
(2002) 10 P&H CK 0118

In the Punjab And Haryana At Chandigarh

Case No : Regular Second Appeal No. 4778 of 1999

United India Insurance Co. Ltd. and Another

APPELLANT

Vs

Rajinder Pal Sood

RESPONDENT

Date of Decision : 23-10-2002

Acts Referred:

Citation : (2004) ACJ 1301 : (2003) 133 PLR 643 : (2003) 1 RCR(Civil) 449

Hon'ble Judges : M.L. Singhal, J

Bench : Single Bench

Advocate : Ravinder Arora, for the Appellant; T.N. Gupra, for the Respondent

Final Decision : Allowed

Judgement

M.L. Singhal, J.—This regular second appeal has been filed by United India Insurance Co. Ltd. against the judgment and decree dated 26.8.1999 of Additional District Judge, Ludhiana reversing that of Additional Civil Judge (Senior Division), Khanna dated 12.12.1997 and resultantly decreeing the respondent-plaintiffs suit for the recovery of Rs.67,860/- i.e., Rs.58,000/- payable under the Insurance policy and Rs.98607- on account of interest for the period 12.3.1992 to 11.8.1993 @ 12% per annum.

2. Facts: Plaintiff Rajinder Pal Sood filed suit for the recovery of Rs.67860/- i.e. Rs.58,000/- payable under the insurance policy and Rs.9860/- as interest for the period 12.3.1992 to 11.8.1993 @ 12% p.a. on the basis of Hospitalisation, and Domiciliary Benefit Hospitalisation Insurance Policy dated 21.8.1991, on the allegations, that on 21.8.1991, he was at his old residence at Khanna where duly constituted attorney of the United India Insurance Co. Ltd. approached him with a view to securing Hospitalisation and Domiciliary Benefit Hospitalisation Insurance Policy. Hospitalisation and Domiciliary Hospitalisation Insurance Policy for one year i.e. 21.8.1991 to 21.8.1992 which was issued to him after getting him fully and properly medically examined and after fully satisfying himself about the other particulars. He received annual premium of Rs.1500/-from him. In this

manner, complete contract of insurance was reached between the parties. He felt acute pain in chest along with suffocation and went to Escorts Heart Institute and Research Centre, Okhla Road, New Delhi on 25.11.1991 for consultation where he was admitted. He paid consultation fee vide receipt dated 25.11.1991. On 26.11.1991, he was subjected to Cardiac Catheterisation and Angiography test. He was advised regularisation by CABG (Bye Pass Surgery). On 5.12.1991 bye pass surgery was performed on him in Escorts Heart Institute and Research Centre, Okhla Road, New Delhi. He was discharged on 15.12.1991. He was finally declared fit on 20.3.1991. He wrote letter dated 22.3.1992 to United India Insurance Co. Ltd. for reimbursement of the insurance claim. United India Insurance Co. Ltd. instead of reimbursing him of the amount of insurance policy, vide letter dated 5.3.1993 repudiated the claim due to breach of warranty. Although he had incurred Rs. 1,19,000/-, he lodged claim against the United India Insurance Co. Ltd. for Rs.58,000/- with interest @ 12% p.a. thereon.

3. Defendant-United India Insurance Co. Ltd. contested the suit urging that his claim was justifiably repudiated by them as he had obtained Hospitalisation and Domiciliary Benefit Hospitalisation Insurance Policy by misrepresentation and by concealing true facts as to the state of his health as on 21.8.1991. After he had lodged insurance claim, Sh. S.C. Mehta, Managing Director, Strategic Security Consociates detective and Investigators, Head Office, Chandigarh was put by them on investigating the genuineness or otherwise of his claim. After investigation, he submitted his report on 14.12.1992 stating that he was known diabetic since 25 years having angina due to exertion (Class II-III) and dyspnea on exertion since a couple of years. He was investigated for non-evasive cardiological investigations by the Escorts Heart Institute and Research Centre, Okhla Road, New Delhi on 17.8.1991 and was strongly positive for reversible myocardial ischaemia and invasive cardio. Coronary artery bye pass grafting x3 was done on him on 5.12.1991, It was urged that he was thus aware about his heart trouble before getting the policy. He was also aware about his being a known diabetic. He obtained policy on 21.8.1991 after he had become known about the result of invasive cardio investigations done on him on 17.8.1991 at Escorts Heart Institute and Research Centre, Okhla Road, New Delhi. In nutshell, the insurance claim was repudiated on account of suppression of material facts by him as to the state of his health as on 21.8.1991 when he obtained the insurance policy. On the pleadings, the following issues were framed :-

1. Whether the plaintiff is entitled to recover the amount claimed? OPD
 2. Whether the insurance policy is vitiated by misrepresentation and fraud? OPP
 3. Whether the suit is time barred? OPD
 4. Whether the suit is not maintainable? OPD
 5. Relief.
4. Vide order dated 12.12.1997, Additional Civil Judge, (Senior Division), Khanna

dismissed the plaintiffs suit in view of his finding that the policy dated 21.8.1991 was vitiated by fraud and misrepresentation and the repudiation of the policy was justified by the United India Insurance Co. Ltd.

5. Plaintiff went in appeal which was allowed by Additional District Judge, Ludhiana vide order dated 26.8.1999 and he decreed his suit for the recovery of Rs.68,760/- payable under the policy plus Rs.9860/- as interest @ 12% per annum for the period of 12.3.1992 to 11.8.1993.

6. United India Insurance Co. Ltd, has come up to this court through this appeal.

7. In this appeal, following question of law arises:

"Whether the insurance company was justified in repudiating the policy if there was suppression of material facts by the insured when he obtained policy as to the state of his health and he obtained this policy fraudulently ?"

8. It was submitted by the learned counsel for the United India Insurance Co. Ltd. that the respondent/ plaintiff was not honest in making disclosures about the state of his health when the proposal form was filled by him. It was submitted that in the column "details of any knowledge of any positive existence or presence of any ailment, sickness or injury which may require medical attention in immediate future", his reply is "no". In the column "details of medical treatment/surgical operation during preceding 12 months", this reply is "no". He stated that he did not get himself examined on 17.8.1991 at Escorts Heart Institute and Research Centre, Okhla Road, New Delhi whereas the fact of the matter is that he had got himself examined at Escorts Heart Institute and Research Centre, Okhla Road, New Delhi on 17.8.1991. There were non-invasive cardiological investigations that were carried out on him. TMT done on 17.8.1991 was strongly positive for reversible myocardial ischaemia. It was submitted by the learned counsel for the appellant that while filling up the proposal form on 21.8.191 for obtaining policy, he should have disclosed that on 17.8.1991, non-invasive cardiological investigations had been carried out on him at Escorts Heart Institute and Research Centre, Okhla Road, New Delhi. TMT done on 17.8.1991 was strongly positive for reversible myocardial ischaemia. It was submitted that when on 25.11.1991 he was admitted for bye-pass surgery, he gave history about the state of his health. He disclosed that he was known diabetic since 25 years, known case of coronary artery disease. He had been having angina on exertion (class II-III) and dyspnoea on exertion (class II-III) since last few years which had been on an increase lately. CART done on 26.11.1991 revealed severe double vessel disease with normal left ventricular function, LEVF 60%. In view of his symptomatic status and CART findings, he was advised for surgery. On 5.12.1991 coronary bypass surgery grafting x3 was done. It was submitted that as per insurance policy, disease already existing at the time of inception of insurance, is not covered. It was submitted that he succeeded in getting insurance policy for Hospitalisation and Domiciliary Benefit Hospitalisation Insurance Policy by concealing true facts on 21.8.1991,

9. Faced with this position, learned counsel for the respondent submitted that merely on the ground that the insurer at the time of effecting insurance with the insurance company is not proper. Matter of repudiation of policy should not be dealt with in a mechanical and routine manner but should be one of extreme care and caution. In support of his submission, he drew my attention to Life Insurance Corporation of India and Others Vs. Smt. Asha Goel and Another, where it was held that approach of the insurance company in the matter of repudiation of a policy admittedly issued by it should be one of extreme care and caution. It should not be dealt with in a mechanical and routine manner. Repudiation of the claim by the insurance company merely on grounds that insured who died of acute Myocardial Infarction and cardiac arrest and had not disclosed correct information regarding his health at time of effecting insurance with the corporation is not proper. On a fair reading of Section 45 it is clear that it is restrictive in nature. Second part to section lays down that no policy of life insurance effected after the coming into force of this Act shall, after expiry of period prescribed from 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 in any other document leading to the issue of the policy, was inaccurate or false. It lays down there conditions for applicability of the second part of the section namely:- (a) the statement must be on a material matter or must suppress facts which it was material to disclose; (b) the suppression must be fraudulently made by the policy holder; and (c) the policy (holder) must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose. Mere inaccuracy or falsity in respect of some recitals or items in the proposal is not sufficient. The burden of proof is on the insurer to establish these circumstances and unless the insurer is able to do so there is no question of the policy being avoided on ground of mis-statement of facts."

10. Learned counsel for the respondent submitted that Insurance Company should have examined some doctor from Escorts Heart Institute and Research Centre, Okhla Road, New Delhi to prove that on 17.8.1991, non-invasive cardiological investigations had been reported on him and TMT done on 17.8.1991 was strongly positive for reversible myocardial ischaemia.

11. Suffice it to say, the certificate Ex.P4 was relied upon by the respondent himself.

12. Learned counsel for the respondent submitted that non-mention of the non-invasive cardiological investigations carried out on him on 17.8.1991 would not be suppression of material facts pertaining to the state of his health as on 12.8.1991 when he obtained this policy. It was submitted that unless an insurer shows that the statement on the basis of which the policy was sought to be avoided by him was on a material matter or facts have been suppressed which it was material for the policy holder to disclose and that it was fraudulently made by the policy holder and that the policy holder knew at the time of making the

statement that it was false or that it suppressed facts which it was material to disclose, policy cannot be called in question. In *Mithoolal Nayak Vs. Life Insurance Corporation of India*, ; the Hon'ble Supreme Court laid down three conditions for the application of second part of Section 45. They are:-

- (i) the statement must be on a material matter or must suppress facts which it was material to disclose;
- (ii) the suppression must be fraudulently made by the policy holder, and (iii) the policy holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose.

In this case, the insurance company has repudiated its liability under the policy on the ground that the insured had deliberately made mis-statement and withheld material information regarding his health at the time of taking out the insurance policy. In *Lakshmi Insurance Co. Ltd v. Bibi Padma Wati* AIR 1961 Pb. 1961, a Division Bench of this Court held that "the insurance company has also to discharge the onus, that the representations alleged to be fraudulent were material and made with the insured's knowledge and wrongful intent regarding the condition of his health, family history, age, habits, occupation etc. The insurer must show that the statement made by the insured were such which he knew or should have known that they were untrue and were made willfully in bad faith and with intent to conceal or deceive. Tek Chand, J. (as His Lordship then was) speaking for the Bench opined that "By Section 45 the nice distinction created by the doctrine of warranty under the English Common Law has been eliminated. The insurer cannot avoid the consequences of the insurance contract by simply showing inaccuracy or, falsity of the statement made in the proposal for insurance, or in any report of the medical officer, or in any other document leading to the issue of the policy. Burden is cast on the insurer to show that statement on the basis of which the policy is sought to be avoided by him was on a material matter or, facts have been suppressed which it was material for the policy holder to disclose. It has further to be proved that the statement was fraudulently made by the policy holder with the knowledge of the falsity of the statement at the time when it was made, or that the suppression was of material facts which had not been disclosed. Therefore, in the case of policies of life insurance which are not expected by the two year rule, proof of deliberate fraud and not merely of constructive fraud or of misstatements has to be shown in order to avoid the policy."

13. In this case, it is quite patent that the respondent did not make a true disclosure of facts regarding the state of his health. It can be said that he rather indulged into suppression of material facts regarding the state of his health at the time he took this policy. Respondent should have made a clean breast about the state of his health at the time he filled up the proposal form. He should have told that he was diabetic since 25 years, known case of coronary artery disease, he was having angina on exertion (Class II-III) and dyspnoea on exertion (class II-II) since a couple of years.

14. Learned counsel for the respondent submitted that the proposal form was filled up by the insurance agent. He did not bring home to him the implications of various columns in the proposal form. Suffice it to say, in the proposal form, there is a note "I confirm having completed the Proposal Form myself after reading the Prospectus fully. All the statements made above and to answers given are wholly true and correct to the best of my knowledge and belief. I have disclosed all particulars material to the risk. It is hereby understood and agreed, that the statements, answers and particulars are based on which the insurance is being granted. If after the insurance is effected, it is found that the statements, answers or particulars are incorrect or untrue in any respect, the insurance Company shall be under no liability under this insurance". Respondent cannot thus say that the implications of each of the columns of the proposal form were not brought home to him by the insurance agent.

15. In my opinion, the learned Additional District Judge fell in error of law while reversing the judgment and is accordingly allowed. Judgment and decree of Additional District Judge, Ludhiana dated 26.8.1999 are set aside and those of Additional Civil Judge (Senior Division), Khanna dated 12.12.1997 are restored. In consequence, the respondent plaintiffs suit fails and is dismissed. No order as to costs.