IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION
WRIT PETITION NO. 1244 OF 2023
WITH
INTERIM APPLICATION NO. 830 OF 2023

TATA AIG General Insurance Co. Ltd. .....*Petitioner*

: Versus :

1. Vinay Sah, Insurance Ombudsman,
Pune (state of Maharashtra except Mumbai
Metro)
2. Gauri V. Raut ....*Respondents*

Ms. Maithili Parikh *with Mr. Nabeel Malik & Ms. Sanjana Sapra i/b. Tuli & Co. for the Petitioner.*

Mr. Avinash Fatangare *with Ms. Archana Shelar, for Respondent No.2.*

CORAM : SANDEEP V. MARNE, J.
DATED : 3 SEPTEMBER 2025.

JUDGMENT :

1) This an unfortunate case, where all three male members of the family passed away in a short span of 6 months leaving behind the family in penury. The widow's claim towards insurance availed by her husband as a part of package of housing loan availed for purchase of their home, is repudiated by the Petitioner insurance company. Due to widow's inability to repay the housing loan, the finance company has attached the flat for sale. The Insurance Ombudsman has allowed the claim preferred by the widow and has directed Petitioner to pay to her the claim

amount of Rs.27,00,000/- vide impugned award dated 21 November 2022. Petitioner is aggrieved by the award dated 21 November 2022 and has filed the present petition.

2) Brief facts of the case are that Respondent No. 2 and her late husband dreamt of owning a house. They planned to purchase of Flat No. 704 on 7th floor of building Sonadevi Residency situated at plot No. 1, 9/2a and 12/4, Survey No. 1 village Temghar, Bhiwandi, Dist. Thane (**the Flat**). The husband of Respondent No. 2 was working as a teacher in ABS International School. After negotiations, sale consideration of the flat was agreed at Rs.30,70,000/-. The duo registered an Agreement for Sale with the developer on 31 March 2017. Respondent No. 2 and her husband approached India Infoline Housing Finance Limited (**IIFL**) for disbursement of housing loan, which sanctioned a loan amount of Rs.27,00,000/- to the couple. However, in the sanction letter dated 24 June 2017, a condition was imposed for compulsory availing of insurance policy. The sanction letter stated that insurance premium of Rs.84,767/- was included in the loan amount. This is how total loan amount sanctioned to the couple was Rs.27,84,767/-, out of which Rs. 84,767 was debited and paid by IIFL directly to Petitioner while the balance amount was disbursed to the couple. The loan amount of Rs. 27,84,767 was repayable in 27 years through Equated Monthly Instalments (**EMI**) of Rs.22,631/-. After receipt of insurance premium of Rs. 84,767 from IIFL, Tata AIG General Insurance Company Limited (Petitioner) issued Group Credit Secure Insurance Policy in the name of Mr. Vishal Suryabhan Raut

(husband of Respondent No. 2). The insurance policy included coverage for specified and defined critical illnesses for Rs.27,00,000/-. It is the case of Respondent No. 2 that insurance policy was never supplied to her or to her husband and it was internal arrangement between IIFL and the Petitioner.

3) In the year 2020, the husband of Respondent No. 2 secured a new job at Vapi, Gujrat and shifted along with his family in a licensed premises at Vapi. On 10 April 2021, the husband of Respondent No. 2 started suffering from fever and visited a doctor. Since there was no improvement in his condition, he was brought to Bhiwandi on 12 April 2021 and was hospitalized in Shree Saish Hospital, Bhiwandi for treatment. It is the case of Respondent No. 2 that her husband suffered from severe cardiac arrest on 15 April 2021 and passed away within 15 to 20 minutes. After securing a copy of the insurance policy, Respondent No. 2 lodged the claim by filling the claim form. On 15 July 2021, Petitioner requested for certain documents to process the claim and particularly called for Electrocardiogram (ECG) and other relevant reports. Respondent No. 2 informed the Petitioner on 16 July 2021 that ECG and other tests could not be conducted. Petitioner forwarded all medical papers of the deceased to Dr. Asrani, its panel medical professional, and based on the medical report, Petitioner repudiated the claim on 20 October 2021 on the ground of absence of any medical documents to substantiate the cause of death due to any critical illness as specified and defined under the insurance

policy. On 06 November 2021, Respondent No. 2 produced letter of Dr. Rashmin Jain, who had treated the insured at the hospital certifying that the insured had suffered heart attack.

4) In the above background, Respondent No. 2 filed the complaint with Insurance Ombudsman under Rule 13(1)(b) of the Insurance Ombudsman Rules 2017, challenging repudiation of her claim. Petitioner contested the complaint by filing self-contained note dated 13 September 2022. The Insurance Ombudsman passed award dated 21 November 2022 directing Petitioner to pay to Respondent No. 2 the entire claim of amount of Rs.27,00,000/-. Aggrieved by the award dated 21 November 2022, the Petitioner has filed the present petition.

5) By order dated 14 June 2023, the petition has been admitted and this Court refused to grant any interim relief observing that the claim ***prima facie*** appeared to be covered by the policy clause. On account of refusal of interim relief, Respondent No. 2 has filed execution proceedings before District and Sessions Court, Thane. Petitioner accordingly moved the petition for final hearing. Respondent No. 2 has filed affidavit-in-reply opposing the petition. Since pleading are complete, the petition is taken up for final hearing with consent of the learned Counsel appearing for the parties.

6) Ms. Parikh, learned Counsel appearing for the Petitioner-Insurance Company would submit that the Insurance Ombudsman has grossly erred in awarding the claim in favour of

Respondent No. 2 ignoring the terms and conditions of the policy. That the policy covered only listed and defined critical illnesses. That though Myocardial Infarction (first heart attack of specific severity) is included in the list of specified critical illness, no evidence was produced by the Respondent No. 2 to demonstrate that the death of the insured was caused due to heart attack. She would submit that in the chest X-ray of the insured, the cardiac size was reflected as normal. That the insured was hospitalized during the second wave of COVID-19 pandemic and has apparently succumbed to illness other than cardiac arrest. She would rely upon opinion of Dr. C.H. Asrani, who has examined entire case papers and has opined that the insured was never treated for heart attack. That the treatment given to the insured was for infection and sepsis, which are both common in diabetics. That the treatment administered was for infection and COVID-19, not for the illness of acute myocardial infarction. That acute myocardial infarction has been added to the certificate without any evidence. That the certificate of Dr. Rashmin Jain, dated 06 November 2021, was issued long after death of the insured and the opinion recorded therein is not supported by any medical reports.

7) Ms. Parikh would further submit that what was issued to the insured was not a usual mediclaim or health insurance policy. That the policy was issued with specific reference to the housing loan availed by the insured. That the policy included name of IIFL as the intermediary. That since the policy was issued with specific reference to the housing loan, the claim under the

policy must be in strict conformity with the terms and conditions. That if critical illness cannot be established, no claim under the policy could have been sanctioned. That there is nothing on record to indicate that the insured had suffered from myocardial infarction and that the said illness was deliberately included in belated certificate issued by the insured's doctor without any supporting medical reports.

8) Ms. Parikh would further submit that the terms of insurance policy are required to be strictly construed by resorting to a plain reading of terms and conditions of insurance policy. In support, she would rely upon judgment of Apex Court in ***National Insurance Co. Ltd. Vs. Chief Electoral Officer and Others***[1]. She would rely upon judgment of this Court in ***Aditya Birla Sun Life Insurance Company Limited Vs. Insurance Ombudsman***[2] in support of her contention that medical report of the expert *(which happened to be same as that of present case)* could not have been ignored by Insurance Ombudsman.

9) The petition is opposed by Mr. Fatangare, learned Counsel appearing for Respondent No. 2. He would submit that the insurance policy was a part of compulsory package while availing the housing loan. That the insured or Respondent No. 2 were never provided with copy of the insurance policy. That the death is caused by severe heart attack and the insured passed away within

1 2023 SCC ONLINE SC 115
2 2022 SCC ONLINE BOM 1673

15 to 20 minutes leaving no time for conducting any tests. The couple was sanctioned housing loan/mortgage loan/loan against property of Rs.27,84,767/- and Rs.6,44,374/-. The couple executed loan agreement and offered security of the flat by depositing title deeds thereof with IIFL. That after claiming hefty premium of Rs.84,767/-, the Petitioner-Insurance Company has wrongfully repudiated the claim of Respondent No. 2. He would rely upon judgment of the Supreme Court in *Gokal Chand Vs. Axis Bank*[3] and Punjab and Haryana High Court in *New India Assurance Company Limited Vs. Smt. Usha Yadav & others*[4]. Mr. Fatangare would submit that IIFL has issued notice under Section 32 of the Securitisation and Reconstruction of Financial Assets and Enforcement of Security Interest Act, 2002 due to non-repayment of the amount of housing loan and has taken symbolic possession of the flat. He would submit that if the claim of Respondent No. 2 is rejected, she would lose ownership and possession of the flat which will be sold by IIFL for recovery of outstanding amount of Rs.31.30 Lakh and Rs.6.95 Lakh.

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

11) As observed in opening portion of the judgment, this is an unfortunate case where the husband of Respondent No. 2 has passed away on 15 April 2021 and his wife is unable to repay the housing loan on account of repudiation of claim by Petitioner-

3 2022 SCC ONLINE SC 1720
4 2008 SCC ONLINE P&H 594

Insurance Company. The insurance policy was availed as a part of housing loan package in association with IIFL. The insurance policy was supposed to secure repayment of the housing loan in the event of an unfortunate incident. Though the unfortunate incident in the form of death of the insured has occurred, Petitioner-Insurance Company has refused to sanction the claim, which would have satisfied the outstanding housing loan amount. It appears that the entire family of Respondent No. 2 suffered from multiple calamities during the year 2021. Respondent No. 2 lost her husband on 15 April 2021. Within 3 months, she lost her brother-in-law, late Mr. Ravindra Raut. In October 2021, she lost her father-in-law, late Mr. Suryabhan Raut. This is how 3 male members of the family expired within a short time span of 6 months leaving behind only 3 ladies in the house (Respondent No. 2 aged 36, mother-in-law aged 59, sister-in-law aged 29) and 2 minor children (daughter of Respondent No. 2 aged 10 years and daughter of sister-in-law aged 7 years). On account of death of earning members, Respondent No. 2 is unable to repay the loan which has put the house at the risk of being sold by IIFL. After losing her husband, the widow will lose the shelter as well.

12) The Petitioner-Insurance Company has repudiated the claim on the ground that the insured was not found to have suffered from any critical illness as listed and defined under the policy. It would therefore be necessary to consider the background in which the policy was issued and its terms and conditions. It

appears that there was a tie-up between Petitioner-Insurance Company and IIFL, where IIFL included a condition while sanctioning the loan for compulsory availing of insurance policy of the Petitioner. This is clear from a stipulation in the final sanction letter dated 24 June 2017. Though the housing loan was only of Rs. 27,00,000/-, the loan amount sanctioned was indicated at Rs. 27,84,767/-. The sanctioned loan amount included insurance premium of Rs. 84,767/-. The insured did not pay the said amount of premium, but the same was sanctioned as part of loan and was disbursed directly to Petitioner. This is clear from the total premium amount indicated in the policy of Rs.84,767/-, which was added in the loan amount of Rs. 27,00,000/- and the actual amount of loan shown to have disbursed was Rs. 27,84,767/-. Thus, the couple received disbursement of loan amount of only Rs.27,00,000/- whereas Rs.84,767/- was paid by IIFL directly to the Petitioner-Insurance Company. It is claimed by Respondent No. 2 in her affidavit-in-reply that copy of the insurance policy was also never provided to the couple. This shows that Respondent No. 2 and her husband did not have any choice but to avail the insurance policy as a part of sanction and disbursement of loan by IIFL. Obviously, therefore, a representation was made to the couple that the policy would secure repayment of the loan amount in the event of occurrence of an unfortunate event. Under the heading 'additional conditions to comply prior to disbursal' in the sanction letter issued by IIFL, condition No. 4 was as under:

> ***"4. Insurance of Rs.84,767/- is included in loan amount"***

13) Petitioner issued Group Credit Secure Policy in the name of the husband of Respondent No. 2 for a tenure of 5 years commencing from 25 July 2017 and ending on 24 July 2022, the sum insured was Rs.27,00,000/-. Intermediary's name in the policy was indicated as IIFL and the name of the lending institution was also indicated as IIFL. Thus, this was not a standalone insurance policy which the insured had voluntarily applied for and the policy was a part of housing loan package and a compulsory condition for availing the loan from IIFL. Name of Respondent No. 2 was indicated as nominee in the policy. The policy coverage and benefits were as under:

Policy Coverage and Benefits:

Sl. No.	Benefits	Applicant	Co-applicant		
			1	2	3
1	Critical Illness – Sum Insured (Rs)	2700000.00			
2	Accidental Death – Sum Insured (Rs)	2700000.00			
3	Accidental Permanent Total Disability – Sum Insured (Rs)	2700000.00			
4	Education Benefit – Sum Insured	2700000.00			
5	Involuntary loss of Employment	Upto 3 EMIs			
6	Fire & Special Perils including Earthquake: a. Earthquake – Building	Upto Sum Insured			
	b. Fire – Building	Upto Sum Insured			
	c. Riot Strike Malicious Damage – Building	Upto Sum Insured			
	d. Storm Cyclone Typhoon Tempest – Building	Upto Sum Insured			

14) Total premium of Rs.84,767/- was shown to have been paid for the policy. Thus, sum insured of Rs.27,00,000/- covered critical illness. Section 1 of the terms and conditions of the policy dealt with critical illness. The relevant part of Section 1 of the policy is as under:

Section 1: Critical Illness

While this policy is in force, We shall pay the insured person the sum insured as a lump sum for the listed critical illness subject to the following conditions.

a. The insured Person experiences a Critical Illness specifically listed and defined in this Policy
b. The Critical Illness experienced by the Insured is the first incidence of that Critical Illness
c. The signs or symptoms of the Critical Illness experienced by the Insured Person commenced beyond waiting period of more than 90 days following the Issue Date of the Certificate of Insurance or Inception Date, whichever is later.
d. None of the General or Specific Limitations or Exclusions specifically contained in this Policy applies
e. Only one claim shall be payable to the insured regardless of the number of Critical Illness, incapacities or treatments suffered by him/her
f. The policy shall cease on the payment of the first critical illness and no subsequent renewals can be done for the policy
g. Covered Critical Illness: A "Critical Illness" shall mean any one of the following critical illness with specific meaning as defined in the policy.

Sl. No	Critical Illness
1	Cancer
2	End Stage Renal Failure
3	Multiple Sclerosis
4	Major Organ transplant
5	Heart Valve Replacement
6	Coronary Artery Bypass Graft
7	Stroke
8	Paralysis
9	Myocardial Infarction (First Heart Attack of specific severity)

10	Blindness
11	Third Degree Burns
12	Creutzfeldt -Jakob disease
13	Primary (Idiopathic) Pulmonary Hypertension
14	Motor Neuron Disease with Permanent Symptoms
15	Progressive Scleroderma

15) Perusal of the policy coverage and benefits would indicate that sum insured of Rs.27,00,000/- was payable if the insured person experienced a critical illness, which was specifically listed and defined under the policy. Insurance cover of Rs.27,00,000/- was also provided for accidental death and for accidental permanent total disability. Coverage of educational benefits of Rs.27,00,000/- was also included in the policy. In the event of involuntary loss of employment, coverage to the extent of payment of 3 EMIs was included. Additional coverage in respect of fire, earthquake, etc. was also included to the extent of the sum insured.

16) It thus appears that the sum insured was payable for treatment towards critical illness, but the policy appears to be silent if death of the insured was caused on account of illness, which is not part of the specified and defined illnesses. The sum insured was payable only when death was caused due to accident. Thus, if the insured person suffered from the critical illness and recovered after 3 to 4 months and is able to repay his EMIs, he would receive the claim amount though he is capable of repaying the loan amount. On the other hand, if death of the insured person

was caused due to illness which is not specified, nothing would become payable to the nominee though the nominee may not be in the position to repay the housing loan outstanding amount. The policy sold as a part of housing loan package after charging hefty premium of Rs.84767 *(for insurance for only five years)* would provide no solace to the nominee upon death of the insured, but would protect the insured in case he survives the critical illness. A borrower, who is forced to secure insurance policy as a part of home loan package, would opt for the same under an assurance that his nominee would receive the claim amount after his death and use the same for repayment of the home loan. This is the purport of availing the insurance policy bundled with the home loan. However if the policy, upon its plain reading, does not cover death of the insured due to 15 specified illnesses, but covers survival of the insured after suffering from the 15 specified illnesses, the policy becomes absurd, especially when considered from the objective why the same is bundled with the home loan package. There is thus ambiguity in the terms and conditions of the insurance policy.

17) Turning to the facts of the case, the Insured initially started suffering from fever while being at Vapi and a local medical professional *(Dr. Dinesh D. Prajapati)* was consulted on 10 April 2021. Dr. Prajapati advised conduct of investigations like Blood Test, Urine Test and Chest X-ray. Petitioner has heavily

relied on Chest X-ray which indicated that the cardiac size of the insured was normal. The X-ray also indicated that *'there is a patchy pneumonitis seen on the left side'*. The insured was brought back to Bhiwandi and was hospitalised in Shree Saish Hospital on 12 April 2021. The insured however passed away within 3 days on 15 April 2021. It is the case of Respondent No.2 that the insured suffered a severe cardiac arrest on 15 April 2021 which caused his death within 15 to 20 minutes leaving no time for conducting any investigations relating to heart ailment. The letter dated 16 November 2021 issued by Dr. Rashmin Jain and Shree Saish Hospital, Bhiwandi indicates that the insured was admitted in the hospital for suspected COVID pneumonitis and breathlessness. On second day of hospital admission, he was put on Bipap Machine. The letter indicates that the insured complained of sudden onset of chest pain and went into cardiac arrest within 15 to 20 minutes leaving no time to conduct ECG, CPK, CPK MB, 2D Echo etc. The letter indicates that emergency resuscitation method was applied but the insured passed away.

18) After lodging of the claim, Petitioner referred the case to its panel doctor (*Dr. C.H. Asrani*) who has given a report dated 2 August 2021 on 4 queries raised by the Petitioner as under:

> ***Opinion required:***
> ***Q1. Whether insured has suffered a 1st Heart Attack?***
> *No. Insured has not suffered any heart attack. There is no mention of any coronary symptoms, serial ECGs or even Troponin / CK-MB report.*
> ***Q2. Whether insured has been treated for Heart Attack?***
> *No. Insured has not been treated for any angina / acute coronary syndrome / coronary artery disease or heart attack.*

Insured has been treated for infection and sepsis – both common in diabetics. From the treatment sheets of 14th a& 15th (admitted on 14th and died on 16th), it is evident that he was being treated for Covid (no RT-PCR report). His line of treatment was for infection and Covid.

Q3. What is the Exact cause of Death?

Exact cause of death is sepsis and septicemia. Acute myocardial infraction has been added to the certificate without any evidence of the same in the ICPs.

Q4. What should be the next step?

Insurer should seek any evidence from the hospital of death due to myocardial infarction.

Conclusion: Insured did not suffer from any heart attack. His line of management in the hospital as well as cause of death is sepsis and septicemia.

19) Dr. Asrani thus opined that the insured did not suffer from heart attack and that his line of treatment in the hospital, as well as the cause of death is sepsis and septicemia. Thus, there is difference of opinion between two medical professionals. Dr. Rashmin Jain who actually treated the insured has certified that the cause of death was cardiac arrest, whereas, Petitioner's Medical Expert has attributed the death to sepsis and septicemia. Since the illness of sepsis and septicemia are not included in the listed and defined critical illnesses in the policy, Petitioner has proceeded to repudiate the claim of Respondent No.2.

20) The Insurance Ombudsman was faced with two conflicting reports of the medical professionals. The opinion of Dr. Rashmin Jain is based on first-hand information as the said professional has actually treated the insured. As against this, the opinion of Dr. Asrani is based merely on perusal of the papers. The opinion of Dr. Asrani is premised essentially on absence of any papers showing diagnosis of heart ailment or treatment leading to

cardiac arrest of the insured. This is properly explained by Dr. Rashmin Jain stating that the death was caused within few minutes of the insured complaining of chest pain leaving no time for conduct of any diagnostic investigations. He has however certified that the insured was put on Bipap Machine. Faced with this situation, the Insurance Ombudsman has held that if the insured was to survive for some time, conduct of tests could have been possible but merely because tests are not conducted on account of sudden death, it cannot be concluded that cardiac arrest cannot be a cause for death. The Insurance Ombudsman held that breathlessness and chest pain were symptoms of heart attack and therefore the claim of Respondent No.2 was admissible. In my view, the finding recorded by the Insurance Ombudsman after perusal of the documentary evidence on record are plausible findings. There is no perversity in the findings recorded by the Insurance Ombudsman. He has not ignored any relevant material nor has he taken into consideration something which was irrelevant. The opinion expressed by the Insurance Ombudsman appears to be well supported by material on record. Therefore, no case is made out for interference in the findings recorded by the Insurance Ombudsman by this Court in exercise of jurisdiction under Article 227 of the Constitution of India.

21) It is Ms. Parikh's contention that the Petitioner is entitled to rely solely on the expert opinion of Dr. C.H. Asrani and that it was impermissible for Insurance Ombudsman to question the findings of the Medical Expert and replace its own opinion with

the opinion of the Medical Expert. In ordinary circumstances, what Ms. Parikh contends could have been correct. However, in the present case, the opinion of Dr. C.H. Asrani is based essentially on account of non-availability of any reports or case papers suggesting line of treatment for heart ailment. On the other hand, there is a direct opinion of the Medical Professional who treated the insured certifying that he suffered a massive and sudden cardiac arrest resulting in his death in 15-20 minutes leaving no time for conduct of any tests. In these peculiar circumstances, the Insurance Ombudsman has weighed opinion of both the Medical Experts and has held that mere absence of opportunity to conduct tests could not be a reason to disbelieve the cause of death as heart attack.

22) Perusal of the report of Dr. Asrani dated 2 August 2021 would indicate that he has reproduced documents such as chest X-ray and case papers of Shree Saish Hospital in his report and has thereafter discussed references of various websites relating to diabetes mellitus and diabetes and sepsis. After incorporation of chest X-ray report and hospital case reports and reproducing references from website, Dr. Asrani has straightaway proceeded to answer the four queries. The first query was whether insured had suffered the first heart attack. Dr. Asrani straightaway proceeded to answer "No" stating that the insurance had not suffered any heart attack because there was no mention of Troponin or CK-MB report. Dr. Asrani has noted the certificate issued by the Hospital, but has proceeded to ignore the same with a vague observation

while answering query no.3 that *'Acute myocardial infraction has been added to the certificate without any evidence of the same in the ICPs'*. Dr. Asrani has not opined that while being treated for sepsis or septicemia, it was impossible for insured to suffer cardiac arrest. He has not explained in any manner as to how the insured who got admitted in his hospital on 12 April 2021 could pass away within three days on 15 April 2021 or that the death in such short span was impossible of being associated with the cardiac arrest though the insured may be treated for sepsis and septicemia. There is no discussion in the opinion as to how the infection and sepsis which are common in diabetics can cause death within three days. Even if it is believed that the insured was being treated for COVID and sepsis infection, it was not impossible for the insured to suffer a cardiac arrest. In such circumstances, the opinion of the doctor who actually treated the insured cannot be ignored altogether and report of the Dr. Asrani cannot be blindly accepted which is premised only on account of inability of Respondent No.2 to produce any test reports relating to cardiac arrest. Therefore, in the peculiar facts and circumstances of the case, the Insurance Ombudsman is otherwise justified in arriving at the conclusion that cardiac arrest cannot altogether be ruled out as the cause of death.

23) Ms. Parikh has relied on judgment of the Apex Court in ***National Insurance Corporation Ltd.*** (supra) which reiterates the settled position that the terms of insurance policy are required to be strictly construed. There can be no dispute to the proposition

that plain reading of the terms and conditions of the policy is required to be resorted to and contract of insurance cannot be interpreted liberally to read into it something, which is not expressly provided for. However, even if the insurance contract in the present case is literally and plainly construed, there is some material to infer that the cause of death could be a cardiac arrest which is a critical illness covered by the policy. However, even if one was to blindly accept the opinion of Dr. C.H. Asrani to conclude that the insured did not suffer from cardiac arrest, it otherwise sounds quite absurd that an insured, who suffers from critical illness of cardiac arrest but recovers after treatment and goes back to his job/profession/business and is able to pay EMIs of housing loan can be paid claim to the extent of Rs.27,00,000/- but another insured whose death is caused due to ailment not covered by the policy and whose nominee is unable to bear the EMIs due to death of sole earning member in the family, is forced to handover possession of the house for being sold by the finance company to recover the housing loan amount. Here there appears to be clear element of ambiguity in the insurance policy and the principle of ***contra proferentem*** would apply where ambiguous terms of insurance policy would receive an interpretation favorable to the insured. The principle of ***contra proferentem*** can be invoked while interpreting the provisions of insurance contract. In ***Haris Marine Products Vs. Experts Credit Guarantee Corporation Ltd.***[5], the Apex Court has held as under :

5 2022 SCC ONLINE SC 509

B. *Rule of contra profertem*

19. It is entrenched in our jurisprudence that an ambiguous term in an insurance contract is to be construed harmoniously by reading the contract in its entirety. If after that, no clarity emerges, then the term must be interpreted in favour of the insured i.e. against the drafter of the policy. In deciding the applicability of a cover note on houses swept away by floods, a Constitution Bench of this Court in General Assurance Society Ltd. v. Chandumull Jain held as follows : (SCC OnLine SC Para 11)

> *"11 . ...* In other respects there is no difference between a contract of insurance and any other contract except that in a contract of insurance there is a requirement of uberrima fides i.e. good faith on the part of the assured and the contract is likely to be construed contra proferentem that is against the company in case of ambiguity or doubt .... *(I)n interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves."*
>
> (emphasis supplied)

While the Court ultimately denied insurer's liability, it laid down the manner in which ambiguities were to be interpreted. Since then, a catena of judgments has upheld this approach.

20. In *United India Insurance* Co. *Ltd.* v. *Pushpalaya Printers,* a Division Bench of this Court was confronted with interpreting the term "impact" in an insurance policy for protection against damage caused to the insured building. Interpreting the term to include damage caused by strong vibrations by heavy vehicles without *"direct"* impact, this Court held : (SCC pp. 698-99, para 6)

> "6. The only point that arises for consideration is whether the word "impact" contained in Clause 5 of the insurance policy covers the damage caused to the building and machinery due to driving of the bulldozer on the road close to the building ... *(I)t is also settled position in law that if there is any ambiguity or a term is capable of two possible interpretations, one beneficial to the insured should be accepted consistent with the purpose for which the policy is taken, namely, to cover the risk on the happening of certain event . ... Where the words of a document are ambiguous, they shall be construed against the party who prepared the document. This rule applies to contracts of insurance and Clause 5 of the insurance policy even after*

> *reading the entire policy in the present case should be construed against the insurer."*
>
> (emphasis supplied)

21. Similarly, Similarly, in *Sushilaben Indravadan Gandhi v. New India Assurance Co. Ltd.*, this Court charted the evolution of the rule of contra proferentem, and relied on its explanation as provided under *Halsbury's Laws of England* :

> "*Contra proferentem rule.*- Where there is ambiguity in the policy the court will apply the contra proferentem rule. Where a policy is produced by the insurers, it is their business to see that precision and clarity are attained and, if they fail to do so, the ambiguity will be resolved by adopting the construction favourable to the insured. Similarly, as regards language which emanates from the insured, such as the language used in answer to questions in the proposal or in a slip, a construction favourable to the insurers will prevail if the insured has created any ambiguity. This rule, however, only becomes operative where the words are truly ambiguous; it is a rule for resolving ambiguity and it cannot be invoked with a view to creating a doubt. Therefore, where the words used are free from ambiguity in the sense that, fairly and reasonably construed, they admit of only one meaning, the rule has no application."

22. **The rule of contra proferentem thus protects the insured from the vagaries of an unfavourable interpretation of an ambiguous term to which it did not agree.** The rule assumes special significance in standard form insurance policies, called *contract d' adhesion* or boilerplate contracts, in which the insured has little to no countervailing bargaining power. This consideration is highlighted in the facts of this case, since the risks that ECGC is mandated to cover is its business, and other insurers rarely foray into the field.

24) However, in the facts of the present case, it is even necessary to go to the extent of applying the principle of ***contra-proferentem*** since there is some evidence to indicate that the insured did suffer from cardiac arrest which is one of the critical illnesses covered under the insurance policy.

25) The case involves extremely unfortunate circumstances where three male members of the family passed away in short span of six months leaving behind only five family members, none of whom were earning members. After the death of husband, brother-in-law and father-in-law of Respondent No.2, the surviving members were Respondent No.2, her sister-in-law and two minor daughters. IIFL who included the insurance premium in the loan amount has initiated proceedings for attachment and sale of the flat on account of inability of Respondent No.2 to repay the loan amount. The very objective of availing the insurance policy was to secure repayment of loan in the event of death or incapacitation of the borrower. The insurance policy was compulsorily provided for IIFL in order to protect its interest in addition to interest of its borrowers. Inclusion of insurance policy as a part of home loan package assures swift repayment of loan in the event of unfortunate death or incapacitation of the borrower where the finance company is not required to adopt lengthy procedure of attachment and sale of secured properties. So far as borrower is concerned, his/her family member and dependents are relieved from the burden of repaying the loan and can continue to reside in the purchased house by availing loan in the event of loss or incapacitation of the borrower. However, this noble objective is completely frustrated on account of actions of the Petitioner-Insurance Company. It has attempted to find loopholes with a view to wriggle out of the obligation to disburse claim amount to Respondent No.2, who now faces attachment and sale of the flat

purchased out of the housing loan on account of repudiation of claim by the Petitioner. If this Court allows the petition and sets aside the order of Insurance Ombudsman, IIFL would attach and sell the residential house of Respondent No.2 to recover outstanding loan amount and Petitioner-Insurance Company would indulge in profiteering by not disbursing the claim amount even in a genuine case involving death of insured borrower. This is yet another factor why this Court would be loathe in interfering with the order passed by the Insurance Ombudsman as not only the view of the Insurance Ombudsman is plausible, but the final conclusion is otherwise valid. The Petitioner has invoked extraordinary jurisdiction of this Court under Articles 226 and 227 of the Constitution of India. The jurisdiction is both discretionary, as well as equitable. In exercise of supervisory jurisdiction under Article 227, this Court is not expected to correct every error of fact or even a legal flaw when a final finding is justified or supported. In *M/s. Garment Craft Versus. Prakash Chand Goel*[6] the Apex Court has held in para-15 as under:

> "15. Having heard the counsel for the parties, we are clearly of the view that the impugned order is contrary to law and cannot be sustained for several reasons, but primarily for deviation from the limited jurisdiction exercised by the High Court under Article 227 of the Constitution of India. The High Court exercising supervisory jurisdiction does not act as a court of first appeal to reappreciate, reweigh the evidence or facts upon which the determination under challenge is based. Supervisory jurisdiction is not to correct every error of fact or even a legal flaw when the final finding is justified or can be supported. The High Court is not to substitute its own decision on facts and conclusion, for that of the inferior court or

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> tribunal. The jurisdiction exercised is in the nature of correctional jurisdiction to set right grave dereliction of duty or flagrant abuse, violation of fundamental principles of law or justice. The power under Article 227 is exercised sparingly in appropriate cases, like when there is no evidence at all to justify, or the finding is so perverse that no reasonable person can possibly come to such a conclusion that the court or tribunal has come to. It is axiomatic that such discretionary relief must be exercised to ensure there is no miscarriage of justice."

26) Reliance by Ms. Parikh on judgment of this Court in ***Aditya Birla Sunlife Insurance*** (supra) is of no assistance for resolving the controversy at hand. The judgment deals with case of non-disclosure of information about pre-existing ailment. The insured therein was a well-known case of schizophrenia and hypertension and died due to septicemia with multiple organ failure. The insured had not disclosed the existing ailment of schizophrenia and hypertension while securing the policy. Also, the case involved Insurance Ombudsman completely ignoring the opinion of Dr. C.H. Asrani (*same Medical Expert consulted in the present case as well*), which is not the case here. In the present case, the Insurance Ombudsman has taken into consideration opinion of Dr. C.H. Asrani. Therefore, the judgment in ***Aditya Birla*** (supra) rendered in the peculiar facts of that case has no application to the present case.

27) Mr. Fatangare has relied upon judgment of the Apex Court in ***Gokal Chand*** (supra) which also involved the case of insurance policy issued to secure loan sanctioned to the borrower.

The insured had applied for home loan for which life insurance policy was issued by the insurer. From the loan amount sanctioned to the insured, insurance premium was deducted and paid to the insurance company. The apex court took into consideration the business arrangement between Axis Bank (Finance Company) and Max Life Insurance Corporation (Insurance Company) and noted that the premium amount for policy was debited while sanctioning home loan by Axis Bank and directly credited in the account of the Insurance Company. After learning about the death of the insured, the insurance company returned the policy and premium amount and repudiated the claim. The Apex Court held that the conduct of the insurer was not in good faith and was malafide. It is held in paras-28 to 31 as under:

> 28. Guided by the above judgment in like circumstances, the latter ratio is applicable to the facts at hand. Though, we acknowledge that there is no excessive delay in the current case between medical test and repudiation unlike in D. Srinivas [D. Srinivas v. SBI Life Insurance Co. Ltd., (2018) 3 SCC 653 : (2018) 2 SCC (Civ) 604] , where the period was over 2 years, what needs to be focused upon in the interest of justice is the trigger and surrounding circumstances which led to the rejection of proposal by the Insurance Company. In that light, the conduct of Respondent 2 cannot be countenanced against the good faith standards that an insurance contract warrants.
>
> 29. In this case, the precondition for the home loan as stipulated by the respondents was that life of the borrower will have to be insured. Only after assessment of the applicant's credentials, the loan was approved. When the loan amount was sanctioned, the premium amount was kept aside and was credited to the insurance Company and the insured was subjected to a medical test which showed normal health status. Thus, premium was accepted and retained for the life insurance and no change of this

> position was found necessary even after the treadmill test result of the insured.
>
> 30. This entire procedure would suggest, at least from the insurer's perspective, that the insurance process was complete and all mandatory requirements were met. Significantly, there was no contrary communication by Respondent 2 indicating otherwise as well. Moreover, when the death information was conveyed to the respondents, most surprisingly, that was the trigger that led to the Insurance Company to issue a back dated letter deferring the insurance process, which was followed by refund of the premium a few days later, and then the repudiation after that.
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> 31. The case at hand shows clear mala fide on the part of Respondent 2 in the manner they dealt with the insurance policy, after learning of the death of the insured person on intimation from the affected persons. The way the issue was addressed by Respondent 2 following the information conveyed does fail, in our opinion, the test of Reasonable Conduct. On top of that, to cover up their late reaction, most tellingly, the antedated letter under the garb of an unfounded medical reason was dispatched. These in our opinion, amount to a clear case of deficiency of service and a non-bona fide conduct by Respondent 2. The contrary finding in the impugned order do not pass our judicial scrutiny.

In the present case as well, this Court finds the conduct of the finance company and the Petitioner to be far from *bona-fide*. They entered into internal business arrangement where IIFL has virtually acted as an insurance agent of the Petitioner while selling the policy to its borrower. The case does not involve voluntary application by the insured for insurance policy. Since insurance policy is bundled with the home loan package, Petitioner insurance company ought to have sanctioned the claim after death of the insured by accepting the opinion of the Doctor who has treated him.

28) Considering the overall conspectus of the case, this Court does not find any valid reason to interfere in the order passed by the Insurance Ombudsman. In fact, this Court would have been justified in imposing costs on the Petitioners for their conduct in erroneously refusing the claim of Respondent No.2 and in making her litigate for the last four long years. By their conduct Petitioner has pushed the widow to such a position where her home is attached for sale by IIFL. However, it is seen that the Insurance Ombudsman has already awarded interest at applicable bank rate plus 2% extra from the date of rejecting of claim till the date of payment. Therefore, while dismissing the petition, this Court directs that the entire payment due under the Award of the Insurance Ombudsman shall be paid by the Petitioner to Respondent No.2 within a period of 4 weeks.

29) The Writ Petition is accordingly **dismissed.** Rule is discharged. Interim Application also stands disposed of.

[SANDEEP V. MARNE, J.]