
(1960) 08 AP CK 0019
In the Andhra Pradesh High Court
Case No : Appeal No. 325 of 1955

New India Assurance Co. Ltd.	Vs	APPELLANT
Tambireddi Subba Raghavareddi		RESPONDENT

Date of Decision : 27-08-1960

Acts Referred:

Insurance Act, 1938 — Section 45

Citation : AIR 1961 AP 295

Hon'ble Judges : Satyanarayana Raju, J;Kumarayya, J

Bench : Division Bench

Advocate : V. Parthasarathi, for the Appellant; K. Ramachandra Rao, for the Respondent

Final Decision : Dismissed

Judgement

Satyanarayana Raju, J.—This is an appeal from the judgment and decree of the Court of the Subordinate Judge, Nellore, in O. S. No. 66 of 1954.

2. The suit was by the assignee of a policy-holder for payment of the sum insured on the life of his adoptive father, Virareddi. The defendant in the action is the New India Assurance Company Limited, a Company incorporated under the Indian Companies Act, having their Head Office at Bombay and carrying on life insurance business in the former composite State of Madras through their Branch Office at Madras.

3. During the pendency of the appeal was enacted the Life Insurance Corporation Act (XXXI of 1956) providing for the nationalisation of life insurance business in India by transferring all such business to a Corporation established for the purpose. By virtue of Section 7 of the-Act, all the assets and liabilities appertaining to the controlled business of all insurers were transferred to and1 vested in the Life Insurance Corporation. By reason of this provision, the Life Insurance Corporation has come on-record as the appellant.

4. In order to appreciate the points raised in the appeal, it is necessary to state

in some detail the facts out of which the controversy arises. Virareddi was born on the 20th June, 1901. He was the village munsif of Vidavalur in the District of Nellore. He was possessed of considerable landed property -- the evidence is that he had about 80 acres of land -- and he was in affluent circumstances. When he was about 30 years old, he lost his wife. He did not remarry and remained) a widower ever, since. Having had no natural issue, he adopted the plaintiff.

In the year 1945, he was asked by the Revenue Department to undergo a refresher course for forty days. On grounds of ill health he applied for and got two months" leave from the 7th September, 1945. Thereafter he was involved in a case of rioting as could be seen from the judgment of the Sessions Court. Nellore in S.C. No. 30 of 1945. Virareddi was there convicted of an offence punishable u/s 147 of the Indian Penal Code, and sentenced to two years" simple imprisonment and to a fine of Rs. 1000/-, and in default, to six months simple imprisonment. It is common ground that he was discharged from the Madras Penitentiary in 1947, after undergoing the jail term.

5. On the 21st August, 1947, Virareddi submitted a proposal to the New India Assurance Co. Ltd., (hereinafter referred to as "the insurers") for a policy on his life for a sum of Rs. 20,000/-. He applied for what is known as a whole life policy. In his application, Ex. B. 1, he gave his age next birth day as 47 years. The proposal contains a statement by the insured that he was in a sound state of health and that he was of sober and temperate habits.

To the proposal was appended a declaration by the insured that the statement and answers were true in every particular and that he agreed that the statement and declaration along with further statement to be made before the medical examiner and declaration relative thereto should be the basis of the contract between him and the insurers and that if any untrue averment be contained therein, the contract of assurance should be absolutely null and void and all moneys paid in respect thereof should be forfeited.

6. In the case of a policy exceeding Rs. 5,000/- the regulations of the insurers provide for the medical examination of the insured by two of their Doctors. Accordingly, D.W. 2 and another Doctor examined) the insured and recorded his personal statements. Exs. B-2 and B-3. A reference to the answers given by the insured in these statements will be made later. Both the Doctors certified that his was a first class life.

Presumably because the insured was far advanced in age, the insurers intimated him that they were "prepared to issue not a whole life policy but an endowment policy for thirteen years". Eventually, however, a 15 years endowment policy was agreed upon and the insurers" final acceptance was communicated to the insured on the 19th December, 1947. The endowment policy was issued on 7-1-1948,

The insured paid the premia regularly up till 1950, when owing .to non-payment of the premium amount, the policy lapsed. On the 28th February, 1950, the

insured applied for revival of his policy after making a further declaration to the insurers of his continued good health. The insured died on the 29th February 1952. The death register extract gave the cause of death as dysentery.

7. On the 1st April, 1952, the plaintiff, the adoptive son of Virareddi and the assignee of the policy, informed the insurers of the death of the insured and forwarded the usual claim papers. Nearly one year three months later, the insurers repudiated their liability on the ground that the insured had given false and inaccurate answers to some of the questions in the proposal for insurance (Ex. B, 1) and In the personal statements (Exs. 8. 2 and B. 3) made before the medical consultants of the insurers to the effect that he had no previous ailment, sickness or disease and had never before consulted a medical practitioner.

This repudiation is contained in a letter, Ex. A-3 dated the 30th July, 1953, from the insurers to the plaintiff stating that as a result of the enquiries made by them after the death of the insured, they had come to know that for a long time prior to his death the insured had been suffering from various diseases, viz., hepatitis and enlarged liver, and that he had, in fact, undergone treatment for the same "in several hospitals". After the issue of a lawyer's notice, the plaintiff instituted the suit on the 26th March, 1954, for recovery of Rs. 22, 470/- representing interest thereon at 8 per cent per annum from the date of the claim to the date of the suit.

8. The plaintiff averred that under the terms of the policy, Ex. B. 13, it was inter alia provided that after the expiry of 15 years from the date of the policy or in the event of the death of the insured, whichever was earlier, a sum of Rs. 20,000/- was payable to the insured, if he survived the period of 15 years, or to his heirs and] legal representatives In the event of his dying earlier, and that the insured at the time of his application for insurance, and prior thereto and at all material times, was in normal health.

9. The liability of the insurers was disputed on the ground that the policy had no effect as a valid contract owing to mis-representation or concealment of material facts by the insured in the answers which he gave to certain questions in the proposal as also in the answers given by him in his personal statements made before the medical consultants of the insurers.

10. Now, the aim of all life insurance is to make provision against the dangers which beset human life. The subject matter of a contract of life assurance is a human being who, according to the law of nature, is bound to die at some time or other. It is a most "natural event but is uncertain as to the point of time at which it will happen. Every man must face the risk of death although various factors contribute to its happening sooner or later; the circumstances in which he is placed, habits the mode of life, his age, occupation and a host of other circumstances. Since the insurers proceed on the calculation of the average duration of human life, based on a consideration of these and similar factors, it is of the utmost importance that such personal details of the life insured ought to

be revealed to them as being likely to affect their calculations.

11. Apart from the answers to the questions in the proposal form, the insurers require the insured to submit to an examination by their medical consultants who themselves put a number of questions to the insured before they express their opinion as to the personal health, past and present, of the insured. There is a duty on the applicant for life insurance to answer the questions put to him in the proposal form or by the medical examiner honestly and truthfully.

The duty of good faith is of universal application to all classes of insurance. The proposal form, usually concludes with a declaration which is often required to be separately signed by the proposer so as to draw his particular attention to the importance of what he is doing by which the proposer either warrants that the statements contained in the proposal are true or agrees that they should be the basis of the contract between the parties or accepts that their truth is to be a condition precedent to the validity of the contract. In completing, signing and submitting the proposal form, the proposer is providing information on which the insurers act in deciding whether to accept the proposal at all, or if so, at what premium¹. There is, therefore, ;t duty on the part of the proposer to make a full and frank disclosure of material facts and to be accurate in representations which he makes as to material facts.

12. Insurers Have been introducing into their policies an express stipulation making the representations and statements contained in the proposal and the answers in the personal statements the basis of the contract and as part of it. By a stipulation of this character, the insured guarantees the absolute truth of all those representations, statements and answers; and whether they be material Or immaterial, if any one of them is untrue, the contract is avoided".

In order to mitigate the rigour of this rule, the Indian Legislature has imposed statutory restrictions upon the right of the insurers to avoid a policy of life insurance on the ground of mis-statements made by the applicant in the proposal and declaration for life assurance. It is enacted by Section 45 of the Insurance Act 1938 (Central Act IV of 1938) which runs :

"No policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall, after the expiry of two years from the date on which it was affected, 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 reference, 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 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."

13. This section prescribes a statutory period of two years within which it is open to the insurers to repudiate liability under the contract on the ground of false and inaccurate information furnished by the insured. The effect of this provision is that after "the expiry of the two years in either of the cases contemplated therein, the insurers are prevented from relying upon the usual term that the truth of the statements made in the proposal and the answers in the declaration, form the basis of the contract.

Under the section, the policy cannot be avoided on the ground of misstatements or untrue answers, unless the insurers are able to establish (1) that the statement was inaccurate or false, (2) that such statement was on a material matter or that the statement suppressed facts which it was material to disclose, (3) that the statement was fraudulently made by the policy-holder, and (4) that the policy-holder knew at the time of making the statement that it was false to his knowledge or that facts which it was material to disclose had been suppressed". This provision places the burden of proof on the insurers to establish the above circumstances and unless the insurers are able to do so, there is no question of the policy being" avoided on the ground of misstatement of facts.

14. In the present case, the insurance was admittedly effected after the coming into force of the Act, and a period of two years has expired from the date on which the policy was effected. It is, therefore, incumbent on the insurers to establish that in the proposal for insurance and in the statements made by him before the medical consultants, the insured suppressed facts which it was material to disclose and that he made fraudulent misrepresentations . The question for determination now is whether the insurers have succeeded in establishing that the insured made statements which were false to his knowledge or suppressed facts which it was material to disclose.

15.-27. (His Lordship then considered the evidence given by the Insurers and continued as under):

28. After a careful consideration of the whole of the evidence, we are not satisfied that the insurers have succeeded in discharging the onus which lay upon, them. The evidence of D.W. 1 is unreliable. The documentary evidence tendered by the insurers 25 insufficient and inconclusive. The medical evidence adduced by them falls far short of what should be required, especially where charges of fraud are made, but also with respect to the allegation that the statements made by the insured were untrue.

29. "Hepatitis", according to the medical dictionary, means "inflammation of the

liver". The medical consultants of the insurers found that the condition of the liver of the insured was normal. It is quite possible that the insured himself had no knowledge that he was afflicted with that condition. It was explained by D.W. 2 himself, one of the medical consultants of the insurers, that a normal examination for insurance purposes would not reveal ordinary hepatitis and special tests should be done by a technician in a well equipped laboratory. If an experienced Doctor could not without special tests discover the existence of the condition known as hepatitis, is it reasonable to expect the insured, an ignorant lay man, to disclose that disease assuming that he suffered from the same? It is worthy of mention that the obligation to disclose does not extend to matters not within the knowledge of the proponent for insurance,

30. For these reasons, we think that the conclusion arrived at by the learned trial Judge that the plaintiff is entitled to succeed is correct. This appeal is therefore dismissed with costs.