(2008) 02 NCDRC CK 0034

In the National Consumer Disputes Redressal Commission

REGIONAL COMMISSIONER COAL MINES PROVIDENT FUND — APPELLANT

Vs

Bhojraj — RESPONDENT

Date of Decision : 20-02-2008

Acts Referred:

Citation : 2008 2 CPJ 137

Hon'ble Judges : J.D.Kapoor , Rumnita Mittal J.

Final Decision : Appeal allowed

Judgement

1. THE claim of the appellant against medi-claim policy was repudiated by the respondent on the ground that the policy in question was not a renewed policy but a fresh contract and since the appellant was suffering from pre-exiting disease, the claim was not maintainable. Consequently the appellant filed instant complaint before District Forum.

2. VIDE impugned order dated 23. 10. 2002, the District Forum dismissed the complaint of the appellant by accepting the version of the respondent Insurance Company. Feeling aggrieved the appellant has preferred this appeal.

Case of the appellant in brief was that the appellant is the regular customer of the respondent since 1990-91 though she could not renew the policy after 1994 but again insured in the year 1997-98, and continued the policy for 1998-99 and 1999-2000. The premium amount was always collected by the agent of the respondent. She underwent treatment in December 1999 of which information was given to the respondent on 23. 12. 1999. She filed a claim with the respondent but it was turned down by the respondent on the ground that the policy was fresh and the disease was an old one or pre-existing. She has stated that her policy was for the period 3. 3. 1997 to 2. 3. 1998 then from 5. 3. 1998 to 4. 3. 1999 and 10. 3. 1999 to 9. 3. 2000 and the break in periods could be due to the fact that the premium amount was deposited late by the agent. Her plea therefore is that as far as she is concerned, these were no fresh policies and only renewals. She has denied that the disease was pre-existing as the respondent has failed to give any specific date of disease or any reason which led

him to believe that the appellant was in the knowledge of the same (She was treated for breast cancer). She has prayed that the respondent be directed to reimburse the amount of claim with interest @18% p. a. and Rs. 1,00,000 and compensation and cost of the litigation.

3. AS against this the stand taken by the respondent was that there was a break in insurance policy. Her previous medi-claim policy was from 5. 3. 1998 to 4. 3. 1999 and the appellant got the fresh policy from 10. 3. 1999 to 9. 3. 2000 after a gap of six days. The policy taken by the appellant for the period 10. 3. 1999 to 9. 3. 2000 is current policy and hence considered by the respondent as a fresh policy. Therefore there was no deficiency in service on the part of the respondent. They have refused to accept that the appellant was regular customer as there was break in the period of policy. They have further denied that any agent or officer of the Insurance Company ever collected the premium amount from the appellant. In fact the appellant vide her letter dated 30. 3. 2000 received by the respondent on 2. 4. 2000 clearly states that the appellant was not in town and could not send the premium in time. Further that the patient was admitted with history of awareness of lump in the right breast and was suffering from "infiltrating duct carcinoma of breast with metastasis. The discharge summary further says that there were "multiple painful lumps in both breasts twelve months back and the patient was got examined in March 1999. The appellant was fully aware of the disease since 1998 and hence the disease was pre-exiting at the time of current policy which was taken for the period 10. 3. 1999 to 9. 3. 2000. Even if we accept the version of the respondent that it was a fresh policy still the ground of repudiation of the claim was not justified. Unless and until a person is hospitalized or undergoes operation for a particular disease in the near proximity of obtaining the insurance policy, he cannot be accused of concealing the factum of suffering from such disease at the time of obtaining the policy as he comes to know about the medical terminology of the disease when he lands up in the hospital for treatment including the operation.

4. THE disease should be pre-existing which means that the disease for which a person has received treatment should have been existing and in the knowledge of the person. If later on in the treatment it is found that the person has also been suffering from disease in the past he is not expected or supposed to disclose the same in the proposal form. In the instant case no such circumstance or fact was brought out by the respondent as the appellant had never been treated or hospitalized or undergone any operation for any disease whatsoever much less for which she was admitted. Consumer being a layman is not supposed to know the medical terminology of the disease for which he has never been treated or hospitalized or undergone operation. Day-to-day problem of any kind of malaise that are controllable on day-to-day basis which are normal wear and tear of human life are not the diseases that are required to be referred in the proposal form. In the instant case the discharge summary only states that there were multiple painful lumps in both breasts twelve months back. It does not mean that the appellant should know about this as she has never been subjected

to any test or undergone operation for the said problem. Thus by no stretch of imagination the appellant can be accused of concealing factum of pre-existing disease and as such the complaint was wrongly dismissed by the District Forum.

5. ON the import and meaning of words "disease" and "pre-existing disease" in relation to insurance contract we have in highly extensive and dissective manner drawn certain conclusions. For ready reference our conclusions are as under: (i) ''disease'' means a serious derangement of health or chronic deep-seated disease frequently one that is ultimately fatal for which an insured must have been hospitalized or operated upon in the near proximity of obtaining the mediclaim policy.

(ii) Such a disease should not only be existing at the time of taking the policy but also should have existed in the near proximity. If the insured had been hospitalized or operated upon for the said disease in the near past, say, six months or a year he is supposed to disclose the said fact to rule out the failure of his claim on the ground of concealment of information as to "pre-existing disease".

(iii) Malaise of hypertension, diabetes, occasional pain, cold, headache, arthritis and the like in the body are normal wear and tear of modern day life which is full of tension at the place of work, in and out of the house and are controllable on day-to-day basis by standard medication and cannot be used as concealment of ''pre-existing disease'' for repudiation of the insurance claim unless an insured in the near proximity of taking of the policy is hospitalized or operated upon for the treatment of these diseases or any other disease.

(iv) If insured had been even otherwise living normal and healthy life and attending to his duties and daily chores like any other person and is not declared as a ''diseased person'' as referred above he cannot be held guilty for concealment of any disease, the medical terminology of which is even not known to an educated person unless he is hospitalized and operated upon for a particular disease in the near proximity of date of insurance policy say few days or months.

(v) Disease that can be easily detected by subjecting the insured to basic tests like blood test, ECG etc. the insured is not supposed to disclose such disease because of otherwise leading a normal and healthy life and cannot be branded as ''diseased person''.

(vi) Insurance Company cannot take advantage of its act of omission and commission as it is under obligation to ensure before issuing medi-claim policy whether a person is fit to be insured or not. It appears that Insurance Companies don''t discharge this obligation as half of the population is suffering from such malaises and they would be left with no or very little business. Thus any attempt on the part of the insurer to repudiate the claim for such non-disclosure is not permissible, nor is ''exclusion clause'' invokable.

(vii) Claim of any insured should not be and cannot be repudiated by taking a clue or remote reference to any so-called disease from the ''discharge summary'' of the insured by invoking the ''exclusion clause'' or non-disclosure of ''pre-existing disease'' unless the insured had concealed his hospitalization or operation for the said disease undertaken in the reasonable near proximity as referred above.

(viii) Day-to-day history or history of several years of some or the other physical problem one may face occasionally without having landed for hospitalization or operation for the disease cannot be used for repudiating the claim. For instance an insured had suffered from a particular disease for which he was hospitalised or operated upon 5, 10 to 20 years ago and since then had been living healthy and normal life cannot be accused of concealment of ''pre-existing disease'' while taking mediclaim policy as after being cured of the disease, he does not suffer from any ''disease'' much less the ''pre-existing disease''.

(ix) For instance, to say that insured has concealed the fact that he was having pain in the chest off and on for years but has never been diagnosed or operated upon for heart disease but suddenly lands up in the hospital for the said purpose and therefore is disentitled for claim bares dubious design of the insurer to defeat the rightful claim of the insured on flimsy ground. Instances are not rare where people suffer a massive attack without having even been hospitalised or operated upon at any age say for 20 years or so.

(x) Non-disclosure of hospitalization/or operation for disease that too in the reasonable proximity of the date of mediclaim policy is the only ground on which insured''s claim can be repudiated and on no other ground.

6. IN view of the foregoing reasons we allow the appeal, set aside the impugned order with the direction to the respondent to reimburse the amount of claim. We further award Rs. 25,000 as compensation for mental agony and harassment suffered by the appellant, which shall include the cost of litigation. The payment shall be made within one month from the date of receipt of this order. Bank Guarantee/fdr, if any, furnished by the appellant be returned forthwith.

A copy of this order as per the statutory requirements be forwarded to the parties free of charge and also to the concerned District Forum and thereafter the file be consigned to Record Room.

7. COPY be sent to Presidents of all the District Forums. Appeal allowed.

