IN THE SUPREME COURT OF PAKISTAN
(Appellate Jurisdiction)

PRESENT:
MR. JUSTICE UMAR ATA BANDIAL
MR. JUSTICE SAJJAD ALI SHAH
MR. JUSTICE MUNIB AKHTAR

CIVIL APPEAL NO.350 OF 2020
(On appeal from the judgment dated 09.05.2018 of the Peshawar High Court, Peshawar passed in FAO No.49-P of 2014.)

State Life Insurance Corporation of Pakistan ... Appellant

vs

Atta Ur Rehman ... Respondent

For the Appellant : Mr. Sana Ullah Zahid, ASC

For the Respondent : Ex-parte.

Date of Hearing : 03.03.2021

JUDGMENT

Munib Akhtar, J.: One Mr. Abdul Rehman took out a life insurance policy with the appellant insurance company on or about 01.08.2002. The insured passed away on 07.02.2010 and the respondent, his legal heir, lodged a claim under the policy. That claim was rejected vide letter dated 15.04.2011. No specific reason, as such, was given as to why the claim was not accepted. The respondent commenced proceedings, on or about 25.11.2011, before the Insurance Tribunal constituted under the Insurance Ordinance, 2000 ("Ordinance"). Issues were framed and evidence led by the parties. By judgment dated 07.06.2014 the Tribunal decreed the claim in the sum of Rs. 400,000/-, which was the insured amount. There was an appeal to the High Court, which was dismissed by means of the impugned judgment dated 09.05.2018. The appellant petitioned this Court, where leave to appeal was granted vide order dated 16.03.2020.

2. Before us learned counsel renewed the primary plea taken by the appellant, which was that there had been a breach of the duty of utmost good faith by the insured. It was submitted that for some years prior to the policy the appellant had had a cardiac condition

(i.e., coronary disease), which was so severe that it had even required a heart operation. That condition was continuing at the time of the policy. This was however not disclosed to the appellant when the insured applied for life insurance. This was a material concealment which vitiated the policy, and allowed the appellant to avoid the same. Reference was made to s. 75 of the Ordinance, which puts the duty of utmost good faith on a statutory basis. Reliance was also placed on *Jubilee Insurance Co. Ltd. v. Ravi Steel Company* PLD 2020 SC 324 where, at para 8, ss. 75 and 76 were considered.

3. Expanding on the factual basis of his submissions, learned counsel submitted that the insured, an employee of WAPDA, had been suffering from diabetes and a heart condition for approximately 12 years prior to the taking out of the policy. He had been operated upon, and coronary artery bypass grafting was carried out in or around 1997. It was submitted that these medical conditions were concealed by the appellant. Learned counsel strongly relied on the evidence of one Dr. Suliman, DMS WAPDA Hospital Peshawar and the medical record/history of the insured that was produced by him. It may be noted that the doctor appeared as a witness summoned by the appellant. It was contended that the policy stood vitiated, thus relieving the appellant from liability in terms thereof.

4. We have heard learned counsel (the respondent being ex parte) and considered the record and the case relied upon. Contracts of insurance belong to that limited category which are regarded as being *uberrimae fidei*, i.e., of the utmost good faith. This rule was developed over centuries by the common law in its many facets and aspects and was regarded as fundamental to insurance law. Section 75 merely codified the central aspect of the rule. It had of course applied in full even under the predecessor legislation, the Insurance Act, 1938 ("1938 Act"), which did not have an equivalent provision. Interestingly, it appears that the central aspect of the rule, which allows a contract to be avoided for breach of utmost good faith, has now essentially been abolished in the United Kingdom: see the Insurance Act, 2015 (s. 14) and the Consumer Insurance (Disclosure and Representations) Act, 2012 (s. 2). Of course, it continues in full force in this jurisdiction. Notwithstanding the legislation just referred to, the rule continues to be treated in all its aspects in English treatises on insurance

law. Obviously it is neither possible nor desirable to consider the whole of the rule here, in the entirety of its facets and aspects. However, in order to make intelligible our consideration of the submissions made by learned counsel some aspects will have to be touched upon. It will be convenient to set out certain extracts from a well-known treatise on the subject, *MacGillivray on Insurance Law* (14th ed., 2018). This work treats the rule in Chapter 17, which has the advantage that the effect of the UK legislation just referred to is not dealt with there, the same being taken up separately in other chapters of the work (see para 17-001). The general rule is set out in para 17-009 (in all the extracts below the internal citations are omitted):

> "**The general rule stated.** Subject to certain qualifications considered below, the insured 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 insurer but neither known nor deemed to be known by the insurer. Breach of this duty by the insured 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...."

The next para explains what is meant by facts known to the insured:

> "**Facts known to the insured.** The duty of disclosure extends only to facts which are known (or deemed in law to be known) to one party and not to the other. 'The duty is a duty to disclose,' said Fletcher Moulton LJ in *Joel v Law Union and Crown Insurance* [[1908] 2 KB 863, 884], 'and you cannot disclose what you do not know. The obligation to disclose, therefore, necessarily depends upon the knowledge you possess.'"

It will be seen that a breach of the duty will allow the insurer to avoid the contract only if (a) the fact not disclosed was material to the insurer's appraisal of the risk; (b) was known or deemed known to the insured; (c) but was not known or deemed known to the insurer; (d) and it is for the insurer to show that the non-disclosure induced it to make the contract on the relevant terms. What is meant by inducement is explained in para 17-029:

> "**Inducement.** To succeed in a defence of non-disclosure the insurer must prove not only that the insured failed to disclose a material fact but also that the non-disclosure induced the making of the contract in the sense that he would not have made the same contract if he had known the matters in question. This means that the non-disclosure must have been an effective cause of the underwriter making the contract on the terms agreed, but it need not have been

> the sole cause. The insurer must establish that, had he known the undisclosed circumstances, he would not have concluded it either on the same terms or at all. If he would have made the same contract, the non-disclosure cannot have made a difference. Inducement is shown if disclosure of the relevant fact would have led the underwriter to ask further questions which, if answered correctly, would have prompted him to impose different terms...."

The matters which the insurer knows or is deemed to know are set out, inter alia, in section 6 of the Chapter. One aspect of it relates to business practice and custom (para 17-082):

> "**Business practice and custom.** The insurer is presumed to know not only the ordinary incidents of ordinary risks but the ordinary incidents of peculiar risks if he undertakes them. "Every underwriter," said Lord Mansfield, "is presumed to be acquainted with the practice of the trade he insures. If he does not know, he ought to inform himself" [*Noble v Kennoway* (1780) 2 Doug. KB 510, 512; 99 ER 326; [1780] EngR 105]. So, if insurers cover a building where celluloid is stored, and they are informed of it, they cannot afterwards complain that they did not know celluloid was inflammable. If, however, the insured carried on his manufacture or trade by an unusually hazardous or novel process outside the reasonable contemplation of someone familiar with it, he ought to disclose this fact."

With this conspectus of the rule in mind, we turn to the facts of the present appeal.

5. Among the record produced by the appellant at the trial were the statements made by the insured when the policy was taken out regarding his medical condition/history, and also the results of his medical examination (also carried out at that time). That examination was by a doctor of the appellant's choice. The section of the record titled "Life Proposed's Personal Statement of Health", signed by the insured and dated 30.07.2002 contained a number of questions, which had to be answered by the applicant regarding his medical condition and health status. One of those questions (No. 7) was as follows:

> "Do you now or have you ever had Small-pox, Heart Disease, Diabetes, High Blood Pressure, TB, Cancer, Nervous or Psychological disorder? If so specify with dates."

This question was answered by the insured in the negative, i.e., "No". This answer, when read with the evidence of the aforementioned Dr. Suliman (which showed that the insured had had a history of coronary disease and had undergone heart surgery) established, learned counsel submitted, that there had been a deliberate concealment of a material fact known to the

insured and, hence, breach of the duty of utmost good faith, which allowed the appellant to avoid the contract. We have carefully considered this submission. The record clearly establishes that the insured did have heart disease and had been operated upon on account thereof. The negative answer given to the question was a non-disclosure of a fact that was material. The question however remains whether this was a fact that was not to be deemed known to the appellant, and/or whether it induced it to issue the policy on the terms as stated therein.

6. The reason why the questions just mentioned remain is because the appellant did not merely rely on the answers given by the insured in the aforementioned "Life Proposed's Personal Statement of Health". The insured was also thoroughly medically examined by a doctor of its own choice. The doctor's report, also dated 30.07.2002, gave the insured a clean chit. In the sections relating to coronary matters (and indeed all others) the medical health/status of the insured was stated to be perfectly normal. The remarks of the examining doctor are also pertinent. He found the insured to be: "fit. first class [sic]". When this medical examination and report are considered in the light of the evidence as a whole, it is clear that the appellant was induced to issue the life insurance policy not on account of the statements made by the latter and, as presently relevant, the response given to question No. 7. Rather, it was the examination by the appellant's own medical examiner and his report that was clearly the most important factor, and instrumental in inducing the appellant to go forward in the matter. Furthermore, it is a fact so well known that judicial notice can be taken of it that insurers in the life insurance business do not issue policies without a thorough medical examination of the person proposed to be insured, and unless the resultant report is found satisfactory or acceptable. This is the industry custom and practice uniformly followed in all cases. If therefore the medical examiner chosen by the insurer is negligent or the SOPs established for the examination (again, by the insurer) are so lax as to fail to result in a properly thorough examination, the burden of that fault lies on the insurer. In such a situation the insured cannot be held to account for any non-disclosure such as would enable the insurer to escape liability on the policy unless there is fraud or a fraudulent misrepresentation. In the actual facts of the present case, had the coronary condition of the insured prior to 2002 been

so bad as learned counsel sought to make out before us it would certainly have been discovered by the appellant's own medical examiner. That he did not do so, and gave a report that essentially totally belied the stance subsequently taken by the appellant in its attempt to avoid the contract effectively puts paid to that stance. It cannot, in our view, be accepted and was rightly rejected by the Tribunal and the High Court.

7. The medical reports generated and statements made in relation to the issuance of life insurance policies have been given recognition in both the 1938 Act and the Ordinance. It is now necessary to consider those provisions, as they are also important for the outcome of the appeal.

8. As noted above, s. 75 of the Ordinance codifies the central aspect of the duty of utmost good faith. Section 79 contains the remedies available to an insurer when there is, inter alia, a breach by an insured of the duty of disclosure. Section 80 then makes certain special provisions for a policy of life insurance. The 1938 Act also had a similar provision, in s. 45. For ease of reference these are set out in tabular form:

80. Policy not to be called in question on ground of mis-statement after two years.- Notwithstanding anything in section 79, ... no policy of life insurance ... shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the policy holder, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy holder and that the policy holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose:	**45**. **Policy not to be called in question on ground of mis-statement after two years.** No policy of life insurance ... shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose: Provided that nothing in this

Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the benefits payable under the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.	section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

It will be seen that the two provisions are virtually identical. After two years, a life insurance policy cannot be avoided on the ground of any falsity or inaccuracy in, or of, any statement made of the sort indicated in the provisions, unless the insurer is able to show that (a) the statement was on a material matter or suppressed facts that it was material to disclose; (b) it was made fraudulently by the insured; and (c) the insured knew at the time of making the statement that it was false or suppressed facts that it was material to disclose. The conditions are cumulative, i.e., the failure by the insurer to establish any one of them is fatal for the defence (and the onus lies on the latter). Section 80 was recently applied by this Court in *State Life Insurance Corporation of Pakistan and another v. Shazia Mir Arshad* 2019 CLD 1263 (leave refusing order of a learned two-member Bench). The insurer there sought to avoid a policy on essentially the same ground as here: that the insured had made a material misstatement regarding his health at the time the policy was taken out. Relying, inter alia, on s. 80 it was held that the insurer was unable to do so. Reliance was placed on a decision of the Supreme Court of India, where that Court had considered s. 45 of the 1938 Act (which continues to remain in force there). Leave to appeal was refused. Here we must also notice an earlier leave refusing order of this Court (by a learned two-member Bench), *Muhammad Faisal and another v. State Life Insurance Corporation and others* 2008 SCMR 456 ("*Muhammad Faisal*"). Interestingly, the matter originated as a summary chapter suit under Order 37 CPC but eventually evolved into a suit under the 1938 Act. It was held in this Court that as s. 45 had not been initially (and specifically) pleaded by the claimants it was not open for them to resist the insurer's avoidance of the policy on the ground of a materially false statement made by the insured (regarding his age at the time the policy was taken out).

The plea under s. 45 was, it appears, taken for the first time in this Court. In our view, this decision cannot, with respect, be taken to be authority for the proposition that the plea of s. 80 must be taken by the claimants at the time of filing the claim (earlier, in a court of law and now before the Insurance Tribunal). Section 80 creates a legal bar which has to be overcome by the insurer, if it can do so in terms thereof. The bar itself is automatic and, given that it is triggered merely by passage of the stipulated period, hardly requires any evidence to be led by the claimants. It is for the insurer to take the plea that it is *not* hit by the bar, and then establish its case by leading appropriate evidence that the three conditions stipulated therein exist. To this extent, what is said in para 4 of the decision in *Muhammad Faisal* cannot, with respect, be regarded as good law.

9. In the present case, the appellant did not take the plea that the bar contained in s. 80 did not apply in the facts and circumstances of the case. Even otherwise, there is nothing on the record to show that the non-disclosure by the insured (i.e., his answer to question No. 7) was fraudulent. On any view of the matter the statement made by him could not be taken by the appellant to defeat the policy and avoid the contract.

10. It is also pertinent to consider, briefly, s. 81 of the Ordinance. It empowers, in subsection (1), the Insurance Tribunal to disregard, subject to the conditions of the section, any avoidance of the policy if it of the view that such avoidance would be “harsh and unfair”, even if it is established that such avoidance was “on the ground of fraudulent failure to comply with the duty of disclosure or fraudulent misrepresentation”. In the context of life insurance even if an insurer were to overcome the bar created by s. 80, s. 81 may yet prevent it from avoiding the claim. It is interesting to note that subsection (3) provides, inter alia, that in “exercising the power conferred by sub-section (1), the Tribunal ... shall have regard to the need to deter fraudulent conduct in relation to insurance”. It is to be expected that the Tribunal will take a robust view of its powers under s. 81 and take recourse to it in a manner that achieves its objective and purpose. However, nothing definitive or binding can be said here regarding this provision as it was not involved in the present matter. What is said in this para is only by way of a signpost for the future.

11. It is left only to consider the decision relied upon by learned counsel, *Jubilee Insurance Co. Ltd. v. Ravi Steel Company* PLD 2020 SC 324. That was a leave refusing order of a learned two-member Bench. The matter was not of life insurance, and involved facts and circumstances far removed from those at hand. In fact, as noted in the decision, there had been an earlier round of litigation up to this Court, which had ended adversely to the insurer. The matter decided by the cited decision arose out of an application under s. 12(2) CPC. This decision does not, with respect, have any relevance for the present appeal.

12. In view of the foregoing analysis and discussion, we conclude that there is no merit to the present appeal, which fails and is hereby dismissed.

Judge

Judge

Judge

Announced in Court on 25.6.2021 at Islamabad

Judge

Approved For Reporting