
(2014) 10 P&H CK 0028

In the Punjab And Haryana At Chandigarh

Case No : Civil Writ Petition No. 4695 of 2013 (O and M)

The Oriental Insurance Co. Ltd.

APPELLANT

Vs

Naresh Sharma and Others

RESPONDENT

Date of Decision : 07-10-2014

Acts Referred:

Constitution of India, 1950 — Article 12 14
Contract Act, 1872 — Section 23

Citation : (2015) ACJ 2478 : (2015) 178 PLR 75

Hon'ble Judges : Ritu Bahri, J

Bench : Single Bench

Advocate : Ashwani Talwar, Advocate for the Appellant; Ashok Tyagi, Advocate for the Respondent;

Final Decision : Dismissed

Judgement

Ritu Bahri, J.

1. Challenge in this petition is to the order dated 15.11.2012 (Annexure P-1) passed by the Permanent Lok Adalat (Public Utility Services), Gurgaon-respondent No. 3, whereby the petitioner-insurance company has been directed to pay an amount of Rs. 2,00,000/- along with interest at the rate of 9% per annum to the claimant. Naresh Sharma-respondent No. 1 had taken a mediclaim policy bearing No. 215300/48/2011/5248 for the period from 25.01.2010 to 24.01.2011 (Annexure P-2) from the petitioner-company and assured a sum of Rs. 2,00,000/-. This policy was subsequently renewed to be valid from 25.01.2011 to 24.01.2012. Respondent No. 1 suffered from headache, giddiness and hypertension on 03.01.2012, due to which, he was got admitted in Madanta Hospital, Gurgaon, from where he was discharged on 07.01.2012. He was treated by Dr. Achint Malhotra. During this period, he incurred a sum of Rs. 3,33,877/- on his treatment. Thereafter, he made a claim to the petitioner-insurance company for reimbursement of the amount, which was incurred by him on his treatment. But, his claim was not entertained by the petitioner. Therefore,

he filed an application before the Permanent Lok Adalat-respondent No. 3.

2. Before the Permanent Lok Adalat, the stand of the petitioner-company was that vide letter dated 06.02.2012, the applicant-respondent No. 1 had been informed that necessary documents had not been received despite three query letters. On this account, the benefit had been denied. The claim was denied on the ground that charges relating to the treatment of the disease were not payable in the first two years of the policy period and it was explained to claimant-respondent No. 1 at the time of granting the aforesaid policy.

3. The Permanent Lok Adalat, after making attempts for reconciliation, decided the claim of respondent No. 1 in view of the Division Bench judgment delivered in Iffco Tokio General Insurance Company Ltd. Vs. Permanent Lok Adalat (Public Utility Services), Gurgaon and Others, .

4. Learned counsel for the petitioner-company has argued that the aforesaid judgment, relied upon by the Permanent Lok Adalat, would not be applicable to the facts of the present case. Naresh Sharma-applicant was suffering from headache, giddiness and hypertension, due to which, he was admitted in Madanta Hospital, Gurgaon on 03.01.2012 and remained admitted till 07.01.2012. He incurred a sum of Rs. 3,33,877/- on his treatment. As per exclusion clause of policy (Annexure P-2), disease of hypertension, on account of which claimant-respondent No. 1 had got himself admitted in the hospital, was excluded in the first two years of policy period. Claimant was in the second year of the policy, which had been renewed on 25.01.2011. Therefore, he was not entitled for the facility of cashless treatment. There was no breach of any term of the policy on the part of the petitioner-company. Hence, the claim has been wrongly accepted by the Permanent Lok Adalat.

5. A perusal of the policy (Annexure P-2) does not show any of the exclusion clauses. The other ground for rejecting the claim of applicant-respondent No. 1 was that necessary papers have not been supplied to the company. However, during the course of proceedings before the Permanent Lok Adalat, the bills were produced and effort was made to amicably resolve the dispute. As per clause 4.3 of the policy (Annexure P-2), the applicant-respondent No. 1 could not be reimbursed the charges during the currency of the policy. Clause 4.3 is reproduced as under:--

"4.3 The expenses on treatment of following ailment/diseases/surgeries for the specified period are not payable if contracted and/or manifested during the currency of the policy. If these diseases are pre-existing at the time of proposal, the exclusion No. 4.1 for pre-existing condition SHALL be applicable in such cases.

6. At serial No. XVII of the above table, the exclusion clause relates to hypertension, as per which, for a period of two years, no reimbursement can be claimed for the said disease. While deciding the claim, the Permanent Lok Adalat has made reference to a Division Bench judgment delivered in Iffco Tokio Genera

Insurance Company s, case (supra). The facts of this case are not applicable in the present case as, hyper technical objection was taken by the insurance company to reject the claim of the applicant. The claim of the applicant in that case was denied on the ground that he had been suffering from that disease for the past 8 years and it was a case of preexisting disease, which was covered under the exclusion clause of the policy. The applicant had made premium for three years and his claim could not be denied on the above said ground. The Division Bench held that after accepting premium for three years, his claim could not be denied on the ground that he was suffering from that disease for the past 8 years. This clause was struck down on the principle that bargaining power of the parties was unequal and the consumer had no freedom to contract and such a power was to be considered unfair.

7. In the facts of the present case, the petitioner had taken the policy in the year 2011 and as per the terms of the policy in the exclusion clause, he could not get reimbursement for certain diseases for certain period of time. Hypertension was one of the diseases, for which, he could not claim reimbursement for first two years of the policy.

8. The question for examination would be, "whether an exclusion clause at all can be made in the insurance policy."

9. This issue had come up for consideration before a Division Bench of the High Court of Life Insurance Corporation of India and Another Vs. Shri Rajiv Khosla and Another, . In that case, one of the conditions was that the policy would stand cancelled in case the life insured died before the deferred date. The Division Bench held that Insurance Regulatory Authority under the Insurance Regulatory and Development Act, 1999, had a duty to regulate, promote and ensure orderly growth of insurance business and reinsurance business. No insurance policy could be introduced in the market or modified without prior scrutiny and approval of IROA. Deferred date policies for children issued by LIC had been approved by IRDA. Therefore, the action of Corporation could be stated to be unfair inasmuch as incorporation of deferred date in special conditions of policy did not appear as unfair, unreasonable or unconscionable. In the aforesaid case, It was further observed as under:--

"22. In P.C. Chacko and Another Vs. Chairman, Life Insurance Corporation of India and Others, , a two Judge Bench has opined thus: We are not unmindful of the fact that Life Insurance Corporation being a State within the meaning of Article 12 of the Constitution of India, its action must be fair, just and equitable but the same would not mean that it shall be asked to make a charity of public money, although the contract of insurance is found to be vitiated by reason of an act of the insured. This is not a case where the contract of insurance or a clause thereof is unreasonable, unfair or irrational which could make the court carry the bargaining powers of the contracting parties. It is also not the case of the Appellants that in framing the aforesaid questionnaire in the application/proposal form, the Respondents had acted unjustifiably or the conditions imposed are

unconstitutional.

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24. From the aforesaid decisions, the principles that are culled out are that every action of the State or public authority or the person whose action, involves public element should primarily be guided by public interest; that though the insurer is free to evolve a policy based on business principles, yet the insurance being a social security measure, it should be consistent with the constitutional animation and conscience of socio-economic justice enshrined in the Constitution of India; that there is a distinction between the frontiers of the public law domain and the private law field; that an unfair and untenable or irrational clause in a contract is amenable to judicial review; that there are distinctive features between general insurance and life insurance inasmuch as in case of life insurance policy, certain sum is agreed to be paid by the insurance company in the event of the death of the insured or a contingency arising as indicated in the policy and the only obligation of the insured is to pay the premium; that where a statute does not provide for a compulsory insurance, the parties are free to choose their own terms of contract; that in the absence of any statutory liability, the insurance company cannot be forced by courts to take on liabilities which they do not want to take on; that if the action of the State is violative of the equality clause contained in Article 14 of the Constitution of India, a writ petition would be maintainable in the contractual field; that the State and its authorities including the instrumentalities of the State have to show justness, fairness and reasonableness in all their activities in the field of contract, otherwise they invite discomfort to Article 14 of the Constitution of India; that the jurisdiction of the superior court can be invoked under Article 14 of the Constitution of India as also Section 23 of the Contract Act to strike down a clause in the contract which the court feels to be unconscionable having regard to the unequal bargaining powers of the parties; and that the contract of insurance is fundamentally based on faith and are contracts of uberrima fides."

10. The Hon"ble Supreme Court in *United India Insurance Co. Ltd. Vs. Great Eastern Shipping Co. Ltd.*, , has laid down guidelines for interpreting the policies issued by the insurance companies. In para 17 of the judgment, the Hon"ble Supreme Court has observed as under:--

"17. After considering the" ratio with regard to the construction of the terms of the policy it transpires that while interpreting the policy the courts should keep in view the intention of the parties as well as the words used in the policy. If the intention of the parties subserves the expression used therein then the expression used in that context should be given its full and extended meaning. In the present case, as is apparent on reading of the Institute Cargo clause and the coverage, terms of the policy and the extended coverage, the intention that appears from these terms and conditions that the goods were first covered from port in China, destination in Calcutta port and thereafter extended coverage was sought and in that it was extended to any part of the Republic of India. If these

two terms of the policy are read in conjunction then it clearly transpires that the goods are covered till they reach the destination in any part of India. If the extended cover would not be given the policy would extend to Calcutta port. If extended coverage is read, which clearly stipulates that this extension is covered on same terms and conditions of the original policy then it could mean that the policy has been covered till the goods reach the consignee in any part of the country in India. In fact, the extended coverage was only meant for the goods to be covered till they reach destination either by rail or road in any part of the country. If this extended coverage is not interpreted to mean that goods should reach the destination in any part of India, then the extended coverage on payment of higher premium would be meaningless. The coverage was sought because the final destination of the goods was not at Calcutta port. When the coverage was extended on same terms and conditions that would mean that the goods were covered till the same reached in any part of the country in India. In the present case, the goods reached the Calcutta Port and they were taken to different sheds. But unfortunately, the goods were destroyed by fire at Calcutta port itself. Therefore, we are of the view that since the goods were covered from Calcutta port till the same reach its destination and they were lying on storage, that would cover the goods by the extended policy and the insurer cannot defeat the claim of the claimant that the goods once reached the destination at Calcutta the policy stood discharged. The contention of Mr. Mehra that the extended coverage does not cover the goods in transit till they reach any part of the country is not correct because the transit infers storage also till it reaches its destination. The damage on the rail or road would also include that in transit the goods are to be kept in transit shed, the policy would cover that also. If this interpretation is not given then the extended coverage would be of no use. Looking to the expression used in the background of the intention of the parties, it clearly transpires that once the goods were insured, then till they reach any part of the country shall be covered by the extended coverage. Therefore, the contention of Mr. Mehra cannot be accepted."

11. The Hon"ble Supreme Court in United India Insurance Co. Ltd. Vs. Harchand Rai Chandan Lal, , held that the terms and conditions of the insurance policy will govern the contract between the parties and those terms and conditions must be directed towards achieving the object of the Act by satisfying the purpose of insurance. Any such complicated or misleading conditions and clauses which are beyond the understanding and expectation of a common man and lead to defeating the very purpose of insurance, need to be modified. In this judgment, the Hon"ble Supreme Court was dealing with a case, where there was a contract of insurance for a sum of Rs. 7 lacs against burglary/house breaking policy. As per the policy, burglary and or house breaking would mean theft involving entry to or exit from the premises by forcible and violent means or following assault or violence or threat thereof to the insured or to his employees or to the members of his family. The insurance company took a plea that the insured has to establish that the theft or burglary took place preceding with force or violence

and if, he could not prove the same, then the insurance company could repudiate the claim of the insured. In para 16 of the aforesaid judgment, the Hon"ble Supreme Court observed as under:--

"But before parting with the case we would like to observe that the terms of the policy as laid down by the Insurance Company should be suitably amended by the Insurance Company so as to make it more viable and facilitate the claimants to make their claim. The definition is so stringent in the present case that it gives rise to difficult situation for the common man to understand that in order to maintain their claim they will have to necessarily show evidence of violence or force. The definition of the word burglary should be given meaning which is closer to the realities of life. The common man understands that he has taken out the Policy against theft. He hardly understands whether it should precede violence or force. Therefore, a policy should be a meaningful policy so that a common man can understand what is the meaning of burglary in common parlance. Though we have interpreted the present policy strictly in terms of the policy but we hope that the Insurance Companies will amend their policies so as to make them more meaningful to the public at large. It should have the meaning which a common man can easily understand rather than become more technical so as to defeat the cause of the public at large."

12. Further, the Hon"ble Supreme Court in *General Assurance Society Ltd. v. Chadmull Jain and another*, 1966 AIR (SC) 1644, held that there was no difference between a contract by Insurance and any other contract, except that in a contract of insurance there is requirement of *uberrima fides* i.e. Good faith on the part of the assured. In para 11 of the said judgment, it has been held as under:--

"A contract of insurance is a species of commercial transactions had there is a well-established commercial- practice to send cover notes even prior to the completion of a proper proposal or while the proposal is being considered or a policy is in preparation for delivery. A cover note is a temporary and limited agreement. It may be self-contained or it may incorporate by reference the terms and conditions of the future policy. When the cover note incorporates the policy in this manner, it does not have to recite the term and conditions, but merely to refer to a particular standard policy. If the proposal is for a standard policy and the cover note refers to it, the assured is taken to have accepted the terms of that policy. The reference to the policy and its terms and conditions may be expressed in the proposal or the cover note or even in the letter of acceptance including the cover note. The incorporation of the terms and conditions of the policy may also arise from a combination of references, in two or more documents passing between the parties. Documents like the proposal, cover note and the policy are commercial documents and to interpret them commercial habits and practice cannot altogether be ignored. During the time the cover note operates, the relations of the -parties are governed by its terms and conditions, if any, but more usually by the terms and conditions of the policy

bargained for and to be issued. When this happens the terms of the policy are incipient but after the period of temporary cover, the relations are governed only by the terms and conditions of the policy unless insurance is declined in the meantime. Delay in issuing the policy makes no difference. The relations even then are governed by the future policy if the cover notes give sufficient indication that it would be so. In other respects there is no difference between a contract of insurance and any other contract except that in a contract of insurance there is a requirement of uberrima fides i.e., good faith on the part of the assured and the contract is likely to be construed contra proferentem that is against the company in case of ambiguity or doubt. A contract is formed when there is an unqualified acceptance of the proposal. Acceptance may be expressed in writing or it may even be implied if the insurer accepts the premium and retains it. In the case of the assured, a positive act on his part by which he recognises or seeks to enforce the policy amounts to an affirmation of it. This position was clearly recognised by the assured himself, because he wrote, close upon the expiry of the time of the cover notes, that either a policy should be issued to him before that period had expired or the cover note extended in time. In interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves. Looking at the proposal, the letter of acceptance and the cover notes, it is clear that a contract, of insurance under the standard policy for fire and extended to cover flood, cyclone etc. had come into being."

13. As per the consistent view of the Hon^{ble} Supreme Court with regard to the terms of contract of an insurance policy, the following rules can be followed:--

"(i) the insurer is not at a weak bargaining position while entering into the terms of the insurance policy;

(ii) the exclusion is misleading and creating unnecessary confusion for repudiating the claim of the applicant;

(iii) whether after accepting reasonable clauses of exclusion, the applicant can be paid or reimbursed the claim;

(iv) whether the exclusion clause 4.3 was entered into by the applicant in good faith and is not misleading."

14. The consistent view of the Courts above, is that the terms of the insurance policy have to be incorporated in the language and spirit with which, both the parties have agreed. As per exclusion clause 4.3 at Serial No. XVII of policy (Annexure P-2), any claim for hypertension during first two years of the policy was not reimbursable. This condition has been accepted by the claimant-respondent No. 1 and any payment with regard to hypertension can be disallowed by the insurance company, as the term "hypertension" does not require any further clarification. The applicant-respondent No. 1 was admitted in Madanta Hospital, Gurgaon on 03.01.2012. As per the documents submitted, he

had suffered headache, giddiness and hypertension on 03.01.2012. After his admission in Madanta Hospital, Gurgaon, he was discharged on 07.11.2012. He was treated by Dr. Achint Malhotra for four days. Echo test was conducted upon him. As per the insurance policy (Annexure P-2), there are as many as 21 exclusion clauses therein. A careful reading of these clauses shows that certain usual diseases like arthritis, cataract, Piles, diabetes gout and rheumatism, surgery of gallbladder etc. have been excluded for first two years. A perusal of these clauses further shows that heart disease does not find mention in any of 21 exclusion clauses. The applicant-respondent No. 1 was admitted in Madanta Hospital, Gurgaon with symptoms of giddiness, hypertension and headache. All the three conditions cannot be read at serial No. XVII of exclusion clause 4.3 of the policy (Annexure P-2). In normal course, a patient suffering from hypertension is not required to be admitted in a hospital. Applicant-respondent No. 1 was suffering from headache, giddiness and hypertension. As per the medical bills (Annexure P-3), the investigation shows that the symptoms could lead to a heart disease. X-ray of the chest and Echo test of the patient was conducted on 04.01.2012. Hence, a prolonging treatment of four days could not be the result of simple hypertension. It could be the symptoms of heart disease or heart attack. Hence, the claim of respondent No. 1 for reimbursement of medical bills could not be rejected by relying on exclusion clause 4.3 as mentioned in the insurance policy (Annexure P-2). The object of the insurance policy is to secure a patient when he is admitted in hospital in an emergent condition. The exclusion clause has to be read to the benefit of the patient in genuine circumstances.

15. In the present case, applicant-respondent No. 1 was admitted in Madanta Hospital, Gurgaon, with suffering of headache, giddiness and hypertension. It could not be a case for rejecting his claim on the basis of exclusion clause. The Permanent Lok Adalat has rightly given a direction to petitioner-insurance company to reimburse the claim to the extent of Rs. 2,00,000/-. No ground is made out to interfere in the impugned order/Award dated 15.11.2012 passed by the Permanent Lok Adalat (Public Utility Services), Gurgaon.

Dismissed.