IN THE HIGH COURT OF JUDICATURE AT BOMBAY

CIVIL APPELLATE JURISDICTION

WRIT PETITION NO.18745 OF 2024

Prakash Mehta ...*Petitioner*

-Versus-

1. The Insurance Ombudsman for State of Goa and Mumbai Metropolitan Region

2. Care Health Insurance Ltd. ...*Respondents*

MR. AKSHAY PATIL *with Ms. Girija Balkrishnan, Mr. Jarin Doshi and Ms. Devika Mahadekar i/b. M/s. Malvi Ranchoddas & Co. for the Petitioner.*

MR. RAJESH KANOJIA *with Ms. Deepika Prabhala, Ms. Sangita Upadhyay i/b. M/s. Res Juris for Respondent No.2.*

CORAM: SANDEEP V. MARNE, J.

JUDGMENT RESERVED ON: 5 MAY 2025.

JUDGMENT PRONOUNCED ON: 9 MAY 2025.

JUDGMENT :

1) ***Rule***. Rule is made returnable forthwith. With the consent of the learned counsel appearing for parties, the Petition is taken up for final disposal.

2) The Petitioner has filed the present Petition challenging the Award dated 10 June 2024 passed by the Insurance Ombudsman,

Mumbai, thereby rejecting the complaint preferred by him, in which he had challenged repudiation of claim by the second Respondent-Insurance Company. The claim of the Petitioner was towards expenditure incurred by him towards medical treatment of Rs.17,77,147/-.

3) Briefly stated, facts of the case are as under:-

Petitioner had secured Health Insurance Policy from M/s. Royal Sundaram General Insurance Company Ltd. (***Royal Sundaram***) having policy cover of Rs.3,00,000/-, which commenced from 3 September 2003. Under the policy, Petitioner and his wife were covered under health insurance. Policy was renewed every year till 2020 and with no-claim bonus, the insurance cover had gone up to Rs. 4,50,000/- over the period of years. Petitioner was persuaded to port the health insurance policy from Royal Sundaram to Care Health Insurance Ltd. (Respondent No.2) with offer of provision of normal floater insurance cover of Rs. 5,00,000/- for himself and his wife. He was also persuaded to enhance the policy cover known as 'top-up' cover by Rs. 50,00,000. Accordingly, with porting of the policy, Petitioner and his wife were given normal policy cover of Rs.5,00,000/- and under the top-up plan, the policy cover was enhanced to Rs.55,00,000/- jointly for the benefit of the Petitioner and his wife. Petitioner paid aggregate premium of Rs.13,23,634/- to the second Respondent, which issued Health Policy No.33902486 for a period of three years commencing from 29 September 2021 to 28 September 2024. Petitioner was diagnosed with tumour in his abdomen in July-2022 and was subjected to several diagnostics tests including biopsy. The diagnostics revealed that he was suffering from Non-Hodgkin's

Lymphoma (cancer) and was advised to undergo chemotherapy and radiation therapies. He was admitted in Breach Candy Hospital for the purpose of biopsy on 22 July 2022 and for the purpose of chemotherapy on 3 August 2022. Petitioner submitted a Claim Form on 18 August 2022. However, he received claim denial letter dated 3 September 2022 by which Respondent No.2 stated that the claim was not payable as per policy terms and conditions citing the reasons of (i) non-disclosure of habit of daily drinking alcohol at the time of policy inception and (ii) non-disclosure. Similar letter was received by the Petitioner on 4 September 2022. On 5 September 2022 one more claim denial letter was received by the Petitioner in which following two reasons were stated for denial of claim:

(i) Denial non-disclosure of habit of daily drinking alcohol at the time of policy inception.

(ii) Non-disclosure of material facts /pre-existing ailments at time of proposal.

4) Petitioner underwent chemotherapy on medical advice on 5 occasions between September-2022 to November 2022. He also underwent radiation between 26 December 2022 to 20 January 2023 in Sir H. N. Reliance Hospital. In connection with his medical treatment, he submitted total 7 claims as under :

Sr. No.	Date	Claim Intimation No.	Claim No.	Amount Claim (Rs.)
1.	18.08.2022	1008202200694	92568172	5,01,825/-
2.	13.09.2022	1008202200694	92623765	1,21,560/-
3.	06.10.2022	1008202200694	92677914	1,25,143/-

4.	22.10.2022	NISR091020220750	92718112	1,35,440/-
5.	08.11.2022	REM3110202201894	92784818	1,17,832/-
6.	28.11.2022	CPR2111202200046	92759358	1,32,647/-
7.	01.02.2023	E0010807820	92947953	6,42,700/-

5) Six additional claims submitted by Petitioner (at Serial Nos. 2 to 7 of the table) were also denied by the second Respondent vide letters dated 7 November 2022, 10 November 2022, 11 December 2022, 13 December 2022, 20 February 2023 and 1 March 2023 with remarks such as:

- Deny under permanent exclusion: Condition caused by suicide or substance abuse / intoxication (daily consumption of alcohol),
- Permanent exclusion: condition caused by suicide or substance abuse / intoxication etc.
- Non-disclosure of drinking alcohol at the time of policy inception,
- Non-disclosure of material facts/ pre-existing ailments at time of proposal.

6) Petitioner contested the reasons for rejection of his claims vide email dated 7 September 2022 and 12 December 2022. He escalated the issue to Manager, Customer Service of the second Respondent vide email dated 3 January 2023. However, the Manager wrote back to the Petitioner stating that he was found to be a patient with a history of daily alcohol drinking prior to policy inception, which medical condition was not disclosed at the time of taking the policy. Therefore, the claim was repudiated in accordance with policy terms and conditions i.e. on the ground of non-disclosure of material facts. Petitioner wrote back to the

Manager, Customer Service on 28 February 2023. He received a response from the second Respondent calling him upon to show cause within 15 days failing which the second Respondent threatened cancellation of the policy and forfeiture of the entire premium. Petitioner responded to the notice on 28 March 2023 and 30 March 2023. He received email dated 18 April 2023 repudiating and reiterating the contents of earlier email dated 28 March 2023. However, instead of cancelling the policy as threatened, the second Respondent issued renewal notice dated 24 May 2024 to the Petitioner calling upon him for payment of premium for renewal of the policy. He received several such emails for payment of premium and renewal of the policy.

7) Petitioner filed Complaint dated 14 July 2023 with Insurance Ombudsman, Mumbai raising a claim in the sum of Rs.17,77,151/-, compensation of Rs.10,00,000/-, costs of Rs.50,000/- and penal interest from Respondent No.2. It appears that Respondent No.2 did not file any reply opposing the complaint. However, during the course of hearing on 5 June 2024, Respondent No.2 produced certain documents, and the Petitioner complains that he was not provided with copies of the said documents. By Award dated 10 June 2024, the Insurance Ombudsman has however held that no deficiency is found in the action of Respondent No.2 and the complaint has been closed. Petitioner is aggrieved by Award dated 10 June 2024 passed by the Insurance Ombudsman and has accordingly filed the present Petition.

8) Mr. Patil, the learned counsel appearing for the Petitioner would submit that the Insurance Ombudsman has grossly erred in rejecting Petitioner's complaint. That Respondent No.2 did not file any reply before the Insurance Ombudsman reflecting the exact reason for repudiation of the claim. That therefore the Insurance Ombudsman adjudicated the complaint only in respect of solitary reason of habit of consumption of alcohol every day. He would submit that the Petitioner had availed the policy from Royal Sundaram in the year 2003, which was renewed every year upto 2020 and was merely ported to Respondent No.2 with top-up coverage based on representations made to him by the agents of Respondent No.2. That consumption of alcohol cannot be treated as non-disclosure of material information affecting the policy. That in any case, alleged consumption of alcohol did not cause the disease (Non-Hodgkin's Lymphoma). That there is no nexus between consumption of alcohol and the disease suffered by the Petitioner. He would therefore submit that repudiation of claim on the ground of non-disclosure of alcohol consumption by the Petitioner is clearly misconceived.

9) So far as the alleged non-disclosure of pre-existing ailment is concerned, Mr. Patil would submit that this ground was never argued before the Insurance Ombudsman by Respondent No.2. That the reason of Petitioner suffering from hypertension has been invented directly in the Affidavit-in-Reply without arguing the same before Insurance Ombudsman. That the impugned order is not premised on non-disclosure of Petitioner suffering from hypertension as a valid reason for

repudiation of the claim. In any case, according to Mr. Patil, hypertension being a mere lifestyle disease, cannot have any nexus with the ailment of cancer suffered by the Petitioner. He would submit that non-disclosure of ailment of hypertension therefore cannot amount to material suppression for repudiating the claim. In support, he would rely upon judgment of Apex Court in ***Manmohan Nanda Versus. United India Assurance Company Limited and another***[1]. He would also rely upon judgment of Delhi High Court in ***Pavan Sachdeva Versus. Office of the Insurance Ombudsman and another***[2] in which it is held that ailment suffered prior to 48 months cannot be a reason for rejection of insurance claim. That in the present case also requisite information was sought only for a period of 48 months.

10) Mr. Patil would further submit that what is rejected by the second Respondent-Insurance Company is mere insurance scheme and not insurance policy. That Petitioner was threatened with rejection of insurance policy and forfeiture of insurance premium. However, far from repudiating the policy, Respondent No.2 repeatedly called upon the Petitioner to renew the insurance policy, which would indicate that non-disclosure of alleged alcohol consumption or hypertension has not been treated by the Insurance Company as an impediment for offering insurance cover to the Petitioner. That such conduct would also demonstrate non-existence of any nexus between the ailment of hypertension and insurance cover. He would submit that Respondent No.2 has retained the entire insurance premium instead of rejecting the

[1] (2022) 4 SCC 582
[2] 2020 SCC OnLine Del 2119

insurance policy, which would have made them liable for refund of substantial portion of insurance premium. Mr. Patil would therefore pray for setting aside the order passed by the Insurance Ombudsman and for sanction of the claim of the Petitioner.

11) Petition is opposed by Mr. Kanojia, the learned counsel appearing for second Respondent-Insurance Company. He would submit that Petitioner has suppressed material information while seeking insurance cover. That despite being fully aware that he was a known case of hypertension, he suppressed the same while filling up the form for insurance cover. That pre-existing ailments is a determining factor for offering insurance cover and premium amount. That disclosure of ailment of hypertension would have increased the insurance premium. Additionally, Petitioner also underwent hemorrhoid surgery, which again was suppressed by him. That during the course of his medical treatment, it was borne out that Petitioner had the habit of consuming alcohol every day, which would materially affect the insurance contract. Petitioner was required to disclose consumption of alcohol in the insurance form and he deliberately suppressed the same. He would submit that the insurance claim has rightly been repudiated on twin grounds of non-disclosure of habit of regularly consuming alcohol as well as non-disclosure of pre-existing ailment of hypertension. He would submit that Petitioner cannot undertake reverse exercise of non-disclosure of pre-existing ailment and thereafter finding out link between such ailment and the disease suffered by him. It was his duty to make true and correct disclosure of all material facts which would affect the

decision of the insurer to offer insurance cover as well as to determine the insurance premium. In support of his contentions, Mr. Kanojia would rely upon judgment of ***Branch Manager, Bajaj Allianz Life Insurance Company Ltd. and others Versus. Dalbir Kaur***[3] and ***Export Credit Guarantee Coprn. of India Ltd. Versus. M/s. Garg Sons International***[4]**.** He would pray for dismissal of the Petition.

12) Rival contentions of the parties now fall for my consideration.

13) Petitioner's claim for total sum of Rs.17,77,147/- has been rejected by the second Respondent-Insurance Company vide several claim denial letters issued from time to time. Petitioner is accused of not disclosing the habit of daily consumption of alcohol and about pre-existing ailment at the time of submission of proposal. The Respondent No.2 has not been consistent in citing the exact reasons for denial of claim of Petitioner. In some of the claim denial letters, the reason of pre-existing ailment of hypertension has not been indicated at all. To illustrate, in the claim denial letters dated 7 November 2022 (3 letters) following reasons were indicated:

> Deny under permanent exclusion: condition caused by suicide or substance abuse/intoxication (daily consumption of alcohol)
>
> Permanent exclusion: Condition caused by suicide or substance abuse /intoxication

14) Thus, in three letters sent on 7 November 2022 in respect of three separate claims, the reason of non-disclosure of pre-existing

[3] Civil Appeal No.3397 of 2020, decided on 9 October 2020.
[4] (2013) 1 S.C.R. 336

ailment was not indicated in any manner. In rest of the letters, the second reason reflected in claim denial letters is '*non-disclosure of material facts/pre-existing ailments at the time of proposal*'. However, the exact nature of pre-existing ailment has not been indicated in any manner.

15) The trend of inconsistencies further continued when Petitioner received replies from Manager, Customer Service after escalating the matter at higher levels in the organization of the second Respondent-Insurance Company. In email dated 14 January 2023, the Manager, Customer Service indicated following reasons for denial of insurance claim:

> You may please note that the above referred Policy was issued and risk was accepted on the basis of disclosure made by Policyholder while applying for the Policy with us. The disclosures made by you were accepted in good faith. If the correct health status of the proposed life to be insured has been disclosed at the inception stage, the policy would not have been issued on the same terms and conditions.
>
> Since the correct and complete disclosures with regard to your health were not made at the time of taking the policy, your claim has been repudiated in accordance to the Policy Terms and Conditions, i.e. on the ground of Non-disclosure-Disclosure of Material Facts.

Thus, in the entire email dated 14 January 2023, there is no allegation of non-disclosure of pre-existing ailments.

16) This is how the second Respondent-Insurance Company does not appear to be consistent in citing reasons for rejection of Petitioner's insurance claim. What really makes the case of Respondent No.2 worse is the manner in which the case was argued before the Insurance

Ombudsman. Respondent No.2 apparently did not argue the ground of non-disclosure of pre-existing ailment of hypertension before the Insurance Ombudsman. As observed above, Respondent No.2 apparently did not even file reply opposing Petitioner's complaint. It appears that it orally opposed the complaint by production of few documents. The contentions raised on behalf of Respondent No.2 have been reproduced by the Insurance Ombudsman in the Award dated 10 June 2024 as under:

> Contention of the Respondent:
> The respondent insurer states that the complainant not disclosed his habit of drinking alcohol daily, during the inception of policy. Hence the claims were repudiated as per policy termination.

Thus, in the contentions as recorded in the impugned Award, Respondent No.2 did not raise the ground of non-disclosure of pre-existing ailment of hypertension for rejecting Petitioner's insurance claim.

17) The Insurance Ombudsman has dismissed the complaint filed by Petitioner by recording following reasons:

> Observation and conclusions:
> The Forum has heard both the parties and perused the documents on record. The complainant states that he had been insured with Royal Sundaram General insurance Co since 2003 and he ported the policy to the respondent insurer in 2021. The complainant has not submitted any copy of previous policies to substantiate his statement. As per the current policy document, it was incepted on 23.09.2017. Further, the complainant states that he was covered under top-up policy Enhance-2 issued by the respondent insurer for the period 12.07.2021 to 11.07.2024 against a sum insured of Rs.55,00,000/- with a deductible amount of Rs.5,00,000/-. As per the policy document, it was incepted

> on 12.07.2021. Hence, continuity benefit can be given for the base policy of sum insured Rs.5,00,000/- only and it cannot be given to the top up policy of sum insured Rs.55,00,000/-. The complainant states that he was diagnosed with Non Hodgkin's Lymphoma in 2022 and underwent chemotherapy and radiation treatment several times. He states that he preferred claims amounting to Rs. 17,77,147/- with the insurer and the insurer repudiated the claims stating non-disclosure of alcohol drinking habit during the inception of policy. The insurer states that as per ICP document of the Breach Candy Hospital dated 22.07.2022, the complainant had the habit of consuming alcohol every day and it was not disclosed during the inception of policy. The insurer states that during the tele call recording the complainant confirmed that he was consuming alcohol occasionally. The respondent insurer submitted a copy ICP document, copy of proposal form and audio clip of tele call recording to substantiate their statement. The Forum perused the document and noted that the complainant has not revealed his drinking habit in the proposal form even though there is a question "Do you smoke, consume alcohol or chew tobacco, gutka, Paan or use of recreational drugs". This is non-disclosure of material facts which affects the judgment of the underwriter. As per policy condition no. 1.21 Disclosure of Information Norm, "The policy shall be void and all premium paid hereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact." The Forum is of the considered opinion that the claim has been denied in accordance with the terms and conditions of the policy and hence the decision of the Respondent Insurer does not call for any intervention by the Forum. Consequently, no relief can be granted to the complainant and the complaint stands closed.

18) The Insurance Ombudsman has considered only the ground of habit of consuming alcohol while upholding the rejection of insurance claim by Respondent No.2. It was apparently not made aware of pre-existing ailment of hypertension being a ground for rejection of insurance claim nor has it considered the effect of non-disclosure of ailment of hypertension on Petitioner's entitlement to insurance claim. Respondent No.2 has not challenged the Award dated 10 June 2024 and is apparently satisfied with the reasons recorded by the Insurance Ombudsman. It has thus not complained about the Insurance

Ombudsman not recording the ground of non-disclosure of pre-existing ailment of hypertension or non-dealing with the same in the Award dated 10 June 2024. Even in the Affidavit-in-Reply filed on behalf of the second Respondent-Insurance Company, no averment is made that Respondent No.2 argued the ground of non-disclosure of pre-existing ailment before the Insurance Ombudsman. It is thus clearly established that ground of non-disclosure of pre-existing ailment of hypertension was never argued by the second Respondent-Insurance Company before the Insurance Ombudsman.

19) However, during the course of hearing of the present Petition, so also in the Affidavit-in-Reply, it is sought to be suggested that non-disclosure of pre-existing ailment of hypertension is the main ground for rejection of the insurance claim of the Petitioner. In fact, during the course of submissions made by Mr. Kanojia, it is repeatedly highlighted that non-disclosure of pre-existing ailment of hypertension is the real reason for rejection of insurance claim. He has contended that if Respondent No.2 was made aware about pre-existing ailment of hypertension, it would have either not issued the insurance policy or would have charged higher insurance premium. In the light of conduct of the second Respondent-Insurance Company in not even arguing the ground of pre-existing ailment of hypertension before the Insurance Ombudsman, the issue for consideration is whether the said ground can be permitted to be argued before this Court? Ordinarily the answer to the question would be in the negative. While exercising the supervisory and corrective jurisdiction under Article 227, this Court cannot decide

correctness of the Award on the basis of something which was never argued before the Forum. However, by momentarily ignoring second Respondent's conduct of not arguing the ground of pre-existing ailment, I proceed to examine correctness of both the reasons of alcohol consumption and pre-existing ailment of hypertension cited in the claim denial letters.

20) So far as the first ground of Petitioner being in the habit of consuming alcohol, reliance was placed before the Insurance Ombudsman on declarations made by the Petitioner in the proposal form in which he stated against column *'Do you smoke, consume alcohol, or chew tobacco, ghutka or paan or use any recreational drugs*. *If Yes then please provide the frequency of amount consumed*', Petitioner apparently did not disclose that he used to consume alcohol. The second Respondent-Insurance Company has produced at Exhibit-A, copy of proposal form and questionnaire in which above referred column is shown to have been left blank by the Petitioner. Thus, the Petitioner did not select the option *'no'* against the relevant column but left the same blank. However, in the Affidavit-in-Reply Respondent No.2 has averred that *'The present respondent submits that the petitioner has mentioned "No" in the said proposal form'*. However, page-293 produced alongwith the Affidavit-in-Reply does not reflect option *'No'* against the relevant column.

21) As observed above, Respondent No.2 did not file any reply opposing the complaint before the Insurance Ombudsman. However, it appears that certain documents were produced before the Insurance

Ombudsman without filing reply The Respondent-Insurer submitted a copy ICP document, copy of proposal form and audio clip of telecall recording to substantiate its claim. The Insurance Ombudsman has relied on *'ICP document of the Breach Candy Hospital dated 22.07.2022'*. It is Petitioner's complaint that copy of the said document was never provided to him. Even with the Affidavit-in-Reply, copy of the said document has not been produced by Respondent No.2. It is therefore difficult for this Court to verify the information reflected in the said ICP document of Breach Candy Hospital. The Insurance Ombudsman has however observed that *'The insurer states that as per ICP document of the Breach Candy Hospital dated 22.07.2022, the complainant had the habit of consuming alcohol every day and it was not disclosed during the inception of policy.'*

22) Thus, there is absolutely no document before me from which it can be concluded that the Petitioner was in the habit of consuming alcohol every day. However, apart from alleged disclosure of information about the habit of daily consumption of alcohol by the Petitioner from ICP document of Breach Candy Hospital, there are no further details forthcoming about how the such consumption had any effect on health of the Petitioner. There is nothing to indicate that the alleged habit of consumption of alcohol has contributed to any illness suffered by the Petitioner. There is no data about quantity of alcohol consumed by the Petitioner every day.

23) There is apparent contradiction in the findings recorded by the Insurance Ombudsman. It has held by perusing the ICP document of

Breach Candy Hospital that the Petitioner had the habit of consuming alcohol every day. On the other hand, it also recorded *'The insurer states that during the tele call recording the complainant confirmed that he was consuming alcohol occasionally'.* Thus, there is no consistency in the findings recorded by the Insurance Ombudsman about the daily consumption of alcohol by the Petitioner. It is not clear as to whether the tele call recording was made by the Second Respondent-Insurance Company or the same was made by Breach Candy Hospital. It is also not known as to when the said tele call recording was made, if it was made by Respondent No.2. In my view, therefore there is absence of concrete material to arrive at a finding that the Petitioner was in the habit of consuming alcohol every day. On the contrary, the Insurance Ombudsman has apparently considered evidence which suggests only occasional consumption of alcohol by the Petitioner.

24) The Petitioner was diagnosed with Non-Hodgkin's Lymphoma which is a type of cancer starting in lympatic system which is a part of body's immune system. There is absolutely no evidence on record to indicate that Petitioner's occasional consumption of alcohol has contributed to cancer, for which he was required to take medical treatment. The Insurance Ombudsman has not even made an attempt to establish nexus between Petitioner's occasional consumption of alcohol and the disease suffered by him. While the Insurance Ombudsman has relied on policy condition No. 1.21 rendering the policy void and providing for forfeiture of premium in the event of misrepresentation, misdescription or non-disclosure of any material fact, it has ignored the position that the insurer did not invoke the said clause for the purpose of

repudiation of the insurance policy nor has forfeited the premium paid. This aspect is being dealt with in detail in the latter part of the judgment. Suffice it to hold at this juncture that Petitioner's occasional consumption of alcohol could not have been a ground for repudiation of insurance claim.

25) In its recent decision in ***Life Insurance Corporation of India Versus. Sunita and others***[5], the Apex Court has dealt with a case in which the insured had taken a policy, which provided for hospital cash benefit. The insured was hospitalised with severe abdominal pain and vomiting and passed away after about a month-long treatment. The claim raised by his wife was repudiated by the insurer stating that the deceased had concealed material information relating to his chronic alcoholism as the prescription slip issued by another hospital reflected a remark that '*habitual of chronic alcohol intake'*. The case thus involved death arising out of alcohol misuse. The National Consumer District Redressal Commission had concluded that the death of the deceased was unrelated to his pre-existing liver disease. The Apex Court disagreed with the said finding and held that hospitalisation of the deceased was for severe abdominal pain and vomiting which complications are commonly associated with chronic liver disease. The Apex Court held that the cardiac arrest which ultimately led to the death was not on isolated event unrelated to the pre-existing chronic liver disease. The Apex Court held in paras-11 to 16 as under :

> 11. The appellant contends that the claim was repudiated based on clear evidence that the deceased was a chronic alcoholic. The prescription slip from

[5] SLP(C) No. 15354/2020 decided on 3 March 2025.

Siwach Hospital, dated 02.05.2014—one day before the deceased's hospitalization at Ganga Ram Hospital—explicitly mentions a history of "chronic alcohol intake." Thus, the hospitalization and subsequent death resulted from a self-afflicted condition due to alcohol misuse, which falls squarely within the policy's exclusion clause.

12. The respondent-claimants, on the other hand, argue that there is no cogent evidence to support the repudiation. They submit that the existence of an insurance policy and the death of the insured entitle them to reimbursement of medical expenses.

13. Upon examining the record, we find merit in the appellant's submissions. The lower forums failed to correctly interpret the terms and conditions of the Jeevan Arogya Plan. Notably, this is a hospital cash benefit policy, not a medical reimbursement policy. Therefore, even if the claim had been otherwise valid, the claimants would not have been entitled to full reimbursement of hospitalization costs, as directed by the lower forums.

14. More significantly, the deceased provided false information in the proposal form. The relevant question in the form asked:"Does the Life Insured consume Alcohol/Cigarettes/Bidis or tobacco in any form?" The deceased answered "No." The policy was issued based on this declaration. However, evidence on record—including the Siwach Hospital prescription—clearly establishes that the deceased was a chronic alcoholic. This fact was not disclosed at the time of obtaining the policy. Since the Jeevan Arogya Plan was issued under a Non-Medical General Scheme (where no pre-policy medical examination was conducted), the insurer relied solely on the accuracy of the insured's declarations.

15. The SCDRC rejected the Siwach Hospital prescription on the ground that it was dated nearly a year after the policy was taken. However, this reasoning is flawed. Chronic liver disease, caused by prolonged alcohol consumption, does not develop overnight. The deceased's alcoholism was a longstanding condition, which he knowingly suppressed while subscribing to the policy. Given this suppression of material facts, the appellant was justified in repudiating the claim under the exclusion clause.

16. The NCDRC erred in concluding that the deceased's death was unrelated to his pre-existing liver disease. The record shows that he was hospitalized for severe abdominal pain and vomiting—complications commonly associated with chronic liver disease. He remained hospitalized for nearly a month before succumbing to a cardiac arrest. Given this medical history, it cannot be said that the cardiac arrest was an isolated event, unrelated to the pre-existing chronic liver disease.

26) Thus, though the case of ***Life Insurance Corporation of India Versus. Sunita*** appears to be having some resemblance especially in respect of declaration made by the insured, the Apex Court ultimately reversed the decision of State and National Consumer District Redressal Commissions by establishing nexus between the death of the deceased and his liver disease arising out of chronic alcoholism. In the present case, there is nothing on record to establish nexus between the Petitioner's occasional consumption of alcohol and the cancer suffered by him.

27) The present case does not involve either addiction to alcohol or decease arising out of chronic alcoholism. Mere occasional consumption of alcohol cannot be a ground for rejection of insurance claim where there is absolutely no nexus between alcohol consumption and cancer suffered by the Petitioner. In my view therefore, the first ground of rejection of claim by the Second Respondent-Insurance Company of consumption of alcohol is clearly misplaced and has been erroneously accepted by the Insurance Ombudsman.

28) Coming to the second ground of rejection of insurance claim of non-disclosure of pre-existing ailment of hypertension, the Insurance Ombudsman never had an occasion to deal with this ground as the insurer had never the argued the same before it. However, Mr. Kanojia has been more emphatic on this ground of non-disclosure to justify rejection of the claim than the ground of consumption of alcohol. As observed above, Mr. Kanojia has infact not pressed the ground of consumption of alcohol beyond the point and according to him non-disclosure of pre-existing ailment of hypertension is the real ground for

rejection of Petitioner's claim under the policy. He has relied upon discharge Summary of Breach Candy Hospital dated 5 August 2022 in which under the column '*Significant Past History*' it has mentioned that *'Known case of hypertension and past h/o hemorrhoid surgery'.* Out of these two, the ground of pre-existing ailment of hypertension sought to be pressed in service for rejection of Petitioner's claim. It is contended that in the questionnaire to the proposal form, the Petitioner was required to disclose in the column *'Does any person(s) to be insured has any pre-existing diseases*'. Petitioner declared *'No'* against this column. It is therefore contended that Petitioner suppressed the information about the ailment of hypertension.

29) It must be noted that Petitioner and his wife have been insured since the year 2003 through Royal Sundaram. The said insurance policy was renewed every year and was in force for 17 long years till 2020. It is Respondent No.2 who approached the Petitioner for porting of the policy. It appears that the Petitioner had not raised any claim with Royal Sundaram and 'no claim bonus' has accrued, which got transferred to Respondent No.2. There are two emails prior to porting of the policy which shows the solicitation made by the Second Respondent-Insurance Company to the Petitioner. As a matter of fact, the earlier policy of Royal Sundaram was only for Rs.3,00,000/- and there was no claim bonus of Rs.1.5 lakhs and therefore upon porting, Respondent No.2 ought to have offered insurance of only Rs. 4.5 lakhs to the Petitioner and his wife. However, Respondent No.2 offered higher insurance amount of Rs.5,00,000/- for the purpose of attracting the customer of Royal

Sundaram to itself. This is clear from following representation made in email dated 28 August 2024 by Respondent No.2 :

> 7- Also suminsured is increasing, means your existing policy from royal Sundaram is of lakhs with 1.5 lakhs no claim bonus, but here will port your policy in 5 lakhs base suminsured so that you can easily use your top up also which you have already taken.

30) Also with regard to pre-existing condition, following representation was made :

> 3-No waiting period on any pre-existing condition.

31) This is how Respondent No.2 lured the Petitioner to port the policy from Royal Sundaram to itself. Petitioner's date of birth is 12 February 1942 and at the time of porting of the policy in the year 2021, he was almost 79 years of age. Despite this, Respondent No.2 decided to offer health insurance to the Petitioner and his wife by porting the policy of Royal Sundaram. Additionally, they offered to increase the insurance cover substantially under the top up cover though the Petitioner was at an advanced age of 79 years. This is how health insurance policy of Rs.55,00,000/- was sold to the Petitioner under which he and his wife were insured for a period of 3 years. Considering the advanced ages of the duo, Respondent No.2 charged hefty premium of 13,23,634/-. Thus, for securing health insurance of Rs.55,00,000/- for a period of 3 yeas, Petitioner paid hefty insurance premium of Rs.13,23,634/- to the second Respondent-Insurance Company.

32) After being detected with Non-Hodgkin's Lymphoma, Petitioner submitted total seven claims aggregating to Rs.17,77,147/- which have been repudiated by the insurer. In the initial claim denial letter dated 3 September 2022 only the remark of *'non disclosure'* was mentioned. However, in the subsequent claim denial letter dated 5 September 2022, the non-disclosure was linked to 'existing ailment'. As observed above, when the case was escalated to higher authorities, reply dated 14 January 2023 dealt with only the reason of alcoholism and the same did not contain a whisper about ailment of hypertension being the reason for rejection of the claim. This appears to be the reason why the ground of ailment of hypertension was apparently not argued before the Insurance Ombudsman. Having not argued the ground of pre-existing ailment of hypertension before the Insurance Ombudsman, the said ground is now sought to be pressed by Respondent No.2 possibly after realising that the first ground of occasional consumption of alcohol may not be sufficient to support denial of claim.

33) It is contended by the Petitioner that there is no possible nexus between Petitioner's ailment of hypertension and Non-Hodgkin's Lymphoma suffered by him. As observed above, the Insurance Ombudsman was not even made aware of rejection of claim on the ground of non-disclosure of pre-existing ailment of hypertension and therefore no attempt is made by it to establish a nexus between hypertension and the disease which was medically treated. Respondent No.2-Insurer has taken a conscious call of offering health insurance policy of Rs.55,00,000/- to the insured who was at an advanced age of 79 years and would have attained the age of 82 years at the end of the policy.

It took a conscious call of insuring him despite noticing his advanced age by charge a hefty premium from him. Hypertension, being a lifestyle disease, is very common amongst elderly persons. The risk associated with hypertension is much lesser as compared to the risk of medical treatment due to advanced age of a person. The fact that the insurer took a conscious call to insure the Petitioner upto age of 82 years on payment of hefty premium, makes it difficult to believe that non-disclosure of ailment of hypertension by the Petitioner would have affected the mind of the insurer. The Insurer prepared itself to take the risk of insuring the Petitioner for Rs. 55,00,000/- by accepting about 25% of the insurance cover as insurance premium. There is absolutely zero nexus between the disease of cancer suffered by the Petitioner that of pre-existing ailment of hypertension. What must also be noted is that Petitioner has been insured since the year 2003 by Royal Sundaram without raising any claim for 17 long years. It is unfortunate that he was detected with cancer in the year 2022 after securing a policy from Respondent No.2. Respondent No.2 was fully aware that it was insuring a person of advanced age, who was likely to be 82 years old by the time the insurance cover was to end in the year 2024. It still took a risk of insuring him.

34) What is more significant is to note is the fact that even at the age of 82 years and after noticing that Petitioner had recovered from cancer, Respondent No.2 was willing to renew the insurance policy and sent several letters calling him upon to pay the premium regularly. By renewal notice dated 24 May 2024, by which time Petitioner had crossed the age of 82 years, Respondent No.2 offered 'Enhance-2' policy for sum insured of Rs.55,00,000/- for a period of 3 years on payment of premium

of Rs.9,10,467/-. Respondent No.2 kept on sending such renewal notices on 27 June 2024, 1 July 2024, 8 July 2024, 9 July 2024, 12 July 2024, 16 July 2024, 22 July 2024, 9 August 2024 and 11 August 2024. Thus even after expiry of the first policy in July 2024, Respondent No.2 was willing to renew the old policy upon accepting another set of hefty premium of Rs.9,10,467/-.

35) Thus, by the time renewal notices were sent, Respondent No.2 had acquired knowledge of alleged drinking habits as well as pre-existing ailment of hypertension. Despite knowledge of both the aspects, Respondent No.2 was willing to offer health insurance of Rs.55,00,000/- to the Petitioner and his wife at their advanced age of 82 year and 78 years respectively on lower premium of Rs.9,10,467/-. As observed above, initially for health insurance of Rs.55,00,000/- after porting of the policy, Respondent No.2 charged aggregate premium of Rs.13,23,634/- from the Petitioner. However, after passage of 3 years, when the Petitioner crossed the age of 82 years and after acquiring knowledge of all the three aspects of his alleged drinking habit, pre-existing ailment of hypertension and the disease of cancer suffered by him, Respondent No.2 was still willing to renew the policy for a further period of 3 years on reduced premium of Rs.9,10,467/-. This conduct on the part of the insurer would leave no manner of doubt that the pre-existing ailment of hypertension had absolutely no nexus with the disease suffered by the Petitioner nor disclosure thereof would have materially affected its mind while offering the insurance policy.

36) What must also be noticed is the fact that Respondent No.2 took a conscious call of only rejecting the insurance claim and it did not repudiate the insurance policy. In this regard, it would be relevant to notice the concerned covenants and the terms and conditions of the Insurance policy. Clause-7.1 provided as under:

> 7.1 Disclosure to Information Norm
>
> If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld or if a Claim is fraudulently made or any fraudulent means or devices are used by the Policyholder or the Insured Person or any one acting on his/their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited ab initio to the Company.

37) Thus, if any material information was withheld by the insured, the insurer was entitled to forfeit the premium paid to it. Accordingly, Petitioner was issued show cause notices by Respondent No. 2 on 14 March 2023 and 30 March 2023. However, after receipt of replies from the Petitioner, Respondent No.2 did not cancel the policy as threatened. The policy was not only continued but the same was infact sought to be renewed. In the renewal notices, it was specifically mentioned that the policy was in force and was due for renewal on 11 July 2024. This is yet another factor to infer that non-disclosure of previous ailment of hypertension or occasional consumption of alcohol by the Petitioner did not materially affect the insurance contract.

38) It may also be relevant to note Clause-7.1 of the policy dealing with '*renewal term*'. Under Clause-7.9 (d) it was agreed as under :

> (d) The Company will ordinarily not refuse to renew the Policy except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured.

39) Thus, the misrepresentation was one of the grounds available for the insurer not to renew the insurance policy. However, the insurer did not treat non-disclosure of habit of consumption of alcohol and non-disclosure of previous ailment of hypertension as misrepresentation and offered to renew the insurance policy. This is yet another factor for inferring that the mind of the insurer would have been affected on disclosure of occasional consumption of alcohol and pre-existing ailment of hypertension.

40) Petitioner has relied upon judgment of the Apex Court in ***Manmohan Nanda*** (supra) in which overseas medical policy was availed by the Appellant therein for insuring his travel to USA. He was medially examined which revealed that he had Diabetes-Type II. The insurance policy was issued. The Appellant felt unwell upon reaching USA and was required to be admitted. He underwent surgery and three stems were required to be inserted to remove the blockage from the heart vessels. The claim was submitted under the overseas claim policy which was repudiated on the ground that the Appellant had an history of hyperlipidaemia and diabetes and that the policy did not cover pre-existing conditions and complications arising therefrom. In the light of the above factual background, one of the issues before the Apex Court was about effect of non-disclosure and nexus between the pre-existing disease and treatment availed by the Appellant in USA. The Apex Court examined the entire case law and held in paras-37 to 40 as under:

37. 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.* [*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.

38. 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.

39. 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:

39.1. 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".

39.2. 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".

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

40. 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.

41) On the issue of nexus, the Apex Court held in para-69 as under :

> 69. 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 Mellitus-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.

42) Applying the law expounded by the Apex Court in ***Manmohan Nanda*** it is difficult to hold in the present case that pre-existing ailment of hypertension or occasional consumption of alcohol by the Petitioner was a material fact which would have affected the mind of the insurer while offering insurance policy. Also there appears to be no nexus between the disease of cancer suffered by the Petitioner with the ailment of hypertension or his habit of occasional consumption of alcohol. There is nothing on record to indicate that the disease of cancer was a direct offshoot of hypertension or occasional consumption of alcohol.

43) Mr. Kanojia has relied upon judgment of the Apex Court in ***Branch Manager, Bajaj Allianz Life Insurance Company Ltd*** (supra) which has distinguished the judgment in ***Sulbha Prakash Motegaonkar & Ors vs Life Insurance Corporation of India***[6]. In ***Sulbha Prakash Motegaonkar***, there was

[6] Civil Appeal No.8245/2015 decided on 5 October 2015.

suppression of pre-existing ailment of lumbar spondilitis and it was found that the pre-existing ailment was unrelated to the cause of death. It was also held by the Apex Court that the pre-existing ailment was not life threatening disease. In ***Branch Manager, Bajaj Allianz Life Insurance Company Ltd.,*** the deceased was suffering from serious pre-existing medical condition of stomach ailment and from vomiting of blood which required availing of treatment. It is in the light of these peculiar facts that the Apex Court considered the proximity of undergoing treatment to the date of death and found that non-disclosure of ailment materially affected the decision to offer insurance. The Apex Court held in para-13 as under :

> 13. The medical records which have been obtained during the course of the investigation clearly indicate that the deceased was suffering from a serious preexisting medical condition which was not disclosed to the insurer. In fact, the deceased was hospitalized to undergo treatment for such condition in proximity to the date of his death, which was also not disclosed in spite of the specific queries relating to any ailment, hospitalization or treatment undergone by the proposer in Column 22 of the policy proposal form. We are, therefore, of the view that the judgment of the NCDRC in the present case does not lay down the correct principle of law and would have to be set aside. We order accordingly.

44) Mr. Kanojia has however relied on observations made by the Apex Court in para-9 of the judgment which read thus :

> 9. A contract of insurance is one of utmost good faith. A proposer who seeks to obtain a policy of life insurance is duty bound to disclose all material facts bearing upon the issue as to whether the insurer would consider it appropriate to assume the risk which is proposed. It is with this principle in view that the proposal form requires a specific disclosure of pre-existing ailments, so as to enable the insurer to arrive at a considered decision based on the actuarial risk. In the present case, as we have indicated, the proposer failed to disclose the vomiting of blood which had taken place barely a month prior to the issuance of the policy of insurance and of the hospitalization which had been occasioned

> as a consequence. The investigation by the insurer indicated that the assured was suffering from a pre-existing ailment, consequent upon alcohol abuse and that the facts which were in the knowledge of the proposer had not been disclosed. This brings the ground for repudiation squarely within the principles which have been formulated by this Court in the decisions to which a reference has been made earlier. In ***Life Insurance Corporation of India vs Asha Goel,*** this Court held:
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> > "12…The contracts of insurance including the contract of life assurance are contracts uberrima fides and every fact of material (sic material fact) must be disclosed, otherwise, there is good ground for rescission of the contract. The duty to disclose material facts continues right up to the conclusion of the contract and also implies any material alteration in the character of risk which may take place between the proposal and its acceptance. If there is any misstatements or suppression of material facts, the policy can be called into question. For determination of the question whether there has been suppression of any material facts it may be necessary to also examine whether the suppression relates to a fact which is in the exclusive knowledge of the person intending to take the policy and it could not be ascertained by reasonable enquiry by a prudent person."

45) However, the above observations are made in the light of unique facts of the case where the insured had pre-existing ailment arising out of alcohol abuse and used to vomit blood and had chosen to suppress the same while procuring insurance policy. In my view, therefore the judgment of the Apex Court in ***Branch Manager, Bajaj Allianz Life Insurance Company Ltd.*** would have no application to the peculiar facts and circumstances of the present case.

46) Reliance by Mr. Kanojia on judgment of the Apex Court in ***Export Credit Guarantee Coprn. of India Ltd.*** (supra) has little relevance to the facts of the present case. The judgment is relied on in support of the contention that it is impermissible for court to substitute the terms of the contract under the garb of construing terms incorporated in the agreement of insurance. In the present case, no attempt is made to

rewrite the terms of insurance contract. What is being decided is the issue as to whether non-disclosure of habit of occasional consumption of alcohol and pre-existing ailment of hypertension would have materially affected the decision of the insurer to issue the insurance policy. As observed above, Respondent No.2 was infact eager to renew the insurance policy even after noticing the three aspects of habit of occasional consumption of alcohol, pre-existing ailment of hypertension and most importantly, the treatment for cancer availed by the insured.

47) The conspectus of the above discussion is that he impugned Award passed by the Insurance Ombudsman is indefensible and liable to be set aside. The Insurance Ombudsman has committed a gross error in rejecting the complaint of the Petitioner. It has not undertaken the exercise of establishing nexus between alleged habit of occasional consumption of alcohol with the disease of cancer suffered by the Petitioner. It has not taken into consideration the fact that the insurance policy was continued by Respondent No.2 despite rejection of the claim. It has ignored the position that the policy was offered to the Petitioner at an advanced age of 79 years by accepting hefty premium of Rs.13,23,634/- for offering insurance of Rs.55 lakhs. In my view therefore the impugned Award of the Insurance Ombudsman deserves to be set aside.

48) In fact, this Court does not appreciate rejection of claim of the Petitioner by second Respondent-Insurance Company. The conduct exhibited by it in continuing the insurance policy and seeking to renew the same by seeking another set of hefty premium from the Petitioner is most certainly not appreciated. The conduct of the insurer clearly

indicates that its mind would never have been affected by disclosure of occasional consumption of alcohol or pre-existing ailment of hypertension. It was ready to renew the insurance policy despite knowledge of both the facts and even though third additional factor of disease of cancer was added to it, it offered to renew the insurance policy at the advanced age of 82 years at reduced premium of Rs.9,10,467/-. In my view, therefore rejection of insurance claim by the second Respondent is clearly baseless.

49) The petition accordingly succeeds, and I proceed to pass the following order:

(I) Award dated 10 June 2024 passed by the Insurance Ombudsman is set aside.

(II) The second Respondent-Insurance Company is directed to pay to the Petitioner sum of Rs. 17,771,51/- together with interest at the rate of 8% p.a. from the date of filing of the complaint i.e. w.e.f. 14 July 2023.

50) With the above directions, the petition is **allowed and disposed of.**

[SANDEEP V. MARNE, J.]