and the representation made by an insured in the proposal form filled in and submitted by him without subjecting the insured to any medical tests. It was also pointed out that the proposal form contains a declaration to the effect that if after the insurance is effected, it is found that the statement, answers or particulars stated in the proposal form and its questionnaire are incorrect or untrue in any respect, the insurance company shall incur no liability under this insurance. It was, thus, asserted that the insured having suppressed the fact that he was suffering from Diabetic Nephropathy/Chronic Renal Failure, which fact was within his knowledge, the respondent was justified in repudiating the claim.

10. The core question for consideration is whether the fact that at the time of taking out the mediclaim policy, the policy holder was suffering from chronic Diabetes and Renal failure was a material fact and, therefore, on account of non-disclosure of this fact in the proposal form, the respondent - Insurance Company was justified in law in repudiating the claim of the appellant?

11. Having bestowed our anxious consideration to the matter, we are of the opinion that in the light of the material on record, answer to the question posed has to be in the affirmative.

12. There is no dispute that Section 45 of the Insurance Act, 1938 (for short "the Act"), which places restrictions on the right of the insurer to call in question a life insurance policy on the ground of mis-statement after a particular period, has no application on facts at hand, inasmuch as the said provision applies only in a case of life insurance policy. The present case relates to a mediclaim policy, which is entirely different from a life insurance policy. 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 hospitalizations. 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, 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 Vs. Law Union & Crown Ins. Co.1)

13. In United India Insurance Co. Ltd. Vs. M.K.J. Corporation2, 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 [1908] 2 K.B. 863

(1996) 6 SCC 428 believing the contrary. (Also see: Modern Insulators Ltd. Vs. Oriental Insurance Co. Ltd.3).

14. MacGillivray on Insurance Law (Tenth Edition) 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."

15. Over three centuries ago, in Carter Vs. Boehm4, Lord Mansfield had succinctly summarised the principles necessitating a duty of disclosure by the assured, in the following words:-

> "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 to 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 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 risqui run is really different from the risqui understood and intended to be run at the time of the agreement...The policy (2000) 2 SCC 734 (1766) 3 Burr. 1905 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."

16. Having said so, as noted above, the next question for consideration would be as to whether 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?

17. 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".

18. 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.'

19. 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 Policyholders' 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) xxx xxx xxx
> (b) xxx xxx xxx
> (c) xxx xxx xxx
>
> (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.

20. 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.

21. Bearing in mind the aforestated legal position, we may advert to the facts in hand. As noted earlier, the proposal form contained the following two questions:

> "10. Details of illness/would : Sound Health which may require treatment in near future
>
> 11. Details of Treatment/surgical : Nil operation in the last two months Details of Treatment Duration of Treatment From.....to.....
>
> Doctor / Hospital
>
> If fully recovered, attached certificate
>
> For attending Doctor/Surgeon"

22. Answers given by the proposer to the two questions were "Sound Health" and "Nil" respectively. It would be beyond anybody's comprehension that the insured was not aware of the state of his health and the fact that he was suffering from Diabetes as also chronic Renal failure, more so when he was stated to be on regular haemodialysis. There can hardly be any scope for doubt that the information required in the afore- extracted questions was on material facts and answers given to those questions were definitely factors which would have influenced and guided the respondent - Insurance Company to enter into the Contract of Mediclaim Insurance with the insured. It is also pertinent to note that in the claim form the appellant had stated that the deceased was suffering from Chronic Renal Failure and Diabetic Nephropathy from 1st June, 1990, i.e. within three weeks of taking the policy. Judged from any angle, we have no hesitation in coming to the conclusion that the statement made by the insured in the proposal form as to the state of his health was palpably untrue to his knowledge. There was clear suppression of material facts in regard to the health of the insured and, therefore, the respondent - insurer was fully justified in repudiating the insurance contract. We do not find any substance in the contention of learned counsel for the appellant that reliance could not be placed on the certificate obtained by the respondent from the hospital, where the insured was treated. Apart from the fact that at no stage the appellant had pleaded that the insured was not treated at Vijaya Health Centre at Chennai, where he ultimately died. It is more than clear from the said certificate that information about the medical history of the deceased must have been supplied by his family members at the time of admission in the hospital, a normal practice in any hospital. Significantly, even the declaration in the proposal form by the proposer authorises the insurer to seek information from any hospital he had attended or may attend concerning any decease or illness which may affect his health.

23. Before parting with the case, we may also deal with the submission of learned counsel for the appellant that the order of the National Commission is flawed because it has declined to interfere on a wrong premise that both the Fora below had arrived at "concurrent findings", which was not so. It is true that there is an apparent error in the order of the National Commission, inasmuch as the State Commission had, in fact, disagreed with the view taken by the District Forum but having regard to the fact that on our independent examination of the material on record, the claim by the appellant has been found to be fraudulent, we are of the opinion that no useful purpose would be served by remitting the matter to the National Commission for fresh adjudication on merits.

24. In view of the foregoing discussion, we do not find any merit in this appeal, which is dismissed accordingly but with no order as to costs.

.....J. (D.K. JAIN) .....J. (R.M. LODHA) NEW DELHI;

JULY 10, 2009.