IN THE HIGH COURT OF KARNATAKA AT BENGALURU

DATED THIS THE 21ST DAY OF OCTOBER, 2022

BEFORE

THE HON'BLE MR. JUSTICE M. NAGAPPRASANNA

WRIT PETITION No.14346 OF 2021 (GM-RES)

BETWEEN:

1 . MRS. JAYA ELIZABETH MATHEW

2 . MR.PRENEESH OMMEN

... PETITIONERS

(BY SRI APOORV KHATOR, ADVOCATE FOR
SRI PARASHURAM A.L., ADVOCATE)

AND:

1 . INSURANCE OMBUDSMAN FOR THE STATE OF KARNATAKA
OFFICE OF THE INSURANCE OMBUDSMAN (KARNATAKA)
19/19, JEEVAN SOUDHA BUILDING
GROUND FLOOR, 24TH MAIN
J.P.NAGAR, 1ST PHASE
BENGALURU – 560 078
REPRESENTED BY ITS SECRETARY.

2 . HDFC ERGO GENERAL INSURANCE COMPANY LTD.,
1ST FLOOR, 165, BACKBAY RECLAMATION
H.T.PAREKH MARG, CHURCHGATE
MUMBAI – 400 059
REPRESENTED BY THE MANAGER.

... RESPONDENTS

(BY SRI S.KRISHNA KISHORE, ADVOCATE FOR R2;
R1 – SERVED)

THIS WRIT PETITION IS FILED UNDER ARTICLES 226 AND 227 OF THE CONSTITUTION OF INDIA PRAYING TO QUASH AWARD DTD 29.03.2021 ARISING FROM COMPLAINT PASSED BY R-1 VIDE ANNX-A; QUASH THE REPUDIATION LETTER BY WAY OF E-MAIL DTD 14.12.2020 ISSUED BY R-2 VIDE ANNX-H; DIRECT TO R-2 TO ALLOW THE CLAIM OF THE PETITIONERS IN TERMS OF REIMBURSEMENT FORM DTD 29.09.2020 VIDE ANNX-G AND DIRECT THE RELEASE OF THE AMOUNT OF RS.28,43,684/- (RUPEES TWENTY EIGHT LAKHS FORTY THREE THOUSAND SIX HUNDRED AND EIGHTY FOUR ONLY) WITH APPROPRIATE INTEREST.

THIS WRIT PETITION HAVING BEEN HEARD AND RESERVED FOR ORDERS ON 12.10.2022, COMING ON FOR PRONOUNCEMENT THIS DAY, THE COURT MADE THE FOLLOWING:-

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ORDER

The petitioners are before this Court calling in question order dated 29-03-2021 passed by the 1st respondent/Insurance Ombudsman declining to accept the insurance claim of the petitioners, sought quashment of letter of repudiation dated 14-12-2020 issued by the 2nd respondent/Insurance Company and a consequential direction of issuance of a writ in the nature of mandamus directing release of an amount of Rs.28,43,684 being the Insurance claim of the petitioners.

2. Heard Sri Apoorv Khator, learned counsel for the petitioners and Sri S.Krishna Kishore, learned counsel for the 2nd respondent.

3. *Shorn* of unnecessary details, facts in brief, as borne out from the pleadings, are as follows:-

The petitioners are wife and husband respectively. 1st respondent is the Insurance Ombudsman and the 2nd respondent is the insurer/HDFC Ergo General Insurance Company ('the Company' for short). The petitioners having a desire of building a house opted

for home loan through the 2nd respondent/Company. The loan came with "Home Suraksha Plus' dated 29-04-2017 and was to be for a period of 5 years from 29-04-2017 to 28-04-2022. The policy covered major medical illness and procedures to an amount of Rs.56,87,368/- jointly for both the petitioners. On 10-08-2020, it appears that the Doctors at Vikram Hospital diagnosed the 1st petitioner to be suffering from Multiple Sclerosis and started treatment immediately. After the treatment, the insurance claim was made on the strength of the insurance coverage that was given by the 2nd respondent/Company in its policy dated 29-04-2017. The claim was repudiated by communication of the 2nd respondent dated 14-12-2020 on the ground that the 1st petitioner was diagnosed to be suffering from multiple sclerosis from 27-03-2017 and the ailment was a pre-existing ailment which had not been divulged by the petitioners while filling the form claiming such insurance. Against the said repudiation, the petitioners approached the Insurance Ombudsman challenging repudiation by the 2nd respondent/Company. The Insurance Ombudsman by an order dated 29-03-2021 affirms repudiation of the claim of the petitioners and also holds that the petitioners were guilty of their non-

disclosure of information about serious illness notwithstanding it being in their knowledge. It is the order of repudiation by the 2nd respondent/Insurance Company and the order of the 1st respondent/Insurance Ombudsman that drives the petitioners to this Court in the subject petition.

4. The learned counsel appearing for the petitioners would contend that on 27-03-2017 the 1st petitioner had developed only giddiness and vomiting and was diagnosed as vertigo and the further diagnosis of the 1st petitioner was multiple sclerosis. It is for the first time the Doctors at Vikram Hospital opined that the 1st petitioner is suffering from multiple sclerosis. Therefore, the petitioners had no occasion to mention a problem that would occur in future when the insurance policy was taken. On these technical grounds the claim of the petitioners is rejected. The learned counsel would seek to place reliance on the co-ordinate Bench decision of this Court in ***MRS. SHIVAPRABHA JAYAPRAKASH SHETTY v. UNION OF INDIA – Writ Petition No.52434 of 2018*** decided on 20-08-2019; Division Bench judgment of this Court in ***NATIONAL INSURANCE COMPANY LIMITED v. SHIVAPRABHA***

JAYAPRAKASH SHETTY – Writ Appeal No.3944 of 2019 decided on ***19-02-2020***; order of the High Court of Delhi in ***PAVAN SACHDEVA v. OFFICE OF THE INSURANCE OMBUDSMAN AND ANOTEHR – W.P.(C) 6304 of 2019*** decided on ***27-07-2020*** and a decision of the Madras High Court in ***JASMINE EBENEZER ARTHUR v. HDFC ERGO GENERAL INSURANCE COMPANY LIMITED AND OTHERS – W.P.Nos. 22234 of 2016 and others*** decided on ***6-06-2019***.

5. On the other hand, the learned counsel for the 2nd respondent/Insurance Company enters appearance and files detailed statement of objections and taking support from the documents appended to the objections would seek to contend that the petitioners are guilty of suppression of pre-existing illness, notwithstanding the policy making it clear that if any pre-existing illness of any kind particularly which are mentioned in the policy ought to have been mentioned. Since pre-existing illness clearly relates to multiple sclerosis, the petitioners being guilty of such suppression, the claim cannot be accepted and the order of the insurance company repudiating the said claim is in consonance with

law. So, is the order passed by the Insurance Ombudsman is the submission of the learned counsel appearing for the 2nd respondent and would seek dismissal of the petition. The learned counsel would seek to place reliance upon the following the judgments of the Apex Court: (i) ***BRANCH MANAGER, BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED AND OTHERS v. DALBIR KAUR – AIR 2020 SC 5210***; (ii) ***RELIANCE LIFE INSURANCE COMPANY LIMITED AND ANOTHER v. REKHABEN NARESHBHAI RATHOD – (2019) 6 SCC 175***; (iii) ***SATWANT KAUR SANDHU v. NEW INDIA ASSURANCE COMPANY LIMITED – (2009) 8 SCC 316*** and that of the High Court of Judicature at Bombay in (iv) ***ADITYA BIRLA SUN LIFE INSURANCE COMPANY LIMITED v. THE INSURANCE OMBUDSMAN AND ANOTHER - W.P.No.7804 of 2021*** decided on ***18-08-2022***.

6. I have given my anxious consideration to the submissions made by the respective learned counsel and perused the material on record; in furtherance whereof, the issue that falls for my consideration is:

" Whether repudiation of the claim of the petitioners is valid in the eye of law?"

7. The afore-narrated facts though are not in dispute would require a little elaboration. The policy was attached to a home loan that was granted by the HDFC Bank and the policy is titled "Home Suraksha Plus" to be in operation between the dates 29-04-2017 and 28-04-2022. Since the issue relates to the dates anterior to the policy itself, a little walk in history would be required to consider the case of the petitioners.

8. On 27-03-2017 the 1st petitioner developed giddiness and vomiting. She is initially taken to Baptist Hospital who advised to undergo MRI on her. A team of medical experts at Baptist hospital on going through the results of MRI and other medical examination had opined as follows:

> *"DIAGNOSIS:* *ACUTE VERTIGO WHITE MATTER DISEASE OF CNS"*

What could be gathered from the report is that the diagnosis was acute vertigo white matter disease of CNS ('Central Nervous System'). The course in the hospital as described was 'symptomatic

treatment with beta histines'. MRI done outside showed T2 hyper intense lesion in the dorso medial aspect of upper pons (multiple sclerosis). Neurology opinion was advised at discharge. It was seen that the 1st petitioner was symptomatically better. Regular monitoring was also advised. The review was to be with the Neurology Department on 10-04-2017. Therefore, the 1st petitioner was thus diagnosed with a symptomatic attached to multiple sclerosis. Even in terms of the opinion, though it is bracketed, nonetheless it was found. Therefore, there was a doubt in the minds of the doctors that it could be multiple sclerosis as it was attached to Central Nervous System. This discharge was made on 30-03-2017 after about 3 days of the 1st petitioner being an inpatient. Barely after 30 days of getting discharged, the petitioners were offered the insurance policy and it was accepted by them on 29-04-2017. Now the policy is required to be noticed. The policy does contain coverage of major medical illness and procedures. The policy directed the petitioners to tick appropriate condition in case the person proposed for insurance has been diagnosed or is suffering from any symptoms or has undergone any of the below

medical condition. The clauses of the policy which are relevant are as follows:

"Kindly tick the appropriate condition incase the person proposed for insurance (i) Has been diagnosed or is suffering from any symptoms or (ii) Has undergone treatment for any for the below mentioned conditions.

	Hypertension	*Diabetes*	*Cancer*	*Stroke*	***Multiple Sclerosis***	*Coronary Artery Bypass Surgery*	*Paralysis*	*Kidney failure*	*Heart Valve Replacement*	*Myocardial Infarction (Heart attack)*	*Major Organ Transplant*	*others*
Insured I												
Insured II												

One of the afore-mentioned columns related to **multiple sclerosis**. The afore-quoted were the conditions in the policy.

9. The 1st petitioner on 10-08-2020 developed symptoms that were again became a problem with the Central Nervous System and got admitted to Vikram Hospital. The Doctors at Vikram Hospital diagnosed the problem to be multiple sclerosis. The discharge summary would read as follows:

"<u>Diagnosis:</u> DEMYELINATING DISEASE – MULTIPLE SCLEROSIS – VITAMIN D DEFICIENCY."

After the diagnosis and for the period the petitioner was inpatient medical reimbursement claim was made by the petitioners. The claim comes to be repudiated by an electronic communication dated 14-12-2020 which reads as follows:

> *"Dear MR OMMEN PRENEESH,*
>
> *We refer the captioned claim intimation on **18/09/2020** and have carefully reviewed the documents submitted by you to validate the eligibility of claim basis policy terms and condition.*
>
> *We regret to inform you that the claim for **Critical Illness** does not meet the requirement for its eligibility as per the Policy terms and conditions. Since the claim is not admissible and losses not payable, we are constrained to close the claim as "No claim" in our records.*
>
> *We would like to draw your attention. Your claim has been declined due to below mentioned reason which is the basis for disallowing the claim. an extract of which is mentioned below for your ready reference.*
>
> ***As per the documents received and verification, Insured was diagnosed to be suffering from Multiple Sclerosis since 27/03/2017. As the date of Inception of policy is 29/04/2017; the ailment is pre-existing in nature. Hence this claim is being repudiated as per Section 3 C 1 of policy terms conditions as per which no payment will be made by the Company for any claim directly or indirectly caused by, based on arising out of or howsoever attributable to any Critical illness for which care, treatment or advice was recommended by or received from a Physician, or which first manifested itself or was contracted before the start of the Policy Period or for which a claim has or could have been made under any earlier policy.***

We sincerely express our inability to serve you, given the circumstances. However, we look forward to service your requirements in future.

Thanking you in anticipation

HDFC ERGO General Insurance Company Limited
6th Floor, Leela Business Park, Andheri Kurla Road, Andheri (East), Mumbai-400059".

(Emphasis added)

The claim is declined on the ground that the patient had been diagnosed with multiple sclerosis since 27-03-2017, the policy coming into effect from 29-04-2017 and, therefore, the illness was a pre-existing illness and the claim cannot be allowed. This was called in question before the 1st respondent/Insurance Ombudsman. The Insurance Ombudsman by his order dated 29-03-2021 disallowed the claim, affirmed repudiation by the Insurance Company, after granting opportunity of personal hearing also to the petitioners. The reasons so rendered by the Insurance Ombudsman are as follows:

"21. Result of personal hearing with both the parties (Observations & Conclusions):

The dispute is with regard to repudiation of hospitalisation claim by RI.

Personal hearing by the way of online Video-conferencing through Goto Meet was conducted in the said case. Mrs. Jaya (Complainant) along with her husband and Ms. Amala along with Dr Ravi (Representative of RI) presented their case.

Confirmation from all the participants about the clarity of audio and video was taken and to which the participants responded positively. This Forum has perused the documentary evidence available on record and the submissions made by both the parties during the personal hearing.

Medical records of 2012 of Columbia Asia Hospital reveal that she has history of Vertigo since pre pregnancy. The MRI report of Columbia Asia Hospital dt 27.03.2017 reveals that doctor on the basis of the symptoms experienced by IP suggested that she might be suffering from MS. T2/Flair hyperintense ovoid lesion was seen in dorsomedial aspect of upper pons. Hyperintense-T2 lesions are defined as sharply demarcated regions of high signal intensity compared with surrounding brain tissue. The report suggested features could be possible of demyelinating etiology like MS and less likely of infective etiology. Thereafter she was hospitalised Bangalore Baptist Hospital from 27.03.2017 to 30.03.2017. The Discharge Summary of Bangalore Baptist Hospital records the final diagnosis as Acute Vertigo and White Matter Disease of the CNS.

Internet Study reveals that White matter disease or leukoaraiosis is a disease that affects the nerves that link various parts of the brain to each other and to the spinal cord. White matter is tissue that includes nerve fibers (axons), which connect nerve cells. A fatty tissue called myelin covers the axons. These axons connect the neurons of the brain and spinal cord and signal nerve cells to communicate with one another. Degeneration of the white matter -specifically, the myelin sheaths can affect a person's mood, focus, muscle strength, vision, and balance. White matter disease may develop with conditions associated with aging, such as stroke, but it can also affect young people due to conditions such as cerebral adrenoleukodystrophy and multiple sclerosis (MS).

The condition that results in damage to the protective covering (myelin sheath) that surrounds nerve fibers in the brain, optic nerves and spinal cord is called demyelination. MRI is the imaging modality of choice to

assess demyelinating disorders of the brain and the cord and, together with the clinical and laboratory findings, can accurately classify them in most cases.

Forum notes that IP took the policy immediately after being diagnosed with above conditions. Perusal of proposal form reveals that IP was required to disclose any signs and symptoms of MS along with an option to disclose any other medical condition in the proposal form.

Forum notes that column for MS was left blank even though MRI report of Columbia Asia Hospital suspected signs of MS. Further, neither the pre-existing medical condition of vertigo nor the diagnosis of white matter disease of CNS was disclosed in the "Others" column in proposal form dt 22.04.2017. Relevant excerpt from proposal form is shared below:

….   ….   ….

In Satwant Kaur Sandu Vs New India Assurance on 10 July, 2009, Hon'ble Supreme Court has held that:

> *"A mediclaim policy is a non-life insurance policy meant to assure the policy holder in respect of certain expenses pertaining to injury, accidents or hospitalizations. Nonetheless, it is a contract of insurance falling in the category of contract uberrimae fidei, meaning a contract of utmost good faith on the part of the assured. Thus, it needs little emphasis that when an information on a specific aspect is asked for in the proposal form**, an assured is under a solemn obligation to make a true and full disclosure of the information subject which is within his knowledge**. It is not for the proposer to determine whether the information sought for is material for the purpose of the policy or not."*

Under the facts of the case, the Forum finds that IP has failed to disclose her pre-existing medical condition in the proposal thus depriving RI of the opportunity to assess the risk. Accordingly the Forum concurs with repudiation of RI. The complaint is Disallowed."

(Emphasis added)

Not Approved

The Insurance Ombudsman on looking at the medical records of the 1st petitioner right from 2012 comes to conclude that the records would reveal history of Vertigo since pre-pregnancy and the suggestion at Columbia Asia Hospital or Baptist Hospital was that she might be suffering from MS and the discharge summary of the Baptist Hospital was **'White Matter Disease of the CNS"**. The research of the study is made and the claim is rejected.

10. The contention of the learned counsel for the petitioners is that it is not a pre-existing illness. It was for the first time diagnosed to be multiple sclerosis. This submission goes against the records and is unacceptable. Medical terminology cannot be fixed in terms of nomenclature though every diagnosis of the 1st petitioner related to multiple sclerosis. In the light of the aforesaid analysis, it is germane to notice the judgment of the Apex Court on the issue of a mediclaim policy. The Apex Court in the case of ***SATWANT KAUR SANDHU v. NEW INDIA ASSURANCE COMPANY LIMITED***[1] has held as follows:

> ***"18. A mediclaim policy is a non-life insurance policy meant to assure the policy-holder in respect of certain***

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[1] ***(2009) 8 SCC 316***

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> ***expenses pertaining to injury, accidents or hospitalisations. Nonetheless, it is a contract of insurance falling in the category of contract uberrimae fidei, meaning a contract of utmost good faith on the part of the assured. Thus, it needs little emphasis that when an information on a specific aspect is asked for in the proposal form, an assured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. It is not for the proposer to determine whether the information sought for is material for the purpose of the policy or not. Of course, the obligation to disclose extends only to facts which are known to the applicant and not to what he ought to have known.*** *The obligation to disclose necessarily depends upon the knowledge one possesses. His opinion of the materiality of that knowledge is of no moment. (See Joel v. Law Union & Crown Insurance Co. [(1908) 2 KB 863 (CA)]).”*
>
> *(Emphasis supplied)*

The Apex Court holds that a mediclaim is a non-life insurance policy meant to assure the policy holder in respect of certain expenses of hospitalizations. It is a contract of insurance falling under the category of contract ***Uberrimae fidei*** which would mean contract of utmost good faith on the part of the assured.

Later, the Apex Court in the case of ***RELIANCE LIFE INSURANCE COMPANY LIMITED AND ANOTHER v. REKHABEN NARESHBHAI RATHOD***[2] has held as follows:

> ***“21.*** *In LIC v. G.M.Channabasamma [LIC v. G.M.Channabasamma, (1991) 1 SCC 357], a two-Judge Bench of this Court held: (SCC pp. 359-60, para 7)*

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[2] ***(2019) 6 SCC 175***

"7. … It is well settled that a contract of insurance is contract uberrima fides and there must be complete good faith on the part of the assured. The assured is thus under a solemn obligation to make full disclosure of material facts which may be relevant for the insurer to take into account while deciding whether the proposal should be accepted or not. While making a disclosure of the relevant facts, the duty of the insured to state them correctly cannot be diluted. Section 45 of the Act has made special provisions for a life insurance policy if it is called in question by the insurer after the expiry of two years from the date on which it was effected. Having regard to the facts of the present case, the learned counsel for the parties have rightly stated that this distinction is not material in the present appeal. If the allegations of fact made on behalf of the appellant Company are found to be correct, all the three conditions mentioned in the section and discussed in Mithoolal Nayak v. LIC [Mithoolal Nayak v. LIC, 1962 Supp (2) SCR 571: AIR 1962 SC 814: (1962) 32 Comp Cas 177] must be held to have been satisfied."

… … ….

23. *In Satwant Kaur [Satwant Kaur Sandhu v. New India Assurance Co. Ltd., (2009) 8 SCC 316: (2009) 3 SCC (Civ) 366] this Court considered a case which arose from a decision of the NCDRC. The insurer had repudiated a claim under a health insurance policy on the ground that the policy-holder was suffering from chronic diabetes and renal failure. This, according to the insurer, was a material fact a non-disclosure of which in the proposal form justified repudiation of the claim. Section 45, which applies to policies of life insurance, was not applicable since the case related to a mediclaim policy. D.K. Jain, J. speaking for the Bench of two learned Judges, held: (SCC p. 322, para 18)*

"18. A mediclaim policy is a non-life insurance policy meant to assure the policy-holder in respect of certain expenses pertaining to injury, accidents or hospitalisations. Nonetheless, it is a contract of insurance falling in the category of contract uberrima fidei, meaning a contract of utmost good faith on the part of the assured. Thus, it needs little emphasis that when an information on a specific aspect

is asked for in the proposal form, an assured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. It is not for the proposer to determine whether the information sought for is material for the purpose of the policy or not. Of course, the obligation to disclose extends only to facts which are known to the applicant and not to what he ought to have known. The obligation to disclose necessarily depends upon the knowledge one possesses. His opinion of the materiality of that knowledge is of no moment. (See Joel v. Law Union and Crown Insurance Co. [Joel v. Law Union and Crown Insurance Co., (1908) 2 KB 863 (CA)])"

(emphasis supplied)

In taking this view, the Court relied upon the earlier decisions in United India Insurance Co. Ltd. v. M.K.J. Corpn. [United India Insurance Co. Ltd. v. M.K.J. Corpn., (1996) 6 SCC 428] and Modern Insulators Ltd. v. Oriental Insurance Co. Ltd. [Modern Insulators Ltd. v. Oriental Insurance Co. Ltd., (2000) 2 SCC 734] Adverting to the expression "material fact" this Court explained it as: (Satwant Kaur case [Satwant Kaur Sandhu v. New India Assurance Co. Ltd., (2009) 8 SCC 316: (2009) 3 SCC (Civ) 366], SCC p. 323, para 22)

"22. .. any fact which would influence the judgment of a prudent insurer in fixing the premium or determining whether he would like to accept the risk. Any fact which goes to the root of the contract of insurance and has a bearing on the risk involved would be "material"."

In a situation which was not governed by Section 45, this Court applied the fundamental tenet of insurance law, namely, utmost good faith.

... ...

***27.** Materiality from the insured's perspective is a relevant factor in determining whether the insurance company should be able to cancel the policy arising out of the fault of the insured. Whether a question concealed is or is it not material is a question of fact. As this Court held in Satwant Kaur [Satwant Kaur Sandhu v. New India Assurance Co. Ltd., (2009) 8 SCC 316: (2009) 3 SCC (Civ) 366]: (SCC p. 323, para 22)*

> *"22. … Any fact which goes to the root of the contract of insurance and has a bearing on the risk involved would be "material"."*
>
> … … …

33. *The learned counsel appearing on behalf of the insurer submitted that where a warranty has been furnished by the proposer in terms of a declaration in the proposal form, the requirement of the information being material should not be insisted upon and the insurer would be at liberty to avoid its liability irrespective of whether the information which is sought is material or otherwise. For the purposes of the present case, it is sufficient for this Court to hold in the present facts that the information which was sought by the insurer was indeed material to its decision as to whether or not to undertake a risk. The proposer was aware of the fact, while making a declaration, that if any statements were untrue or inaccurate or if any matter material to the proposal was not disclosed, the insurer may cancel the contract and forfeit the premium. MacGillivray on Insurance Law [12th Edn., Sweet and Maxwell (2012). See p. 257 for cases relied upon.] formulates the principle thus:*

> *"… In more recent cases it has been held that all-important element in such a declaration is the phrase which makes the declaration the "basis of contract". These words alone show that the proposer is warranting the truth of his statements, so that in the event of a breach of this warranty, the insurer can repudiate the liability on the policy irrespective of issues of materiality."*

34. We are not impressed with the submission that the proposer was unaware of the contents of the form that he was required to fill up or that in assigning such a response to a third party, he was absolved of the consequence of appending his signatures to the proposal. The proposer duly appended his signature to the proposal form and the grant of the insurance cover was on the basis of the statements contained in the proposal form. Barely two months before the contract of insurance was entered into with the appellant, the insured had obtained another insurance cover for his life in the sum of Rs 11 lakhs. We are of the view that the failure of the insured to disclose the policy of insurance

> ***obtained earlier in the proposal form entitled the insurer to repudiate the claim under the policy."***
>
> *(Emphasis supplied)*

A detailed finding of the apex Court is on the principle of *uberrimae fidei*. Again a three Judge Bench of the Apex Court in the case of ***BRANCH MANAGER, BAJAJ ALLIANZ LIFE INSURANCE COMPANY LIMITED AND OTHERS v. DALBIR KAUR***[3] has held as follows:

> "…. …. ….
>
> ***9. A contract of insurance is one of utmost good faith. A proposer who seeks to obtain a policy of life insurance is duty bound to disclose all material facts bearing upon the issue as to whether the insurer would consider it appropriate to assume the risk which is proposed. It is with this principle in view that the proposal form requires a specific disclosure of pre-existing ailments, so as to enable the insurer to arrive at a considered decision based on the actuarial risk. In the present case, as we have indicated, the proposer failed to disclose the vomiting of blood which had taken place barely a month prior to the issuance of the policy of insurance and of the hospitalization which had been occasioned as a consequence. The investigation by the insurer indicated that the assured was suffering from a pre-existing ailment, consequent upon alcohol abuse and that the facts which were in the knowledge of the proposer had not been disclosed.*** *This brings the ground for repudiation squarely within the principles which have been formulated by this Court in the decisions to which a reference has been made earlier. In Life Insurance Corporation of India v. Asha Goel, this Court held:*

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[3] ***AIR 2020 SC 5210***

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> *"12…The contracts of insurance including the contract of life assurance are contracts uberrima fides and every fact of material (sic material fact) must be disclosed, otherwise, there is good ground for rescission of the contract. The duty to disclose material facts continues right up to the conclusion of the contract and also implies any material alteration in the character of risk which may take place between the proposal and its acceptance. If there is any misstatements or suppression of material facts, the policy can be called into question. For determination of the question whether there has been suppression of any material facts it may be necessary to also examine whether the suppression relates to a fact which is in the exclusive knowledge of the person intending to take the policy and it could not be ascertained by reasonable enquiry by a prudent person."*
>
> *(Emphasis supplied)*

Following the aforesaid judgments, High Court of Bombay in the case of ***ADITYA BIRLA SUN LIFE INSURANCE COMPANY LIMITED v. THE INSURANCE OMBUDSMAN AND ANOTHER***[4] has held as follows:

> ***"30.*** *Considering the aforesaid observations, in my opinion, there is perversity on many counts, on the part of the Insurance Ombudsman in recording such findings. Firstly, the Insurance Ombudsman has completely overlooked the basic requirements of the insurance contract, namely, that there has to be disclosure in good faith which is sine-qua-non for an insurance contract to be enforceable when a claim under such contract is made. The Ombudsman has, in fact, proceeded on surmises and conjunctures when he observes that the Life Assured had good relations with the HDFC Bank Manager, the Petitioner's agent, and hence, there was a possibility of awareness of the medical history of the deceased insured. When the Ombudsman further observes that the proposal form was filled up by the company's executive, is totally extraneous*

[4] *W.P.No.7804 of 2021 decided on 18.08.2022*

and besides the point, inasmuch as it was never the case of Respondent No. 2 that prior to the insured's death, the insured had taken a position that he was not aware about the proposal made by him or his agent and more particularly he was not aware of the contents of such insurance proposal as made to the Petitioner. Thus, for Respondent No. 2, to subsequently say that the deceased insured was not aware of the proposal form and/or that the agent of the Petitioner had filled up the online form, in my opinion, is absolutely untenable and accepting such case of respondent no. 2 by the Insurance Ombudsman, in my opinion, is a glaring perversity. Such reasoning of the Insurance Ombudsman lacks both legal and factual logic. This more significantly, when the insured was himself a medical practitioner by profession. It was, therefore, totally unacceptable for the Ombudsman to observe that the proposal form was not filled up by the insured but by the petitioner's agent which was to the knowledge of the Petitioner would make the insurance contract valid. If it was to be the case that the insured had not himself filled up the proposal form, Respondent No. 2 herself was not in position to make any claim as the contract itself was fundamentally not enforceable as being not made by the deceased insured in the manner as the law would require. However, this is certainly not the case of respondent No. 2.

... ...

32. It is a settled principle of law that a contract of insurance is governed by the principle of utmost good faith namely by the doctrine of uberrima fidae which would imply that all parties to an insurance contract must deal in good faith, making a true declaration of all material facts in the insurance proposal. In the present case, the deceased insured had certainly not disclosed material information. In the context of a party to an insurance contract lacking in making disclosure, learned Counsel for the Petitioner would be correct in placing reliance on the Supreme Court in Reliance Life Insurance Company Ltd. v. Rekhaben Nareshbhai Rathod (supra) wherein the Supreme Court taking a review of the legal position on the principles of an insurance contract has observed that even an incorrect statement which may not be a suppression of a material fact, could be enough for the insurance company to repudiate the contract of insurance policy. *In such context, in paragraphs 28, 29, 30, 31, 32 and 36, the relevant observations as*

made by the Supreme Court are required to be noted, which read thus:

> *"28. Materiality of a fact also depends on the surrounding circumstances and the nature of information sought by the insurer. It covers a failure to disclose vital information which the insurer requires in order to determine firstly, whether or not to assume the risk of insurance, and secondly, if it does accept the risk, upon what terms it should do so. The insurer is better equipped to determine the limits of risk-taking as it deals with the exercise of assessments on a day-to-day basis. In a contract of insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not accept the risk is a material fact. If the proposer has knowledge of such fact, she or he is obliged to disclose it particularly while answering questions in the proposal form. An inaccurate answer will entitle the insurer to repudiate because there is a presumption that information sought in the proposal form is material for the purpose of entering into a contract of insurance.*
>
> ***29. Contracts of insurance are governed by the principle of utmost good faith. The duty of mutual fair dealing requires all parties to a contract to be fair and open with each other to create and maintain trust between them. In a contract of insurance, the insured can be expected to have information of which she/he has knowledge. This justifies a duty of good faith, leading to a positive duty of disclosure. The duty of disclosure in insurance contracts was established in a King's Bench decision in Carter v. Boehm [Carter v. Boehm, (1766) 3 Burr 1905 : 97 ER 1162], where Lord Mansfield held thus : (ER p. 1164)***
>
> *"Insurance is a contract upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only; the underwriter trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that*

the circumstance does not exist, and to induce him to estimate the risque, as if it did not exist."

30. It is standard practice for the insurer to set out in the application a series of specific questions regarding the applicant's health history and other matters relevant to insurability. The object of the proposal form is to gather information about a potential client, allowing the insurer to get all information which is material to the insurer to know in order to assess the risk and fix the premium for each potential client. Proposal forms are a significant part of the disclosure procedure and warrant accuracy of statements. Utmost care must be exercised in filling the proposal form. In a proposal form the applicant declares that she/he warrants truth. The contractual duty so imposed is such that any suppression, untruth or inaccuracy in the statement in the proposal form will be considered as a breach of the duty of good faith and will render the policy voidable by the insurer. The system of adequate disclosure helps buyers and sellers of insurance policies to meet at a common point and narrow down the gap of information asymmetries. This allows the parties to serve their interests better and understand the true extent of the contractual agreement.

31. The finding of a material misrepresentation or concealment in insurance has a significant effect upon both the insured and the insurer in the event of a dispute. The fact it would influence the decision of a prudent insurer in deciding as to whether or not to accept a risk is a material fact. As this Court held in Satwant Kaur [Satwant Kaur Sandhu v. New India Assurance Co. Ltd., (2009) 8 SCC 316 : (2009) 3 SCC (Civ) 366] "there is a clear presumption that any information sought for in the proposal form is material for the purpose of entering into a contract of insurance". Each representation or statement may be material to the risk. The insurance company may still offer insurance protection on altered terms.

32. In the present case, the insurer had sought information with respect to previous insurance policies obtained by the assured. The duty of full disclosure required that no information of substance or of interest to the insurer

be omitted or concealed. Whether or not the insurer would have issued a life insurance cover despite the earlier cover of insurance is a decision which was required to be taken by the insurer after duly considering all relevant facts and circumstances. The disclosure of the earlier cover was material to an assessment of the risk which was being undertaken by the insurer. Prior to undertaking the risk, this information could potentially allow the insurer to question as to why the insured had in such a short span of time obtained two different life insurance policies. Such a fact is sufficient to put the insurer to enquiry.

36. Finally, the argument of the respondent that the signatures of the assured on the form were taken without explaining the details cannot be accepted. A similar argument was correctly rejected in a decision of a Division Bench of the Mysore High Court in V.K. Srinivasa Setty v. Premier Life and General Insurance Co. Ltd. [V.K. Srinivasa Setty v. Premier Life and General Insurance Co. Ltd., 1957 SCC OnLine Kar 27 : AIR 1958 Mys 53] where it was held : (SCC OnLine Kar paras 80-81)

> *"80. Now it is clear that a person who affixes his signature to a proposal which contains a statement which is not true, cannot ordinarily escape from the consequence arising therefrom by pleading that he chose to sign the proposal containing such statement without either reading or understanding it. That is because, in filling up the proposal form, the agent normally, ceases to act as agent of the insurer but becomes the agent of the insured and no agent can be assumed to have authority from the insurer to write the answers in the proposal form.*
>
> *81. If an agent nevertheless does that, he becomes merely the amanuensis of the insured, and his knowledge of the untruth or inaccuracy of any statement contained in the form of proposal does not become the knowledge of the insurer. Further, apart from any question of imputed knowledge, the insured by signing that proposal adopts those answers and makes them his own and that would clearly be so,*

> *whether the insured signed the proposal without reading or understanding it, it being irrelevant to consider how the inaccuracy arose if he has contracted, as the plaintiff has done in this case that his written answers shall be accurate."*
>
> *(Emphasis supplied)*

The Bombay High Court follows the judgment of the Apex Court in the case of ***RELIANCE LIFE INSURANCE COMPANY LIMITED*** *(supra)* and sets aside the order of the Ombudsman which had granted insurance claim of the claimants therein.

11. On a coalesce of the judgments rendered by the Apex Court and that of the Bombay High Court the unmistakable inference would be that mediclaim policy being a non-life insurance policy, is a contract of insurance falling in the category of a contract *uberrimae fidei* which would mean, the contract of utmost good faith on the part of the assured. Divulging pre-existing illness was a duty of the insured. Having not done so, the repudiation of the claim cannot be found fault with in the teeth of the preceding analysis.

12. Insofar as judgments relied on by the learned counsel for the petitioners, they are all distinguishable without much *ado*. In the judgment of a coordinate Bench of this Court in the case of ***MRS. SHIVAPRABHA JAYAPRAKASH SHETTY*** *(supra)* the facts were that the petitioner's husband therein was suffering from cysticero meningitis with arthritis and was intermittently hospitalized during the period of the policy and its renewal and the 2nd respondent therein who was very well aware of the medical history of the petitioner's husband therein had suggested a new policy to be taken viz., "National Parivar Mediclaim Plus". Those are not the facts in the case at hand, as it was held that the husband of the petitioner therein had not died on account of pre-existing disease but he died for sepsis, pancytopenia, left loculated pleural effusion. The Court would hold that the clause with regard to pre-existing illness was not applicable in the factual matrix. Therefore, the said judgment would not lend any assistance to the petitioners. The said judgment was tossed before the Division Bench by the Insurance Company which also comes to be dismissed. Therefore, the finding of the Division Bench which has only affirmed the order of the co-ordinate Bench would also lend no assistance to the

petitioners. The other two judgments relied on by the learned counsel for the petitioners would also become inapplicable, as they are distinguishable on the facts obtaining in those cases without much *ado*.

13. Much reliance is placed on the judgment of Madras High Court in the case of ***JASMINE EBENEZER ARTHUR v. HDFC ERGO GENERAL INSURANCE COMPANY LIMITED*** which concerns the very same insurer. The facts therein would become distinguishable to the facts in the case at hand. The claimant therein was suffering from myocardial infarction and it was a finding that the cause of death was myocardial infarction due to Ventricular Fibrillation. Therefore, the said judgment also is inapplicable to the facts of the case at hand. In the light of the preceding analysis, no fault can be found with the repudiation and the order of Ombudsman affirming the said repudiation and disallowing the claim.

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14. For the aforesaid reasons, the petition undoubtedly meets its dismissal and is accordingly dismissed.

Sd/-
JUDGE

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