
(2012) 02 KL CK 0146
In the High Court Of Kerala
Case No : Writ Petition (C) No. 22679 of 2006

Suresh, P.V.

APPELLANT

Vs

Insurance Ombudsman and another

RESPONDENT

Date of Decision : 16-02-2012

Acts Referred:

Constitution of India, 1950 — Article 226
Insurance Act, 1938 — Section 45
Redressal of Public Grievances Rules, 1998 — Rule 18

Citation : (2012) 1 ILR (Ker) 733 : (2012) 1 KLJ 837

Hon'ble Judges : S. Siri Jagan, J

Bench : Single Bench

Advocate : T.C. Suresh Menon, Sri K.R. Sreekanth, Sri Jibu P. Thomas and Sri Sunil J. Chakkalackal, for the Appellant; Lal George For 2nd Respondent, for the Respondent

Final Decision : Allowed

Judgement

Mr. Justice S. Siri Jagan

1. Aggrieved by the order of the Insurance Ombudsman rejecting the complaint against the repudiation of a claim under a Life Insurance Policy in favour of his deceased wife, the petitioner has filed this writ petition seeking the following reliefs: (i) call for the records leading to the passing of Exts. P-3 and P-5 orders by the respondents and quash the same by the issue of a writ of certiorari or other appropriate writ, order or direction;

(ii) issue a writ in the nature of mandamus directing the second respondent to honour the Policy No. 773896707 issued in favour of late Lalitha and disburse the amount due thereunder to the nominee, the petitioner herein.

(iii) declare that the reasons stated by the respondents to repudiate the claim put forward by the petitioner is highly unsustainable and vitiated by arbitrariness.

The petitioner's wife, Lalitha, took Ext. R-2(a) Insurance Policy dated 28-2-2002,

for Rs. 50,000 from the 2nd respondent--Life Insurance Corporation of India. She died on account of cancer of the cervix on 9-9-2004. Before her death, she paid 10 quarterly premia amounting to Rs. 8860 due on the policy. On the death of the life assured, the petitioner preferred a claim for the insurance amount as per the policy, which was repudiated by the 2nd respondent on the ground that answers to two questions in the negative as to whether the life assured had ever been admitted to any hospital or nursing home for general check-up, observation, treatment or operation and whether the life assured was suffering from or had ever suffered from Diabetes, Tuberculosis, High Blood Pressure, Low Blood Pressure, Cancer, Epilepsy, Hernia, Leprosy or any other disease in Ext. P-1 proposal made by the deceased was incorrect, since she had undergone treatment for Rheumatoid Arthritis and had taken treatment for the same in a hospital, from which it is evident that she had made deliberate and fraudulent misstatements and withheld material information at the time of effecting the assurance. The petitioner's complaint against the repudiation was answered by the 1st respondent-Insurance Ombudsman, by Ext. P-5 order upholding the repudiation by the 2nd respondent, relying on Section 45 of the Insurance Act, 1938, but by granting an ex gratia award of Rs. 5000 holding thus: 7. The Point.--Insurance is a contract of "utmost good faith" (Ubberrima Fide) and, more particularly in life insurance, the insurer, in many cases, has to go by what the proponent states about himself/herself in the proposal. From the insurer's point of view, the claim has to be settled within the legal frame work of the insurance contract-taking into account its terms and conditions, its limitations and restrictions. Whereas equity and fair play demand that the claims have to be settled according to the spirit of the Insurance Contract rather than its letter, yet technical and social obligations to the entire insuring public demand that the claims have to be investigated thoroughly to detect possible fraudulent claims. It is also worth while to note that a party of full age and understanding is normally bound by his/her averments in the document (proposal form) whether he/she reads it, understands it or not. Equity does not save people from the consequences of their own folly. It is, further, profitable to note the principle that extravagant literality and immoderate folly do not, by themselves, provide a passport to equitable relief [Tufflow v. Sporni (1952 (2) TLR 516 at 519)].

8. Having said so much about Insurance Contracts in general, this Forum now goes a little deep into the dispute on hand. The policy had commenced in March 2002 and even as far back as in the year 1999, the insured had undergone inpatient treatment at Jubilee Mission Hospital at Thrissur for Rheumatoid Arthritis. The question No. 31 and its subsidiaries in the proposal form are very specific and having answered both these questions in the negative and to the advantage of the life assured, the complainant now cannot be allowed to say that life assured was totally innocent about such incorrect averments. The hospital records produced by the insurer as well as the oral testimony of the complainant himself have proved the suppression of material facts beyond all doubts. It is no doubt true that the proximate cause of death of the life assured was "Carcinoma

Cervix" and possibly the ailment of cancer was detected only in June 2003 as mentioned by the complainant. But, this position would not improve the case of the complainant in as much as that the earlier episode of illness in the year 1999 and the hospitalization therefor was not mentioned in the proposal form. As far as he (sic) insurer is concerned, this omission on the part of the life assured was a point material to the assessment of risk.

9. Therefore, as per Section 45 of the Insurance Act, the action of the insurer in repudiating the claim is fully justified and it does not call for any interference by this Forum.

10. However, certain facts of the case deserve a moderately sympathetic consideration in the interest of overwhelming natural justice.

11. The life assured was in the early 40s at the time of her death. The ailment of cancer was diagnosed only in June 2003. The earlier hospitalization in the year 1999 was for "swelling at joints", "pain all over the body" and "fever" which was subsequently diagnosed as Rheumatoid Arthritis. It is on record (see letter of the Jubilee Mission Hospital dt. 4-12-2004) that the life assured was on "Ayurvedic treatment". If the life assured or the complainant were aware of the seriousness of the disease, they would have been more careful at least as far as the treatment is concerned. The complainant also had mentioned in his oral testimony before this Forum that they had not understood the seriousness of the questions in the proposal form (Qn. No. 11 etc.). The policy would have acquired paid-up value if it had completed 3 years of premium payment; the life assured had paid as many as 10 quarterly premia amounting to a total of Rs. 8860 as on the date of her death. The life assured had left behind, apart from her husband, a school going son and an unmarried daughter. Therefore, considering the totality of all these circumstances, although the suppression of material facts is proved in the case and the action of repudiation of the claim by the insurer is upheld, a small concession is allowed to the complainant by way of ex gratia under Rule 18 of the RPG Rules, 1998 for the reason that the insured by innocence, probably did not think of the consequence, of her misrepresentation in the proposal. However, considering the fact that though the willful omission to answer accurately for question No. 11(a) & (b) was due to some mistaken idea about her ailments and hospitalization in 1999, I am inclined to allow an ex gratia award of Rs. 5000 to the complainant.

2. The petitioner's contention is that the 2nd respondent had not proved with any reliable evidence that the life assured had fraudulently suppressed any fact which was material to disclose and that at the time of making the statement she had known that the statement was false, the onus of proving which was squarely on the 2nd respondent as per Section 45, since two years had already expired from the date of effecting the policy, at the time of death of the life assured. Therefore, the repudiation by Ext. P-3 and the upholding of the same by Ext. P-5 order of the Insurance Ombudsman are illegal and unsustainable is the contention raised.

3. The 2nd respondent has filed a counter-affidavit supporting the impugned order on the ground that the fact of suppression of the material fact is admitted by the petitioner and that insurance being a contract of utmost good faith, the misstatement is sufficient for valid repudiation of the claim, since as per Clause 5 of Ext R-2(a) policy, the policy holder had specifically undertaken that in case it is found that any untrue or incorrect statement is contained in the proposal, personal statement, declaration and connected documents or any material statement is withheld, subject to Section 45, the policy shall be void. They also rely on the preamble to the policy document to buttress their argument. They would submit that they have discharged their onus of proving their contention and even otherwise it is for the petitioner to prove that the suppression was not material and was made bona fide.

4. In the course of arguments the counsel for the 2nd respondent relied on the decision of the Supreme Court in *Chacko v. L.I.C.* 2008 (1) KLT 698 (S.C.) in support of his contention that it was not necessary for the insurer to establish that the suppression was fraudulently made by the policy holder or that he must have been aware at the time of making the statement that the same was false or that the fact was suppressed which was material to disclose and once it is proved that a false statement has been made in the proposal that is good reason to validly repudiate the claim.

5. The fact that the statements referred to made by the policy holder in Ext. P-1 proposal was wrong was never disputed by the petitioner at any time. The policy holder had undergone treatment for Rheumatoid Arthritis for the period from 18-8-1999 to 24-8-1999 as evidenced by Ext. R-2(b) communication issued to the 2nd respondent by the Jubilee Mission Medical College, Thrissur. Going by Section 45 of the Insurance Act, 1938, the following questions are relevant in the context:

(i) whether the non-disclosure is of a fact which it was material to disclose?

(ii) whether the suppression was fraudulently made by the policy holder?

(iii) whether the policy holder had known at the time of making that it was false or that she suppressed facts which it was material to disclose? and

(iv) whose burden is it to prove the above?

(v) whether that burden has been discharged by the party on whom the burden is?

6. Arguments were advanced before me by both sides mainly on the question of burden of proof u/s 45 and in the course of answering that question the other questions would also stand answered. The petitioner relies on the Section itself and decisions of the Supreme Court in *Mithoolal Nayak Vs. Life Insurance Corporation of India*, and *Life Insurance Corporation of India v. Asha Goel* 2000 (3) KLT S.N. 55 (Case No. 73). The 2nd respondent relies on the Supreme Court's decision in *Chacko's case* (supra) and *Satwant Kaur Sandhu Vs. New*

India Assurance Company Ltd., and the Division Bench decisions of this Court in A.F.A. No. 18 of 2000 and WA. No. 1823 of 2010.

7. Section 45 of the Insurance Act 1938 reads thus:

45. Policy not to be called in question on ground of mis-statement after two years.--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 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 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.

(underlining supplied)

The above Section admits of no doubt or ambiguity as to the fact that after the expiry of two years from the date on which the policy was effected, the policy cannot be called in question on the ground that a statement made in the proposal for insurance 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 policyholder and that the policyholder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose. When the section itself is very clear, there is no scope for interpretation of the same either way. But in Chacko's case (supra), the Supreme Court has held thus in paragraph 16:

16. The purpose for taking a policy of insurance is not, in our opinion, very material. It may serve the purpose of social security but then the same should not be obtained with a fraudulent act by the insured. Proposal can be repudiated if a fraudulent act is discovered. The proposer must show that his intention was bona fide. It must appear from the face of the record. In a case of this nature it was not necessary for the insurer to establish that the suppression was fraudulently made by the policy-holder or that he must have been aware at the time of making the statement that the same was false or that the fact was suppressed which was material to disclose. A deliberate wrong answer which has a great bearing on the contract of insurance, if discovered may lead to the policy

being vitiated in law.

(underlining supplied)

The same, on a cursory reading, would support the 2nd respondents contention that it was not necessary for the insurer to prove that the suppression was fraudulently made by the policy-holder or that he must have been aware at the time of making the statement that the same was false or that that the fact was suppressed which was material to disclose. But that decision has to be appreciated in the light of the facts of that case. That was a case in which the policy-holder took the policy on 21st February 1987. He died on 6th July 1987, i.e. within two years from the date on which the policy was effected, which squarely falls within the exclusion of the burden of proof of insurer in Section 45. This, coupled with the words "in a case of this nature" used by the Supreme Court in that decision, makes it abundantly clear that the Supreme Court has not made any new law to exclude the burden of the insurer to prove that in cases where two years have elapsed after the effecting of the policy the insurer, it is not necessary for the insurer that the suppression was fraudulently made by the policy-holder or that he must have been aware at the time of making the statement that the same was false or that that the fact was suppressed which was material to disclose. The decisions of the Supreme Court in Mithoolal's case (supra) and Asha Goel's case (supra) are also to that effect. The decision in Mithoolal's case (supra) is by a Bench of three judges and that of Chacko's case (supra) is by a Bench of two judges. The Supreme Court decided Chacko's case (supra) after referring to the decisions of Mithoolal's case (supra) and Asha Goel's case (supra) also without expressing any opinion contrary to the law already laid down in those cases, which would go to show that the Supreme Court had rendered the decision only in the context of repudiation of a claim within two years of the date of effect of the policy and that in respect of a claim after two years of effect of the policy, the Supreme Court has not laid down any different law. Therefore the onus of proving that the wrong or even false statement made by the petitioner's wife was fraudulently made by her and that she must have been aware at the time of making the statement that the same was false and that that fact was suppressed which was material to disclose, is squarely on the 2nd respondent. The 2nd respondent relies on the decision in A.F.A. No. 18 of 2000 in support of his contention on the basis of the preamble of Ext R-2(a) policy, which need not be separately considered in view of my decision on the burden of proof u/s 45.

8. The next question is as to whether the 2nd respondent has discharged that burden. The non-disclosure was about the treatment for Rheumatoid Arthritis and the policy-holder died of cervical cancer, which are undisputed facts. The treatment for Rheumatoid Arthritis was three years prior to Ext. P-1 proposal. The policy was issued after the doctor designated by the 2nd respondent had thoroughly examined the proposer, which also cannot be disputed by the 2nd respondent. It is also seen from Ext. P-1 that the policy was taken through an

agent of the 2nd respondent The petitioner has stated that he and his wife were not educated persons, they being a brick manufacturer and an agriculturist respectively, which fact has not been disputed by the 2nd respondent. In the column referred to by the 2nd respondent where the policyholder has given the wrong statement the disease Rheumatoid Arthritis is not specifically mentioned, whereas Diabetes, Tuberculosis, High Blood Pressure, Low Blood Pressure, Cancer, Epilepsy, Hernia, Leprosy are and the disease Rheumatoid Arthritis comes within any other disease mentioned therein. Therefore, prima facie, it is very reasonable to assume that the proposer answered in the negative quite inadvertently, without any motive to suppress that fact. The petitioner also did not dispute the treatment for Rheumatoid Arthritis at any time. These circumstances are sufficient to infer that there is nothing to prima facie show that the wrong answers were deliberately given by the petitioner's wife, knowing the same to be false, fraudulently.

9. The 1st respondent does not mention about any evidence adduced before her by the 2nd respondent. Going by Ext. P-5 and the documents produced by the respondent before this Court. It is reasonable to assume that apart from Ext P-1 proposal, Ext. R-2(a) policy and Ext R-2(b) letter from the Jubilee Mission Medical College, Thrissur, no other evidence was adduced by the 2nd respondent before the 1st respondent as evidence either documentary or oral. The 1st respondent has not stated in Ext. P-5, whether these documents prove that the wrong or even false statement made by the petitioner's wife was fraudulently made by her and that she must have been aware at the time of making the statement that the same was false and that that fact was suppressed which was material, which finding is mandatory for deciding the issue in favour of the 2nd respondent, going by Section 45 of the Insurance Act, 1938. As such the 1st respondent has not considered the case in the perspective which she ought to have as a quasi-judicial authority, which the Insurance Ombudsman is. The question as to whether the wrong or even false statement made by the petitioner's wife was fraudulently made by her or that she must have been aware at the time of making the statement that the same was false or that that the fact was suppressed which was material cannot be decided on these documents alone. The said fact is a state of kind. For proving the same, the agent through whom the proposal was made, the doctor designated by the 2nd respondent, who examined the petitioner's wife before accepting the proposal, and the doctor from Jubilee Mission Medical College, who treated the petitioner's wife for Rheumatoid Arthritis, ought to have been examined as witness. As it stands now, the only proof, at the most, is that the statements made by the petitioner's wife were false. Going by Section 45, for repudiating the claim of the petitioner, it is not sufficient to prove that the statements were false. They have to further prove that the false statements made by the petitioner's wife were fraudulently made by her and that she must have been aware at the time of making the statement that the same were false and that a fact was suppressed which was material. I am not satisfied that the 2nd respondent has discharged

their burden of proving the same, which is mandatory for upholding their repudiation of the claim of the petitioner. I am also satisfied that the 1st respondent has not decided that material question, which goes to the root of the case, which she ought to have mandatorily decided. Certainly a contract of insurance is a contract of utmost good faith, but at the same time it must not be lost sight that it is a contract for social insurance and certain rights under the contract, not stated in the contract are protected by the Insurance Act in the interest of social insurance. The legislature wanted to safeguard the beneficiary of the policy from unreasonable repudiation from the insurer and has therefore consciously cast the burden of proving certain facts squarely on the insurer, which statutory provision has to be strictly construed keeping in mind the object with which the legislature has enacted the provision in the statute.

10. The counsel for the 2nd respondent, relying on the decision of the Division Bench of this Court in W.A. No. 1823 of 2010 would contend that, when the Insurance Ombudsman, in exercise of the wide jurisdiction, including the authority to settle the legal construction of insurance contracts, vested in that authority, places certain constructions of the terms of a disputed contract, this court, in exercise of its jurisdiction under Article 226 of the Constitution shall not sit in judgment regarding the correctness of the decision of the Ombudsman as if it were an Appellate Court. I am of the opinion that the reliance on that decision is clearly misplaced. Here what is posed before me is a pure question of law, which the insurance Ombudsman ought to have decided while passing the impugned order, which she did not and therefore the impugned decision is clearly perverse. It is settled law that perverse decisions of quasi-judicial authorities, even on questions of fact, can be interfered with by this Court in exercise of jurisdiction under Article 226 of the Constitution of India. Here the Insurance Ombudsman has decided a case before her contrary to the statutory provision regarding burden of proof in the matter of insurance claims, as well as binding precedents on the subject, which can be certainly interfered with by this Court in exercise of jurisdiction under Article 226 of the Constitution of India and it is the Constitutional duty of this Court to do so. In view of the above discussion, I have no hesitation to hold that the repudiation of the claim of the petitioner by the 2nd respondent is clearly illegal and unsustainable and the order of the 1st respondent holding otherwise is also unsustainable. Therefore Ext. P-3 order of the 2nd respondent repudiating the claim of the petitioner and Ext. P-5 order of the 1st respondent upholding the same are hereby quashed. The 2nd respondent is directed to pay to the petitioner the insurance amounts due to the petitioner under Ext. R-2 (a) policy, with accrued bonus, if any, and interest @ 9% per annum from the date of the claim, viz. 7th October 2004, till date of payment, as expeditiously as possible at any rate within one month from the date of receipt of a copy of this judgment

The writ petition is allowed as above, but without any order as to costs.