2021 INSC 826

**REPORTABLE**

**IN THE SUPREME COURT OF INDIA**

**CIVIL APPELLATE JURISDICTION**

**CIVIL APPEAL NO.8386/2015**

**MANMOHAN NANDA** **APPELLANT(S)**

**VS.**

**UNITED INDIA ASSURANCE CO. LTD. & ANR** **RESPONDENT(S)**

**J U D G M E N T**

**NAGARATHNA J.**

1. This appeal assails order dated 22nd May, 2015, passed by the National Consumer Disputes Redressal Commission (hereinafter referred to as "the Commission" for brevity) in Consumer Complaint No. 92/2010 by which the complaint filed by the appellant was dismissed.

2. The facts in a nutshell are that the appellant had sought an overseas mediclaim policy- B (hereinafter referred to as "mediclaim policy") as he intended to travel to the United States of America ("USA")

to attend the wedding of his sister-in-law's daughter. The appellant was medically examined at the instance of respondent No. 1 insurance company prior to the consideration of his request for issuance of a mediclaim policy. On his medical examination, the report categorically noted that the appellant had diabetes-type II (also known as diabetes mellitus). No other adverse medical condition was found.

3. In the medical exam report, a specific query was sought as to whether any abnormalities were observed in the electrocardiogram test of the appellant. There was another query regarding any possible illness or disease for which the appellant may require medical treatment in the ensuing trip to the USA. To both these queries, Dr. Jitendra Jain, the doctor who examined the appellant had answered "normal" and "no" respectively. The representative of the respondent insurer on receipt of the medical reports assured the appellant that on verification of the same the policy would be issued.

4. The insurer thereafter accepted the proposal form and issued the Overseas Mediclaim Business and Holiday Policy bearing Policy Number 190100/46/09/ 44/70000008 valid from 19th May, 2009 to 1st June, 2009, to the appellant. Thereafter, the appellant boarded a flight to San Francisco, USA on 19th May, 2009 at around 1:00 a.m. from Delhi airport and reached San Francisco on the same day at

around 2:00 p.m. (local time). On exiting the customs section at San Francisco airport, appellant felt weak and started sweating. His wife got him admitted at the SFO Medical Centre at San Francisco airport and after he received initial medical treatment, he was shifted to the Mills Peninsula Medical Centre (hereinafter referred to as "Medical Centre" for the sake of brevity) where angioplasty was performed on the appellant on 19th May, 2009 and 22nd May and three stents were inserted to remove the blockage from the heart vessels.

5. In order to avail the benefit under the mediclaim policy, appellant's son-in-law contacted M/s Corris International, a foreign collaborator of respondent No. 1 and 2, which was to provide emergency assistance and claims administration services to the insured. M/s Corris International sought certain documents regarding details of treatment given by the Medical Centre as well as details of the mediclaim policy for the purpose of considering the same for indemnifying the appellant. The appellant was discharged on 24th May, 2009.

6. Two and a half months thereafter, appellant started receiving bills from the cardio vascular wing of the Medical Centre and SFO Medical Centre towards the treatment he received at their facility. On 19th August, 2009, the appellant sent a letter annexing all bills in

original as well as the discharge summary to the Divisional Manager of respondent No. 1 at their Bhopal office. The same letter was also sent to respondent No. 2.

7. On 22nd August, 2009, appellant received a letter from respondent No. 2 stating that his claim had been repudiated as the appellant had a history of hyperlipidaemia and diabetes and the policy did not cover per-existing conditions and complications arising therefrom. The said repudiation was with regard to Bill No.1 i.e. the bill raised by the Medical Centre for USD 2,29,719. The appellant protested against the repudiation and requested his claim to be settled on a priority basis as the Medical Centre and the other centre in the USA where he had taken treatment had started pressing for release of payment. In this regard a representation was sent on 16th November, 2009. However, by its letter dated 9th April, 2010, respondent No.1 reiterated its repudiation of the claim made by the appellant.

8. Being aggrieved, the appellant filed a complaint under Section 21 (9) of the Consumer Protection Act, 1986 (hereinafter referred to as "Act" for brevity) against the respondents, being Consumer Complaint No.92/2010 before the Commission. A reply was filed to the complaint by respondent No.1 stating that appellant's claim was rightly rejected by respondent No.2 on the ground of non-disclosure of a pre-existing

disease as the treatment report of the appellant showed prior medication such as statins, which is a lipid lowering medicine. The said reply was filed on 3rd March, 2011. Respondent No.2 also filed its reply on 27th April, 2011. Appellant filed his rejoinder to the replies of the respondents in August, 2011. Appellant also filed an additional affidavit enclosing medical opinions of three doctors on affidavit stating that prescription of statins to a person having diabetes-type II is by way of precaution and not because the patient would be suffering from any cardiovascular disease. Respondent No. 1 and 2 filed their evidence by way of affidavit and thereafter written submissions were filed by both sides. Subsequently, the Commission dismissed the complaint filed by the appellant on the ground of non-disclosure of material facts. Hence this appeal by the claimant.

9. Before proceeding further, it would be useful to encapsulate the reasoning of the Commission for dismissing the complaint filed by the appellant herein, as under:

(i) The Commission concluded that the complainant had a history of hyperlipidaemia and peptic-ulcer disease in addition to diabetes mellitus. Since this was disclosed by the complainant to medical authorities in the USA, the Commission found that there was no reason why he could not have disclosed the condition to the respondent-

insurance company at the time of obtaining the mediclaim policy.

(ii) That statins are lipid lowering agents which are found beneficial in primary and secondary prevention of cardio-vascular complications in diabetics. Given that the complainant had admitted that he had been under statin medication, it was found that he had a pre-existing disease of which disclosure had not been made.

(iii) The Commission held that it was the duty of the complainant to have ensured that complete facts about his health condition were brought to the knowledge of the insurance company at the time of obtaining the insurance policy. The complainant breached this duty of disclosure and acted in a manner contrary to the principle of *'uberima fides'* between the insurer and the insured.

(iv) Having regard to general condition 10 of the policy, the Commission found that for any sickness for which insured had sought advice or had taken medical treatment even at the time of issuance of policy, the insured was not entitled to claim benefit under the policy owing to the "pre-existing exclusion" under the policy.

(v) The Commission held that concealment or non-disclosure of material facts regarding pre-existing heart ailment was a valid ground for repudiation of the insurance claim by the respondent - Insurer.

10. We have heard Mr. Gopal Sankarnarayanan, learned Senior Counsel along with Ms. Zehra khan, learned counsel, for the appellant and Ms. Sunaina Phul, learned counsel for respondent No.1 and perused the material on record.

11. Learned Senior Counsel for appellant submitted that the appellant was about 55 years of age when he and his wife travelled to San Francisco, USA to attend the wedding of his sister-in-law's daughter. Appellant was issued overseas mediclaim policy by respondent No.1 after undergoing the requisite medical tests namely: 1) Blood sugar test, 2) Urine examination 3) Electrocardiogram test. Dr. Jitendra Jain, Assistant Professor in the Department of Medicine, Peoples' Medical College, Bhopal, examined the appellant and answered the medical questionnaire as provided in the proposal form. The mediclaim policy, issued to the appellant was for the period between 19th May, 2009 and 1st June, 2009 and was subsequently extended to 21st June, 2009. The policy in question contained the

nature of coverage and excluded pre-existing conditions as defined in general condition 10. That on boarding the flight to San Francisco from Delhi airport on 19th May, 2009, the appellant travelled in good health and was fit on the flight. It is only on arrival at San Francisco airport that the appellant felt weak and was admitted to the SFO Medical Centre for preliminary treatment and was later shifted to the Medical Centre. The appellant availed the treatment for which the charges were USD 2,41,932, approximately Rs. 1,08,86,940 at Rs.45 per USD. Since the respondent insurer erroneously repudiated the claim made by the appellant, the consumer complaint was filed before the Commission. The Commission by its order dated 22nd May, 2015, without appreciating the case of the appellant in its true perspective, dismissed the complaint on the ground that appellant had not disclosed true and complete information about his health while taking the policy and therefore the repudiation clause applied.

12. It was contended by learned Senior Counsel along with learned counsel for the appellant that the repudiation of the contract on the ground of suppression of pre-existing disease by appellant was wholly erroneous. Our attention was drawn to the fact that respondent No.1 had repudiated the claim on the premise that the appellant was suffering from hyperlipidaemia at the time of seeking the insurance policy and in fact had been prescribed statins, which fact had not

been disclosed to the insurer. It was contended that the appellant had no knowledge that he was suffering from hyperlipidaemia at the time of submission of the proposal form. The obligation to disclose any fact extends only when the said fact is known to the appellant but not otherwise. In support of this submission, reliance was placed on ***Satwant Kaur Sandhu v. New India Assurance Co.* - (2009) 8 SCC 316**. In fact, the proposal form itself stipulates that it should be completed to the best of the insured's "knowledge and belief". The appellant had stated that he was not suffering from hyperlipidaemia and that the same was diagnosed for the first time on 19th May, 2009 at the Medical Centre in San Francisco. The doctor had noted "hyperlipidaemia", under the column "IMPRESSION", after examining the appellant on 21st May, 2009, but the same did not find a place under "discharge diagnosis" issued to the appellant on 24th May, 2009. There was no intention to suppress any material fact by the appellant at the time of filling the proposal form as the appellant had no knowledge that he was suffering from hyperlipidaemia as on 15th May, 2009, when the proposal form was filled by him.

13. It was next contended that the proposal form was worded in such a manner that there was no specific query which could have led to the appellant disclosing that he was suffering from hyperlipidaemia. This argument was made as an alternative submission on the

assumption that the appellant had in fact knowledge that he was suffering from hyperlipidaemia at the time of filling up of proposal form seeking insurance policy.

14. It was further contended that the proposal form and the insurance policy did not define the terms "pre-existing disease," "pre-existing ailment," "pre-existing condition", "disease" or "illness." That query number 2 of part 2 dealing with "medical history" in the proposal form namely "*have you ever suffered from any illness or disease up to the date of making this proposal*", was too vague and the appellant left the column blank. Failure to fill in all the queries in the proposal form cannot be termed as suppression or misdeclaration vide ***Canara Bank v. United India Insurance Co.*** **- (2020) 3 SCC 455**.

15. Further, question number 5 which read, "*Have you ever suffered from any illness or disease or had any accident prior to the first day of insurance*" is also overarching as no person can answer such a question in the negative. Every person to whom a mediclaim policy is offered, would have, at some point of time, suffered from some disease or illness but for the same to be considered as a pre-existing disease, ailment, condition or illness on which ground a claim could be repudiated, there is need for a specific definition to be incorporated in the policy. This is because every disease or illness cannot be

considered as a pre-existing disease or condition so as to exclude the benefit of the policy to a policy holder. According to the learned Senior Counsel for the appellant, the nature of a disease or illness which would exclude a policy holder or an insured from the benefits of the said policy must be clearly mentioned in the policy itself. The same cannot be vague or non-specific so as to enable the insurer to interpret the policy to its benefit whenever a claim is made under the mediclaim policy.

16. It was submitted that for an insurer to repudiate the policy it must establish suppression or a misrepresentation of material facts on the part of the insured vide ***Oriental Insurance Co Ltd. v. Mahendra Construction*** - **(2019) 18 SCC 209** and ***LIC of India v. Smt. G.M. Channabasamma*** - **(1991) 1 SCC 357**. In order to repudiate the policy, the insurance company was also required to prove the following:

(a) That the heart attack suffered by the appellant on 19th May, 2009 was caused by diabetes mellitus-type II and hyperlipidaemia,

(b) That hyperlipidaemia was a "pre-existing condition,"

(c) That this fact was known to the appellant and was suppressed by him at the time of filling up the proposal form, i.e. on 15th May, 2009.

17. Instead, respondent insurer only denied that the acute coronary syndrome for which the complainant-appellant herein had to be treated at the Medical Centre was a sudden and unexpected sickness. The respondents, on the other hand, found that a past history of diabetes mellitus and hyperlipidaemia were the main causes for the cardiovascular ailment for which the insured was treated. In support of this stand, the insurer filed only an affidavit of evidence of its panel doctor, Dr. P.R. Purandare, which merely opined- "*It is obvious that the insured was suffering from diabetes mellitus and hyperlipidaemia. Also, he was taking medications for the same.*"

18. There was no evidence let in by the respondents to show that the pre-existing condition of diabetes mellitus- type II was the cause for the heart attack suffered by the appellant on 19th May, 2009 or that the appellant had any pre-existing heart related illness, disease or condition.

19. It was further urged that the appellant had filed discharge summary notes of the doctors at the Medical Centre where he was treated for the period between 19th May, 2009 and 24th May, 2009 and

a perusal of the said documents would indicate that the appellant was "without prior coronary history." That from the discharge summary notes per se, there can be no proof of the appellant suffering from hyperlipidaemia as on 15th May, 2009 when he filled the proposal form or that the same was a pre-existing condition. That in fact, the discharge summary indicated the "discharge diagnosis" given to the appellant on 24th May, 2009 which only mentioned:

(a) Acute anterior wall myocardial infraction with congestive heart,

(b) Diabetes-type II.

20. That the respondent failed to prove that the heart attack suffered by the appellant on 19th May, 2009 was caused by diabetes mellitus- type II and hyperlipidaemia. That appellant had disclosed that he was a diabetic and was on medication and the tests done for the same showed good results. It was submitted that the respondent further failed to prove that the appellant was suffering from hyperlipidaemia at the time of filling the proposal form and had made a false representation and suppressed material facts.

21. Referring to the specific terms of the insurance policy, it was contented by the learned Senior Counsel for appellant that an insurance policy should be given a purposive interpretation in favour of the insured- appellant herein. The insurance policy and its

components must be read as a whole and given a meaning which furthers the expectations of parties and also of the realities of the insurance business vide ***Canara Bank v. United India Insurance Co.*** - **(2020) 3 SCC 455**. Further, the exemption of liability clauses in insurance contracts are to be construed *contra proferentem*, in favour of the insured in case of ambiguity vide ***Sushilaben Indravadan Gandhi v. New India Assurance Co. Ltd.*** -**(2021) 7 SCC 151**. Reliance was also placed on ***Hari Om Agarwal v. Oriental Insurance Co.*** - **2007 (98) DRJ 246** wherein the Delhi High Court found that repudiation of a claim towards treatment for a heart attack on the ground of pre-existing ailment of diabetes, which was disclosed, was illegal because the object of the insurance policy was to "cater to medical expenses incurred by the assured" and therefore the exclusion clause could be overridden in light of the object.

22. It was contended by learned Senior Counsel for the appellant that the insurance company had failed to prove that the appellant had suppressed any material fact which was in his knowledge at the time of filling the proposal form and that the heart attack suffered by the appellant on 19th May, 2009 arose "out of a pre-existing condition" and was therefore outside the purview of the insurance policy.

23. As opposed to the aforesaid arguments, learned counsel for respondent No.1 supported the repudiation of the policy by the insurer and the dismissal of the complaint by the Commission on grounds of misrepresentation and non-disclosure of material facts in the proposal form, by the appellant insured. It was submitted that had the appellant disclosed that he was suffering from hyperlipidaemia which was an existing disease as on the date of the making of the proposal, the insurer may not have issued the mediclaim policy to him. The insured therefore did not disclose this vital fact and had not answered the column related to illness or disease suffered by him up to the date of the filling up of the proposal form. It was contended that there was a specific clause in the schedule of the policy under the heading "important" to the following effect :

> *"Notwithstanding anything stated in the policy, it is hereby agreed that all claims occasioned by, happening through or in consequence of any disease which is existing on the date of commencement of risk, whether specifically declared or not, the proposal form completed by the insured, is excluded from the scope of the policy."*

24. It was also necessary that the policy form had to be completed disclosing all material facts and failure to do so could nullify the policy itself.

25. It was contended by learned counsel for respondent No. 1 that the medical history which was suppressed by the appellant in the proposal form required to be filled up by him prior to the issuance of the policy, was in fact disclosed to the doctors in USA where he was given treatment, by stating that he was prescribed statins which is for the purpose of controlling/treating hyperlipidaemia. In sum and substance, the submission was that the non-disclosure or the failure to disclose the past medical history relating to a pre-existing medical condition in the proposal form was a good reason to repudiate the policy. This aspect was rightly appreciated by the Commission and consequently the Commission dismissed appellant's complaint, which Order would not call for any interference in this appeal.

26. Learned counsel for the respective parties have relied upon certain judgments of this Court in support of their submissions, which shall be referred to later.

**Points for consideration**

27. Having regard to the submissions of the learned Senior Counsel and learned counsel for the respective sides, the following points would arise for our consideration:

(i) Whether the appellant herein had suppressed or not disclosed material facts in the proposal form which could have led the insurer to repudiate the policy in question?

(ii) Whether the Commission was justified in dismissing the complaint?

(iii) What Order?

28. The fact that a policy namely, Overseas Mediclaim Policy-B, was issued by the respondent insurance company to the appellant is not in dispute. The appellant intended to travel to USA to attend his sister-in-law's daughter's wedding which was to take place in May, 2009. Consequently, the appellant sought an overseas mediclaim policy. Dr. Jitendra Jain, the doctor who examined the appellant prior to issuance of the policy noted as per Annexure A-2 that the appellant had diabetes mellitus-II (DM-2) which was controlled on drugs. There was no mention of any past history of any disease, operation, accident, investigation etc. An electrocardiogram test (ECG) was taken and the doctor noted the same as "normal." The doctor further noted that there was no current illness or disease which would possibly require medical treatment during the proposer's (appellant's) forthcoming trip. The doctor did not recommend any stress test. It was also found that in the blood and urine tests of the appellant there was no trace of sugar. The serum glucose/fasting test result showed 92%,

which was well within the normal values i.e. between 70-110 mgs %. The urine examination also did not reveal any abnormality. Thereafter the appellant was requested to fill up the proposal form.

29. Before we proceed, it is necessary to discuss two aspects of the matter which give rise to the controversy in the present appeal. The first is what may be expressed in the legal maxim *uberrimae fidei* or the principle of good faith and the corresponding principle of disclosure of all material facts by the parties to an insurance policy. The second principle is expressed in the *contra proferentem* rule.

***Uberrimae Fidei***

30. It is observed that insurance contracts are special contracts based on the general principles of full disclosure inasmuch as a person seeking insurance is bound to disclose all material facts relating to the risk involved. Law demands a higher standard of good faith in matters of insurance contracts which is expressed in the legal maxim *uberrimae fidei*.

31. Mac Gillivray on insurance law 13th Ed. has summarised the duty of an insured to disclose as under:

> *"...the assured must disclose to the insurer all facts material to an insurer's appraisal of the risk which are known or deemed to be known by the assured but neither known nor deemed to be*

*known by the insurer. Breach of this duty by the assured entitles the insurer to avoid the contract of insurance so long as he can show that the non-disclosure induced the making of the contract on the relevant terms."*

32. Lord Mansfield in ***Carter v. Boehm*** **(1766) 3 Burr 1905** has summarised the principles necessitating disclosure by the assured in the following words:

*"Insurance is a contract of speculation. The special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the assured 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. The keeping back such circumstance is a fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention, yet still the underwriter is deceived and the policy is void; because the risk run is really different from the risk understood and intended to be run at the time of the agreement. The policy would be equally void against the underwriter if he concealed...Good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from his ignorance of the fact, and his believing the contrary."*

The aforesaid principles would apply having regard to the nature of policy under consideration, as what is necessary to be disclosed are "material facts" which phrase is not definable as such, as the same would depend upon the nature and extent of coverage of risk under a particular type of policy. In simple terms, it could be understood that any fact which has a bearing on the very foundation of the contract of insurance and the risk to be covered under the policy would be a "material fact".

33. Under the provisions of Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations,2002 the explanation to Section 2 (d) defining "proposal form" throws light on what is the meaning and content of "material." For an easy reference the definition of "proposal form" along with the explanation under the aforesaid Regulations has been extracted as under:

> *"2. Definitions.--In these regulations, unless the context otherwise requires-*
>
> *(d) "Proposal Form" means a form to be filled in by the proposer for insurance, for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to accept or decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, terms and conditions of a cover to be granted.*
>
> *Explanation: "Material" for the purpose of these regulations shall mean and include all important, essential and relevant information in the context of underwriting the risk to be covered by the insurer."*

Thus, the Regulation also defines the word "material" to mean and include all "important", "essential" and "relevant" information in the context of guiding the insurer in deciding whether to undertake the risk or not.

34. Just as the insured has a duty to disclose all material facts, the insurer must also inform the insured about the terms and conditions of the policy that is going to be issued to him and must strictly conform to the statements in the proposal form or prospectus, or

those made through his agents. Thus, the principle of utmost good faith imposes meaningful reciprocal duties owed by the insured to the insurer and *vice versa*. This inherent duty of disclosure was a common law duty of good faith originally founded in equity but has later been statutorily recognised as noted above. It is also open to the parties entering into a contract to extend the duty or restrict it by the terms of the contract.

35. The duty of the insured to observe utmost good faith is enforced by requiring him to respond to a proposal form which is so framed to seek all relevant information to be incorporated in the policy and to make it the basis of a contract. The contractual duty so imposed is that any suppression or falsity in the statements in the proposal form would result in a breach of duty of good faith and would render the policy voidable and consequently repudiate it at the instance of the insurer.

36. In relation to the duty of disclosure on the insured, any fact which would influence the judgment of a ***prudent insurer*** and not a ***particular insurer*** is a material fact. The test is, whether, the circumstances in question *would* influence the prudent insurer and not whether it *might* influence him vide ***Reynolds v. Phoenix***

***Assurance Co. Ltd.*** **(1978) 2 Lloyd's Rep. 440.** Hence the test is to be of a prudent insurer while issuing a policy of insurance.

37. The basic test hinges on whether the mind of a prudent insurer would be affected, either in deciding whether to take the risk at all or in fixing the premium, by knowledge of a particular fact if it had been disclosed. Therefore, the fact must be one affecting the risk. If it has no bearing on the risk it need not be disclosed and if it would do no more than cause insurers to make inquiries delaying issue of the insurance, it is not material if the result of the inquiries would have no effect on a prudent insurer.

38. Whether a fact is material will depend on the circumstances, as proved by evidence, of the particular case. It is for the court to rule as a matter of law, whether, a particular fact is capable of being material and to give directions as to the test to be applied. Rules of universal application are not therefore to be expected, but the propositions set out in the following paragraphs are well established :

> (a) Any fact is material which leads to the inference, in the circumstances of the particular case, that the subject matter of insurance is not an ordinary risk, but is exceptionally liable to be affected by the peril insured against. This is referred to as the 'physical hazard".

(b) Any fact is material which leads to the inference that the particular proposer is a person, or one of a class of persons, whose proposal for insurance ought to be subjected at all or accepted at a normal rate. This is usually referred to as the 'moral hazard'.

The materiality of a particular fact is determined by the circumstances of each case and is a question of fact.

39. If a fact, although material, is one which the proposer did not and could not in the particular circumstances have been expected to know, or if its materiality would not have been apparent to a reasonable man, his failure to disclose it is not a breach of his duty.

40. Full disclosure must be made of all relevant facts and matters that have occurred up to the time at which there is a concluded contract. It follows from this principle that the materiality of a particular fact is determined by the circumstances existing at the time when it ought to have been disclosed, and not by the events which may subsequently transpire. The duty to make full disclosure continues to apply throughout negotiations for the contract but it comes to an end when the contract is concluded; therefore, material facts which come to the proposer's knowledge subsequently need not be disclosed.

41. Thus, a proposer is under a duty to disclose to the insurer all material facts as are within his knowledge. The proposer is presumed to know all the facts and circumstances concerning the proposed insurance. Whilst the proposer can only disclose what is known to him, the proposer's duty of disclosure is not confined to his actual knowledge, it also extends to those material facts which, in the ordinary course of business, he ought to know. However, the assured is not under a duty to disclose facts which he did not know and which he could not reasonably be expected to know at the material time. The second aspect of the duty of good faith arises in relation to representations made during the course of negotiations, and for this purpose all statements in relation to material facts made by the proposer during the course of negotiations for the contract constitute representations and must be made in good faith.

42. The basic rules to be observed in making a proposal for insurance may be summarized as follows :

(a) A fair and reasonable construction must be put upon the language of the question which is asked, and the answer given will be similarly construed. This involves close attention to the language used in either case, as the question may be so framed that an unqualified answer amounts to an assertion by the proposer that

he has knowledge of the facts and that the knowledge is being imparted. However, provided these canons are observed, accuracy in all matters of substance will suffice and misstatements or omissions in trifling and insubstantial respects will be ignored.

(b) Carelessness is no excuse, unless the error is so obvious that no one could be regarded as misled. If the proposer puts 'no' when he means 'yes' it will not avail him to say it was a slip of the pen; the answer is plainly the reverse of the truth.

(c) An answer which is literally accurate, so far as it extends, will not suffice if it is misleading by reason of what is not stated. It may be quite accurate for the proposer to state that he has made a claim previously on an insurance company, but the answer is untrue if in fact he has made more than one.

(d) Where the space for an answer is left blank, leaving the question un-answered, the reasonable inference may be that there is nothing to enter as an answer. If in fact there is something to enter as an answer, the insurers are misled in that their reasonable inference is belied. It will then be a matter of construction

whether this is a mere non-disclosure, the proposer having made no positive statement at all, or whether in substance he is to be regarded as having asserted that there is in fact nothing to state.

(e) Where an answer is unsatisfactory, as being on the face of it incomplete or inconsistent the insurers may, as reasonable men, be regarded as put on inquiry, so that if they issue a policy without any further enquiry they are assumed to have waived any further information. However, having regard to the inference mentioned in head (4) above, the mere leaving of a blank space will not normally be regarded as sufficient to put the insurers on inquiry.

(f) A proposer may find it convenient to bracket together two or more questions and give a composite answer. There is no objection to his doing so, provided the insurers are given adequate and accurate information on all points covered by the questions.

(g) Any answer given, however accurate and honest at the time it was written down, must be corrected if, up to the time of acceptance of the proposal, any event or

circumstance supervenes to make it inaccurate or misleading.

***[Source : Halsbury's Laws of England, Fourth Edition, Para 375, Vol.25 : Insurance]***

43. Sometimes the standard of duty of disclosure imposed on the insured could make the insured vulnerable as the statements in the proposal form could be held against the insured. Conversely, certain clauses in the policy of insurance could be interpreted in light of the *contra proferentem* rule as against the insurer. In order to seek specific information from the insured, the proposal form must have specific questions so as obtain clarity as to the underlying risks in the policy, which are greater than the normal risks.

***Contra Proferentem Rule***

44. The *Contra Proferentem* Rule has an ancient genesis. When words are to be construed, resulting in two alternative interpretations then, the interpretation which is against the person using or drafting the words or expressions which have given rise to the difficulty in construction, applies. This Rule is often invoked while interpreting standard form contracts. Such contracts heavily comprise of forms with printed terms which are invariably used for the same kind of contracts. Also, such contracts are harshly worded against individuals

and not read and understood most often, resulting in grave legal implications. When such standard form contracts ordinarily contain exception clauses, they are invariably construed *contra proferentem rule* against the person who has drafted the same.

45. Some of the judgments which have considered the *contra proferentem* rule are referred to as under :

a) In ***General Assurance Society Ltd., v. Chandmull Jain* - AIR 1966 SC 1644**, it was held that where there is an ambiguity in the contract of insurance or doubt, it has to be construed *contra proferentem* against the Insurance Company.

b) In ***Delhi Development Authority v. Durga Chand Kaushish* - AIR 1973 SC 2609**, it was observed:

> "In construing a document one must have regard, not to the presumed intention of the parties, but to the meaning of the words they have used. If two interpretations of the document are possible, the one which would give effect and meaning to all its parts should be adopted and for the purpose, the words creating uncertainty in the document can be ignored."

c) Further, in ***Central Bank of India v. Hartford Fire Insurance Co. Ltd.* AIR 1965 SC 1288**, it was held:

> "What is called the contra proferentem rule should be applied and as the policy was in a standard form contract prepared by the insurer alone, it should be interpreted in a way that would be favourable to the assured."

d) In ***Md. Kamgarh Shah v. Jagdish Chandra*** **AIR 1960 SC 953**, it was observed that where there is an ambiguity it is the duty of the court to look at all the parts of the document to ascertain what was really intended by the parties. But even here the rule has to be borne in mind that the document being the grantor's document it has to be interpreted strictly against him and in favour of the grantee.

e) In ***United India Insurance Co. Ltd. v. Orient Treasures (P)*** **(2016) 3 SCC 49** this Court quoted Halsbury's laws of England (5th Ed. Vol. 60, Para 105) on the *Contra Proferentem* rule as under :

> "Contra proferentem rule.-Where there is ambiguity in the policy the court will apply the contra proferentem rule. Where a policy is produced by the insurers, it is their business to see that precision and clarity are attained and, if they fail to do so, the ambiguity will be resolved by adopting the construction favourable to the insured. Similarly, as regards language which emanates from the insured, such as the language used in answer to questions in the proposal or in a slip, a construction favourable to the insurers will prevail if the insured has created any ambiguity. This rule, however, only becomes operative where the words are truly ambiguous; it is a Rule for resolving ambiguity and it cannot be invoked with

> a view to creating a doubt. Therefore, where the words used are free from ambiguity in the sense that, fairly and reasonably construed, they admit of only one meaning, the Rule has no application."

f) Learned counsel for the appellant have relied upon ***Sushilaben Indravadan Gandhi and Ors. v. The New India Assurance Co. Ltd. and Ors.*** **(2021) 7 SCC 151** wherein it was observed that any exemption of liability clause in an insurance contract must be construed, in case of ambiguity, *contra proferentem* against the insurer. In the said case reliance was placed on ***Export Credit Guarantee Society v. Garg Sons International*** **(2014) 1 SCC 686** wherein this court held as under:

> *"The insured cannot claim anything more than what is covered by the insurance policy. "The terms of the contract have to be construed strictly, without altering the nature of the contract as the same may affect the interests of the parties adversely." The clauses of an insurance policy have to be read as they are. Consequently, the terms of the insurance policy, that fix the responsibility of the insurance company must also be read strictly. The contract must be read as a whole and every attempt should be made to harmonise the terms thereof, keeping in mind that the Rule of contra proferentem does not apply in case of commercial contract, for the reason that a Clause in a commercial contract is bilateral and has mutually been agreed upon."*

46. Delving on the facts of the case and on consideration of IMT-5 and IMT-16 of the comprehensive private car (B) policy with regard to

the limitation of liability clause, it was observed that the *contra proferentem* rule applies in case of real ambiguity and if on a reading of the whole policy the meaning of the clauses of a contract are clear there is no room for the application of the doctrine. On the facts of the said case, the appeal was allowed by holding that the insurance company was liable to pay the entire amount claimed. The said case arose from an appeal against the order of the High Court of Gujarat wherein the Court had directed that the liability of the insurer shall be limited to a sum of Rs. 25,000/- and the remaining claim amount shall be payable by the employer (hospital) of the deceased. Ambiguity arising with regard to the interpretation of the term 'employee' as appearing in the limitation of liability clause in the insurance contract was construed *contra proferentem* against the insurance company by holding that the deceased was not an employee of the hospital and that therefore, the entire liability would lie upon the insurer. This Court, therefore, required the insurer therein to pay the entire claim amount to the wife of the deceased.

47. MacGillivray on Insurance Law (9th Ed., Sweet and Maxwell London, 1997 at p. 280) deals with the rule of *Contra Proferentem* as under :

> *"The contra proferentem Rule of construction arises only where there is a wording employed by those drafting the Clause which leaves the court unable to decide by ordinary*

> *principles of interpretation which of two meanings is the right one. 'One must not use the Rule to create the ambiguity - one must find the ambiguity first.' The words should receive their ordinary and natural meaning unless that is displaced by a real ambiguity either appearing on the face of the policy or, possibly, by extrinsic evidence of surrounding circumstances."*

48. Colinvaux's Law of Insurance (6th Ed., 1990 at p. 42) has elucidated on the said rule in the following words:

> *"Quite apart from contradictory clauses in policies, ambiguities are common in them and it is often very uncertain what the parties to them mean. In such cases the Rule is that the policy, being drafted in language chosen by the insurers, must be taken most strongly against them. It is construed contra proferentem, against those who offer it. In a doubtful case the turn of the scale ought to be given against the speaker, because he has not clearly and fully expressed himself. Nothing is easier than for the insurers to express themselves in plain terms. The assured cannot put his own meaning upon a policy, but, where it is ambiguous, it is to be construed in the sense in which he might reasonably have understood it. If the insurers wish to escape liability under given circumstances, they must use words admitting of no possible doubt."*

49. The aforesaid principles could be applied to the present case having regard to the nature of the policy in question i.e. a mediclaim policy, the specific queries in the proposal form and the answers thereto given by the appellant in the context of the general and specific clauses therein.

50. But before entering upon the factual controversy in the instant case, it would be useful to discuss the relevant judgments cited at the Bar :

(i) Learned Senior Counsel for appellant have relied upon the following judgments in support of the claim of the appellant :-

***a) Satwant Kaur Sandhu v. New India Assurance Co.* (2009) 8 SCC 316 :**

In the said case the husband of the appellant therein had taken a mediclaim policy provided by the respondent insurer therein for the period from 7th May, 1990 to 6th May, 1991. The appellant therein suddenly fell ill and was admitted to a hospital in Ludhiana and thereafter to a health centre in Chennai where his condition deteriorated ultimately leading to his death on 26th December, 1990. The insurance company therein was informed about his death and a claim for reimbursement was made. The respondent insurer therein made inquiries from Madras Institute of Nephrology (Health Centre) and obtained a certificate dated 6th May, 1992, stating that the deceased was a known case of “chronic renal failure/diabetic

nephropathy" and that the complainant was on regular haemodialysis at his place leading to his death. The insurance company therein repudiated the claim. The core question considered by this Court in the said case was whether the fact that the policy holder was suffering from chronic diabetes and renal failure at the time of taking out the mediclaim policy was a material fact and therefore, on account of non-disclosure of this fact in the proposal form, the respondent Insurance Company was justified in law in repudiating the claim of the appellant therein.

This Court dealt with the concept of material fact and observed at para 20 as under:

> *"20. The upshot of the entire discussion is that in a Contract of Insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not to accept the risk is a "material fact". If the proposer has knowledge of such fact, he is obliged to disclose it particularly while answering questions in the proposal form. Needless to emphasise that any inaccurate answer will entitle the insurer to repudiate his liability because there is clear presumption that any information sought for in the proposal form is material for the purpose of entering into a Contract of Insurance."*

Ultimately this Court held as under:

> *"21. Bearing in mind the aforestated legal position, we may advert to the facts in hand.*

> *As noted earlier, the proposal form contained the following two questions:*
>
> *Details of illness which may require treatment in the near future;*
>
> *Details of treatment/surgical operation in the last two months.*
>
> *Answers given by the proposer to the two questions were "Sound Health" and "Nil" respectively. It would be beyond anybody's comprehension that the insured was not aware of the state of his health and the fact that he was suffering from diabetes as also chronic Renal failure, more so when he was stated to be on regular haemodialysis. There can hardly be any scope for doubt that the information required in the afore- extracted questions was on material facts and answers given to those questions were definitely factors which would have influenced and guided the respondent - Insurance Company to enter into the Contract of Mediclaim Insurance with the insured."*

Learned counsel for the respondent insurer has also relied upon ***Satwant Kaur Sandhu*** *supra* and has emphasised on para 20 of the said judgment extracted above.

It was observed that there was clear suppression of material facts relating to the health of the insured and that therefore, the respondent insurer was fully justified in repudiating the insurance contract. But the aforesaid judgment is sought to be distinguished by learned counsel for appellant.

(b) In ***LIC of India v. Smt. G.M. Channabasemma*** **(1991) 1 SCC 357,** it was observed that there is an obligation upon the assured to disclose all material facts which may be relevant to the insurer but after issuing a policy, the burden of proving that the insured had made false representations and suppressed material facts is on the insurer. In the said case, it was held that the physician's statement did not lead to a conclusion that the respondent therein was influenced by a serious disease for a long time. On consideration of the evidence led by the parties therein, it was observed that the insurer had failed to prove that the insured was suffering from diabetes or tuberculosis at the time of filling up the proposals for the policies or that he had given any false answer in his statements or suppressed any material fact which he was under a duty to disclose. The finding of the Trial Court that the assured had committed fraud on the insurer while taking out the policies was reversed and the appeal was allowed.

(c) ***Canara Bank v. United India Insurance Co.*** **(2020) 3 SCC 455**, is a case in which this Court held that if a column is left blank, the insurance company

should ask the insured to fill up the column. If the insurance company while accepting the proposal form does not ask the insured to clarify any ambiguity then the insurance company after accepting premium cannot urge that there was a wrong declaration made by the insured. Leaving out a column blank does not mean that there was a misdescription of facts. To make a contract void, the non-disclosure should be of some very material fact. Therefore, the insurer therein was directed to indemnify the insured in the case. The judgment in ***Satwant Kaur Sandhu*** (supra) was distinguished and held not applicable in this case.

*d)* ***Hari Om Agarwal v. Oriental Insurance Co.*** **2007 (98) DRJ 246,** is a decision on a mediclaim policy. In the said case, it was held that the insured had suffered from diabetes as well as hypertension at the time of submission of the proposal. The insured was advised to undergo ECG which he did. Thereafter, the proposal was accepted and the cover note was issued. Clause 4.1 of the policy therein came up for interpretation. It was observed that hypertension and diabetes could lead to a host of ailments such as stroke, cardiac disease, renal

failure, liver disorder, depending upon various factors. Such ailments can equally arise in non-diabetics and those without hypertension. Giving a contextual interpretation to clause 4.1 of the policy, it was observed that such an interpretation was necessary to avoid rendering a medical cover meaningless. Hence the main purpose rule was pressed into service by holding that clause 4.1 of the said policy could not be used to override the primary liability of the insurer.

(ii) The following citations were relied upon by learned counsel for respondent No. 1 in support of validity of the repudiation of the insurance claim:

*a)* ***Reliance Life Insurance v. Rekhaben Nareshbhai Rathod*****, (2019) 6 SCC 175,** is a case where the insured therein, while seeking a life insurance policy failed to disclose in the proposal form that he had earlier obtained another insurance cover for his life, two months before obtaining the policy in question. The spouse of the assured therein submitted a claim under the terms of the policy after the death of the assured. The insurance company repudiated the claim on the ground of non-disclosure of the fact that insured had

taken out another policy to insure his life before obtaining the policy in question. The State Commission found that the repudiation of claim was unjustified as the omission of the insured to disclose a previous policy of insurance would not have influenced the mind of a prudent insurer. The National Commission affirmed the findings of the State Commission. In an appeal before this Court, the decision of the National Commission was reversed and the Court allowed the claim to be repudiated by the insurer. It was held that the disclosure of the earlier cover was material to an assessment of the risk which was being undertaken by the insurer. The duty of full disclosure required that no information of substance or interest to the insurer be omitted or concealed.

*b)* In ***Life Insurance Corporation of India v. Manish Gupta*****, (2019) 11 SCC 371**, the respondent therein had obtained a mediclaim policy from the appellant insurer. The proposal form sought disclosure of health details and medical information of the assured. With regard to the query as to whether the proposer/assured had suffered from any "cardio-vascular disease e.g.

palpitations, heart attack, stroke, chest pain," the assured answered in the negative. The assured underwent a mitral valve replacement surgery. A claim for treatment expenses was made by the hospital where treatment was administered and the said claim was repudiated by the insurer on the ground of non-disclosure of pre-existing cardiac condition. An appeal filed before this Court was allowed. This Court, on consideration of documentary material placed before it found that the discharge card of the assured recorded his history of "rheumatic heart disease since childhood." This Court therefore allowed the repudiation of claim by the insurer on the ground that the assured had failed to disclose, at the time of seeking the mediclaim policy, that he had suffered from rheumatic heart disease since childhood.

51. We have also considered the following judgments :

*c)* In ***Branch Manager Bajaj Allianz Life Insurance Co. v. Dalbir Kaur*** - **AIR 2020 SC 5210,** a proposal form was submitted to the appellant therein for a life insurance policy containing questions pertaining to the health and medical history of the proposer and required

a specific disclosure as to whether the proposer had undergone any treatment. The proposer answered the queries in the negative. Further a query regarding specific diseases or disorders suffered was also responded to in the negative. A policy of insurance was issued by the insurer on 12th August, 2014, insuring the life of the proposer for a sum of Rs. 8.50 lakhs payable on maturity with the death benefit of Rs. 17 lakhs. On 12th September, 2014, the insured, Kulwant Singh, died giving rise to a claim under the policy. The claim was subjected to an independent investigation and the records revealed that the deceased had been suffering from hepatitis C. The claim was repudiated giving rise to a consumer complaint which was allowed by the District Forum. The appeal before the State Forum was also dismissed, so also by the National Commission, the revision was dismissed. Being aggrieved the insurance company had preferred an appeal before this Court. It was held that the investigation conducted by the insurer in the said case clearly indicated that the deceased was suffering from a pre-existing medical condition which was not disclosed to the insurer despite specific queries

relating to any ailment, hospitalisation or treatment undergone by the proposer in column 22 of the proposal form therein. Hence the judgment of the Commission was set aside but since the claim amount was paid to the respondent, exercising jurisdiction under Article 142 of the Constitution it was directed that no recoveries be made by the respondent insurer therein.

In the aforesaid judgment, this Court distinguished ***Sulbha Prakash Motegaonkar and Ors. v. Life Insurance Corporation of India*, Civil Appeal No. 8245/2015** decided on 5th October, 2015, by holding that in the said case the assured therein suffered myocardial infraction and succumbed to it. The claim was repudiated by the insurance company on the ground that there was a suppression of a pre-existing lumbar spondylitis. It was in this background that this Court held that the alleged concealment was of such a nature that would not dis-entitle the deceased from getting his life insured. In other words, the pre-existing ailment was clearly unrelated to the cause of death.

52. On a consideration of the aforesaid judgments, the following principles would emerge:

(i) There is a duty or obligation of disclosure by the insured regarding any material fact at the time of making the proposal. What constitutes a material fact would depend upon the nature of the insurance policy to be taken, the risk to be covered, as well as the queries that are raised in the proposal form.

(ii) What may be a material fact in a case would also depend upon the health and medical condition of the proposer.

(iii) If specific queries are made in a proposal form then it is expected that specific answers are given by the insured who is bound by the duty to disclose all material facts.

(iv) If any query or column in a proposal form is left blank then the insurance company must ask the insured to fill it up. If in spite of any column being left blank, the insurance company accepts the premium and issues a policy, it cannot at a later stage, when a claim is made under the policy, say that there was a suppression or non-disclosure of a material fact, and seek to repudiate the claim.

(v) The insurance company has the right to seek details regarding medical condition, if any, of the proposer by getting the proposer examined by one of its empanelled doctors. If, on the consideration of the medical report, the insurance company is satisfied about the medical condition of the proposer and that there is no risk of pre-existing illness, and on such satisfaction it has issued the policy, it cannot thereafter, contend that there was a possible pre-existing illness or sickness which has led to the claim being made by the insured and for that reason repudiate the claim.

(vi) The insurer must be able to assess the likely risks that may arise from the status of health and existing disease, if any, disclosed by the insured in the proposal form before issuing the insurance policy. Once the policy has been issued after assessing the medical condition of the insured, the insurer cannot repudiate the claim by citing an existing medical condition which was disclosed by the insured in the proposal form, which condition has led to a particular risk in respect of which the claim has been made by the insured.

(vii) In other words, a prudent insurer has to gauge the possible risk that the policy would have to cover and accordingly decide to either accept the proposal form and issue a policy or decline to do so. Such an exercise is dependant on the queries made in the proposal form and the answer to the said queries given by the proposer.

53. We shall now consider the facts of the present case. The relevant portion of proposal form for the overseas mediclaim policy-B is extracted as under:

| |
|---|
| UNITED INDIA INSURANCE COMPANY LIMITED |
| Regd. & Head Office United India House 24, Whites Road, CHENNAI-600 014 |
| PROPOSAL FORM FOR OVERSEAS MEDICLAIM POLICY-B |
| (Business & Holiday) |
| (To be submitted in Original with 2 Copies) |
| (Available to persons in the age group of 6 months to 70 years) |
| IMPORTANT |
| PLEASE MAKE SURE YOU READ AND FULLY UNDERSTAND THIS DOCUMENT BEFORE YOU TRAVEL FROM THE REPUBLIC OF INDIA |
| FAILURE TO FOLLOW THE INSTRUCTION GIVEN COULD RESULT IN REJECTION OF ANY CLAIM THAT MIGHT BE MADE |
| THE OVERSEAS MEDICLAIM POLICY PROVIDES INDEMNITY FOR EXPENSES NECESSARILY INCURRED FOR IMMEDIATE TREATMENT OF ILLNESS, DISEASES CONTRACTED OR INJURY FIRST SUSTAINED (DURING THE PERIOD OF INSURANCE OF OVERSEAS TRAVEL SUBJECT TO POLICY TERMS & CONDITIONS) AND IN ADDITION ALSO PERSONAL ACCIDENT TOTAL LOSS OF CHECKED BAGGAGE, DELAY OF CHECKED BAGGAGE, LOSS OF PASSPORT AND PERSONAL LIABILITY COVERS (DURING THE PERIOD OF INSURANCE OF OVERSEAS TRAVEL SUBJECT TO POLICY TERMS & CONDITIONS). |
| IN THE ABSENCE OF MEDICAL REPORTS AS SPECIFIED IN |

| |
|---|
| ITEM II B SUM INSURED WILL STAND REDUCED TO AN EQUIVALENT AMOUNT OF US $ 10,000 IN RESPECT OF MEDICAL EXPENSES INCURRED THROUGH ILLNESS OR DISEASE ONLY, SUBJECT TO EXCLUSION OF PRE-EXISTING DISEASE. |
| THE ATTENTION OF THE PROPOSER IS DRAWN TO ITEM II (MEDICAL HISTORY) OF THE PROPOSAL FORM ESPECIALLY IN RELATION TO PREVIOUS TREATMENT FOR ILLNESS OR DISEASE SUCH AS RENAL DISORDERS, OR DISEASES CEREBRAL OR VASCULAR STROKES, HEART AILMENT OF ANY KIND, MALIGNANCY, TUBERCULOSES, ENCEPHALITIS, NEUROLOGICAL DISORDERS, GALL BLADDER DISORDER, ARTHRITIS REQUIRING SURGERY AND IF ANY TREATMENT HAS BEEN RECEIVED FOR ANY OF THE ABOVE DISORDERS AT ANY TIME IN THE PAST, SUCH TREATMENT MUST BE DISCLOSED TO THE POLICY ISSUING OFFICE. |
| NEITHER THE INSURERS NOR CLAIMS SETTLING AGENTS SHALL BE RESPONSIBLE FOR THE AVAILABILITY, QUALITY OR RESULTS OF ANY MEDICAL TREATMENT OR THE FAILURE OF THE INSURED TO OBTAIN MEDICA TREATMENT. |
| THE PROPOSAL FORM SHOULD BE COMPLETED TO THE BEST OF YOUR KNOWLEDGE & BELIEF & ALL MATERIAL FACTS SHOULD BE DISCLOSED FAILURE TO DO SO MAY NULLIFY COVER UNDER THE POLICY ISSUED. |
| NOTE: Plan A-1, A-27, A-3 (Worldwide travel excluding USA/Canada)<br>Plan B-1, B-2, B-3 & B-4 (Worldwide travel including USA/Canada)<br>Plan E-1 & E-2 (Corporate Frequent Travel to all destinations including USA/Canada) |
| IF |
| a) The proposer is travelling to USA &/or Canada & is above 40 years, OR |
| b) The proposer is travelling to any other country and is above 60 years, OR |
| c) Answer to questions in II(A) reveal that the proposer had suffered any time the past or is suffering from any disease/illness. |
| The Proposal form should be accompanied with 1) ECG printout with report & 2) fasting blood sugar & urine sugar urine strip test report of any other medical report required by the company etc. along with the attached questionnaire II(B) to be completed & signed by the doctor with minimum M.D. qualification conducting the test. In the absence of such medical tests & reports due to a shortage of time before travel, cover may still be granted subject to a satisfactory proposal form by the sum insured under policy, in respect of expenses incurred for the treatment of illness disease shall be restricted to US $ 10,000 only, which shall not cover the cost of Medical treatment for pre-existing disease. In case of accident however the full sum insured benefit would be available. |

54. The proposal form was submitted by the appellant on 15th May, 2009. The proposed date of departure of the appellant to USA was 19th May, 2009. As required, the proposal form was accompanied with: (a) ECG test printout with report, (b) fasting blood sugar and urine strip test report. The proposal form also stated :

> *"In the absence of such medical tests and reports due to a shortage of time before travel, cover may still be granted subject to a satisfactory proposal form by the sum assured under the policy, in respect of expenses incurred for the treatment of illness, disease shall be restricted to US 10,000 Dollars only which shall not cover the cost of medical treatment for pre-existing disease. In case of accident, however, the full sum of insured benefit will be available."*

55. Learned counsel for the insurer contended that in the columns dealing with medical history - query no. 2 which reads, *"have you ever suffered from any illness or disease up to the date of making this proposal"* no answer was given by the appellant. Hence, there was suppression of the fact that the appellant was suffering from a heart disease for which he was prescribed statins and the said fact was material fact as it related to a pre-existing disease or illness which is excluded under the policy. In support of this submission, reliance was placed on the following clause:

> *"IMPORTANT*
> *Notwithstanding anything stated in the policy it is hereby and agreed that all claims occasioned by, happening through or in consequence of any disease which is existing at the date of commencement of risk, whether specifically declared or not, the proposal form completed by the insured, is excluded from the scope of the policy."*

In support of this clause, reliance was placed on clause 10 (b) (typed as 11 (b) in Annexure A-6.) and 10 (c) which state that the policy was not designed to provide an indemnity in respect of medical services, the need for which arises out of a pre-existing condition as defined under clause 10 (b). A pre-existing condition was defined to mean *"any sickness for which the insured person had sought medical advice or had taken medical treatment in the preceding 10 months prior to the commencement of travel."*

56. It was contended that there was non-disclosure or suppression of the fact that the appellant had been advised to take statins owing to a cholesterol problem, which is a risk-factor for cardiac disease and this fact was not disclosed in the proposal form whereas it was mentioned to the doctor who treated the appellant in USA. Hence the repudiation of the policy was justified.

57. We have considered the aforesaid submissions in light of the relevant clauses in the proposal form and by taking into consideration the arguments of the learned Senior Counsel for the appellant.

58. On a reading of the queries pertaining to medical history it is noted as under:

(i) Query no. 1 which reads, *"are you in good health and free from physical and mental disease and infirmity?"* The answer given was *"yes."*

This indicates the current status of health at the time of filling up of the proposal form.

(ii) On the other hand, query no. 2 which reads *"have you ever suffered from any illness or disease up to the date of making this proposal?"*, is a query with regard to the past health condition of the insured.

*(iii)* The above is discerned from query no. 4 which reads, *"have you ever been admitted to any hospital, nursing home/clinic for treatment or observation?"*

*(iv)* Query no. 5 which reads, *"have you suffered from any illness or disease or had an accident prior to the first day of insurance?"*

59. On a contextual and conjoint reading of the aforesaid queries it is evident that the object of seeking answers from a proposer to the aforesaid queries was, as a prudent insurer to discern whether the proposer had any pre-existing condition for which he had taken medical advice or medical treatment in the 12 months preceding the commencement of travel. Any disclosure of an illness or disease suffered/diagnosed in 12 months preceding the commencement of travel would indicate a pre-existing condition which fact may lead a prudent insurer not to provide an indemnity in respect of medical

services, the need for which may arise during the term of the mediclaim policy or lead the insurer to reduce the scope and coverage of risk under the policy.

60. In the instant case, since the appellant herein answered query no. 1 in the affirmative and query no. 4 and 5 in the negative it implies that he did not suffer from any illness or disease up to the date of making his proposal apart from what had been disclosed by him, namely diabetes mellitus-II. The respondent insurer being appraised about the said medical condition of the appellant, issued policy to the appellant herein. The respondent insurer did not consider the said medical condition of the appellant as a risk factor for any possible cardiac ailment during the term of the policy so as to decline acceptance of the proposal form and issuance of the mediclaim policy. Also, report of the ECG was considered by one of the panel doctors of respondent-insurer and having found the same to be normal, the policy was issued to the appellant.

61. That apart, query no. 8 in the policy is worded in following terms:

> *"Please give details of any knowledge of any positive existence of any ailment, sickness or injury which may require medical attention whist on tour abroad."*
>
> The answer to the same was *"NIL."*

62. In support of the aforesaid answer, the submission of learned Senior Counsel along with learned counsel for appellant was that ECG report and blood and urine test reports were given as the appellant had knowledge of his ailment, namely, diabetes mellitus-II and the same were taken into consideration favourably by the insurer as the said reports showed normal results. It was contended by learned Senior Counsel for the appellant that the appellant had no knowledge of any heart ailment which could require medical attention whilst on tour abroad.

63. It was further submitted that the appellant was on statins and the same was prescribed to him as diabetes mellitus-II which was disclosed by the appellant in the proposal form is one of the risk factors for cardiac disease. Thus, in order to reduce the risk of a cardiac ailment in future, statins were prescribed. The same is also prescribed for controlling hyperlipidaemia but the appellant did not suffer from any heart ailment or hyperlipidaemia.

64. We find considerable force in the argument made on behalf of the appellant. This is because while diabetes mellitus-II is a risk factor for a cardiac ailment in a person, it is not a hard and fast rule that every person having diabetes mellitus-II would necessarily suffer from a cardiac disease. Conversely, a person who does not suffer from

diabetes mellitus-II can also suffer from a cardiac ailment. Thus, what the appellant had knowledge of was the existence of diabetes mellitus-II, for which he was under treatment. In order to disclose the status of the said disease he had submitted his ECG report, blood and urine test reports which showed normal results. The fact that ECG report showed normal parameters would indicate that the appellant had no cardiac disease. The prescription of statins to the appellant was only as a precaution to prevent a possible cardiac ailment from developing in the future as diabetes mellitus-II is a risk factor for such a disease. But by that, it cannot be deduced or inferred that because the appellant had a cardiac ailment or hyperlipidaemia, he was prescribed statins.

65. Further, what was required to be disclosed in query no. 8 under the caption medical history was

> *"Knowledge of any positive existence of any ailment, sickness or injury which may require medical attention whist on tour abroad"*

This means that any ailment, sickness or injury of which the proposer had positive knowledge of, and which may require imminent medical attention whilst on tour abroad and during the term of the policy had to be disclosed. If the proposer had no knowledge of any ailment he had, obviously there could be no disclosure of any ailment or sickness which would require medical attention whilst on tour

abroad. In fact, the aforesaid query has also to be considered in the context of the further declaration sought by the insurance company to the effect that the proposer was:

> *(a) not travelling against the advice of a physician,*
> *(b) not on the waiting list of any medical treatment,*
> *(c) not travelling for the purpose of receiving medical treatment,*
> *(d) not received a terminal prognosis for a medical condition before the date of submitting the proposal form.*

66. Viewed in the aforesaid perspective, it is held that the respondent insurance company could not have repudiated the policy on the ground that acute myocardial infraction suffered by the appellant on landing at San Francisco, USA was a *"pre-existing and related complication"* which was excluded under the policy. The insurer was informed about the pre-existing condition of the appellant, namely, diabetes mallitus-II and it was for insurer to gauge a related complication under the policy as a prudent insurer and then issue the policy when satisfied. In the absence of the same, the treatment availed by the appellant for acute myocardial infraction in USA could not have been termed as a direct offshoot of hyperlipidaemia and diabetes mellitus so as to be labelled as a pre-existing disease or illness which the appellant suffered from and had

not disclosed the same. At any rate, the appellant had in the proposal form disclosed that he was suffering from diabetes mellitus-II and for which the medical test reports were submitted along with the proposal form which were considered by the insurance company before the policy was issued to the appellant. In fact, the appellant stated in his representation dated 16th November, 2009, against the repudiation of the policy that he was taking lipid-lowering medicines not because he was suffering from hyperlipidaemia but as it was customary to take such medication for prevention of cardio-vascular complications in diabetics. He also stated that he had informed the physician, Dr. Jitendra Jain, who examined him prior to obtaining the policy, of the medicines he had been taking. Therefore, the insurance company was well aware of the fact that the insured was a diabetic and was taking all necessary medication for preventing further complications and controlling the disease. Hence in our view, there was no suppression of any material fact by the appellant to the insurer.

67. Further on the disclosures made by the appellant with regard to his existing disease, namely diabetes mellitus-II, the insurance company considered the same and issued the policy in question to the appellant. The respondent insurance company as a prudent insurer considered the details given by the appellant in the proposal form and issued the policy. The insurance company did not think that the

medical and health condition of the appellant was such which did not warrant issuance of a mediclaim policy. The insurance company therefore did not decline the proposal of the assured as a prudent insurer.

68. Therefore, the respondents were not right in stating that as per the terms and conditions of the policy "*all the complications arising out of pre-existing condition is not payable*." As already noted, acute myocardial infraction can occur in a person who has no history of diabetes mellitus-II. One of the risk factors for the aforesaid cardiac episode is diabetes mellitus-II. The fact that the appellant had diabetes mellitus-II was made known to the insurance company. Therefore, it is observed that any complication which would arise from diabetes mellitus-II was also within the consideration of the insurer. Despite the aforesaid facts regarding the medical record of the insured, the insurance company decided to issue the policy to the appellant. The aforesaid clause has to be read against the respondent insurer by applying the *contra proferentem* rule against it. Otherwise, the very contract of insurance would become meaningless in the instant case. Hence, in our considered view, the respondent-insurance company was not right in repudiating the policy in question.

69. The object of seeking a mediclaim policy is to seek indemnification in respect of a sudden illness or sickness which is not expected or imminent and which may occur overseas. If the insured suffers a sudden sickness or ailment which is not expressly excluded under the policy, a duty is cast on the insurer to indemnify the appellant for the expenses incurred thereunder.

70. Hence in the instant case, the repudiation of the policy by the respondent insurance company was illegal and not in accordance with law. Consequently, the appellant is entitled to be indemnified under the policy. In view of the aforesaid discussion, we hold that the Commission was not right in dismissing the complaint filed by the appellant herein.

71. The appeal is allowed in the following terms:

(i) The respondents are directed to indemnify the appellant regarding the expenses incurred by him towards his medical treatment within a period of one month from the date of receipt of a copy of this judgment with interest at the rate of 6% per annum from the date of filing the claim petition before the Commission till realisation.

(ii) Since the expenses incurred by the appellant was in terms of US Dollars and the claim would be paid in terms of Indian

Rupees, the exchange rate as it existed on the date the claim petition was filed by the appellant herein before the Commission or at Rs.45 INR, whichever is lesser, shall be reckoned for the purpose of determining the conversion rate of US Dollars into Indian Rupees *vide* ***Meenakshi Saxena & Anr. Vs. ECGC Limited (formerly known as Export Credit Guarantee Corporation of India Limited) & Anr.*** – (2018) 7 SCC 479.

(iii) The appellant is also entitled to Rs. 1,00,000/- payable by the respondents towards the cost of litigation.

**.....J**
**[DR DHANANJAYA Y CHANDRACHUD]**

**.....J**
**[B.V. NAGARATHNA]**

**NEW DELHI;**
**6th DECEMBER, 2021.**