

(2007) 09 DEL CK 0147
In the Delhi High Court
Case No : Writ Petition (C) 656 of 2007

Hari Om Agarwal

APPELLANT

Vs

Oriental Insurance Co. Ltd.

RESPONDENT

Date of Decision : 17-09-2007

Acts Referred:

Constitution of India, 1950 — Article 12, 14, 226, 32
General Insurance Business (Nationalisation) Act, 1972 — Section 19

Citation : (2009) ACJ 891 : AIR 2008 Delhi 29

Hon'ble Judges : S. Ravindra Bhat, J

Bench : Single Bench

Advocate : J.S. Bakshi, for the Appellant; M.B. Aggarwal, for the Respondent

Final Decision : Allowed

Judgement

S. Ravindra Bhat, J.—The petitioner seeks appropriate directions to the respondent(hereinafter called `` the insurer`` close) to reimburse the expenses incurred by him for his medical treatment, in accordance with the policy of insurance(hereinafter called `` mediclaim``).

2. The respondent is in the business of Insurance. The petitioner is a chartered accountant by profession. He was retained for the job carrying auditing the respondent's Division Office No. 7, Delhi. At that time, i.e May 2001 the insurer's agents/employees allegedly represented to petitioner that he should take an Individual Mediclaim Policy to cover his health. On a pointed query from petitioner that, if he could be insured, as he was a diabetic, a hypertension and had undergone a cataract operation of an eye, he was assured by respondent's representative that he would be eligible for such a policy and that he had to furnish complete details of the medication being undergone by him at that point of time.

3. The petitioner filled up the proposal form, underwent the necessary medical tests suggested by the respondent and fully disclosure his existing medical

condition. An ECG was also conducted, as required, on 3.5.2001 and supplied to the respondent. The said ECG showed "NAD" in the heart condition. After satisfying itself as to the insurable interest of the petitioner, individual Medclaim Policy No. 2002/34 was issued to him effective from 10th May, 2001. No claim was under the said Policy; it was renewed with effect from 10th May, 2002 through Policy No. 2003/31. No Claim was preferred against the said Policy also. Again the cover was renewed effective 10th May 2003 through Policy No. 2004/17. Yet again it was extended w.e.f. 10th May, 2004 by Policy No. 2005/30. No Claim was made against this policy too. Finally the Policy was extended for the period 10th May, 2005 to 9th May, 2006 through Policy No. 2006/44. This Policy carried a cumulative bonus of 15% due to "no claim" against for the previous four years. The sum insured against the said policy was Rs. 2,30,000/- inclusive of the bonus.

4. The petitioner, on 22.8.2005, visited Dr. N.C. Krishnamani for a check up. He was diagnosed of suspected heart function disorder. An angiography was performed at Metro Golden Heart Institute by Dr. J.C. Mohan on 8.9.2005 and "triple vessel disease" was diagnosed. The petitioner was advised ``CABG`` which was performed on 29.11.2005 at Delhi Heart and Lung Hospital by Dr. Ganesh K. Mani. The total charges for surgery and medical expenses on pre-operation and post operation was Rs. 2,31,330/-. The petitioner after fully recovering submitted his claim papers for process of claim on 30.3.2006/31.3.2006.

5. It is alleged that M/s. Genins India Ltd, the insurer's agent did not approve for ``cashless`` treatment, (ie. the procedure whereby the insured is permitted treatment and the insurer directly pays the medical bills) by letter dated 19.11.2005. He was advised to file the claim in due course. The petitioner later submitted his bills, and claimed full reimbursement. The petitioner's insurance cover had in the meanwhile been renewed, through Policy No. 211700/48/2007/67 effective from 10th May, 2006. He claims that at the time of renewal, he was again assured that his pending claim made by letter dated 30.3.2006 would be settled.

6. After some correspondence, the respondent insurer repudiated its liability on 31.10.2006. The impugned letter is in the following terms:

DEPTT:MISC DATE : 31/10/2006

(WITHOUT PREJUDICE)

SH. HARI OM AGARWAL

4320/3, ANSARI ROAD

DARYA GANJ

NEW DELHI - 110002

RE: MEDICLAIM UNDER POLICY NO. 211700/48/2006/44

CLAIM NO. 211700/48/2006/000133A/C SH. HARI OM
AGARWAL

This has reference to the above mentioned subject.

We have sent your claim file to our TPA and as per their opinion the claim is not payable due to claim falls out of the scope of coverage under the terms and conditions of policy as per under exclusion clause HTN, DM, CATARACT, PRE-EXISTING.

We are repudiated your claim and close your file.

Thanking you.

7. The repudiation of the petitioner's claim has been attacked as unreasonable and arbitrary. It is alleged that the petitioner at all relevant times fully disclosed his existing medical condition; he was medically examined according to procedures and stipulations, by the insurer. The policy was issued, premium accepted. Later, successively, the mediclaim policies were duly renewed. When the time arrived for relief, on account of an ailment, the respondents promptly repudiated the claim. The ground that the cardiac disease was a pre-existing medical complication was vague.

8. It is contended that in terms of Section 19 of General Insurance Business Nationalization Act, the insurer has carry on business in General Insurance to to develop it to the best advantage of the community. Mr. J.S. Bakshi, learned Counsel contended that denial of reimbursement of the medical expenses for Rs. 2.30,000/- was utterly arbitrary. The view of the insurer that the cardiac condition i.e. critical triple vessel coronary artery disease was pre-existing disease was a mere excuse to escape liability, and not bona fide. Learned Counsel relied upon the disclosure made by the petitioner when the proposal for mediclaim/insurance was submitted on 9.5.2001. A copy of that form has been placed on record.

9. Learned Counsel relied upon the column of history of pre-existing conditions, disclosing that the petitioner was a diabetic since 10 years and a patient of hypertension since three years, in 2001. The description of medication administered him, namely, insulin for diabetic and diamicron as well as the other medication for hypertension too was not withheld. In these circumstances, the impugned communication stating that the petitioner was not entitled to reimbursement under the mediclaim policy because he had a pre-existent condition that was specifically excluded, is not acceptable.

10. Learned Counsel relied upon the judgment of this court in Shri Mukut Lal Duggal Vs. United India Insurance Co. Ltd., and submitted that the respondent which falls within the extended definition of ``the State'' under Article 12 of the Constitution cannot deny its liability to reimburse the amount. Learned Counsel submitted that in that case this Court held the arbitrary denial of renewal of

existing mediclaim policy by refusing to accept premium was held to be unsustainable. It was submitted that the Court rejected the contention that there was no obligation on the insurer to renew the policy in case the insurer suffered serious illness leading to procedures such as coronary heart surgery etc.

11. Learned Counsel further relied upon the decision of the Supreme Court reported as *Biman Krishna Bose Vs. United India Insurance Co. Ltd.*, and a judgment of the Division Bench of Gujarat High Court reported as *United India Insurance Co. Ltd. v. Mohan Lal Aggarwal* AIR 2004 Guj. 191.

12. The insurer has justified its stand in the return filed in these proceedings. An objection to maintainability on the ground that the disputes should be gone into in civil proceedings, or before the consumer forums under the Consumer Protection Act, has been made. It is also averred that the insurer was justified in rejecting the claim as covered under the ``pre-existing condition'' clause.

13. Learned Counsel for the respondent submitted that this court should not entertain the present petition under Article 226 since alternative remedies exist and the dispute would be better adjudicated through those channels. It was also contended that the petitioner concealed material facts from the insurer about previous existing ailments and diseases. It was contended that in terms of exclusion clause i.e. 4.1, the policy could only cover known risks but not unforeseen circumstances arising out of such risks.

14. Learned Counsel relied upon Clause 4.1 to say that both parties to the policy were clear as to what kind of diseases were covered by the mediclaim insurance policy. The definition of pre-existing condition included sickness or symptoms that existed prior to the insurance policy regardless of knowledge of the insurer. It also included complications arising out of the pre-existing diseases/conditions.

15. Learned Counsel submitted that being a contract of special character, where benefit is sought to be secured by the insured, the latter under an obligation to disclose all facts by exercising the highest good faith. In not doing so and withholding vital information the petitioner forfeited his right to claim reimbursement. Learned Counsel submitted that in these circumstances, the denial of liability by the insurer was justified and legal.

16. The relevant clause of the mediclaim policy in this case reads as follows:

4. EXCLUSIONS:

4.0 The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured Person in connection with or in respect of:

4.1 Such diseases which have been in existence at the time of proposing this insurance. Pre-existing conditions means any injury which existed prior to the effective date of this insurance. Pre-existing condition also means any sickness or its symptoms which existed prior to the effective date of this insurance, whether

or not the insured person had knowledge that the symptoms were relating to the sickness. Complications arising from pre-existing disease will be considered part of that pre-existing condition.

4.2 Any expenses on hospitalisation/domiciliary incurred during first 30 days from the date of commencement of insurance cover except in case of injury arising out of accident.

17. In Biman Krishna's case (supra) the Supreme Court held as follows:

2. The appellant, Biman Krishna Bose, has appeared in person. He argued that the High Court even after setting aside the order refusing to renew the policy, was not justified in directing the appellant to take fresh mediclaim policy. According to the appellant, by the said order of the High Court he has been placed at a great disadvantageous position. The appellant referred to the exclusion clause of the policy taken out by him. Relevant Clauses 2.1 and 2.1.14 of the mediclaim policy run as under:

2.1- The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

2.1.14- All diseases/injuries which are pre-existing when the cover incepts for the first time.

On the strength of the exclusion clause, the appellant urged that in case the appellant is required to take fresh mediclaim policy, all the diseases which have surfaced during the period the policy was not renewed shall be treated as pre-existing diseases and the same would neither be covered by the fresh policy nor he will be paid the money which he has incurred for treatment of the said diseases during the relevant time and Therefore, the order of the High Court be set aside. We find substance in the argument.

18. High Courts, while exercising jurisdiction under Article 226 of the Constitution usually refrain adjudicating disputes of contracting parties, after the finalization of terms. The courts desist from deciding essentially disputed questions of fact. Yet, this rule is subject to an important exception, i.e if the facts are not in dispute, and the executive policies or action, even post contract display elements of public law dispute, scrutiny under Article 226 or Article 32 cannot be barred. Therefore once the State or its instrumentality is party to a contract, it has an obligation in law to act fairly, justly and reasonably, as enjoined by Article 14 of the Constitution of India. A deviation from this obligation can entitle the court, even under Article 226 to entertain the dispute, in exercise of its discretion. Thus, in ABL International Ltd. and Another Vs. Export Credit Guarantee Corporation of India Ltd. and Others, , the Supreme Court summarized the appropriate approach to be followed in such cases, in the following terms:

From the above discussion of ours, the following legal principles emerge as to the

maintainability of a writ petition:

(a) In an appropriate case, a writ petition as against a State or an instrumentality of a State arising out of a contractual obligation is maintainable.

(b) Merely because some disputed questions of fact arise for consideration, same cannot be a ground to refuse to entertain a writ petition in all cases as a matter of rule.

(c) A writ petition involving a consequential relief of monetary claim is also maintainable.

19. In *Life Insurance Corporation of India v. Consumer Education and Research Centre* 1995 (4) SCC 482, the Supreme Court, after reviewing in detail several previous decisions on the obligations of state instrumentalities, to act fairly in a non-arbitrary manner, held that actions of the State, its instrumentalities and public authorities or of persons whose actions bear insignia of public law element or public character are amenable to judicial review and that legality of such actions would be tested upon the anvil Article 14. Public law remedy, through judicial review under Article 226 was defined as intervention where the actions of State or its agencies, bearing the imprint of public interest, can be examined. Fairness and non-arbitrariness are considered as two immutable pillars supporting the equality principle, an unshakeable threshold of state and public behavior. Every action, policy or even change of policy in the realm of State activity should be informed, fair and non- arbitrary.

20. The *Life Insurance Case* (supra) itself concerned issuance of policy of insurance; the later case decided by the Supreme Court, i.e *Biman Chandra Bose* concerned a dispute relating to mediclaim policy. Likewise, *Mukutlal Duggal* (decided by this Court) and *Mohan Lal Aggarwal*, (decided by the Gujarat High Court) have shown the way; mediclaim policies, and disputes arising from them, can be adjudicated in writ jurisdiction. Here, additionally ,there is no dispute on facts. The respondent does not deny that the petitioner disclosed, in May 2001 itself, his medication as well as existing ailments, such as a decade old case of diabetes, and hypertension. Apart from these, he was also medically examined; his ECG was obtained. Premia were paid, successively for over five years; the petitioner was even granted cumulative no-claim bonus. The question is whether in these circumstances, the plea that Clause 4.1 excluded liability is justified.

21. The bone of contention, or the point of dispute is the precise meaning of ``complications arising from pre-existing disease will be considered part of that pre-existing condition."`. This stipulation itself occurs in an exclusion clause. There is some authority that an exclusion clause, in the context of a contract of insurance, which is an assurance whose main purpose has to be prominence ,, should be construed strictly (Ref. *Skandia Insurance Co. Ltd. Vs. Kokilaben Chandravadan and Others*, ; *B.V. Nagaraju Vs. M/s. Oriental Insurance Co. Ltd.*, Divisional Officer, Hassan, The primacy given to the main purpose, notwithstanding that contracting parties agreed to certain exclusions, is founded

on the principle of interpretation that if contracting parties seek to achieve a certain purpose by entering into an agreement, the existence of exclusion clauses should be strictly interpreted and if it tends to defeat the main purpose, should be read down by the Court; if that is not possible, the court should altogether ignore it (Ref Halsbury, LC in Glynn v. Margeston and Co. 1893 AC 351.

22. If the rule indicated in the preceding paragraph were kept in mind, it would be apparent that the object of the insurance policy is to cater to medical expenses incurred by the insured. That is the ``main purpose`` of the contract of insurance. The object of the exclusion clause is to except the liability of the insurer. In a sense this is at variance with the object of the policy. Nevertheless, it is a part of the contract; the court should firstly seek to harmonise the all the clauses, and attempt to give effect to it. If one proceeds on this premise, the concept of ``pre-existing condition`` has to be understood. Clause 4.1 defines it as any injury which existed prior to the effective date of the insurance; and any sickness or its symptoms which existed prior to the effective date of the insurance, whether or not the insured had knowledge that the symptoms were relating to the sickness. It is apparent that even if there were known diseases or conditions, which were disclosed and for which there was a likelihood of complications arising in the future, the insurer sought to distance itself from the liability. There is no dispute here that diabetes was a condition at the time of submission of proposal; so was hyper tension. In a sense these were ``old ailments``; the petitioner was advised to undergo ECG, which he did. The insurer accepted the proposal and issued the cover. One may ask, what then was the cover for. It is not an accident cover policy, or a life policy. Now, it is universally known that hypertension and diabetes can lead to a host of ailments, such as stroke, cardiac disease, renal failure, liver complications, etc, depending upon varied factors. That implies that there is probability of such ailments; equally they can arise in non-diabetics or those without hypertension. Unless the insurer spelt out with sufficient clarity ,the purport of its clauses, or charged a higher premia, at the time of accepting the proposal, the insured would assume and perhaps, reasonably that later, unforeseen ailments would be covered. Thus, it would be apparent that giving a textual effect to Clause 4.1 would in most such cases render the mediclaim cover meaningless; the policy would be reduced to a contract with no content, in the event of the happening of the contingency. Therefore, I am of the opinion that Clause 4.1 cannot be allowed to override the insurer's primary liability; the ``main purpose`` rule would have to be pressed into service. This finding is reinforced in this case, as the insurer renewed the policy, in 2006, after the petitioner underwent the CABG procedure.

23. In view of the above discussion, the refusal by the insurer to process and reimburse the petitioner's claim is arbitrary and unreasonable; as a state agency, it has to set standards of model behavior; its attitude here has displayed a contrary tendency. A direction is issued to the respondent to process the petitioner's claim, and ensure that he is reimbursed for the procedure undergone by him according to the claim lodged with it, within six weeks.

24. The petition is allowed; rule made absolute in the above terms. The respondent shall bear the costs of these proceedings, quantified at Rs. 15,000/- ; it shall be paid to the petitioner within six weeks.