OPEN BOOK EXAMINATION

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Roll No.....

Time allowed : 3 hours ***Maximum marks : 100***

Total number of questions : 6 ***Total number of printed pages : 4***

NOTE : *Answer* ***ALL*** *Questions.*

1. Shri Prithipal Singh, 48 years of age, on 7th May, 1990, secured for himself a mediclaim policy from X General Insurance Co. Ltd. Necessary formalities were completed by him in this regard after due consultation with and guidance of the insurance company's agent. Shri Singh nominated his wife Smt. Satwant Kaur as the beneficiary under the policy. The policy was for a period of due year and has to run from 7th May, 1990 to 6th May, 1991. The annual premium charged by the company was ₹ 1,500 which was duly paid in cash by the insured.

In filling the proposal form leading to the issue of the policy Shri Singh, while answering questions 10 and 11 thereof, had clearly stated that he had not suffered from any illness in the past and that he had not undergone any medical procedures.

On 11th September, 1990, Shri Singh fell ill suddenly and was admitted to a local hospital at Lndhiana where he was residing. The Ludhiana hospital, in the course of the treatment, suggested his shift to a specialised hospital and hence on 7th December, 1990, Shri Singh was shifted to the Madras Institute of Nephrology, Chennai also known as Vijaya Health Centre. While under treatment in the Chennai hospital, Shri Singh's condition deteriorated and ultimately he died in the Chennai hospital on 26th December, 1990.

Smt. Sawant Kaur intimated the insurer X General Insurance Co. Ltd., of her husband's death early in January 1991 and followed up the intimation with a claim statement in February 1991 in which she had claimed a reimbursement of medical and hospital charges of ₹ 5,23,500.

The insurance company made enquiries with the Madras Institute of Nephrology and obtained a certificate from them on 6th May, 1992 stating that the deceased Shri Singh was a known case of chronic renal failure/diabetic nephropathy; that he was on a regular haemo-dialysis for some years and also after admission into their Institute and suffered from severe breathlessness leading to the development of a sudden cardiac arrest leading to death on 26th December, 1990. Their certificate also mentioned that the insured was a confirmed diabetic for the last 16 years of his life. In the circumstances, the insurance company by its letter of 30th August, 1993 repudiated the claim and informed Mrs. Singh so.

Feeling aggrieved, Mrs. Singh approached the Consumer Dispute Redressal Forum with the prayer that the insurance company should be directed to pay her claim fully along with interest on the claim amount at 24% per annum and also compensation for causing her mental agony. Additionally, she claimed that the litigation expenses should be fully granted to her. The insurance company,

in defence, stated before the authority that the claim was unsustainable and had been refused by it on the strength of the report of the treating hospital. The insurer also pointed out that while filling the proposal form, the insured had specifically started against columns 10 and 11 that he had always been in sound health and had not undergone any medical treatment or operation in the 12 months prior to the date of proposal. The medical report issued by the Madras hospital confirmed that the insured was a confirmed diabetic and was suffering from chronie renal failure or diabetic nephropathy. The insurer also relied on certificates obtained from two independant doctors to state that the claim was not payable as material facts relating to the health of the insured had been concealed at the time of taking the policy. They indicated that even though they had not treated the insured personally, they were of the view that the facts established that the claim could not be paid.

After hearing the parties, the District Forum rejected the opinion/view of the independant doctors since they had neither seen nor treated the deceased. The Forum also held that the report of the Chennai hospital was not supported by any circumstantial evidence and was thus not to be relied upon. On this basis, the Forum held in favour of the claimant and against the insurance company and that the claim be paid. The District Forum also concluded that the insurance company was guilty of deficiency of service and that the repudiation of the claim was not based on any full material information. The forum also felt that there was an inordinate delay on the part of the insurance company in dealing with the claim under the policy. The forum directed the insurance company to pay the claim along with interest at 12% per annum from 1st April, 1991, that is, 3 months after the death of the insured, till date of payment. The forum also directed the insurance company to pay Mrs. Singh ₹ 1,000 as costs of litigation.

Not satisfied with the District Forum's decision, the insurance company filed an appeal before the State commission reiterating the same facts as had been pressed before the District forum. The State commission, on hearing the parties, allowed the appeal of the insurance company and part of its order dated 31st December, 1998 read as under : "Death of the insured occurred within seven months of taking the mediclaim policy and section 45 of the Insurance Act is not even remotely attracted. We are of the considered view that repudiation of the claim was on a consideration of the aforesaid record of the Madras Institute of Nephrology and therefore answer to col. 10 of the proposal form amounted to misrepresentation of and suppression of material facts regarding health made by the policyholder. No case of deficiency in service has been established."

Mrs. Singh filed a revision petition before the National Commission. The National Commission dismissed the revision petition stating that as it was a case of concurrent finding of facts recorded both by the District Forum and the State Commission, "there was no reason to interfere and hence dismissed." However, the learned counsel for the respondent submitted that the repudiation of the claim was fully justified because at the time of submission of the proposal form, the proposer had made a false declaration that he was possessing a sound health and had not undergone any treatment in the last 12 years and taking the facts disclosed as correct, the policy was issued. It was urged that the mediclaim policy was issued solely on the basis of facts disclosed and

the representation made by an insured in the proposal form filled in and submitted by him without subjecting the insured to any medical tests. It was also pointed out that the proposal form contained a declaration to the effect that if after the insurance is effected, it was found that any statements, answers or particulars stated in the proposal form and its questionnaire were found to be incorrect or untrue in any respect, the insurance company shall incur no liability under the policy.

It was thus asserted that the insured having suppressed the fact of his suffering from chronic renal failure/diabetic nephropathy, which fact was within his knowledge, the insurance company was justified in repudiating the claim. There was a clear suppression of material facts in regard to the health of the insured and, therefore, the insurance company was fully justified in repudiating the insurance claim/contract. The National Commission did not find any merit in the revisim petition and dismissed it. No order was made by the Commission as to the costs of litigation.

Based on the facts given above, deal with the following issues :

(*a*) Was the insurance company justified in repudiating the claim ? Was there any breach of faith in the case ?

(*10 marks*)

(*b*) Define the principle of utmost good faith and state the pertinent interpretation of IRDAI with regard to material facts.

(*10 marks*)

(*c*) What is the implication of Section 45 of the Insurance Act ? Is a reference to that section relevant to the above case ?

(*10 marks*)

(*d*) Explain the coverage available under a medi-claim policy and state the exclusions under such a policy.

(*10 marks*)

(*e*) Explain the importance of conditions and warranties as applicable to medi-claim insurance with reference to the above case. Was there any breach of such provisions ?

(*10 marks*)

2. Mr. Rajiv Shukla residing in Delhi purchased on 9th May, 2016 a Honda Car for ₹ 8,00,000. The vehicle was registered as DL 2CJ 8745. He, thereafter, applied for a comprehensive insurance policy with Pioneer General Insurance Co. Ltd. and after ascertaining the annual premium, issued a cheque in favour of the insurance company for ₹ 19,000 as premium for a comprehensive coverage of the vehicle for a period of twelve months commencing from 11th May, 2016. The insurance company accordingly issued Mr. Shukla with a comprehensive motor policy for the period from 11th May, 2016 to 10th May, 2017.

On presentation of the cheque issued by Mr. Shukla by the insurance company, it was dishonoured on 14th May, 2016 on the ground "insufficiency of funds" and an intimation was sent to Mr. Shukla by the insurance company on 16th May, 2016.

Meanwhile, while returning from his office on 15th May, 2016, the vehicle that was driven by Mr. Sukla met with an accident and suffered damages. A third-party walking on the road also sustained injuries and had to be hospitalised. The accident was reported by Mr. Shukla to the police and a FIR was also lodged.

On the basis of the above facts, answer the following questions :

(*i*) Does Mr. Rajiv Shukla have a valid claim in respect of damage to his car DL 2CJ 8745 as a result of the above accident ?

(*10 marks*)

(*ii*) Discuss the concept of liability of third party claims.

(*10 marks*)

(*iii*) Does the person walking on the road who sustained injuries and had to be hospitalised, have a right as third party to claim for injury under the policy ?

(*10 marks*)

3. A is an individual and owns extensive properties. He has insured them against comprehensive risks with a general insurer. One property X was insured for a sum of ₹ 8,00,000 against fire and incidental risks. The property was lost to a fire accident and A made a claim against the insurance company. After getting a report from a surveyor, the insurer rejected the claim stating that there had been some breaches in warranties.

A comes to you for advice as to how to proceed further. What course of action will you suggest to A to enable him to prove the claim against the insurer ?

(*5 marks*)

4. You are running a business subject to market risks. You want to procure from an insurance company a comprehensive cover. You are informed that agents and brokers are insurance intermediaries who will help you to negotiate a proper cover with an insurer.

As a business person seeking a cover, who will you approach for discussions and guidance in this regard — an agent or a broker ? Give reasons for your answer.

(*5 marks*)

5. What are the disclosure requirements that have been prescribed by IRDAI for insurance companies under the corporate governance guidelines ?

(*5 marks*)

6. Differentiate between risk, peril and hazard.

(*5 marks*)

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