

**IN THE DELHI STATE CONSUMER DISPUTES REDRESSAL
COMMISSION**

Date of Institution: 31.10.2017

Date of Hearing: 06.02.2025

Date of Decision: 03.03.2025

FIRST APPEAL NO.- 608/2017

IN THE MATTER OF

M/S ORIENTAL INSURANCE CO. LTD.,
THROUGH ITS REGIONAL MANAGER:
MR. ALOK SRIVASTAVA,
REGIONAL OFFICE:
1ST FLOOR, CORE-1, SCOPE MINAR,
DISTRICT CENTRE, LAXMI NAGAR,
DELHI-110092.

**(Through: Mr. Brijesh Kumar Sharma &
Mr. Siddharth Sulani, Advocates)**

...Appellant

VERSUS

- 1. MRS. KAUSHALYA DEVI BANSAL,**
(LR/WIFE OF THE DECEASED RESPONDENT),
W/O LATE MR. RAGHUBIR SARAN BANSAL,
- 2. MR. PANKAJ BANSAL,**
(LR/SON OF THE DECEASED RESPONDENT),
S/O LATE MR. RAGHUBIR SARAN BANSAL,
BOTH RESIDENT OF:
R/O 303, SECOND FLOOR, AMBICA VIHAR,
PASCHIM VIHAR, DELHI-110087.
- 3. MRS. UMA JAIN,**
(LR/DAUGHTER OF THE DECEASED RESPONDENT),
D/O LATE MR. RAGHUBIR SARAN BANSAL,
W/O MR. GAURAV JAIN,
R/O 1070, SECTOR-6, URBAN ESTATE,
KARNAL-132001.

(Through: Mr. Amit Kumar Maihan, Advocate)

...Respondent

CORAM:**HON'BLE JUSTICE SANGITA DHINGRA SEHGAL (PRESIDENT)****HON'BLE MR. J.P. AGRAWAL, MEMBER (GENERAL)**

Present: Mr. Siddharth, proxy counsel for Mr. Brijesh Kumar Sharma, counsel for the Appellant.

Mr. Rakesh Kumar along with Mr. Binny Sethi, counsel for the Respondent.

PER: HON'BLE JUSTICE SANGITA DHINGRA SEHGAL,**PRESIDENT****JUDGMENT**

1. The facts of the case as per the District Commission record are:

"1...that the complainant had taken a mediclaim insurance policy bearing No.272900/48/2014/2439 from the for the period from 25.05.2013 to 24.05.2014 for himself and his wife for a sum insured of Rs.5,00,000/- each. It is alleged that the complainant has less appetite, constipation, pain and swelling in both limbs since 10 days and was admitted in M/s Sri Balaji Action Medical Institute, Paschim Vihar, Delhi on 12.10.2013 and was diagnosed as suffering from Septicemia Hyponatremia-SIADH. It is further alleged that the complainant was discharged on 20.10.2013. It is alleged that the complainant spent a sum of Rs.1,70,038/- on his treatment. It is further alleged that in the last week of October, 2013 the complainant needed medical attention and again on 25.10.2013 admitted in M/s Jaipur Golden Hospital and was diagnosed as suffering from Duodnal Mucosa Denudation with Erythema, Cholelithiasis, Mild Prostomegaly etc. and the same was discharged on 01.11.2013 and spent a sum of Rs.1,07,246/- on his treatment inclusive of medicine, hospital expenses etc. It is alleged that on both the occasions/ hospitalization the complainant approached the O.P with a request for cashless treatment but the TPA of the O.P denied the cashless treatment to the complainant. It is further alleged that the complainant spent total sum of Rs.2,77,284/- of his treatment. It is alleged that after discharge from the Hospital filed the claims with the

O.P for a sum of Rs.1,70,038/- + Rs.1,07,246/- respectively being the amount spent by the complainant on his treatment. It is further alleged that the complainant submitted to the TPA of the O.P all the necessary document and medical bills etc. It is alleged that the O.P's TPA vide e-mail dated 11.11.2013 repudiated/ rejected both the claims of the complainant. It is further alleged that the O.P's TPA vide mail dated 30.11.2013 intimated the complainant that the complainant's first claim was repudiated under exclusion 4.2 of the terms and conditions of the policy. It is alleged that the complainant provided to the O.P's TPA the complete original record of indoor treatment as per their requirement. It is further alleged that the complainant has made several inquiries to the office of the O.P to inquire about the complainant's claims. It is alleged that the O.P's TPA intimated the complainant vide e-mail dated 26.12.2013 that the complainant claim's was approved for a sum of Rs.81,475/- against the second claim i.e. a sum of Rs. 1,07,246/-. It is further alleged that the complainant further approached the O.P stating therein that the complainant's claim for a total sum of Rs.2,77,284/-. It is alleged that the O.P's TPA again vide e-mail dated 20.01.2014 intimated the complainant that a sum of Rs.11,339/- was further approved for payment. It is further alleged that the O.P has totally released a sum of Rs.92,814/- against the claim of Rs.2,77,284/-. It is alleged that the complainant further approached the O.P with a request for reconsideration of the first claim and for release of the balance amount of the second claim. Despite repeated request and letters the O.P did not accede to the request of the complainant. On these facts complainant prays that the O.P be directed to pay a sum of Rs.1,84,470/- being the amount less paid by the O.P against the expenses incurred by the complainant towards hospital and medical expenses along with interest @ 18% and also to pay cost and compensation as claimed.

2. O.P appeared and filed its written statement. In its written statement O.P has alleged that the policy in question was firstly obtained by the complainant from the O.P only on 25.05.2012 for the period of one year w.e.f. 25.05.2012 to 24.05.2013 and

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the same was renewed vide policy bearing No.272900/48/2014/2439 which was issued for the period of one year w.e.f. 25.05.2013 to 24.05.2014 whereas the patient aged about 81 years was hospitalized at twice as per the medical records, firstly in Sri Balaji Action Medical Institute w.e.f. 12.10.2013 and admitted with a case of "SEPTICAEMIA HYPONATREMIA-SIADH" with the known case of HTN & old CVA left hemiparesis vide discharge summary issued by the concerned hospital. However, the TPA M/s Medi-Assist India, of the answering O.P process the claim of the complainant and found that the claim of the complainant falls in the 2nd year of policy period, which comes under the exclusion clause 4.2 as well as clause 4.1 of the policy terms, conditions and exclusions. It is further alleged that the claim of the complainant was rightly repudiated vide letter/ mail dated 30.11.2013 and followed by a letter (sent by the O.P.), upon receiving the recommendations from the TPA. Dismissal of the complaint has been prayed for."

2. The District Commission after taking into consideration the material available on record passed the judgment dated **04.05.2017**, whereby it held as under:

"5. The controversy involved in the present case is as to whether the repudiation of claim by the O.P was justified or not. The contents of written statement filed on behalf of O.P would explicitly demonstrate that the claim was rejected on the basis of exclusion clause 4.2 as well as clause 4.1 which provided for compensation of such disease as suffered by complainant after continuous policy for two years. It has been specifically mentioned in the written statement that insured was a known case of HTN & old CVA which was not payable in the first year of the policy as happened in the present case. In a way the O.P appeared to be under misconception that it was a case of pre-existing disease. It needs to be clarified that every disease is not a pre-existing disease, pre-existing disease one which was suffered by the insured immediately before taking the policy or the one of which he had conscious knowledge for

treatment and hospitalization/ surgery but this is not a case at hand.

The Hon'ble State Commission in case titled National Insurance Co. Ltd. Vs Smt. Krishna Avtar Aggarwal II (2005) CPJ 747, held as under:

"Insurance- Medclaim policy- Repudiation of claim- Concealment of pre- existing disease alleged- Complaint allowed by Forum- Hence appeal- Non- disclosure of disease for which insured was treated 15/20 years before, not amounts to concealment- Word 'existing' means disease which exists at time of taking the policy- O.P. should have ensured that person in whose favour policy was being given was entitled to same or not- Contributory negligence on part of O.P. cannot be ruled out- O.P. liable under policy- Order of Forum upheld."

Now the question arises as to whether the exclusion clause 4.1 and 4.2 of the terms and conditions of the policy can be pressed into service by the O.P to refute the claim of the complainant. The perusal of the policy would show that the policy is subject to conditions, clauses, warranties, endorsements and further declare that policy shall pay for hospitalization expenses for medical/ surgical treatment at any Nursing Home/ Hospital in INDIA as an in-patient defined in the policy. It means all medical expenses during subsistence of policy shall be payable by O.P. No terms and conditions of policies were incorporated in the policy itself. The O.Ps have not placed on record any evidence that terms and conditions were supplied to the insured at the time of policy or any time subsequent thereto. In case titled IV (2014) CPJ 14A (CL) HAR. Oriental Insurance Co. Ltd. Vs Vivek Rekhan, the claim filed on the basis of medclaim policy was repudiated by the insurance company on the basis of exclusion clause. The court held that the insurance company vaguely denied without pointing out as to in which manner and on which date terms and condition were supplied to the complainant. In case titled I (2000) CPJ 1 (SC) M/s Modern Insulators Ltd. Vs Oriental Insurance Co. Ltd., it was held that

it is the fundamental principle of insurance law, that utmost A good faith, must be observed by the contracting parties, and good faith forbids either party, from non-disclosure of the facts, which the parties knew. The insured has a duty to disclose all the facts, and similarly it was the duty of the insurance company, and its agents, to disclose all the material facts, in their knowledge, as obligation of good faith applies to both equally. Therefore, unless terms and condition have been supplied to the complainant before taking a policy, exclusion clause cannot be enforced. It is not a case where the insurance has completely repudiated the claim of the complainant but a case where they had approved a sum of Rs.81,475/- and lastly released a sum of Rs.92,814/- but failed to establish as to why the remaining amount as sought by complainant in the present complaint was not payable. Therefore, non-payment of full claim to the complainant amounted to deficiency in service on the part of O.P.

7. Therefore, we award a sum of Rs.1,84,470/- with interest @ 6% p.a. with interest @ 6% p.a. from the date institution of the complaint till payment, we further award a sum of Rs.10,000/- towards harassment mental agony loss of time which will also include cost of litigation. Ordered accordingly.”

3. Aggrieved by the aforesaid order of the District Commission, the Appellant/Opposite Party has preferred the present Appeal contending that the District Commission failed to appreciate the exclusion clause 4.1 and 4.2 of the policy according to which, the claim of the Respondent was repudiated by the Appellant. The counsel for the Appellant further submitted that District Commission failed to appreciate that the Respondent/Complainant never raised the objection that the terms and conditions were not supplied to them through his Complaint. Lastly, the counsel for the Appellant submitted that the District Commission erred in holding the deficiency of service on the part of Appellant. Pressing the

aforesaid contention, the Appellant prayed for setting aside the Impugned order.

4. The Respondent (now deceased), through its reply, denied all the allegations of the Appellant and submitted that there is no error in the impugned order as the entire material available on record was properly scrutinised before passing the said order.
5. The parties were directed to file written submissions, the same have been filed by the Appellant wherein it relied upon the following judgments in support of its case:
 - a) *Civil Appeal No. 2776 of 2002 titled "New India Assurance Co. Ltd." decided on 10.07.2009;*
 - b) *Revision Petition No. 1009/2015 titled New India Assurance Co. Ltd. Vs. Rekha Malhotra & Ors. decided on 26.10.2016;*
 - c) *Revision Petition No. 2314 of 2012 titled C.N. Mohan Raj Vs. M/s New India Assurance Co. Ltd. decided on 08.10.2012.*
6. On the other hand, the written submissions have also been filed by the Respondent (now deceased), wherein, the Respondent has relied upon the following judgments in support of his case:
 - a) *Sulbha Prakash Motegaonkar Vs. LIC, 2015 SCC OnLine SC 1880;*
 - b) *Revision Petition No. 3619 of 2013 titled "Satish Chander Vs. BAGIC decided on 11.06.2016.*
7. We have perused the material available on record and heard the counsel appearing on behalf of the parties.
8. The *main question* for consideration before us is *whether the District Commission erred in holding deficiency of service on the part of Appellant.*
9. From the chronology of the events, we find that the Mediclaim policy in question has been firstly issued by the Appellant on 25.05.2012 and

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thereafter renewed for the period of 25.05.2013 to 24.05.2014 vide policy bearing number 272900/48/2014/2439 for himself and his wife for a sum insured of Rs. 5,00,000/- each. Further, the Respondent (now deceased) got admitted in M/s Sri Balaji Action Medical Institute, Paschim Vihar, Delhi on 12.10.2013 and was diagnosed from Septicemia Hyponatremia-SIADH and spend an amount of Rs. 1,70,038/- on his treatment and thereafter, again admitted to M/s Jaipur Golder Hospital on 25.10.2013 and discharged on 01.11.2013, where the Respondent spent an amount of Rs. 1,07,246/- on his treatment. Therefore, the Respondent spent a total amount of Rs. 2,77,284/- and claimed the said amount from the Appellant and the Appellant released an amount of Rs.92,814/- for both claims and denied the remaining claim vide repudiation letter dated 30.11.2013 on the ground that the claim of the Respondent comes under the exclusion clause 4.1 and 4.2 and therefore, the same was repudiated by the Appellant.

10. On perusal of record, we find that the claim of the Respondent has been partially allowed by the Appellant before the filing of the complaint case no. 280 of 2016 and the remaining claim of the Respondent was repudiated on the ground that the Respondent was suffering from pre-existing disease. Therefore, on the concept, meaning and import of word disease, pre-existing disease in reference to medical insurance policy, this Commission has drawn following ten conclusions in a highly extensive, dissecting manner in their decision in ***First Appeal no. 482 of 2005*** titled as ***Pradeep Kumar Garg Vs. National Insurance Co. Ltd.*** decided on ***01.08.2008***.

These are as under:

- a. *Disease means a serious derangement of health or chronic deep-seated disease frequently one that is ultimately fatal for which an insured must have been hospitalized or operated upon in the near proximity of obtaining the mediclaim policy.*
- b. *Such a disease should not only be existing at the time of taking the policy but also should have existed in the near proximity. If the insured had been hospitalized or operated*

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upon for the said disease in the near past, say, six months or a year he is supposed to disclose the said fact to rule out the failure of his claim on the ground of concealment of information as to pre-existing disease.

- c. Malaise of hypertension, diabetes, occasional pain, cold, headache, arthritis and the like in the body are normal wear and tear of modern day life which is full of tension at the place of work, in or out of the house and are controllable on day to day basis by standard medication and cannot be used as concealment of pre-existing disease for repudiation of the insurance claim unless an insured in the near proximity of taking of the policy is hospitalized or operated upon for the treatment of these diseases or any other disease.*
- d. If insured had been even otherwise living normal and healthy life and attending to his duties and daily chores like any other person and is not declared as a diseased person as referred above he cannot be held guilty for concealment of any disease, the medical terminology of which is even not known to an educated person unless he is hospitalized and operated upon for a particular disease in the near proximity of date of insurance policy say few days or months.*
- e. Disease that can be easily detected by subjecting the insured to basic tests like blood tests, ECG etc. the insured is not supposed to disclose such disease because of otherwise leading a normal and healthy life and cannot be branded as diseased person.*
- f. Insurance company cannot take advantage of its act of omission and commission as it is under obligation to ensure before issuing medi-claim policy whether a person is fit to be insured or not. It appears that insurance companies don't discharge this obligation as half of the population is suffering from such malaises and they would be left with no or very little business.*

Thus any attempt on the part of the insurer to repudiate the claim for such non-disclosure is not permissible, nor is exclusion clause invocable.

- g. Claim of any insured should not be cannot be repudiated by taking a clue or remote reference to any so called disease from the discharge summary of the insured had concealed his hospitalisation or operation for the said disease undertaken in the reasonable near proximity as referred above.*

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- h. *Day to day history or history of several years of some or the other physical problem one may face occasionally without having landed for hospitalisation or operation for the disease cannot be used for repudiating the claim. For instance an insured had suffered from a particular disease for which he was hospitalised or operated upon 5, 10 to 20 years ago and since then had been living healthy and normal life cannot be accused of concealment of pre-existing disease while taking mediclaim policy as after being cured of the disease, he does not suffer from any disease much less the pre-existing disease while taking mediclaim policy as after being cured of the disease, he does not suffer from any disease much less the pre-existing disease.*
- i. *For instance to pay that insured has concealed the fact that he was having pain in the chest off and on for years but has never diagnosed or operated upon for heart disease but suddenly lands up in the hospital for the said purpose and therefore is disentitled for claim bares dubious design of the insurer to defeat the rightful claim of the insured on flimsy ground. Instances are not rare where people suffer a massive attack without having even been hospitalised or operated upon at any age say for 20 years or so. Non-instance of hospitalisation/or operation for disease that too in the reasonable proximity of the date of mediclaim policy is the only ground on which insured claim can be repudiated and on no other ground.”*

11. This Commission has taken a view in that case that unless and until a person is hospitalised or undergoes operation for a particular disease in the near proximity of obtaining insurance policy or any disease for which he has never been hospitalised or undergone operation is not a pre-existing disease. If a person conceals the factum of his/her hospitalisation of a particular disease or operation undergone by him/her in the near proximity of obtaining the insurance policy, only then it can be termed a concealment of factum of disease and doctrine of good faith under Section 45 of the Insurance Act can then alone be pressed in by Insurance company and not otherwise.

12. Further, it is well settled law that the Insurance company before issuing the policy should have examined the person through medical tests in order to check whether the person is suffering from any pre-existing diseases. However, in present case, the Respondent has failed to show any evidence that any medical tests or examination was done, before issuing the said policy in question. Additionally, we find that the Appellant had failed to file any evidence before the District Commission as well as before this Commission in order to reflect that the Respondent was suffering from pre-existing disease.
13. Be that as it may, the fact is also clear that the claim of the Respondent was repudiated on the basis of Exclusion clause, which were mentioned in the terms and conditions of the policy. However, it is clear that the terms and conditions of the policy were not provided to the Respondent at the time of renewal the policy in question. Also, it is well settled law that the Insurance Company cannot repudiate the claim on the basis of Exclusion clause, if the same has not been provided to the Policy holder at the time of issuing the policy.
14. Furthermore, to support our observation, it is appropriate to refer to the case of “*Bharat Watch Company through its partners vs. National Insurance Company Ltd.*” reported at **2019 (6) SCC 212**, wherein the Hon’ble Apex Court has held as under:

“We find from the judgment of the District Forum that it was the specific contention of the appellant that the exclusionary conditions in the policy document had not been communicated by the insurer as a result of which the terms and conditions of the exclusion were never communicated. The fact that there was a contract of insurance is not in dispute and has never been in dispute. The only issue is whether the exclusionary conditions were communicated to the appellant. The District Forum came to a specific finding of fact that the insurer did not furnish the terms and conditions of the exclusion and special conditions to

the appellant and hence, they were not binding. When the case travelled to the SCDRC, there was a finding of fact again that the conditions of exclusion were not supplied to the complainant.

Having held this, the SCDRC also came to the conclusion that the exclusion would in any event not be attracted. The finding of the SCDRC in regard to the interpretation of such an exclusionary clause is evidently contrary to the law laid down by this Court in Harchand Rai (supra). However, the relevance of that interpretation would have arisen provided the conditions of exclusion were provided to the insured. The NCDRC missed the concurrent findings of both the District Forum and the SCDRC that the terms of exclusion were not made known to the insured. If those conditions were not made known to the insured, as is the concurrent finding, there was no occasion for the NCDRC to render a decision on the effect of such an exclusion.

In the circumstances, the NCDRC was in error in reversing the decisions of the District Forum and the SCDRC which were grounded on a pure finding of fact that the terms of exclusion were not made known to the insured.”

15. On perusal of the above settled law, it is clear that unless the insured is duly informed about the terms and conditions of the policy, the Exclusion clauses of the policy cannot be made applicable. Returning to the facts of the present case, it is clear that the copy of the terms and conditions containing clauses was not supplied to the Respondent as no proof of service has been filed by the Appellant before the District Commission as well as before this Commission to prove that the said terms and conditions were duly supplied by it. Therefore, Exclusion clauses in the said policy are not applicable in the present case. Hence, the District Commission was right in holding the deficiency on the part of the Appellant.
16. Infact, we are in agreement with the reasons given by the District Commission and fail to find any cause or reason to interfere in the findings of the District Commission. In view of the above discussion, ***we uphold***

the order dated 04.05.2017 passed by the District Consumer Disputes Redressal Commission (North), Tis Hazari, Delhi.

17. *Accordingly, the present Appeal stands dismissed with no order as to costs.*
18. Application(s) pending, if any, stand disposed of in terms of the aforesaid judgment.
19. FDR, if any be released in favour of the Legal Representatives of the Respondent.
20. The judgment be uploaded forthwith on the website of the commission for the perusal of the parties.
21. File be consigned to record room along with a copy of this Judgment.

**(JUSTICE SANGITA DHINGRA SEHGAL)
PRESIDENT**

**(J.P. AGRAWAL)
MEMBER (GENERAL)**

Pronounced On:
03.03.2025

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