**IN THE HIGH COURT OF KERALA AT ERNAKULAM**

**PRESENT**

**THE HONOURABLE MR. JUSTICE P.M.MANOJ**

**MONDAY, THE 8TH DAY OF SEPTEMBER 2025 / 17TH BHADRA, 1947**

**WP(C) NO. 13244 OF 2017**

**PETITIONER :**

**DR.A.M.MURALEEDHARAN**
**AGED 58 YEARS**
**DHANASREE, TC. ROAD, NELLOONNI,MATTANNUR, KANNUR DISTRICT, PIN 670702**

**BY ADVS. SHRI.R.PARTHASARATHY**
**SHRI.B.KRISHNAN**

**RESPONDENTS :**

1 **THE SENIOR DIVISIONAL MANAGER**
**LIFE INSURANCE CORPORATION OF INDIA,(LIC OF INDIA)**
**'JEEVAN PRAKASH',DIVISIONAL OFFICE, PB.NO. 177,KOZHIKODE, PIN 673 001**

2 **THE MANAGER**
**LIC OF INDIA (HEALTH SERVICES), KOZHIKODE 673 001**

**BY ADV SMT.S.LAKSHMY**

**THIS WRIT PETITION (CIVIL) HAVING BEEN FINALLY HEARD ON 22.08.2025, ALONG WITH WP(C).40088/2017, THE COURT ON 08.09.2025 DELIVERED THE FOLLOWING:**

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**L.I.C. OF INDIA (HEALTH SERVICES),KOZHIKODE - 673 001.**

**BY ADV SMT.S.LAKSHMY**

**THIS WRIT PETITION (CIVIL) HAVING BEEN FINALLY HEARD ON 22.08.2025, ALONG WITH WP(C).13244/2017, THE COURT ON 08.09.2025 DELIVERED THE FOLLOWING:**

C.R.

**P.M. MANOJ, J**

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WP(C) No. 13244 & 40088 of 2017

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Dated this the 8th day of September, 2025

**JUDGMENT**

The above captioned writ petitions are preferred against the denial of the full claim and the complete rejection of the subsequent claim by the respondent insurance company, and seeking a direction to quash Exts.P8, P14 and P15.

2. It is the case of the petitioner that he is the policyholder under a policy (LIC's health plus plan table 901) valid up to 31.03.2024, which commenced on 31.03.2008. It covers medical treatment for the petitioner along with three other family members, namely his wife and two children, as evident from Ext.P1 insurance policy.

3. Due to hospitalisation of his wife, the petitioner submitted a claim petition for a sum of Rs.60,093/- along with supporting documents on 02.05.2016. She was hospitalized from 12.04.2016 to 22.04.2016. Then, the petitioner was directed to provide the

history and duration of the hysterectomy, as certified by the treating doctor, along with the first consultation paper. In this regard, two communications were effected on 27.05.2016 and 11.06.2016. The petitioner also received a communication to provide the previous treatment papers of implantation done and the placement of DJ Stent, and the treatment details of the hysterectomy of March 2016 by communication dated 26.09.2016, that is Ext.P4.

4. It was responded to by a reply dated 12.10.2016. Even thereafter, a similar communication was issued to the petitioner on 08.11.2016. That was also responded to by the petitioner, and requested not to drag the issue. Even then, the claim of the petitioner was not acted upon. He preferred a reminder on 25.01.2017 along with a certificate issued by the Urologist. Then the 1st respondent sanctioned the claim, which was limited to Rs.5,600/- against a claim of Rs.60,093/-, stating that "the benefits under the policy are not directly related to actual expenses incurred by you. The benefits are calculated based on the initial Daily Benefit opted by you in the proposal forms, on the life of the beneficiary referred above and the period of hospitalization and

type of surgery eligible as per the Policy Terms and Conditions as elaborated in conditions and privileges referred to in the policy Document."

5. The said order dated 04.02.2017 issued by the 1st respondent was initially challenged in W.P.(C) No.13244 of 2017, which is a document marked as Ext.P8 in both the writ petitions. The petitioner also preferred a petition to review the said order, which is produced as Ext.P9 in that writ petition and sought for quashing Ext.P8 and expeditious disposal of Ext.P11, the claim petition. During the pendency of the said writ petition, the petitioner's wife continued treatment at Vedanayagam Hospital Ltd., Coimbatore. She was admitted there between 01.08.2016 and 24.08.2016, during which an expenditure of about Rs.1,80,000/- was incurred.

6. Then the petitioner preferred another claim petition for the said amount on 22.09.2016. This was during the pendency of the earlier writ petition as mentioned above. Then the respondents issued a communication dated 28.04.2017, directing the petitioner to produce the following details.

1. The history, duration and treatment papers of hernia repair done in past, certified by the treating doctor.

2. The certificate from the treating doctor as to which the surgical scar was excised.

3. The indoor case papers.

In the light of said request, the surgeon of the petitioner's wife, who treated her in the year 2006 issued a communication on 30.05.2017, which is produced as Ext.P13. Thereafter, it was communicated to the petitioner that the claim preferred by him cannot be considered at all due to pre-existing illness, irrespective of prior medical treatment or advice.

7. It is contended by the petitioner that the reason assigned for rejecting the subsequent claim was unusual, since the hernia repair surgery undergone by his wife, in the year 2006, has no connection with the present disease, namely Vesicovaginal fistula repair. Therefore, the reliance on a pre-existing illness as the ground for rejection is completely erroneous. The rejection was issued as per Ext.P14, and a similar communication followed.

Hence, the petitioner challenges Ext.P8, P14 & P15 by preferring this writ petition.

8. In response to the contentions in the writ petition, the respondents have preferred a counter affidavit wherein the existence of the policy is admitted. However, it is stated that, as per condition No.2 of the Policy Document "Health related benefits payable subject to policy being in force", the benefits covered thereunder are hospital cash benefit, major surgical benefit and domiciliary treatment benefit. Condition No.3 prescribes the limitations under the head 'Benefit limits', which specifies the categories of health-related benefits. Further, condition No.6 provides for certain exclusions, including pre-existing conditions and exclusions applicable to major surgical benefits. Under these two heads, the list of surgical procedures covered and the percentage of the sum assured payable for major surgeries are provided.

9. The policy conditions are produced as Ext.R1(b), wherein the respondent contends that the hospitalization expenses are not maintainable. It is further submitted that the policy availed by the petitioner is different from the usual medical policies offered by

general insurance companies. While Medi-Claim policies provide reimbursement based on the actual expenses incurred, health policies offer pre-determined benefits subject to the conditions and privileges stipulated therein, and such benefits are not based on the expenses incurred.

10. It is further contended that the first claim in respect of hospitalization for the period from 12.04.2016 to 22.04.2016 was partly allowed as per Ext.P8, by settling the claim for an amount of Rs.5,600/- on the basis of the conditions and privileges contained in Ext.R1(b). The benefits under the policy are not directly related to the actual expense incurred. The surgery-right ureteric re-implantation and bladder closure, is a surgical procedure not coming under the major surgeries covered for insurance as per the list of surgical procedure in Ext.R1(b). As stated earlier, Clause (ii) of condition No.6 provides exclusion relating to the major surgical procedures, i.e. no benefits are available hereunder and no payment will be paid by the Corporation for any claim for major benefit under this policy directly or indirectly caused by, based on, arising out of or attributable to any surgeries not listed in the surgical benefit

annexure. Hence, the claim for Rs.60,093/- is not payable as per the policy conditions. Thereby, it is limited to Rs.5,600/- as per sub-clause (1) (a) of condition No.(ii) (n) of Ext.R1(b).

11. It is further contended that the petitioner's wife was covered with an initial daily benefit of Rs.500/- with a provision for annual increase at the rate of 5% (Rs.25/- i.e. 5% of Rs.500/-) up to a maximum of 50%. Thereby, the applicable daily benefit stood at Rs.700/- in April, 2016. After excluding the first 48 hours, the hospital cash benefit at the rate of Rs.700/- for eight days comes to Rs.5,600/-, which is paid as well. The surgical procedure undergone by the wife of the petitioner is not at all covered under Ext.R1(b) conditions. Thereby, the claim could not be allowed.

12. The subsequent claim for hospitalisation from 01.08.2016 to 24.08.2016 was rejected on the ground that the petitioner's wife had undergone incision hernia repair on 20.01.2006, prior to the commencement of Ext.R1(a). As per the joining form of the policy, the second question pertains to the medical history of the policyholder or beneficiary for the preceding five years, which was answered in the negative by the petitioner. The proforma of application is produced as Ext.R1(c). Thereby, it

is contended that there was a material suppression with respect to the pre-existing condition. Therefore, the claim preferred as per Ext.P11 cannot be considered. Accordingly, it is rejected under 'rejection clause' under sub-clause (2) of condition No.6, “conditions and privileges”, referred to in the policy document, where no benefits will be given by the Corporation for major surgical benefit under the policy directly or indirectly caused by, based on, arising out or howsoever attributable to any pre-existing condition, i.e., any medical condition or any related condition that have arisen at some point before commencement of the coverage, irrespective of any medical treatment or advise. It was further pointed out that cases where the principal insured know, knew or could reasonably have been assumed to have known the existence of such conditions will be deemed to be pre-existing.

13. It is further contended that the contract of insurance is a contract of “*uberrima fides*” which means 'utmost good faith'. Whereby every material fact must be disclosed, failing which the insurer can rescind the contract. Further, it is contended that even if the claim is sanctioned at his request, it would come to

Rs.15,400/- as per the pre-conditions and privileges of the policy as stated earlier (Rs.700/- per day for 22 days).

14. Moreover, it is contended that, as per condition No.26, cooling period where an option has been given to the policyholder to return the policy, is within 15 days from the date of receipt of the policy, if he or she is not satisfied with the terms and conditions of the policy. It was not invoked by the petitioner. Therefore, he is estopped from making claims contrary to the terms and conditions of the policy. The petitioner cannot claim ignorance of those conditions, as he has completely agreed with the conditions. On these assertions, the learned counsel for the respondents submitted that the writ petition is liable to be dismissed.

15. I have heard Sri.R.Parthasarathy, learned counsel for the petitioner and Smt.Lekshmy S, learned Standing Counsel appearing for the respondents.

16. On a primary evaluation of the aforementioned contentions, I deem it appropriate to examine the maintainability of this writ petition as a matter of self-imposed restraint. Since an insurance contract is purely a contractual relationship between the

insurer and the insured, it is ordinarily to be dealt within the jurisdiction of civil courts. However, in certain circumstances, the extraordinary jurisdiction under Article 226 can be invoked. But prior to that, certain questions are to be examined carefully by weighing the facts involved in the issue. Those are :

- Whether the dispute raised is bona fide;
- If a plea of fraud raised by the insurer has prima facie merit and the determination of the issue would necessitate oral and documentary evidence, then whether the writ petition is maintainable;
- If there is a violation of fundamental rights, whether this Court can exercise jurisdiction under Article 226;
- Whether there has been a great miscarriage of justice, and
- Whether there has been a violation of the principles of natural justice.

In the case in hand, the contention of the petitioner is that he subscribed to the policy called 'health plus plan table 901' with effect from 31.03.2008, which is valid up to 31.03.2024. It covers medical treatment for the three members of his family i.e., his wife and children. The petitioner raised a claim in connection with

hospitalisation and treatment of his wife initially between 12.04.2016 to 22.04.2016 and then for a continued future treatment between 01.08.2016 and 24.08.2016. The first claim of the petitioner for an amount of Rs.60,093/- was submitted with all required medical treatment records. The claim was delayed by repeatedly seeking further details even after submitting the necessary details which were certified by respective doctors. Finally, after filing the first writ petition, it was sanctioned by limiting it to Rs.5,600/- on the reason that the policy was not directly related to the actual expenses incurred by the insured. The benefits are calculated based on the initial daily benefits opted by him in the proposal form. Whereas, the subsequent claim for the second hospitalisation for continued treatment, for an amount of Rs.1,80,000/-, was declined on the ground that there was a pre-existing illness, namely, 'hernia repair' done in 2006, which was suppressed by the petitioner in relation to his wife.

17. Going by the above facts, it appears that even for the restriction of initial claim, a satisfactory explanation was not assigned by the insurer. The treatment undergone by the wife of the petitioner was 'vesicovaginal fistula', which is an abnormal

opening between the bladder and vagina, leading to urine leak to the vagina. A common cause for this condition is a bladder injury sustained during gynaecological surgeries like hysterectomy. In the annexure of surgical benefits, coverage is shown for kidney and urinary tract ailments. Though the urinal track is mentioned, the coverage is restricted only to renal transplantation and nephrectomy, while being completely silent about the treatment/surgery with respect to the urinary tract.

18. On the second occasion, the claim was denied on the basis of pre-existing disease. In fact, the insured i.e., the wife of the petitioner, had undergone hernia repair in 2006, which is a procedure to correct hernia, a condition where an organ or tissue protrudes through a weak spot in the surrounding muscle or tissue. The present treatment, however, was for vesicovaginal fistula, which, as stated earlier, is a post-operative complication of hysterectomy. Thereby, denial of benefits on the grounds of a hernia repair done, way back in 2006, or on account of hysterectomy which was performed much after subscribing to the policy amounts to a great miscarriage of justice. Moreover, the

facts involved in this case appear to be bona fide. Hence, at the first instance, it appears that the writ petition is maintainable.

19. Moreover, for deciding the case, it appears that no such oral evidence is required to understand that a miscarriage of justice occurred in this case. The documents submitted in the paper book, as well as the additional information provided directly during hearing, are sufficient to assess the miscarriage done in this case.

20. The right to medical treatment is a right identified under fundamental rights. In fact, once the insured has undergone treatment or a surgical procedure on the expert opinion of the concerned doctor, the insurer cannot deny the claim. Rejection of the claim for the expenses incurred for such treatment availed by the insured amounts to denial of treatment. In **Paschim Banga Khet Mazdoor Samithi v. State of West Bengal** [1996 (4) SCC 37], medical treatment was held as a fundamental right and denial of the same is violative of Article 21. Here, declining the claim in respect of the treatment undergone amounts to denial of treatment itself. Thereby, there is violation of the right to life provided under Article 21 of the Constitution of India.

21. Article 21 stands for the right to life, which is stated to have been violated in the present case. The jurisdiction under Article 226 can be invoked in cases where the denial of medical claims or insurance is made in an arbitrary and unreasonable manner. This position has been held by the Apex Court in **Consumer Education and Research Centre v. Union of India** [1995 (3) SCC 42] wherein it was held that the right to health and medical care is a fundamental right under Article 21. Similarly, in **State of Punjab v. Mohinder Singh Chowla** [1997 (2) SCC 83], it was reiterated that the right to health is an integral part of Article 21.

22. The denial of the claim by Exts.P8, P14 and P15 was made without affording sufficient opportunity to explain the side of the insured. There is no mention in those impugned orders that sufficient opportunity has been given to the insured prior to rejecting his claim, which, prima facie amounts to a violation of principles of natural justice.

23. All these aspects were considered in the light of the dictum laid down by the Apex Court held in **Life Insurance**

**Corporation of India and Others v.Asha Goyal (Smt.) and another** [(2001) 2 SCC 160] in which Paragraphs 10, 11 read as:

> "10. Article 226 of the Constitution confers extra-ordinary jurisdiction on the High Court to issue high prerogative writs for enforcement of the fundamental rights or for any other purpose. It is wide and expansive. The Constitution does not place any fetter on exercise of the extra-ordinary jurisdiction. It is left to the discretion of the High Court. Therefore it cannot be laid down as a general proposition of law that in no case the High Court can entertain a writ petition under Article 226 of the Constitution to enforce a claim under a life insurance policy. It is neither possible nor proper to enumerate exhaustively the circumstances in which such a claim can or cannot be enforced by filing a writ petition. The determination of the question depends on consideration of several factors, like, whether a writ petitioner is merely attempting to enforce his/her contractual rights or the case raises important questions of law and constitutional issues; the nature of the dispute raised; the nature of inquiry necessary for determination of the dispute etc. The matter is to be considered in the facts and circumstances of each case. While the jurisdiction of the High Court to entertain a writ petition under Article 226 of the Constitution cannot be denied altogether, Courts must bear in mind the self-imposed restriction consistently followed by High Courts all these years after the constitutional power came into existence in not entertaining writ petitions filed for enforcement of purely contractual rights and obligations which involve disputed

questions of facts. The Courts have consistently taken the view that in a case where for determination of the dispute raised it is necessary to inquire into facts for determination of which it may become necessary to record oral evidence a proceeding under Article 226 of the Constitution is not the appropriate forum. The position is also well settled that if the contract entered between the parties provide an alternate forum for resolution of disputes arising from the contract, then the parties should approach the forum agreed by them and the High Court in writ jurisdiction should not permit them to by-pass the agreed forum of dispute resolution. At the cost of repetition, it may be stated that in the above discussions we have only indicated some of the circumstances in which the High Courts have declined to entertain petitions filed under Article 226 of the Constitution for enforcement of contractual rights and obligation; the discussions are not intended to be exhaustive. This Court from time to time disapproved of a High Court entertaining a petition under Article 226 of the Constitution in matters of enforcement of contractual rights and obligation particularly where the claim by one party is contested by the other and adjudication of the dispute requires inquiry into facts. We may notice a few such cases; **Mohammed Hanif v. The State of Assam** (1969) 2 SCC 782; **Banchhanidhi Rath v. The State of Orissa and ors.** (1972) 4 SCC 781; **Smt.Rukmanibai Gupta v. Collector, Jabalpur and others** (1980 (4) SCC 556; **Food Corporation of India v. Jagannath Dutta** (1993 Supp (3) SCC 635) **and State of H.P. v. Raja Mehndra Pal and Others** ((1999) 4 SCC 43).

11. The position that emerges from the discussions in the decided cases is that ordinarily the High Court should not entertain a writ petition filed under Article 226 of the Constitution for mere enforcement of a claim under a contract of insurance. Where an insurer has repudiated the claim, in case such a writ petition is filed the High Court has to consider the facts and circumstances of the case, the nature of the dispute raised and the nature of the inquiry necessary to be made for determination of the questions raised and other relevant factors before taking a decision whether it should entertain the writ petition or reject it as not maintainable. It has also to be kept in mind that in case an insured or nominee of the deceased insured is refused relief merely on the ground that the claim relates to contractual rights and obligations and he/she is driven to a long drawn litigation in the civil court it will cause serious prejudice to the claimant/other beneficiaries of the policy. The pros and cons of the matter in the context of the fact situation of the case should be carefully weighed and appropriate decision should be taken. In a case where claim by an insured or a nominee is repudiated raising a serious dispute and the Court finds the dispute to be a s bona fide one which requires oral and documentary evidence for its determination then the appropriate remedy is a civil suit and not a writ petition under Article 226 of the Constitution. Similarly, where a plea of fraud is pleaded by the insurer and on examination is found prima facie to have merit and oral and documentary evidence may become necessary for determination of the issue raised then a writ petition is not an appropriate remedy."

In the light of the above ratio laid down by the Apex Court after examining the aforementioned points, I am of the considered opinion that in this case, the writ petition is maintainable.

24. Section 45 of the Insurance Act, 1938 after amendment in the year 2015 by Act 5 of 2015 is as follows:

> "**45. Policy not be called in question on ground of misstatement after three years**. —(1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.
>
> (2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud:
>
> PROVIDED that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based.
>
> *Explanation I*. —For the purposes of this sub-section, the expression "fraud" means any of the following acts committed by the insured or by his agent, with intent to deceive the insurer or to induce the insurer to issue a life insurance policy: —
>
> (a) the suggestion, as a fact of that which is not true and which the insured does not believe to be true;

(b) the active concealment of a fact by the insured having knowledge or belief of the fact;

(c) any other act fitted to deceive; and

(d) any such act or omission as the law specially declares to be fraudulent. *Explanation II*. —Mere silence as to facts likely to affect the assessment of the risk by the insurer is not fraud, unless the circumstances of the case are such that regard being had to them, it is the duty of the insured or his agent keeping silence, to speak, or unless his silence is, in itself, equivalent to speak.

(3) Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the misstatement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such misstatement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive.

*Explanation*. —A person who solicits and negotiates a contract of insurance shall be deemed for the purpose of the formation of the contract, to be the agent of the insurer.

(4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other

document on the basis of which the policy was issued or revived or rider issued:

PROVIDED that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based:

PROVIDED further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation.

*Explanation*. —For the purposes of this sub-section, the misstatement of or suppression of fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer, the onus is on the insurer to show that had the insurer been aware of the said fact no life insurance policy would have been issued to the insured.

(5) Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal."

Prior to the amendment it stood as follows :

**"45. Policy not to be called in question on ground of mis-statement after two years**

> No policy of life insurance effected before the commencement of this Act shall, after the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policyholder and that the policyholder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose:
>
> PROVIDED that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal."

The Legislative mandate, going by the above provisions both prior to and after the amendment, stands on the same footing, restraining the insurer from stepping back from the promise after completion of the stipulated period. Prior to the amendment, the period prescribed was two years; after amendment, it has been enhanced to three years. Here, in this case, the repudiation of the claim on the alleged reason of pre-existing disease cannot be

raised after the completion of a two-year period, as the case of the petitioner is prior to the amendment.

25. It is contrary to the mandate of Section 45 of the Insurance Act 1938. Section 45 (1) makes it clear that after expiry of three years from the date of issuance of the policy, no policy of life insurance can be called into question on any ground whatsoever. Even within the period of three years, repudiation is permissible only if the insurer proves that there has been suppression or misrepresentation of material facts, which were made fraudulently or with the knowledge of its falsity. The intent of the legislation behind Section 45 is to balance the duty of disclosure cast upon the insured with the need for certainty and security in insurance contracts. The object is to prevent insurers from avoiding liability on technical grounds after having accepted premiums for years. This issue has already been explained by the Apex Court in **Asha Goyal** supra, that the insurer must strictly satisfy the requirement of Section 45 before repudiating a policy. Unless deliberate fraud relating to a material fact is established, repudiation is not permissible.

26. In the case in hand, as stated earlier, the petitioner subscribed to the insurance policy in the year 2008, much prior to the amendment. The claim was raised in the year 2016, hence the unamended provision has application. Under the unamended Section 45, the insurer had the right to recall the policy only within a period of two years from 31.03.2008. However, the claims are raised for the periods between 12.04.2016 to 22.04.2016 and 01.08.2016 to 24.08.2016. Hence, the recalling of the policy or reconsideration of the conditions of the policy is much beyond the period of two years. Moreover, the alleged pre-existed condition (Hernia repair) was neither material to the risk nor related to the present ailment (vesicovaginal fistula). There is nothing to show that there was non-disclosure of pre-existing disease, either fraudulently or with knowledge of its falsity. The conditions under Section 45 are therefore not fulfilled to recall and repudiation of the claim cannot be sustained. Under such circumstances, the contention raised by the counsel for the respondents with respect to Section 45 of the Insurance Act, 1938 on the basis of the afore-mentioned explanation cannot be accepted.

27. Further, there is no specific allegation of fraud as a condition precedent for rejecting the claim, as provided under Clause 22(xi) of the 'Conditions and Privileges' referred to in the policy document, which says "if any of the insured or the claimant shall make or advance any claim knowing the same to be false or fraudulent as regards the amount or otherwise, the policy shall immediately become void and all claims or payment in respect of all the insured under this policy shall be forfeited. Non-disclosure of any health event or ailment/condition/sickness/surgery which occurred prior to taking this policy, whether such condition is relevant or not to the ailment/disease/surgery for which the insured is admitted/treated, shall also constitute fraud." Here the insurer could not establish that there is a purposeful suppression on the part of the insured, to decline the claim. What is stated is only the existence of a pre-existing illness without any proper explanation.

28. It is well settled that suppression of a pre-existing medical condition can justify repudiation of a claim only if the non-disclosed ailment is material to the risk and has a direct nexus with the contingency for which the claim is preferred. A fact is

'material' in insurance law only if it would have influenced the judgment of a prudent insurer in assessing the risk undertaken. Mere non-disclosure of an ailment that has no connection with the present medical condition for which the treatment has been taken cannot be treated as material suppression. To hold otherwise would mean that even trivial or unrelated past conditions could be used to deny coverage, thereby defeating the very purpose of health insurance.

29. In the present case, the ailment for which the insured underwent treatment has no relation to the pre-existing condition said to have been omitted in the proposal form. The insurer, therefore, cannot rely upon such omission to avoid liability, particularly when the insured has paid premiums for this much of period, that is between 2008 and 2016, with a legitimate expectation of the coverage. Courts have consistently held that unless there is fraudulent and wilful suppression of a material fact which has a direct link to the cause of claim, repudiation of the policy cannot be sustained. Here, in this case, there is no nexus between vesicovaginal fistula, the present treatment undergone by the wife of the insured and the Hernia repair, which was done in

the year 2006, the alleged pre-existing condition. There is no medical nexus between the two, nor can the earlier surgery be said to have any bearing on the present illness. Hence, the omission to disclose the Hernia repair cannot be treated as material suppression, and repudiation of the claim on this ground is wholly unjustified.

30. Even on that ground, the detailed contentions taken in the counter affidavit cannot be accepted in the absence of such reasons in the impugned order, in the light of the principles laid down by the Apex Court in **Mohinder Sing Gill and another v. Chief Election Commission and others** [1978 KHC 478].

31. It is a common character of human beings, due to concerns regarding their health, to feel insecure about future contingencies and their ability to bear the financial burdens arising therefrom. Such insecurity becomes a cultivating ground or a manuring situation for the insurance sector. To make use of this insecure feeling of the human being, sweet words, which are showered upon them with respect to the so offered coverage, often conveyed by the canvassers, will lead to a ray of hope.

32. It is a matter of concern that insurers, particularly Public Sector Institutions like the Life Insurance Corporation of India, often repudiate claims on trivial or technical grounds. The object of life insurance is to provide security against unforeseen contingencies, which are defeated when claims are rejected for reasons neither substantial nor material. Insurance is a contract of utmost good faith, and the duty of fairness lies equally on the insurer, as contracts of adhesion policies must be construed in favour of the insured and repudiation for consequential inaccuracies or ambiguities cannot be justified.

33. To permit repudiation on the basis of inconsequential or ambiguous disclosures would not only run contrary to the principle of **contra proferentem** but would also undermine the element of trust which forms the foundation of insurance. Accepting premiums year after year and later evading liability on technicalities undermines the public trust.

34. The principle of **contra proferentem** provides that an ambiguous term in a contract is to be interpreted against the party who drafted it. This doctrine applies when there is uncertainty of the meaning of a contractual clause, particularly in standardised

contracts or situations of unequal bargaining power. It encourages the parties to draft clear and unambiguous terms to avoid potential liability. Thereby, the status of the insured is secured as he has no role in framing the terms and usually has a limited understanding of technical terms. Any ambiguity or unclear clause must be interpreted against the insured and in favour of the insurer. Going by the conditions and privileges referred in the policy documents, it is clear that this doctrine has sufficient application in the present case.

35. The principles of reasonable expectation also have a key role in the case of insurance. A policyholder reasonably expects the insurer to indemnify him against the risk expressly covered. The courts have a bounden duty to protect such reasonable and legitimate expectations of the insured. Under the said circumstances, the contention of the counsel for the respondent with respect to "Cooling off period", which stands only for a period of 15 days as contemplated under Condition No.26 of the conditions and Privileges referred in the policy document, cannot be accepted.

36. The court cannot overlook the fact that the very purpose of a health insurance policy is to provide financial security to an individual at a time of medical emergency. When a policyholder subscribed to such a scheme by paying premiums regularly, the legitimate expectation is that unforeseen medical contingencies, which by their very nature cannot be predicted in advance, will be covered. If the benefit is confined only to certain specified surgeries enumerated in an annexure, it not only introduces an element of arbitrariness but also undermines the very object for which health insurance is taken. No individual can anticipate at any time entering into the contract, what precise surgery or treatment may be necessitated in future.

37. Insurance contracts, though commercial in form, are founded on principles of good faith and fairness. A clause which restricts coverage only to an exhaustive list of surgeries, without regard to the actual medical necessities faced by the insured cannot be said to be just, fair or reasonable. It amounts to defeating the reasonable expectation of the insured who has sought to protect himself or herself against the uncertainties of health. Such narrow interpretation of the coverage is inconsistent

with the social welfare objective underlying health insurance, especially when the insurer is a large public sector undertaking that commands the trust of millions. These observations are made after going through the list of surgical procedures annexed as the surgical benefit annexure along with the conditions and privileges referred to in the policy document.

38. This Court, is therefore, of the considered view that a condition which rigidly limits surgical benefit to an enumerated list of procedures must be construed liberally. If the medical intervention undergone by the insured is of a nature that's comparable in seriousness, necessity, and medical consequence to those listed, the claim shouldn't be denied on the ground of technical non-inclusion. To hold otherwise would reduce the insurance contract to a hollow promise, frustrating its very purpose and leaving the insured unprotected at the very moment when protection is most needed.

39. It is the bounden duty of the insurer to seek clarification before issuing the policy. The insurer must verify doubtful or contradictory entries in the proposal form. Accepting the form without clarification amounts to a waiver of objection. From the

proforma produced as Ext.R1(c) series against the checklist, it appears that the insurer has not exercised such a duty.

40. The insurer is taking the contention that the contract of insurance is a contract of *'uberrima fides*', which means utmost good faith. This doctrine requires parties to a contract, particularly an insurance contract, to reveal all material facts that could influence the other party's decision to enter into an agreement. This standard is higher than general good faith, obligating full and honest disclosure of any information that would impact the risk or terms of the contract. Failure to disclose a material fact can lead to the contract being declared void. It appears that this principle does not apply specifically to the insured but to the insurer as well. Since the correct specifications regarding the range of surgical proceedings under the list of surgical procedures annexed to the conditions and privileges referred to in the policy document are not provided, the insurer has a bounden duty to disclose the exact benefit available to the insured before deciding to subscribe the health policy. Based on the argument raised by the counsel for the petitioner, it appears that this duty was not fulfilled.

41. Therefore, after accepting the policy, and availing the premium year after years, the insurer cannot later repudiate the claim on the ground of some ambiguity. In such cases, the principles of estoppel come into picture, which prevents the insurer from taking advantage of its own failure in disclosing the entire aspect with respect to the coverage of insurance. The proforma produced by the insured reveals the manner in which they are guided in subscribing to the policy.

42. Before parting with, I must express my sincere gratitude to the medical practitioners with whom I discussed the medical complications involved in this case, whose guidance enabled me to arrive at a correct perspective in this matter.

43. Considering the larger interest of the public, who would otherwise be deprived of the very purpose of obtaining insurance, I deem it appropriate to exercise judicial interference. In this case, since the claim had already been rejected nine years ago, it would not be fair on the part of this Court to direct the insurer to reconsider the same. This relief is granted as a matter of abundant caution, to set a precedent in similar situations where a large number of medical claims are rejected by both public and private

sector undertakings in the field of health and life insurance, by pointing out some trivial, unsustainable and arbitrary reasons.

44. On the basis of the aforementioned discussions, I am of the considered opinion that the impugned Exts.P8, P14 and P15 are liable to be interfered with, as the writ petition is maintainable for the reasons aforesaid. Accordingly, Exts.P8, P14 and P15 are quashed and the respondent shall allow the claim of the petitioner without any further delay, since the policy was valid up to 31.03.2024.

On setting aside Exts.P8, WP(C) No.40088 of 2017, there is no further relevance of the prayers sought in WP(C) No.13244 of 2017, since the entire prayers sought in the latter one are completely merged in the prayers sought in WP(C) No.40088 of 2017. Accordingly, WP(C) No.13244 of 2017 is closed, and WP(C) No. 40088 of 2017 is disposed of as above.

Sd/-

**P.M.MANOJ**
**JUDGE**

ttb

**APPENDIX OF WP(C) 13244/2017**

**PETITIONER'S EXHIBITS**

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|---|---|
| **EXHIBIT P1** | **TRUE COPY OF THE FIRST PAGE OF THE POLICY ISSUED BY THE LIFE INSURANCE CORPORATION OF INDIA (FOR SHORT LICE)** |
| **EXHIBIT P2** | **TRUE COPY OF THE COMMUNICATION DATED 27.05.2016 ADDRESSED TO THE PETITIONER.** |
| **EXHIBIT P3** | **TRUE COPY OF COMMUNICATION DATED 11.06.2016 ADDRESSED TO THE PETITIONER** |
| **EXHIBIT P4** | **TRUE COPY OF THE COMMUNICATION DATED 26.09.2016** |
| **EXHIBIT P5** | **TRUE COPY OF THE REPLY DATED 12.10.2016** |
| **EXHIBIT P6** | **TRUE COPY OF THE SIMILAR COMMUNICATION WAS ISSUED TO THE PETITIONER ON 08.11.2016** |
| **EXHIBIT P7** | **TRUE COPY OF THE REMINDER ON 25.01.2017 FILED BY THE PETITIONER ALONG WITH A CERTIFICATE ISSUED BY THE UROLOGIST** |
| **EXHIBIT P8** | **TRUE COPY OF THE ORDER DATED 04.02.2017 OF THE FIRST RESPONDENT.** |
| **EXHIBIT P9** | **TRUE COPY OF THE REPRESENTATION REQUESTING THEM TO REVIEW EXT P8 ON 31.03.2017 FILED BY THE PETITIONER** |
| **EXHIBIT P10** | **TRUE COPY OF THE IMPATIENT BILL ISSUED BY THE HOSPITAL AUTHORITIES** |
| **EXHIBIT P11** | **TRUE COPY OF THE CLAIM PETITION FOR THE SAID AMOUNT FILED AS EARLY AS ON 22.09.2016** |

**RESPONDENTS' EXHIBITS**

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|---|---|
| **Exhibit R1(a)** | **True copy of policy document is produced** |
| **Exhibit R1(b)** | **.True copy of conditions and privileges which has been appended to Exhibit R1(a)** |
| **Exhibit R1(c)** | **True copy of proposal form with Annexure I submitted by the petitioner is produced** |

**APPENDIX OF WP(C) 40088/2017**

**PETITIONER'S EXHIBITS**

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| **EXHIBIT P1.** | **TRUE COPY OF THE FIRST PAGE OF THE POLICY ISSUED BY THE LIFE INSURANCE CORPORATION OF INDIA (FOR SHORT LIC).** |
| **EXHIBIT P2.** | **TRUE COPY OF THE COMMUNICATION DATED 27.05.2016 ADDRESSED TO THE PETITIONER.** |
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| **EXHIBIT P8.** | **TRUE COPY OF THE ORDER DATED 04.02.2017 OF THE FIRST RESPONDENT.** |
| **EXHIBIT P9.** | **A TRUE COPY OF REPRESENTATION REQUESTING THEM TO REVIEW EXT.P8 ON 31.03.2017 FILED BY THE PETITIONER.** |
| **EXHIBIT P10.** | **TRUE COPY OF THE IMPATIENT BILL ISSUED BY THE HOSPITAL AUTHORITIES.** |
| **EXHIBIT P11.** | **TRUE COPY OF THE CLAIM PETITION FOR THE SAID AMOUNT FIELD AS EARLY AS ON 22.09.2016.** |
| **EXHIBIT P12.** | **A TRUE COPY OF THE COMMUNICATION DATED 28.04.2017 OF THE FIRST RESPONDENT.** |
| **EXHIBIT P13.** | **TRUE COPY OF COMMUNICATION DATED 30.05.2017.** |
| **EXHIBIT P14.** | **TRUE COPY OF THE COMMUNICATION DATED 10.06.2017 OF THE FIRST RESPONDENT.** |
| **EXHIBIT P15.** | **TRUE COPY OF COMMUNICATION SIMILAR TO THAT OF EXT.P14 ON 22.09.2017.** |

**RESPONDENTS' EXHIBITS**

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| **EXHIBIT R1(A)** | **TRUE COPY OF POLICY ISSUED UNDER PLAN NO.901 HEALTH PLUSWITH DOC 31-03-2008 IN THE NAME OF THE PETITIONER.** |
| **EXHIBIT R1(B)** | **TRUE COPY OF CONDITIONS AND PRIVILEGES APPENDED TO EXHIBIT R1(A).** |
| **EXHIBIT R1(C)** | **TRUE COPY OF PROPOSAL FORM WIH ANNEXURE I SUBMITTED BY THE PETITIONER.** |