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Course Teacher: Dr. Ashok R Patil

Insurance Law Reading Material
Course Teacher Dr. Ashok R. Patil

Contents

THE "BASIS OF THE CONTRACT CLAUSE" IN INSURANCE LAW[1]

No meaningful reform of insurance law can be achieved without a complete overhaul of the law which has developed around the "basis of the contract" clause in insurance litigation. It is the purpose of the present paper to trace briefly the history and the present state of doctrine in this area and to propose remedial legislation.

The problem may be simply stated. For many kinds of insurance the insured has to fill in a proposal form which is in effect an application form.[2] This proposal form contains a list of questions, and at the end of the form the insured has to sign a declaration, of which the following is typical:

> "I declare that the particulars and statements made by me above are true, and I agree that they shall be the basis of the contract between me and the —— Company."[3]

The effect of this language is to incorporate the insured's answers into the insurance policy although they are not set out in the policy. An incorrect answer to any one of these questions is fatal to the insured's claim. This is so, whether he answered the question in good faith to the best of his knowledge, or, indeed, whether his response related to a material fact or not.

The story of how the law managed to reach this remarkable state of affairs is an extremely interesting one. It is at least necessary to outline this story before proposing any remedy.

The Eighteenth-Century Background

As a necessary preliminary a word must be said about the meaning of the word "warranty" in insurance law.[4] Whatever transformations may have occurred with regard to the use of the word in other

[1] I am much indebted to Professor William F. Young, Jr., of Columbia Law School for reading and criticising an earlier draft of this paper. He is, of course, not responsible for any of the conclusions I have reached in this paper.

[2] "In life and motor-vehicle insurance this practice may be regarded as invariable; in fire insurance we understand that it is unusual; in other classes the practice probably varies." Law Reform Committee Fifth Report (*Conditions and Exceptions in Insurance Policies*) Cmnd. 62 (1957), p. 4, para. 6.

[3] "[T]he general scheme has exhibited many variations, some major and some minor in detail." *Per* Lord Wright in *Provincial Insurance Co.* v. *Morgan* [1933] A.C. 240, 251. I have borrowed my form from Borrie and Diamond, *The Consumer, Society and the Law* (2nd ed., 1968), p. 231.

[4] See, more fully, for an excellent treatment of the subject, Patterson, "Warranties in Insurance Law" (1934) 34 Colum.L.Rev. 595. Note also the important article by Vance, "The History of the Development of the Warranty in Insurance Law" (1911) 20 Yale L.J. 523.

areas of the law of contract,[5] the term " warranty " in insurance law was used, and has continued to be used, in the sense of being a term in the contract which has the force of a condition.

There has been a good deal of justifiable criticism of the doctrine developed in the eighteenth century that any breach of insurance warranty, however immaterial, was fatal to recovery. Often, however, such criticism has overshot its mark and has been directed at doctrines which Lord Mansfield and his brethren never espoused. Thus, for example, Professor Vance, writing in 1922, attacked:

> " The unfortunate and fanciful rule laid down by Lord Mansfield that the truth of any statement, made in an insurance policy is a condition of the contract, and that any inaccuracy in such statement, although immaterial to the risk or actually decreasing it to the benefit of the underwriter, nevertheless wholly avoids the contract." [6]

In the first place, there is no case where a policy was avoided, even though the misstatement had the effect of decreasing the risk to the benefit of the underwriter.[7]

Secondly, if we examine the case law of the period there does not appear to be an instance where the dispute between the insurer and insured related to a clearly immaterial fact. Thus in *Bean* v. *Stupart* [8] and *De Hahn* v. *Hartley* [9] the dispute related to the number of men on board ship, a fact clearly relevant to the possibility of capture, one of the risks insured against; the same is true of *Hibbert* v. *Pigou*,[10] where the issue involved a ship sailing without convoy. Similarly, in *McDowell* v. *Fraser*,[11] in an action on a

[5] See most notably in the sale of goods; see *e.g.* Stoljar, " Conditions, Warranties and Description of Quality in the Sale " (1952) 15 M.L.R. 425 and (1953) 16 M.L.R. 174. Outside the field of the sale of goods, the distinction between condition and warranty seems to be in the process of becoming totally eroded; see *e.g. Hong Kong Fir* v. *Kawsaki Kisen Kaisha* [1962] 2 Q.B. 26.

[6] See his note, " Resuscitation of the Warranty in Fire Insurance " (1922) 32 Yale L.J. 274.

[7] Contrast *e.g.* the decision of the United States Supreme Court in *Jeffries* v. *Economical Life Ins. Co.*, 89 U.S. 47 (1875), where an applicant for life insurance stated in his application that he was single, when in fact he was married. By a provision in the policy all statements in the application were warranted to be true. After his death his administrator sued to recover the face amount of the policy. The Supreme Court denied recovery even though married men are generally better risks than single men because the parties had agreed that the insurer is not to be deceived " to its injury or to its benefit."

[8] (1778) 1 Doug. 11. This case, incidentally, shows that there were limits to Lord Mansfield's adherence to formalism. The insured had warranted that there would be thirty seamen on board ship, whereas in fact only twenty-six persons had signed the ship's articles. Lord Mansfield decided the case in favour of the insured, holding that the insured could add to his twenty-six men the steward, cook, surgeon as well as some boys and apprentices so as to bring the number in excess of thirty. His Lordship took note of the fact that " there is scarcely no such a thing as a ship entirely manned with seamen strictly so called." *Ibid.* at p. 14.

[9] (1786) 1 T.R. 343.

[10] See Park, *Insurance* (3rd ed., 1796), p. 339.

[11] (1779) 1 Doug. 260.

policy taken out on a ship sailing from New York to Philadelphia, it does not require much argument to demonstrate that a statement made by the broker to the underwriter that the ship had been seen safe on the Delaware river on December 11 whereas in fact the ship had been lost on December 9 was a material fact.

Finally, given the hazards of seasonal storms and the war risks which characterised the period, it does not seem unreasonable to treat such facts as the date of sailing,[12] or the nationality of the ship insured [13] as material facts. All these cases are a far cry from Professor Vance's assertion which might lead one to believe that a statement in the policy, "Captain has red whiskers" or "ship painted red [not camouflage]," would be a warranty to be strictly complied with.[14]

Further, there is at least one case indicating that the rule that a warranty must be strictly complied with was more liberally interpreted outside the field of marine insurance law. That case is *Ross* v. *Bradshaw*.[15] The facts in this case were that Sir James Ross had taken out a policy on his life for one year commencing October 22, 1759, and had warranted he was in good health. In fact, the assured had received a wound at the battle of La Feldt in 1747 "which had occasioned a partial relaxation or palsy, so that he could not retain his urine or faeces." [16] Evidence was given by several witnesses that the consequences of Sir James's wound were only "inconvenient" and "not dangerous to his life at the time of the insurance." [17] In the course of his charge to the jury Lord Mansfield observed:

> ". . . such a warranty [of good health] could never mean that a man has not in him the seeds of some disorder. We are all born with the seeds of mortality in us. A man, subject to the gout, is a life capable of being insured, if he has no sickness at the time to make it an unequal contract." [18]

The jury returned a verdict for the plaintiff.

Next, by way of sharp contrast with modern practice,[19] Lord Mansfield sharply limited the manner in which warranties could be created. Thus, in *Pawson* v. *Barnevelt*,[20] counsel for the underwriter offered to produce witnesses to prove that a written memorandum was always part of the policy. "But his Lordship said it was a mere question of law and would not hear the evidence but decided that a written paper did not become a strict warranty by

[12] See *Kenyon* v. *Berthon*, reported in Park, *Insurance* (3rd ed., 1796), p. 32.
[13] See *Woolmer* v. *Muilman* (1761) 1 Wm.Bl. 427.
[14] See Patterson, (note 4, *supra*) at p. 610, n. 78. Professor Patterson made this remark with reference to "judicial utterances" after *De Hahn* v. *Hartley* (note 9, *supra*).
[15] (1761) 1 Wm.Bl. 313.
[16] *Ibid.*
[17] *Ibid.*
[18] *Ibid.*
[19] Compare the observations of Lord Wright on this point in *Provincial Insurance Co.* v. *Morgan* [1933] A.C. 240, 252.
[20] (1779) 1 Doug. 12, note 4.

being folded in the policy." [21] Similarly, in *Bize* v. *Fletcher* [22] he refused to consider a slip of paper that was " wafered " to the policy as a part of the contract.

All these developments must be seen in the light of the most important social fact dominating insurance law during this period, namely that contracts were negotiated among persons of relatively equal bargaining power. As Professor Robert E. Keeton has recently pointed out " . . . it was common for the proposal for insurance to be written by the person desiring insurance, the insurers merely underwriting for designated amounts." [23] Unfortunately, in all too many cases since then judges have failed to give sufficient weight in their decisions to the tremendous inequality in bargaining power which is the predominant feature of the modern insurance contract.

The Genesis of the Clause

The nineteenth-century decisions are troublesome not so much for the results reached in them but rather for some overbroad statements of principle and unnecessary dicta which produced unfortunate results in later cases.

Thus, in *Newcastle Fire Insurance Co.* v. *Macmorran*, Lord Eldon went out of his way to state, although these remarks were clearly unnecessary to the decision before him:

> " If the Court of Session was of opinion that the danger and risk was not greater in mills of the second class than in those of the first class though that were sworn to by five hundred witnesses, it would signify nothing. The only question is, what is the building *de facto* that I have insured." [24]

The basis of the contract clause made its first appearance in a reported case in *Duckett* v. *Williams*.[25] In that case, the trustees of the Provident Life Assurance Company had represented to the Hope Insurance Company that the " herein named John Stephenson is now in good health, and has not laboured under gout, dropsy, fits, palsy, insanity, affection of the lungs or other viscera or any other disease which tends to shorten life." [26] In the event of the trustees making any " untrue averment," the Hope Insurance Company would be entitled both to avoid the policy and to retain the premiums that the Provident Insurance Company had paid. The jury found that the insured was in fact uninsurable. On these facts, Lord Lyndhurst C.B. rejected Provident's argument that their duty to answer " truly " meant only that they made this statement to the best of their knowledge. In his Lordship's view, " two con-

[21] *Ibid.*
[22] (1779) 1 Doug. 284.
[23] See his article, " Insurance Law Rights at Variance with Policy Policy Provisions " (1970) 83 Harv.L.Rev. 961, 966.
[24] (1815) 3 Dow. 255, 265.
[25] (1834) 2 C. & M. 348.
[26] *Ibid.* at p. 349.

sequences are to follow if the statement be untrue: one, that the premiums are to be forfeited; the other that the assurance is to be void." [27] This result is both defensible and rational given the fact that *Duckett* v. *Williams* dealt with a reinsurance situation rather than with an original application for insurance. But the court did not make this distinction and unfortunately Lord Blackburn in *Thompson* v. *Weems* [28] also failed to make the distinction, treating *Duckett* v. *Williams* as an authority in a case of ordinary insurance.

Anderson v. *Fitzgerald* [29] is another case which should, it is submitted, have been decided on narrower grounds. In this case, the insured signed a proposal form with a "basis of the contract" which included the following questions: "Did any of the party's near relations die of consumption or any other pulmonary complaint?" and "Has the party's life been accepted or refused at any office?" Despite the fact that these questions were answered incorrectly, the jury returned a verdict for the insured on the ground that the answers to these questions were not material.[30] The House of Lords reversed the judgments of the Courts of Exchequer and Exchequer Chamber which had left the issue of materiality to the jury. Parke B.,[31] Lord Cranworth [32] and Lord Brougham [33] made light work of the case; put briefly, in their view the basis of the contract clause removed any question of materiality from consideration by the jury. Lord St. Leonards pointed out the dangers of such an extreme position; if adhered to strictly, it would mean that "the policy was not worth the paper upon which it was written" [34] and in future "no prudent man [would] effect a policy of insurance with any company without having an attorney at his elbow to tell him what the true construction of the document is." [35] In his lordship's view what had happened in the present case was that: "The jurymen were perverse, and went wrong in bringing in a verdict contrary to the evidence as to the materiality of the questions." [36] This language suggests that the more appropriate resolution of the case would have been for their lordships to have held that the lower courts should have withdrawn from the jury the issue of the materiality of the insured's replies to these two questions, since these questions clearly related to material facts. On the other hand, one can imagine situations where it would be appropriate to have left to the jury the determination of whether a particular fact was material or not.

[27] *Ibid.* at p. 351.
[28] (1884) 9 App.Cas. 671, 682. For a discussion of this case see the text at notes 37–44, *infra*.
[29] (1853) 4 H.L.C. 483.
[30] The disappearance of the jury in insurance cases has, of course, had a marked effect on the outcome of litigation in this area. To a considerable degree, the difference between English and American law is to be explained by reference to the presence or absence, as the case may be, of the jury.
[31] (1853) 4 H.L.C. 483, 495–499. (Advice to the House of Lords.)
[32] *Ibid.* at pp. 500–505.
[33] *Ibid.* at pp. 505–507.
[34] *Ibid.* at p. 507.
[35] *Ibid.* at p. 514.
[36] *Ibid.*

Thompson v. *Weems* [37] is the last and most important of the nineteenth-century decisions on the basis of the contract clause. While it is impossible to quarrel with the result, the way the result was reached seems to be open to attack. In an application for life insurance, the applicant answered the following questions as follows: " Question 7 (a) Are you temperate in your habits? (b) and have you always been strictly so? (a) ' Temperate ' (b) ' Yes.' " The Lord Ordinary, in a decision affirmed by a majority of the Second Division of the Court of Session,[38] found that the applicant had not made any untrue statements in his declaration. In arguing for the reversal of this decision before the House of Lords, the Solicitor-General for Scotland based his argument for overruling the decision in favour of Weems on narrow (and legitimate) grounds: " The evidence showed that Mr. Weems was not in the ordinary sense of the word ' temperate '; and more than that, he had had warnings and expostulation on the subject, which made it impossible for him to consider himself a person of temperate habits." [39]

All would have been well if their lordships had based their decision in favour of the insurers on the ground that the applicant had acted in bad faith. Instead, Lord Blackburn went out of his way to state that " insurers have a right if they please to take a warranty against [the applicant's] . . . disease, whether latent or not, and it has very long been the course of business to insert a warranty to that effect." [40] This practice might, no doubt, result in a " hard bargain " for the assured if he had innocently warranted what was not accurate, but if he had warranted it, " untruth " without any moral guilt, avoided the insurance.[41]

What is also disturbing about *Thompson* v. *Weems* (as well as *Anderson* v. *Fitzgerald* [42] before it), is that in neither case did a single judge appreciate the proper meaning of questions relating to the applicant's health. It would seem obvious that questions such as " Are any of your immediate family at present in a delicate state of health? " [43] or " (1) What is the present and general state of your health? " and " (2) Do you consider yourself of a sound constitution? " [44] are questions requiring only the assured's opinion on these matters. After all, this is how such questions would be regarded by experts, *i.e.*, medical men to whom these questions were addressed. How much more so must this be the case when the addressee of these questions is a layman should have been evident to their lordships.[45] Once the " opinion-requiring " character of

[37] (1884) 9 App.Cas. 671.
[38] 11 Court Sess.Cas. 4th Series 658 (Lord Rutherford Clark dissented).
[39] (1884) 9 App.Cas. 671, 673.
[40] *Ibid.* at p. 682.
[41] *Ibid.*
[42] (1853) 4 H.L.C. 483.
[43] This was question 2 (b) in the proposal form in *Thompson* v. *Weems* (1884) 9 App.Cas. 671, 678.
[44] This was question 4 of the same proposal; *ibid.*
[45] The point sought to be made in the text was more forcefully put by Fletcher Moulton L.J. *Joel* v. *Law Union and Crown Insurance Co.* [1908] 2 K.B. 863 (C.A.). His lordship stated, *inter alia*: " For instance one of the com-

great care must be taken by the insured in supplying information, since a misstatement with respect to a material fact is liable to render the policy void. As it is, the basis of the contract clause performs little or no " educative " function and, instead, as Lord Greene M.R. pointed out in *Zurich Insurance Co.* v. *Morrison*, it creates " traps " [65] for the insured.

There seems to be little doubt that the " trap " of the basis of the contract clause is and has been used for the most part by disreputable insurers, many of which are financially unstable.[66] But even if it could be shown that this defence is used only by " disreputable " insurers, this would not seriously weaken the argument for legislation. As Professor Kahn-Freund has pointed out recently, in another connection: ' The law, however, is concerned with the marginal cases." [67]

The most powerful argument for maintaining the status quo is that the basis of the contract device is a necessary evil since it relieves the court from the most difficult task of determining whether a particular fact is material or not. It is easy to show that a court may be presented with some very difficult problems. Consider some examples from the law of non-disclosure:

(1) Is it material that an applicant for life insurance failed to disclose the fact of previous rejections by other companies, when he had been accepted by the company to which he had submitted his most recent application? [68]

(2) Is it material than an applicant for motor insurance was previously denied cover for fire insurance? [69]

(3) Is it material, in cases of burglary insurance that the insured had criminal convictions, fifteen [70] or twenty [71] years earlier?

It is true that questions like these are far from easy to resolve but it cannot be said that they are impossible to resolve. Certainly insurers cannot claim that the courts have imposed overly stringent tests in requiring proof of materiality; indeed, an argument can be made that it is, at present, too easy for insurers to establish materiality.[72] Further, proof of materiality has not proved to be

[65] [1942] 1 All E.R. 529, 537. In the same opinion, his Lordship described the basis of the contract clause as a " vicious " device.

[66] It is believed, for example, that the Litigation Committee at Lloyds has been strongly opposed to the raising of this defence to defeat meritorious claims.

[67] See " Trade Unions, the Law and Society " (1970) 33 M.L.R. 241, 242.

[68] *London Assurance* v. *Mansel* (1879) 11 Ch.D. 363 (Held, yes).

[69] *Locker & Woolf Ltd.* v. *W. Australian Insurance Co.* [1936] 1 K.B. 408 (C.A.) (Held, yes).

[70] *Schoolman* v. *Hall* [1951] 1 Lloyd's Rep. 139 (C.A.) (Held, yes).

[71] *Regina Fur Co.* v. *Bossom* [1957] 2 Lloyd's Rep. 466 affirmed by the Court of Appeal [1958] 2 Lloyd's Rep. 425. (Held, yes).

[72] See Hasson, " The Doctrine of Uberrima Fides in Insurance Law—A Critical Evaluation " (1969) 32 M.L.R. 615 esp. at pp. 631–632.

an insuperable obstacle in the United States where this task is made infinitely more difficult by the presence of the jury.

The Shape of Reforming Provisions

Even if the House of Lords were shortly to reverse *Dawsons* v. *Bonnin*,[73] legislation would still be essential. The following provisions are tentatively suggested.

1. No statement of the applicant should avoid the policy or be used in defence to a claim under it, unless it is contained in a written application and a copy of such application must be attached to the policy when it is delivered. Even though many policyholders do not read or understand their policies, this simple procedural provision is necessary to try to avoid the situation described by Lord Wright in *Provincial Insurance Co.* v. *Morgan*:

> " It has often been pointed out by judges that it must be very puzzling to the assured, who may find it difficult to fit the disjointed parts together in such a way as to get a true and complete conspectus of what their rights and duties are and what acts on their part may involve a forfeiture of the insurance. An assured may easily find himself deprived of the benefits of the policy because he has done something quite innocently but in breach of a condition, ascertainable only by the dovetailing of scattered portions." [74]

2. No oral or written misrepresentation or warranty made in the negotiation for a contract or policy of insurance by the insured or on his behalf, shall defeat or avoid the policy or prevent its attaching unless it materially affects either the acceptance of the risk or the hazard assumed by the company. The key word here is " materially." There are three possible definitions of materiality. The first is: what might this insurer have done? The second is the New York statutory solution [75]—with knowledge of the true facts, would this insurer have made this contract? The third is: if he had knowledge of the true facts, would a reasonably prudent insurer have made this contract? Choice number one need not be considered; it should be left coughing and wheezing in its stable. It is submitted that the " reasonably prudent " insurer test, although it does not force " upon the imprudent insurer the consequences of its own lax practices," [76] should be an adequate standard.[77]

3. If it can be shown that the party insuring neither knew nor should have known when concluding the contract that a statement

[73] See note 50, *supra*.
[74] [1933] A.C. 240, 252.
[75] Section 149 (2), N.Y. Ins. Law.
[76] See note, " New York Insurance Code of 1939 " (1940) 40 Colum.L.Rev. 880, 888.
[77] This standard has been adopted by the Marine Insurance Act 1906, s. 20 (2) and by the Privy Council in *Mutual Life Ins. Co.* v. *Ontario Metal Products Co. Ltd.* [1925] A.C. 344.

made by him was incorrect, then such misrepresentation shall not affect the insurer's liability.[78]

This provision will be helpful in dealing with two classes of case. The first kind of case may be illustrated by an an example: A, an applicant for life insurance, is asked if he has any brothers living. He answers " Yes," thinking that his brother overseas is alive, whereas in fact his brother is dead. Assuming the answer is material, A should be entitled to recover.[79]

The second class of case that this provision is intended to deal with are the " opinion " questions. Thus, B, an applicant for life insurance answers " Yes " to the question " Are you in good health? " whereas he is suffering from terminal cancer, a fact of which he is unaware. B should be entitled to recover.[80]

The above provisions represent, of course, only a first step towards the statutory control of insurance contracts. There is urgent need to give very serious consideration to the setting up of appropriate administrative machinery to police unreasonable terms in insurance contracts.[81] At the same time, equally serious attention needs to be given to the feasibility of enacting statutory standard policies in various fields of insurance.[82] Further consideration of these possibilities is, however, beyond the scope of this paper.

R. A. HASSON.*

[78] I have taken this provision from s. 5 of the Swedish Insurance Contracts Act of May 14, 1954. I am indebted to Professor Jan Hellner of the Faculty of Law, University of Stockholm for providing me with a copy of the Act.

[79] These were the facts in *Globe Mutual Life Ins. Association* v. *Wagner*, 188 Ill. 133, 58 N.E. 970 (1900). (The Supreme Court of Illinois granted the insured recovery because his statement amounted to a " representation " rather than a " warranty ".)

[80] This result will be easier to achieve as more insurers get to use a form of proposal where the applicant is asked to give replies to the best of his knowledge and belief, see Housman, *The Law of Life Assurance* (4th ed., 1954), p. 22, cited in Hardy Ivamy, " Insurance Law Revision " (1955) 8 C.L.P. 147, 157, n. 45.

[81] This seems to be Professor Grunfeld's suggestion; see his article, " Reform in the Law of Contract " (1961) 24 M.L.R. 62, 80. For an excellent study of administrative control in this area, see Kimball and Pfennigstorf, " Administrative Control of the Terms of Insurance Contracts: A comparative study " (1965) 40 Indiana L.J. 143.

[82] See Sales, " Standard Form Contracts " (1953) 16 M.L.R. 318, 337 *et seq.*

* B.A. (Cape Town); LL.B. (Lond.); LL.M. (Yale).

THE DOCTRINE OF *UBERRIMA FIDES* IN INSURANCE LAW—A CRITICAL EVALUATION

To give a legal rule a certain rubric is of course a very important way of determining the fate in the future of that particular rule. Few of us are against an " equitable " rule, for example, just as there are bound to be few supporters of a rule which is against " public policy." If we go further and translate our rule into a foreign language, its " goodness " (or " badness " as the case may be) is heavily underlined. Thus a rule requiring " *uberrima fides* " from a contracting party is more impressive sounding than one merely requiring the exercise of " the utmost good faith." Conversely, to say that something is " *contra bonos mores* " seems to be more damning than to say that the same thing is against " public policy."

Whether it is the above factor or some other, it is surely remarkable that the insured's duty to disclose material facts to the insurer on his own initiative—the so-called *uberrima fides* principle—has been subjected to virtually no critical assessment by either English courts or commentators. In this paper, an attempt will be made to suggest that the current English principle is thoroughly unsatisfactory in that it does not reflect the " reasonable expectations " of insurer and insured and in that it is a rule that works against " fairness " in the insurance contract.[1]

An attempt will also be made to show that the classical doctrine on this subject as stated in the leading case of *Carter* v. *Boehm* [2] has been misunderstood and misapplied by English courts. By way of sharp contrast American courts in the nineteenth century correctly understood and interpreted the case.[3]

[1] An attempt will be made to give content to these rather amorphous notions of " good faith " during the course of this paper. For an excellent discussion of these and related notions in the law of insurance, see Kessler, *Forces Sharing the Life Insurance Contract* in University of Chicago Law School Conference on Insurance (Conference Series No. 14, 1954) 3.

I am greatly indebted to Professor Friedrich Kessler for his considerable assistance in helping me to think about, and to give weight to, these considerations. He does not, of course, bear any responsibility for such conclusions as I have reached in the present paper.

[2] (1766) 3 Burr. 1905.

[3] An analogy can be made here with regard to the problem of " insurable interest " in marine insurance law; here also, the " liberal tradition " of Lord Mansfield has prevailed in the United States after being rejected in England. See Lord Chorley, " Liberal Trends in Present-Day Commercial Law " (1940) 3 M.L.R. 272 at 278–279.

Carter v. Boehm and After

In *Rozanes* v. *Bowen* [4] Scrutton L.J. said that, " It has been for centuries in England the law in connection with insurance of all sorts . . . [that] it is the duty of the assured . . . to make a full disclosure to the underwriters without being asked of all the material circumstances . . ." [5]

Since the above passage reflects a very widely held assumption among both English judges and commentators, it would be well to examine its accuracy. It is submitted that the statement quoted above reflects only very recent judicial doctrine and not a rule of great antiquity. Indeed, the alleged principle, so far from being a correct statement of the law in all types of insurance, does not even accurately describe the law with regard to marine insurance in the eighteenth century.

All this leads us to *Carter* v. *Boehm* [6]; in that celebrated decision, it will be recalled, the insurer set up, as a defence against the insured, the argument that the insured had not disclosed (in a marine policy) a highly material fact, namely, the weakness of Fort Marlborough on the island of Sumatra and the probability that the Fort would be attacked by the French. In the course of his judgment Lord Mansfield C.J. laid down as follows:

> " The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only; the under-writer trusts to his representation, and proceeds upon confidence, that he does not keep back any circumstance within his knowledge, to mislead the under-writer into a belief that the circumstance does not exist, and to induce him to estimate the risque, as if it did not exist." [7]

This passage has been repeatedly cited to the point where the rest of the Chief Justice's opinion has been ignored. The effect of this lop-sided reading of the judgment has been to make it appear that it is the insured's duty to supply information while the insurer's role in this process is an entirely passive one.

A reasonably careful reading of the opinion, however, makes it clear that Lord Mansfield placed the responsibility for obtaining the relevant material information on the insurer. After all, it was the insured, and not, as someone familiar only with the quoted passage might have assumed, the insurer, who was the successful party in the litigation.

The most important concealment alleged by the insurer was with regard to the " condition of the place." On this point, Lord Mansfield said:

> " The underwriter knew the insurance was for the governor. He knew the governor must be acquainted with the state of the place. He knew the governor could not disclose it, consistently with his duty. He knew the governor, by insuring, appre-

[4] (1928) 32 Ll.L.R. 98.
[5] *Ibid.*
[6] (1766) 3 Burr. 1905.
[7] *Ibid.* at p. 1909.

> hended, at least, the possibility of an attack. With this knowledge, without asking a question, he underwrote. By so doing, he took the knowledge of the state of the place upon himself. It was a matter, as to which he might be informed in various ways: it was not a matter, within the private knowledge of the governor only." [8]

This passage would seem to indicate beyond any doubt that Lord Mansfield conceived of the insured's duty as being a very narrow one.[9] It is difficult to believe that an English insurer in 1766 would have found it particularly easy to obtain extra-official information on the security of Fort Marlborough from foreign capture but this is precisely what Mansfield required of an underwriter, once such an underwriter had been put " on guard " by the application from the governor for insurance. In short, the insured's duty to disclose arises only with regard to facts that the insured " privately knows, and the [insurer] is ignorant of, and has no reason to suspect." [10]

Perhaps the next most significant case in which Lord Mansfield expressed his views on the subject of the insured's duty to disclose is *Mayne* v. *Walter* (1787).[11] In this case, the insured (plaintiff) sought to recover against the insurer in respect of the loss of super-cargo, which was lost when the ship carrying it was captured by a French privateer. The insurer resisted payment arguing that the insured should have disclosed that there was in force at the relevant time a French ordinance providing that no Dutch ship could carry the super-cargo of a country at war with France on pain of such cargo being seized as prize. Mansfield decided in favour of the plaintiff; the core of his brief judgment is worth quoting in some detail:

> " If both parties were ignorant of it [the ordinance], the underwriter must run all risks: and if the defendant knew of such an edict it was his duty to enquire, if such a supercargo were on board." [12]

Then, in the next sentence follows the statement of principle which underlies this case as well as *Carter* v. *Boehm*.[13] " It must be a *fraudulent* concealment of circumstances, that will vitiate a policy." [14]

[8] *Ibid.* at p. 1915.

[9] It is submitted that the fact that Lord Mansfield regarded the principle of disclosure he was stating in the present case as " applicable to all contracts and dealings," (*ibid.* at p. 1910) tends to support the argument that he thought of the duty of disclosure in narrow terms. Certainly one would not expect so practical a judge to decree something as obviously impractical as a broad duty of disclosure applicable throughout the whole range of contractual dealings.

[10] *Ibid.* at p. 1911.

[11] See the report in Park, *The Law of Marine Insurances* (1787) at p. 220.

[12] *Ibid.*

[13] See note 2, *supra.*

[14] See Park (note 11, *supra*) at p. 221. The decisions in *Carter* v. *Boehm* and *Mayne* v. *Walter* are cited only as examples of Mansfield's approach; the views he states in them are echoed in a number of other significant decisions. See, *e.g.*, *Nobel* v. *Kennoway* (1780) 2 Doug. 510; held underwriter under an obligation to inform himself with respect to the practice of the trade he insures,

The position which Lord Mansfield took up in these and other cases was followed in *Friere* v. *Woodhouse* (1817).[15] In that case, the insurers argued, unsuccessfully, that the insured (plaintiff) should have disclosed the fact of the arrival of the *Victorioso*, a ship which had sailed in company with the insured's ship. Burrough J. held that the times of arrival of vessels must be presumed to be within the knowledge of the underwriters, since they could easily learn of it by consulting Lloyd's printed lists, where such information could be easily obtained. Without speaking of the need to show " fraud," the opinion, in effect, seems to require precisely this before avoiding the policy because of concealment.[16] In the judge's words:

> " What is exclusively known to the assured ought to be communicated; but what the underwriter, by fair inquiry and due diligence, may learn from ordinary sources of information need not be disclosed." [17]

Again, it seems abundantly clear that (even) in cases of marine insurance the insured's duty of disclosure at the end of the eighteenth century was a narrow one. The duty did not arise in respect of facts which the insurer might discover by " fair inquiry " pursued with " due diligence." (We have seen, through the decision in *Carter* v. *Boehm*,[18] that these requirements might be very onerous ones for the insurer, in a particular situation.) Unfortunately, developments in the nineteenth century began to undercut the simple and entirely rational body of principle, whose outline we have traced. It is relevant now to examine some of these developments.

Developments in the Nineteenth Century

In 1828 there was decided the case of *Lindenau* v. *Desborough*,[19] whose facts are so peculiar that it is difficult to appreciate its having any general importance for the subject under discussion. However, largely because of some unnecessary dicta by two judges, the case has acquired a greater importance. The Duke of Saxe Gotha had placed his insurance with the insurer's agents in Germany and the present action was brought to recover money payable on the policy after the Duke's death. The insurer set up as a defence the fact that the Duke's doctors in Germany had mentioned that the Duke was hindered in his speech but they had not made any mention of the Duke's " mental faculties "—a highly relevant omission since

regardless of whether such practice is established or not; and also *Court* v. *Martineau* (1782) 2 Doug. 161, where Lord Mansfield held that an insurer's decision to waive certain information could be inferred from the payment by the insured of a very large premium.

[15] 1 Holt N.P. 572.

[16] See, *e.g.*, *Mackintosh* v. *Marshall* (1843) 11 M. & W. 116; *Foley* v. *Tabor* (1861) 2 F. & F. 662 for similar holdings.

[17] See note 15, *supra*, at p. 573.

[18] See note 2, *supra*.

[19] (1828) 8 B. & C. 586.

the Duke eventually died as the result of a large tumour on the brain which he had had for a number of years and which might well have been the source of his speech and mental difficulties. Lord Tenterden C.J. found for the defendant (insurer); his opinion does not appear to attempt any broad statement of principle. He seemed to attach great importance to the fact that: " In the present case, the insurance was upon the life of a foreigner." [20] On this very narrow basis, the outcome is defensible and rational. The insurer in the circumstances was bound to rely on the assessment of the Duke's doctors; to have required the Duke to come to England for an independent medical examination, one might well assume, was not a practical alternative at the time the case was decided. In their concurring judgments, however, Bayley J. and Littledale J. made general statements of principle, which are remarkable for their breadth. Bayley J. stated:

> " I think that in all cases of insurance, whether on ships, houses, or lives, the underwriter should be informed of every material circumstance within the knowledge of the assured; and that the proper question is, whether any particular circumstance was in fact material and not whether the party believed it to be so. The contrary doctrine would lead to frequent suppression of information, and it would often be extremely difficult to show that the party neglecting to give the information thought it material." [21]

In a similar vein, Littledale J., after pointing out that in cases of life insurance " certain specific questions are proposed as to points affecting in general all mankind," noted in addition: " but there may also be circumstances affecting particular individuals which are not likely to be known to the assurers." [22] The insured was, in his Lordship's view, under a duty to disclose any material facts in this area (regardless of whether the insured believed the fact to be material or not).[23]

In *Bates* v. *Hewitt* (1867),[24] a landmark marine insurance case, there was handed down not only very broad dicta such as we have seen in *Lindenau*, but also a very significant decision which demonstrates clearly the change in legal doctrine from the principles evolved in the eighteenth century.

In *Bates*, a policy had been effected in 1864 on the *Georgia*, a vessel which had been used as a Confederate cruiser in 1863 and 1864 and which was afterwards dismantled and sold to the plaintiff. The name of the *Georgia* had been well known to the British public at the time she was cruising, and after she had been laid up in Liverpool had been the subject of considerable public interest in the

[20] *Ibid.* at p. 591.
[21] *Ibid.* at p. 592.
[22] *Ibid.* at p. 593.
[23] *Ibid.*
[24] (1867) L.R. 2 Q.B. 595.

London Press and in the House of Commons. The defendant, one of Lloyd's underwriters, had been aware of all the ship's notoriety earlier; but at the time the risk was proposed, nothing jogged his memory and he remained unaware that this might be the Confederate cruiser. While the jury found the defendant ignorant with regard to the latter point, they also found that at the time of insuring the cruiser, he had abundant means from the particulars to be found in the slip of identifying the ship. Despite the fact that the insurer therefore had the means available to provide himself with the correct information, a unanimous court held that this did not, nevertheless, release the plaintiff from the duty of disclosure.

All three of the judges who delivered opinions made gallant attempts at trying to show that the principles they were formulating were of considerable antiquity. Thus Lord Cockburn C.J. stated:

> "No proposition of insurance law can be better established than this, *viz.*, that the party proposing the insurance is bound to communicate to the insurer all matters which will enable him to determine the extent of the risk against which he undertakes to guarantee the assured." [25]

It is perhaps significant that no authority is cited in the entire opinion. Mellor J., after making an heroic attempt to reconcile the present decision with what Lord Mansfield said in *Carter* v. *Boehm*,[26] stated the true basis underlying his opinion in the following brief passage:

> "I cannot help thinking that to enable a person proposing an insurance to speculate upon the maximum or minimum of information he is bound to communicate, would be introducing a most dangerous principle into the law of insurance." [27]

Finally, Shee J. after conceding that the underwriter in the present case might "if he had instituted inquiries" have discovered the material fact in question, nevertheless added: "but that he is not obliged to do." [28] It will be remembered that Lord Mansfield saw this matter from a radically different angle in *Carter* v. *Boehm*.[29]

Despite the fact that the approach exemplified by *Lindenau* v. *Desborough* [30] and by *Bates* v. *Hewitt* [31] had become the dominant one by the end of the nineteenth century, it is important to point out that it rested on rather slender authority. Thus in *London Assurance* v. *Mansel*,[32] in the course of prescribing a broad duty of disclosure for an assured who had taken out a life insurance policy, Sir George Jessel M.R. relied on three cases, two of which did not

[25] *Ibid.* at pp. 604–605.
[26] See note 2, *supra*.
[27] See note 24, *supra*, at p. 608.
[28] *Ibid.* at p. 611.
[29] See note 2, *supra*.
[30] See note 19, *supra*.
[31] See note 24, *supra*.
[32] (1879) 11 Ch.D. 363.

deal with an insurance situation of any kind. The first authority relied on was a dictum of Lord Cranworth's in *Dalglish* v. *Jarvie*,[33] a case, " which had nothing to do with insurance, but which referred to the principles on which a special injunction ought to be granted *ex parte*." [34]

The second authority relied on is a dictum of Baron Parke's in *Moens* v. *Heyworth*,[35] which was " a case of an ordinary mercantile contract, not of an insurance contract." [36] The last case relied on is *Lindenau* v. *Desborough*,[37] whose freakish character has been sufficiently indicated above.

The fact that the broad duty of disclosure had not completely triumphed by the end of the nineteenth century is borne out, not only by the reliance placed in cases such as *London Assurance* v. *Mansel* [38] on authorities of doubtful weight, but also by the fact that on a few occasions, the older and more restricted view of disclosure received judicial support. Thus as late as 1895, Lopes L.J. expressed the view in a case decided by the Court of Appeal that mere silence on the part of the insured with regard to a material fact did not avoid a policy, in the absence of fraud.[39]

Twentieth-Century Fundamentalism

The conflict between the " broad " and the " narrow " duty of disclosure may fairly be said to have been finally resolved in favour of the former theory by the decision of the Court of Appeal in *Joel* v. *Law Union and Crown Insurance* (1908).[40] Since the date of that decision the only question has been as to the breadth of the duty to disclose. In *Joel* itself the Court of Appeal drew a distinction: the assured was under no duty to disclose facts he did not know of, since, as Fletcher Moulton L.J. put it, " you cannot disclose what you do not know." [41] On the other hand, if the assured knew of a fact, his duty to disclose was not affected by the fact that he (the assured) thought the fact was not a material one.[42]

In *Australia and New Zealand Bank Ltd.* v. *Colonial and Eagle Wharves Ltd.*,[43] McNair J. remarked *obiter* that the " trend of opinion " supported the view that the assured was under a duty to disclose not only known facts but also such facts, which in the ordinary course of business he the assured might reasonably be expected to discover." [44] In line with this view, Professor Ivamy

[33] (1850) 2 Mac. & G. 231, 243.
[34] See note 32, *supra*, at p. 368.
[35] (1842) 10 M. & W. 147, 157.
[36] See note 32, *supra*, at p. 368.
[37] See note 19, *supra*.
[38] See note 32, *supra*.
[39] See *Hambrough* v. *Mutual Life Insurance Company of N.Y.* (1895) 72 L.T. 140 at 141 (C.A.). See also *e.g.*, the statement by Lord Campbell C.J. in *Wheelton* v. *Hardisty* (1852) 2 El. & Bl. 232 at p. 273: " In the present case the plaintiffs were neither guilty of misrepresentation nor of fraudulent concealment."
[40] [1908] 2 K.B. 863 (C.A.), affirming [1908] 2 K.B. 431.
[41] *Ibid.* at p. 884.
[42] *Ibid.*
[43] [1960] 2 Lloyd's Rep. 241.
[44] *Ibid.* at p. 252.

has argued that an insured is guilty of a breach of duty towards the insurers if he does not disclose facts which he might have discovered if he had made reasonably careful inquiries; the determination of whether or not the insured has complied with this duty will (we are told) " in each case depend on the circumstances." [45]

It is not essential, for present purposes, to decide whether the law on this point is as laid down in *Joel* v. *Law Union and Crown Insurance*, or whether a doctrine of " constructive knowledge " applies to all classes of insurance. It is very unlikely that an insurer will need to rely on the insured's " constructive knowledge " with the possible exception of a marine insurance case. In any event, the argument of this paper is that even the " knowledge-but-not-necessarily-appreciation " standard required of the insured in *Joel* is an excessively high one and should be rejected.

It is now proposed to examine some of the case-law with regard to the duty to disclose four allegedly material facts. These particular facts have been chosen both for their importance in practice and also because they demonstrate very clearly the unfortunate results that are liable to occur when it is sought to apply an unsatisfactory rule.

(1) *The claims history of the insured—including notice of rejection*

The law in this area shows a remarkable cleavage between marine insurance situations (where the duty to disclose is extremely narrow) and the situation prevailing in other fields of insurance law where an unfairly broad duty of disclosure applies.

Thus, although it would be fatal to the assured's claim in a marine insurance situation to represent untruthfully that previous underwriters have taken the proposed risk at the same or at a lower premium,[46] yet the insured is not bound to disclose the fact that the other underwriters have previously declined to accept the same risk.[47] Similarly, the insured is under no duty to report any apprehensions that may have been expressed about the subject-matter of the insurance by other underwriters,[48] or by foreign correspondents.[49]

By way of sharp contrast it is now settled by the decision of the Court of Appeal in *Locker & Woolf Ltd.* v. *W. Australian Insurance Co.*[50] that an insured must report a rejection with regard to an

[45] See *General Principles of Insurance Law* (1966) at p. 78.

[46] *Sibbald* v. *Hill* (1814) 2 Dow. 263.

[47] *Glasgow Assurance Corp.* v. *Symondson* (1911) 16 Com.Cas. 109, especially at p. 119.

[48] *Lebon* v. *Straits Insurance Co.* (1894) 10 T.L.R. 517 (C.A.).

[49] *Cantiere Meccanico Brindisino* v. *Janson* [1912] 3 K.B. 452.

[50] [1936] 1 K.B. 408 (C.A.); *cf.* also the decision in *London Assurance* v. *Mansel* (1879) 11 Ch.D. 363, which penalised an insured for failing to disclose the fact of previous rejections by other companies, despite the fact that the applicant had been accepted by the company to which he had submitted his most recent application.

entirely different type of insurance (*e.g.*, fire insurance) from the type he has now applied for (*e.g.*, motor insurance). The Court of Appeal in *Locker* seems to have been so impressed by the incantation of the phrase *uberrima fides* that it did not bother to deal with the highly relevant argument advanced by counsel for the insured: " If the insurance companies desire to have information as to other insurances, they should make this clear. . . ." [51]

Further, the insurer may avail himself of the principle of *uberrima fides*, even though he (the insurer) has put his question to the insured with regard to previous rejections in an ambiguous form. This is the teaching of the decision in *Glicksman* v. *Lancashire and General Assurance Co.*,[52] a case whose facts seem to be derived from a short story or a novel. In *Glicksman*, the insured, whose natural language was Yiddish to the exclusion of English which he could neither read nor write,[53] sought to take out an insurance policy for a business in which he was a co-partner. The insured answered " No " in reply to the question " Have you ever been refused insurance before? " This answer was correct if " you " were to be read in the plural, but it was not true if " you " referred to the singular as the appellant had been refused insurance when carrying on business alone. Their Lordships held that even if " you " were to be read in the plural, the insurance company could still avoid the policy on the ground that the insured had failed to disclose a material fact, *i.e.*, that he had once personally been refused insurance.

The principal issue in question in this case is best brought out in the brief concurring opinion of Lord Atkinson. His Lordship described as " lamentable " the continued failure of insurance companies to put questions such as the present one " in clear and unambiguous language." [54] Thus, in the present case, the question should have read: " Have you (or either one of you) ever been refused insurance before? " It is respectfully submitted that the House of Lords erred in this case by allowing the insurer to have the best of both worlds; this should not have been permitted even if the insured had been a person of greater sophistication than the illiterate tailor in *Glicksman* v. *Lancashire and General Insurance Co.*

The law with regard to the insured's duty to give details of previous losses seems, unlike the apparently unqualified duty to give details of previous refusals of the insured by an insurer, to be limited, but the extent of these limits is not clear. In *Becker* v. *Marshall* (1922),[55] Scrutton L.J. in the Court of Appeal expressed the view *obiter* that the duty of the insured to give details of pre-

[51] *Ibid.* at p. 42.
[52] [1927] A.C. 139, affirming the decision of the Court of Appeal at [1925] 2 K.B. 593.
[53] *Ibid.* at p. 142 (*per* Viscount Dunedin).
[54] *Ibid.* at p. 144; note also the remarks of Scrutton L.J. on the same subject when the same case was before the Court of Appeal, [1925] 2 K.B. 593 at pp. 606–608.
[55] (1922) 12 Ll.L.R. 413 (C.A.).

vious losses was qualified in various ways. In his Lordship's words: "The question of date must arise, amount must arise, and the circumstances of the loss must arise." [56]

Despite these dicta, *Becker* v. *Marshall* was put forward in the subsequent case of *Ewer* v. *National Employers' Mutual General Insurance Assn. Ltd.*,[57] as an authority supporting an unlimited duty of disclosure by the insured with regard to the details of his (the insured's) previous losses. Happily, in *Ewer*, Mackinnon J. refused to hold that the decision in *Becker* stood for such a "very wide and disastrously general proposition." [58] Unfortunately, the learned judge having satisfactorily explained the decision in *Becker* v. *Marshall*, then proceeded to distinguish it [59] on the basis that in *Becker* v. *Marshall* there was involved a "basis of the contract clause." [60] This essay in distinguishing cases unhappily makes it appear that the limitations with regard to the details of a loss which Scrutton L.J. spelt out in *Becker* v. *Marshall* [61] may be sidestepped by the simple expedient of making the insured guarantee the accuracy of every answer.

Finally, with regard to the duty to give information relating to previous losses, mention should be made of the decision in *Roberts* v. *Avon Ins. Co.*[62] because the factual situation is one that may recur with some frequency in insurance law generally. In *Roberts* v. *Avon Ins. Co.* the insured left a blank in response to the following statement on his proposal form:

> "I have never sustained a loss in respect of any of the contingencies specified in this proposal. . . .
>
> NOTE.—Give date, amount and name of insurers in respect of each loss."

On these facts, Barry J. held that the insurer was entitled to avoid the policy because of the failure of the insured to give details of a previous loss. The learned judge accepted the statement in Macgillivray quoted by the counsel for the insured that a simple failure by the insured to answer a question without more constituted a waiver of such information by the insurer.[63] This,

[56] *Ibid.* at p. 414.
[57] [1937] 2 All E.R. 193.
[58] *Ibid.* at p. 200.
[59] His Lordship distinguished the decision in a subsequent case, *Arthrude Press, Ltd.* v. *Eagle, Star & British Dominions Insurance Co.* (1924) 18 Ll.L.R. 382 on the same ground.
[60] An extended discussion of this type of clause is not possible within the scope of the present paper but, as will be apparent from the examination of subsequent cases, the device whereby the insurer compels the insured to guarantee, regardless of materiality, the accuracy of his (the insured's) answers to questions in the proposal form, is used as an additional weapon (together with the *uberrima fides* doctrine). The leading cases on this subject are the decisions of the House of Lords in *Thomson* v. *Weems* (1884) 9 App.Cas. 671 and in *Dawsons Ltd.* v. *Bonnir* [1922] 2 A.C. 413.
[61] See text at note 56, *supra*.
[62] [1956] 2 Lloyd's Rep. 240.
[63] The relevant passage from Macgillivray appears in the 3rd ed. at p. 503 and is quoted at [1956] 2 Lloyd's Rep. 240 at p. 249.

however, according to his Lordship was not the situation in the present case; in this case the insured's blank implied a negative answer to the question. It is submitted, with respect, that the above distinction is absurd. Leaving a blank to a simple question " Have you suffered any loss? " (at present treated as a waiver situation) would appear to both a reasonable layman or a professional to be as negative a response as was the leaving of a blank in response to the relevant statement in *Roberts* v. *Avon Ins. Co.* In this case, as in so many other situations, the courts have allowed insurers to effect a radical change in the balance of power in an insurance relationship by the mere addition to, or change in, the standard wording of the policy. Given the fair number of people who must (for one or other reason) fail to reply to answers in proposal forms and given also the ease with which in most cases the insurance company can obtain the information withheld, it is extremely difficult to see why insurers should enjoy the freedom to manipulate the rules of the game in their favour in this area.

Rational and equitable rules can, it is submitted, be fashioned for the chaotic and unjust wilderness described above. In the first place, a distinction should be drawn between on the one hand the insured's duty to give details of previous refusals to insure him (or his property), and on the other the insured's duty to give details of previous losses suffered by him (the insured). With regard to the first duty, it is submitted that the marine insurance rule, which does not recognise this duty,[64] should be applied across the entire field of insurance law. This is so because information with regard to a refusal only tells the insurer to investigate his risk with great care. But this, one should have thought, only describes the insurer's duty at the present time with regard to the investigation of all risks. In short, if an applicant for insurance has been rejected by a previous insurer for arbitrary or capricious reasons, it is monstrous to penalise such a person further by holding that his subsequent insurance is void because of his (the applicant's) failure to disclose an earlier capricious refusal! On the other hand, if the applicant was rejected by an earlier insurer for good and sufficient reasons, it is presumably open to the subsequent insurer to ascertain by intelligent and searching questions what those reasons were.

It does not require much argument to establish that an insured's accident history will often be of greatest importance to an insurer. This fact, however, does not argue for a broad duty of disclosure; on the contrary, it is submitted that the duty of disclosure should be a very narrow one. In the first place, the information allegedly withheld must be closely related to the circumstances of the present loss in the manner described by Scrutton L.J. in *Becker* v. *Marshall.*[65] Second, an insurer's failure to ask questions with regard to losses should be regarded as a waiver of this information, as

[64] See cases cited in notes 47–49, *supra.*
[65] See text at note 56, *supra.*

should the insurer's acceptance of blank replies to questions in the proposal form (regardless of the form of the question). Further, an insurer should not be allowed to take advantage of ambiguous questions in the proposal form.[66] Finally, the insurer should not be able to render immaterial information material by the simple expedient of using a " basis of the contract clause." This alternative, unhappily, appears to be open to an insurer.

(2) *Criminal convictions*

The small body of case-law requiring the insured to disclose previous criminal convictions is worthy of note, principally because it illustrates the ludicrously unjust results that are liable to occur from the application of an unsound rule.

By way of example, consider the decision of the Court of Appeal in *Schoolman* v. *Hall*.[67] In that case, the insured suffered a burglary loss which the company admitted to be genuine. The company, nonetheless, raised in defence the fact that the insured had failed to disclose his criminal record. Despite the fact that the insured's record related, in Asquith L.J.'s words " to a dim and remote past," [68]—the most recent of the insured's convictions had take place fifteen years before the taking out of the policy, the court upheld the company's defence.

In addition to rejecting the insured's " materiality " argument, the court in *Schoolman* v. *Hall* also gave short shrift to the insured's second line of argument. This was that since the insured had been asked fifteen questions, the truth and accuracy of which he (the insured) guaranteed, the information given in answer to these questions represented all the information that the insurance company wished to have. All other information, the insurance company must be taken to have waived. Despite its summary rejection by the court, it is submitted that insured's argument is one of very great force and is one which (it is respectfully submitted) should have prevailed.

In *Regina Fur Co.* v. *Bossom*,[69] Pearson J. accepted as material a single conviction for receiving stolen property in 1933, more than twenty years earlier (a " dimmer and remoter past " than was involved in *Schoolman* v. *Hall*).[70] His Lordship's initial reluctance to find that the conviction was material was dispelled, in the first place, by the argument that the delinquent director had occupied a predominant position in the company sought to be insured and second by the evidence of two expert witnesses (both underwriters

[66] *Cf. Glicksman* v. *Lancashire and General Assurance Co.* [1927] A.C. 139 (for discussion see text at notes 52–54, *supra*).
[67] [1951] 1 Lloyd's Rep. 139 (C.A.).
[68] *Ibid.* at p. 143.
[69] [1951] 2 Lloyd's Rep. 466.
[70] The Court of Appeal affirmed Pearson J.'s judgment, without, however, any discussion of the question under consideration here: see [1958] 2 Lloyd's Rep. 425.

from Lloyd's) who stated that they regarded the conviction as a material fact.[71]

Happily, in the most recent decision on the subject, *Roselodge Ltd.* v. *Castle*,[72] some limit seems to have been set to the duty to disclose in this area. In this case, the insurer refused to indemnify the plaintiffs, diamond merchants, who had insured diamonds against all risks on the ground that these facts had not been disclosed: (i) that R, the principal director of the company seeking to effect the insurance, had been convicted of bribing a police officer in 1946 and (ii) that M, the plaintiffs' sales manager, had been convicted of smuggling diamonds into the United States in 1956.

Two of the three underwriters called by the insurer stated their view of the duty to disclose previous convictions in terms that can fairly be described as being outrageously broad. Thus, according to Mr. Archer, one of the experts in question, a man who had stolen apples when he was seventeen, after which time he lived a blameless life for fifty years, was more likely to steal diamonds at the age of sixty-seven than someone who had not committed this youthful indiscretion.[73]

Essaying his own evaluation of the materiality of the two convictions, McNair J. decided that R's conviction in 1946 was not material since it had " no direct relation to trading as a diamond merchant." [74] His Lordship held that in the case of M's conviction, there was such a " direct relationship " and it must be regarded as material. Although this holding obviously represents a more enlightened approach than that demonstrated in the two earlier cases discussed in this section, it is submitted that on the facts in *Roselodge Ltd.* v. *Castle* that the insurer should have been held to have waived the information relating to M's previous conviction. Remarkably enough (given the type of insurance involved in this case), the insurer in *Roselodge Ltd.* v. *Castle* did not ask M. any questions relating to moral hazard. To require the court to step into the breach, as it were, means that in the first place, the court may have to make an extremely difficult decision with regard to the materiality of a particular fact when it lacks both the requisite knowledge to make this determination, as well as adequate means for obtaining such knowledge.[75] Secondly, and perhaps even more seriously, permitting a judge to " second guess " an insurer tends to dilute the well-established and essential duty of the insurer to make the relevant inquiries of the insured.

[71] [1957] 2 Lloyd's Rep. 466 at p. 484.
[72] [1966] 2 Lloyd's Rep. 113.
[73] *Ibid.* at p. 132.
[74] *Ibid.*
[75] Dean Spencer L. Kimball of the Wisconsin Law School has written, in another connection, of the general tendency of American judges in insurance law " to intervene in complex matters about which they know very little "; see his *Essays in Insurance Regulation* (Ann Arbor, 1966) at p. 130. As regards knowledge of insurance practice, it is extremely doubtful if English judges are in a better position than their American brethren.

(3) *Illness*

The body of case-law on the insured's duty to disclose illnesses is not a large one, but the traps which may lie ahead for the insured in this area seem to be sufficiently serious for this subject to receive brief separate treatment.

As a preliminary matter, note should be taken of McCardie J.'s important decision in *Yorke* v. *Yorkshire Insurance Co.*[76] In this case, the learned judge severely restricted the class of persons who might give expert evidence on questions of health to include only those persons who had expert medical knowledge. In these cases, his Lordship stated:

> " . . . the matters at issue are usually physiological, medical, or neuropathic. The directors of insurance companies are but rarely medical men. Seldom, if at all, do they personally see the proposer." [77]

However, nine years before the decision in *Yorke*, the Court of Appeal in *Joel* v. *Law Union and Crown Insurance* [78] allowed insurers to avail themselves of both " the basis of the contract clause," [79] as well as the insured's duty of disclosure. Fletcher Moulton L.J. had this to say of the insurance companies' attempt to pile Pelion on Ossa:

> " Insurers are thus in the highly favourable position that they are entitled not only to bona fides on the part of the applicant, but also to full disclosure of all knowledge possessed by the applicant that is material to the risk. And in my opinion they would have been wise if they had contented themselves with this. Unfortunately the desire to make themselves doubly secure has made them depart widely from this position by requiring the assured to agree that the accuracy, as well as the bona fides, of his answers to various questions put to him by them or on their behalf shall be a condition of the validity of the policy. . . . *I wish I could adequately warn the public against such practices on the part of insurance offices.*" [80]

In *Mutual Insurance Company of New York* v. *Ontario Metal Products Co.*,[81] the insured escaped from the above trap only because he (the insured) was able to avail himself of the protection of the Ontario Insurance Act, which, in effect, provided that only a *material* misrepresentation of fact could void the policy.[82]

That the insured's duty is unreasonably broad in this area, without regard to a " basis of the contract " clause in the policy, is indicated by consideration of a recent decision. In *Godfrey* v. *Britannic Assurance Co.*,[83] the facts were that the insured after

[76] [1918] 1 K.B. 662.
[77] *Ibid.*
[78] [1908] 2 K.B. 863 (C.A.).
[79] See note 60, *supra*.
[80] [1908] 2 K.B. 863 at p. 885 (emphasis added).
[81] [1925] A.C. 344 (P.C.).
[82] See sub-ss. (3) and (4) of s. 156 of the Ontario Insurance Act (R.S.Ont., 1914, c. 183), quoted in the advice of the Board at p. 350.
[83] [1963] 2 Lloyd's Rep. 515.

losing weight underwent a hospital examination in 1959; he was told that he might have minor kidney trouble and that he should take care, although the insured need not consider himself in any sense an invalid. In May 1959 the insured again consulted his doctor and underwent a second examination; as a result of this visit, he was informed that he had a mild chest infection which would clear up if he took the antibiotic tablets which were prescribed. In June 1961, the insured submitted an application for insurance to the insurers, who accepted it a month later. In January 1962, the insured died of common nephritis.

In an action on the policy, Roskill J. upheld the insurer's argument that the insured's failure to disclose the circumstances of the medical examinations (as well as the fact that between 1959 and mid-1961, he had suffered recurrent attacks of sore throat, cough and mild fever) avoided the policy, despite the fact that the insured had not appreciated the materiality of the withheld information.[84]

This result is certainly an arguable one, especially given the fact that the deceased had answered " No " in reply to the following question in his policy application: " Question 5 (*a*): Have you suffered from any illness or accident or received medical advice or treatment, with or without an operation? " On the other hand, given the insured's lack of expertise in medical matters (illustrated in this case by the fact that the insured did not apparently appreciate the materiality of the withheld information) it is submitted that the phrase " medical advice or treatment " in the above question should have been read as referring back to " illness or accident " instead of being regarded as creating a new head of information. Reading the question in this way would have relieved the insured from giving the information withheld.[85] As it is, it is difficult to agree with Roskill J.'s contentions that the present case represented a proper application of the *contra proferentem* doctrine,[86] and that, in the present case, he had avoided " attributing to the assured anything which could fairly only be said to be within the knowledge of a lawyer, a doctor or a man with long experience in a life office." [87]

(4) *Nationality (of insured)* [88]

The bizarre decision of Lush J. in *Horne* v. *Poland* [89] merits attention even although it may no longer represent good law. This

[84] The principal case relied on by his Lordship in this regard is the decision in *Life Association of Scotland* v. *Foster and Others* (1873) 11 Macph. 351. In that case, the assured failed to tell the insurer of a small swelling in her groin which, unknown to her, was a symptom of a rupture from which she died. The Inner House of the Court of Session denied recovery on the ground that there had been a failure to disclose a material fact.

[85] This, in effect, was the argument advanced on behalf of the insured: see [1963] 2 Lloyd's Rep. 515 at p. 527.

[86] *Ibid.*

[87] *Ibid.* at p. 532.

[88] There is a small body of case-law on the " nationality " of a ship. Since these cases are almost invariably the product of wartime conditions, they do not warrant discussion here.

[89] [1922] 2 K.B. 364.

is so for a number of reasons; in the first place, it is by no means clear that the decision can be relegated to the limbo of legal history.[90] Second, if the decision does represent good law, its effect can only be described as catastrophic. Finally, the decision is worthy of note because it represents, in all possibility, the high-water mark in terms of injustice and absurdity that a doctrine purporting to apply conduct in conformity with " absolute good faith " has yet achieved.

In *Horne* v. *Poland*, the insured was an alien who had been born in Roumania and had come to England at the age of twelve; twenty-two years later he took out an insurance policy against burglary. When he claimed in respect of an alleged loss, the insurer pleaded that the insured had failed to disclose the fact of his alien birth and childhood and that this failure to disclose a material fact avoided the policy. Lush J. upheld this defence and found for the insurer.

Alien birth was not inevitably fatal to recovery; this would not be the case where: " [T]he assured . . . [came] from a state where the business and social habits, the training and education that a child receives and the views taken as the observance of legal and other obligations are notoriously exactly as those prevailing here." [91] Seemingly quite independently of the expert evidence tendered in this case (the admissibility of which his Lordship doubted) [92] the learned judge decided that Roumania was not such a state.

Despite this gross essay in xenophobia, and despite Lush J.'s statement toward the end of his opinion that " [I]t would seem more just that underwriters should inquire as to the nationality of proposed insurers [93] if they attach importance to it " no subsequent decision seems to have challenged the fundamental premise of *Horne* v. *Poland*.[94] Rather, the correctness of the decision seems to have been taken for granted, with attempts being made only to limit the scope of the decision. Thus, in *Becker* v. *Marshall*,[95] for example, Scrutton L.J. remarked *obiter* that the presence of a foreign name might put " the underwriter on inquiry as to foreign nationality, if he thought it important. . . ." [96] Similarly, in *Lyons* v. *J. W. Bentley Ltd.*,[97] Lewis J. applied what may be termed a *de minimis*

[90] Not only has any doubt been cast on the correctness of the basic principle stated in the case (see text at notes 95–97, *infra*), but the case seems to be cited with remarkable frequency as a general illustration of the duty to disclose in non-nationality cases.

[91] [1922] 2 K.B. 364 at pp. 365–366.

[92] *Ibid.* at p. 365.

[93] *Ibid.* at pp. 367–368.

[94] In this connection, contrast the decision of the Court of Appeals for the Seventh Circuit in *Roberto et al.* v. *Hartford Fire Insurance Co.*, 177 F. 2nd 811 (7th Cir. 1949) where the insured was not only an alien but had been incarcerated for perjury committed on an application form for citizenship and was liable to deportation for this offence. The Court of Appeals held that, in the absence of inquiry, the insurer had to show that the insured had fraudulently concealed the above information. The court proceeded to hold that the insurer had failed to show that the insured had acted fraudulently.

[95] (1922) 12 Ll.L.R. 413 (C.A.); see also *Carlton* v. *Park* (1922) 10 Ll.L.R. 98.

[96] *Ibid.* at p. 414.

[97] (1944) 77 Ll.L.R. 335.

exception to the duty holding that the duty to disclose foreign birth did not arise in the case of the insured who had been born in Russia but had come to England at the age of five, where he had spent the next sixty years of his life.

The danger in the *Horne* v. *Poland* doctrine becomes particularly acute when that case is considered against the background of apparently very widespread discrimination practised on national (and racial) grounds in at least one field of insurance—namely, that of motor-vehicle insurance—revealed by the PEP study on racial discrimination in 1967.[98] Given the widespread extent of such discrimination, together with the wooden and sterile manner in which the doctrine of *uberrima fides* has generally been applied, it is, unfortunately, not impossible that an English court will follow "industry practice," and hold that a failure on the part of an insured to reveal his nationality (and possibly also his race) voids the policy. An underwriting of the doctrine of *Horne* v. *Poland* in this manner (even if the xenophobic content of the latter opinion were to be omitted) would represent nothing less than a disastrous development.[99]

Expert Evidence

Before attempting to note a brief overall critique of the doctrine, together with some suggestions for its reform, it is necessary to consider briefly the important subject of expert evidence in this area.

Once again, the starting point of wisdom is to be found in Lord Mansfield's opinion in *Carter* v. *Boehm*.[1] In that case, the following remarks were made with regard to the evidence given by the brokers: "It is mere opinion; which is not evidence. It is opinion without the least foundation from any previous precedent or usage."[2] It is not unreasonable to suggest that one of the factors which explains this sceptical attitude to expert evidence lay in the judge's realization that the respective parties did not enjoy equality in terms of access to expert evidence. Remarkably enough, this inequality does not appear to have been made the subject of any

[98] See *PEP Report on Racial Discrimination in England* (April 1967) at p. 100; W. W. Daniel *Racial Discrimination in England* (Penguin Special, 1966) at pp. 200–203 (a study based on and amplifying the PEP survey) which inform us that a West Indian applicant who was carefully matched as regards relevant criteria such as motoring history and occupation with a white Englishman and an immigrant of Hungarian origin, suffered discrimination at the hands of 17–20 insurers, as compared with his two co-applicants. On six occasions cover was refused altogether and on 11 other occasions, the West Indian applicant was quoted a higher premium than was demanded of the other two applicants.

[99] It is unlikely that English law gives relief against this kind of discrimination through some variant of the doctrine of "public policy." For a good discussion of the limited protection afforded by the common law in this regard see Hepple, *Race Jobs and the Law in Britain* (Penguin, 1968) p. 91 *et seq.*

[1] (1766) 3 Burr. 1905.

[2] *Ibid.* at p. 1918.

comment by an English court.[3] This inequality assumes great importance when the limited judicial knowledge of the insurance industry is taken into account; such ignorance would seem to render even more powerful the testimony of " experts."

A non-English case which yet affords an excellent example of present-day English practice in this area is to be found in the majority opinion of the Supreme Court of Canada in *Henwood* v. *Prudential Insurance Co.*[4] In *Henwood*, the insured under a life insurance policy failed to disclose the fact that she had paid several recent visits to a psychiatrist (as well as to other physicians) despite having been asked in the proposal form to list the names of all physicians she had consulted, including those who had treated her " for any nervous disorder." Subsequently, the insured died in an automobile accident in circumstances wholly unconnected with nervous and mental disorder. At the trial the insurer called its own medical and underwriting experts who testified that if the company had had knowledge of the information withheld from it, it would have issued a policy only after a subsequent medical examination and then at a higher premium.

Acting largely on the basis of this uncontradicted evidence, a majority of the court held that the materiality of the withheld information had been established. Spence J. however dissented and it is submitted that his dissenting opinion is greatly to be preferred as against the majority opinion. The learned judge pointed out that the insurer's two expert witnesses not only limited their remarks to the policy of their own company, but they had also expressly confessed they were ignorant of the policies of other insurers with regard to the issue before the court.[5] His Lordship counselled that the adoption of such an approach would result ultimately in the replacement of the " prudent insurer " test by a test which instead made decisive the idiosyncrasy of individual insurers.[6]

CRITIQUE

It is now possible to summarise briefly the various defects of the *uberrima fides* as it exists today. In the first place, current doctrine, so far from representing a restatement of classical doctrine as set out in decisions such as *Carter* v. *Boehm*,[7] sets out an entirely different principle, one largely fashioned during the present century. It is respectfully submitted that *Carter* v. *Boehm* was correctly read

[3] *Cf.*, however, the remarks of a Scottish judge—Lord Robertson in *Zurich General Accident & Liability Insurance Co.* v. *Leven*, 1940 S.C. 406. In the course of his opinion in that case, his Lordship remarked: " I recognise that in a case of this kind it may be difficult for litigants in the position of defenders to procure suitable evidence." *Ibid.* at p. 411.

[4] (1967) 64 D.L.R. (2d) 715 (Sup.Ct.Can). (I am grateful to Professor Bradley E. Crawford of the University of Toronto Law Faculty for a reference to this case.)

[5] *Ibid.* at p. 731.

[6] *Ibid.*

[7] (1766) 3 Burr. 1905.

by a number of American courts in the nineteenth century who read the case as stating a " narrow " rule of disclosure.[8]

More seriously, it is clear (in the words of the Law Reform Committee Report on Conditions and Exceptions in Insurance Policies) [9] that ' . . . a fact may be material to insurers . . . which would not necessarily appear to a proposer for insurance, however honest and careful, to be one which he ought to disclose." [10] Further, the doctrine seems to work harder against laymen than against professionals. The " marine " professional is in the strongest position: in the first place, he does not, as we have seen previously,[11] have to disclose information that has to be disclosed by other classes of applicants. Secondly, it would appear that the courts are more ready to infer a waiver of information by the insurer in a marine insurance situation than in other insurance situations.[12] The land-based professional does not occupy as privileged a position as his marine cousin but he would still appear to be in a stronger position with regard to the working of the doctrine than is the layman who applies for, *e.g.*, life insurance. In the first place, the professional is more likely to know that a duty to disclose exists and to know also what information the insurer needs to know, than is likely in the case with a lay applicant for life insurance. Secondly, it is likely that an applicant for life insurance will be asked more questions (some of them relating to his health, a matter in which he has no expertise) than will be true in the case of a businessman taking out a policy against fire or burglary.

Thirdly, the doctrine is in error in assessing the strength of the parties with regard to knowledge. The doctrine assumes that the insured is in a stronger position than the insurer because he (the insured) has more knowledge than the insurer. But the possession of greater knowledge, it is submitted, puts the insured in a weaker position, since he (the insured) does not know which parts of that information the insurer wishes to have. It is submitted, however, that it is the insurer who should be seen as the stronger party, since

[8] See *e.g.*, the citation of *Carter* v. *Boehm* (together with other authorities, both English and American) in support of a " narrow " duty of disclosure. See *Gates and Downer* v. *Madison County Mutual Ins. Co.* 1 Selden (N.Y.) 469 at p. 475 (1851). There are a number of other opinions in the same vein but it is possible here to mention only the classic opinion of Judge (later Chief Justice) Taft in *Penn Mutual Life Insurance Co.* v. *Mechanics Savings Bank & Trust Co.*, 72 Fed. 413 (C.C.A. 6th 1896).

[9] Cmnd; 62 of 1957. The Committee's remarks on the subject of the *uberrima fides* doctrine do not warrant any detailed discussion. The analysis of the doctrine is extremely superficial and the proposals for its reform timid and confusing.

[10] *Ibid.* p. 4, para. 4. This conclusion is, of course, directly supported by the findings in a number of decided cases.

[11] See cases cited at notes 47–49, *supra*.

[12] Compare, *e.g.*, the decision of the Court of Appeal in *Mann, MacNeal & Steeves Ltd.* v. *Capital Counties Insurance Co.* [1921] 2 K.B. 300 (Insurer's failure to make any inquiry with regard to insured's cargo held to constitute a waiver with regard to such information) with the decision of the same court in. *e.g.*, *Schoolman* v. *Hall* (see text at notes 67–68, *supra*).

he (the insurer), is aware of what information he seeks to have.[13] As against this, the insured, even under the limited formulation of the doctrine, requiring him to disclose only facts within his knowledge,[14] may well be in the position of either not knowing, or else being uncertain as to the materiality of a particular fact.

In short, current doctrine as applied seems to assume that the purchase of insurance is some kind of *emptio spei*. Despite the various gambling analogies which invariably suggest themselves in any discussion of an insurance contract, it is submitted that such a contract is not analogous to, say, the entering of a football pool coupon.[15] Even without the detailed regulation by both legislative and administrative agencies of the terms and conditions of an insurance policy such as exist in the United States, and every European country (with the exception of Holland),[16] it would appear to be necessary to emphasise the fact that the purchase of insurance, whether by layman or by professional, represents a " purchase " of the greatest importance. The failure of this " purchase " will in most cases involve far more serious results for the " purchaser " than is likely to be true in the event of any other defective goods or commodity the insured acquires.

NOTES ON REFORM

It is not within the scope of this paper to offer detailed statutory provisions but some general—if disconnected—remarks on the shape such reforming provisions might take would appear to be in order.

In the first place it is submitted that any reform of *uberrima fides* should take place only as a reform of, at least, the main body of insurance law. Thus, apart from *uberrima fides* itself there should (as a minimum) have to be undertaken a reform of the law relating to conditions and warranties (including the " basis of the contract clause " [17]) and the problems involved in the responsibility of insurance companies for the acts of their " agents." [18] Second,

[13] I am indebted to my friend Professor Arthur A. Leff, Yale Law School, for this suggestion.

[14] *Cf.* the wider duty of disclosure, requiring the insured to make " reasonably careful inquiries " stated in Hardy Ivamy, *General Principles of Insurance Law* (1966) at p. 78.

[15] See, *e.g.*, *Appleson* v. *H. Littlewood Ltd.* [1939] 1 All E.R. 464 (C.A.) (no enforcement of contract because of absence of intent to create legal relations).

[16] See, e.g., the excellent surveys by Kimball and Pfennigstorf, " Legislative and Judicial Control of the Terms of Insurance Contracts: A Comparative Study," 39 Indiana L.J. 675 (1964); " Administrative Control of the Terms of Insurance Contracts: A Comparative Study." 40 Indiana L.J. 143 (1965). Both essays appear, in slightly abridged form, in Kimball, *Essays in Insurance Regulation* (Ann Arbor, 1966).

[17] See note 60, *supra*. Unless the " basis of the contract " problem is satisfactorily dealt with, any attempted reform of the law relating to the insured's duty of disclosure would appear to be futile, since it would seem to continue to be possible to make what is " immaterial " material by the mere addition of a provision in a policy.

[18] See, in particular, the disturbing implications of the Court of Appeal in *Newsholme* v. *Road Transport Insurance Co. Ltd.* [1929] 2 K.B. 356.

it is submitted that any reforming provisions on this subject should not cover the law relating to marine insurance. Both the law and practice in this area, as we have had occasion to note briefly above, appear to work satisfactorily and there would appear to be every argument for leaving well alone in this area.

Turning more specifically to the form revised disclosure provisions might take, it is submitted that, while foreign legislation should obviously be consulted, great care be taken in borrowing statutory provisions. The statutory provisions of many American states, to take but one example, are too brief for English conditions. The brevity of these statutory provisions is to be explained by reference to two very closely connected factors. In the first place, very often the statutory provision will represent no more than codification of the pre-existing common law position. But even where this is not the case, a brief statutory provision will be interpreted in the light of a general judicial solicitude for the position of the insured.

The fact that these circumstances are not present in England makes it advisable that any statutory provisions go into far greater detail than any potential foreign model appears to do.

Without being exhaustive, a model disclosure statute might well provide for the following. In the first place, it might be desirable to provide that an insured is under no obligation to provide information with regard to certain matters. As examples of such " classified " information could be included an applicant's race or nationality; further, the insured should be deemed to be under no obligation to reveal that he has previously been refused insurance.

The key provision in the statute should state in the clearest possible language that any failure by an insurer to ask of an insured information customarily sought by insurers in the type of policy in question should be deemed a waiver of such information. The burden of proof to show that a particular piece of information was so esoteric as not to have been ascertainable by ordinary inquiry should again clearly be placed on the insurer.

The adoption of the above-described waiver principle should reduce the insured's duty of disclosure to (justly) narrow limits. With regard to the disclosure of this " unascertainable " information, the insured should be penalised only if he acted in " bad faith," *i.e.*, if he knew, or had very good cause to believe that a particular piece of information would in fact be material to the insurer. The burden of showing " bad faith " should again be placed on the insurer.

The insured's duty of disclosure should also be recognised in another situation, namely, when the insured comes into possession of material information between the time of the application for a policy and the time the policy is issued. If American case-law is any guide,[19] disputes arise more frequently over the duty to

[19] See, *e.g.*, the cases collected by Patterson, " Insurance Law During the War Years," 46 Colum.L.Rev. 345 at p. 372 (nn. 137 and 138) (1946). The

disclose in this situation than is true of the insured's duty to disclose " unascertainable " information. The duty to disclose such information should be recognised (as it is in American law), except that the policy should be made to spell out clearly that such an obligation exists. It is, it is submitted, all too easy for an insurance applicant to think that a contract has been concluded at the time the policy was applied for.[20]

Again, it might be desirable to expressly provide for the *contra proferentem* principle in a separate provision. Perhaps more valuable than such a provision would be one stating that the insurer is responsible for any ambiguities in questions asked in the application. Indeed, the situation in *Glicksman* v. *Lancashire and General Insurance Co.*,[21] could be set out, with, of course, a different outcome indicated.[22]

Finally, even with a much limited duty of disclosure, it is still desirable to provide that an insurer prove clearly the materiality of some particular piece of information that has been withheld. In particular, serious consideration should be given to reforming the manner in which expert evidence is given, so that the responsibility for ascertaining insurance practice becomes the responsibility of the court, instead of being left, as at present, to the unequal struggle between the parties.[23] Such a system would not attain complete objectivity since obviously most expert testimony will continue to be given by underwriters, but it will at least make it impossible for an insurer to hand-pick his experts or to call " experts " from the insurer's own company.[24]

Would-be reformers frequently make the claim that the changes they propose in any given area of the law are conservative rather than radical in nature. That claim can, it is submitted, be made with special force in the present area. Changes of the kind indicated

insured's obligation to make disclosure of information in such circumstances seems to have been clearly settled by the decision of the United States Supreme Court in *Stipcich* v. *Metropolitan Life Insurance Co.*, 277 U.S. 311 (1928).

[20] It is perhaps this circumstance that explains Professor Patterson's opposition to the doctrine, stating that it placed "a severer burden on the insured [to volunteer information] after the application is signed than before." See his article (previous note) at p. 372.

[21] [1927] A.C. 139 (see text at notes 52–54, *supra*.).

[22] Another case which might be used as an illustration in this connection is the decision in *Brewtnall* v. *Cornhill Motor Insurance Co. Ltd.* (1930) 40 Ll.L.R. 166. In that case, the insured was asked the cost price of her car; she put down £145 but did not disclose that part of this price was made up by part exchange of another car. Charles J. held (correctly, it is submitted) that there had been no failure to disclose a material fact, as the insurance company could have obtained a complete breakdown of the price by framing their question more carefully.

[23] See generally, the discussion of the problem of expert evidence in this area at p. 631, *supra*.

[24] See, *e.g.*, *Henwood* v. *Prudential Insurance Co.* (discussed at p. 632. See notes 4–6).

above would do no more than to bring present-day English doctrine in line both with its " classical " eighteenth-century antecedents as well as the present-day law in the United States and the various countries on the European continent.

R. A. HASSON.*

* B.A. (Cape Town), LL.B. (Lond), LL.M. (Yale) Research Associate, Yale Law School.

acceptance of the 'middle way.' In *GW Atkins Ltd* v *Scot*,[86] rather than award cost of reinstatement for minor defects in tiling under a small building contract, the Court of Appeal awarded £250. The basis for this was professed to be damages for bad workmanship, but in effect it amounts to awarding damages of what Farnsworth would term a 'reasonable sum.' The significance of *Ruxley* may well be the fact that the House of Lords has expressly recognised the existence of the 'middle way' approach, even though the exact basis for awarding such compromise damages still requires further elaboration.

Misrepresentation and Non-disclosure in Insurance Law — Identical Twins or Separate Issues?

John Birds* and Norma J. Hird**

In *Pan Atlantic Co Ltd and Another* v *Pine Top Insurance Co Ltd*,[1] the House of Lords again tackled the vexed question of the meaning of materiality in English insurance law. The main point at issue was to determine the exact meaning of section 18(2) of the Marine Insurance Act 1906, which states:

> Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.

Although *Pan Atlantic* was not itself a marine insurance case, it is now accepted that the law in this area for non-marine insurance is provided for in the MIA.[2] The last major case to be decided in this area was *Container Transport International Inc* v *Oceanus Mutual Underwriting Association (Bermuda) Ltd*.[3] There, the Court of Appeal decided that it did not have to be shown that the misrepresented or non-disclosed fact had had a 'decisive influence' on the mind of the insurer, in the sense that he would have acted differently if he had known the true facts; it was enough to prove that a prudent insurer would 'have wished to know' the facts when making his assessment of the risk. This decision has been much criticised and many saw *Pan Atlantic* as an opportunity for the House of Lords to set the law of insurance back on the right track on the issue of materiality; their Lordships, on a bare majority, rejected the opportunity and approved the *CTI* decision.

Their Lordships did not, though, feel inclined to let all opportunities go to waste. In a painstaking and scholarly judgment which examined almost all the early authorities on this issue, Lord Mustill held that the rules relating to misrepresentation and non-disclosure, at least as they affect materiality and subsequent avoidance, should be, and indeed always have been, the same,[4] even though most insurance companies, judges and modern academic commentators may have thought otherwise. Whilst Lord Mustill's proposition may be a desirable

86 (1980) 7 Const LJ 215.

*Dibb Lupton Broomhead Professor of Commercial Law, University of Sheffield.
**Lecturer in Law, University of Sheffield.

1 [1994] 3 All ER 581.
2 See *Lambert* v *Co-operative Insurance Society* [1975] 2 Lloyd's Rep 485.
3 [1984] 1 Lloyd's Rep 476.
4 See Lord Mustill's judgment, at pp 588–619.

one from a practical point of view, we would argue that the law may be wrong, in theory, to assume that an undisputed principle of misrepresentation must necessarily apply to non-disclosure. Lord Mustill's judgment is, we think, based upon this assumption, but it may be that the rules relating to the two, in insurance law, have always been different. This is not surprising if one considers that the rules relating to misrepresentation have been, in the main, developed by the courts of equity, whilst non-disclosure is decidedly a creature of the common law. We would also respectfully suggest that had their Lordships come to a different decision on the materiality issue, the convoluted reasoning we find later in the majority judgments would have been entirely unnecessary.

The confusion surrounding these issues is compounded by the tendency of insurers, defending an action by an insured on relevant grounds, to plead misrepresentation and non-disclosure indiscriminately — the judiciary's complicity in this has tended to 'merge' the doctrines into one, particularly so far as remedies are concerned.[5] However, at least in theory, there are difficulties with this approach. For example, an innocent misrepresentation, on its true construction, can *never* be an actionable non-disclosure — one is not held liable for not disclosing what one does *not* know, and it is the representor's genuine belief in the truth of his statement that distinguishes the innocent misrepresentation from the fraudulent.

Remedies also present a problem when misrepresentation and non-disclosure are treated as one and the same. Traditionally, the remedy for misrepresentation has always been rescission, granted by the courts of equity — in line with normal equitable principles, this remedy is discretionary only (although it is almost always granted in insurance law). The common law gave no remedy for innocent misrepresentation, although it always recognised fraud. The remedy for non-disclosure *is* a common law remedy however — avoidance of the contract *ab initio*, and it is not discretionary, but the injured party's right. If misrepresentation and non-disclosure are now, to all intents and purposes, the same creature, and an equitable creature, this automatic right to avoid the contract must become questionable. Will the judiciary be able to deny avoidance, even if materiality and inducement are proved, and insist instead that the innocent party settles for damages? A rather large obstacle to this course of action is the judgment in the *Banque Financière* case,[6] where it was stated, in the strongest possible terms, that an action for non-disclosure did not sound in damages! An alternative would be to state clearly that the Misrepresentation Act 1967, where damages are available instead of rescission, applies also to non-disclosure, but this has always been questionable.

The facts

The relevant facts of *Pan Atlantic* can be dealt with briefly. Pan Atlantic reinsured the excess of loss on their direct American liability insurance with insurers other than Pine Top between 1977 and 1982. They reinsured this business with Pine Top

5 See eg *Pan Atlantic* itself, but almost any case in this area over the past 100 years will suffice equally as illustration. See also Hasson, 'Misrepresentation and Non-disclosure in Life Insurance — Some Steps Forward' (1975) 38 MLR 89.

6 *Banque Financière de la Cité* v *Westgate Insurance Co Ltd* [1990] 2 AER 947. The appeal to the House of Lords was on a different point, but their Lordships took the opportunity to express their approval of the Court of Appeal's opinion on the damages issue.

during 1980 and 1981. In 1982, on renewal, Pan Atlantic's broker met with the reinsurers and suggested a lower premium. Their appalling risk record on a certain type of business, and the losses actually sustained in 1981, were misrepresented to Pine Top, by approximately $200,000. During 1982 the losses were, again, disastrous and, as the previous facts had by now come to light, Pine Top sought to avoid the contract for non-disclosure.[7]

The submission by Pan Atlantic was that before a fact could be considered material, the insurer must show: (1) that a prudent insurer, if he had known of the undisclosed fact, would either have declined the risk altogether or charged an increased premium; and (2) that the actual insurer would himself have declined the risk or charged an increased premium. Pine Top, on the other hand, argued that it was enough for the insurer to show that a prudent insurer would have 'wanted to know,' or would have 'taken into account' the unknown fact, even though it would have made no difference to his conduct as a result. They also argued that the effect on the actual insurer was irrelevant.

Materiality

At first instance,[8] Waller J felt bound to accept Pine Top's submission, but was unhappy at the result. The Court of Appeal[9] cared for neither submission and so proposed a slightly different test: if the insurer wishes to avoid the contract, then it must be shown that not only would a prudent underwriter have 'wanted to know' the undisclosed fact, but also that he would have regarded the undisclosed fact as increasing the risk; he does not, however, have to act differently.[10] This does not appear to be, with respect, a very sensible test, because it is difficult to imagine the prudent underwriter *not* acting differently if the risk is definitely increased. All the judges in the Court of Appeal were, in any event, unhappy at the likely outcome of applying this test. Sir Donald Nicholls V-C, in particular, pointed out that because of the inadvertent non-disclosure, the underwriter escaped all liability for his own bad bargain, even though he admitted that, had full disclosure been made, the result would have been only an increased premium, not a decline of the risk altogether.[11] He then went so far as to say that justice and fairness demanded that, in the case of an innocent misrepresentation or non-disclosure, the court ought to be allowed to deny avoidance, and instead to adjust the premium or restrict the cover. We would certainly support such a proposition.[12] At the moment, however, in line with many areas of English civil law, insurance law precedent dictates an 'all or nothing' approach to litigation and leaves little room for ideas of proportionment.[13]

7 This is a perfect illustration of our earlier point about indiscriminate pleadings. This was strictly a misrepresentation, ie a positive statement which later proved to be false (because the loss record was undoubtedly disclosed), rather than a non-disclosure based on silence, but non-disclosure was pleaded.

8 [1992] Lloyd's Rep 101.

9 [1993] 1 Lloyd's Rep 496.

10 *ibid per* Steyn LJ, 505–506.

11 *ibid* 508.

12 See Lord Lloyd's judgment in *Pan Atlantic*, p621, para (h). Rather surprisingly, the Law Commission rejected this approach when they looked at possible reform in both this area and the law relating to warranties in insurance law: Report No 104 (1980) Cmnd 8064, at p 33. The Insurance Ombudsman has, however, taken such action in consumer contracts.

13 We have in mind here not only the present case, but also particularly torts law cases dealing with complicated causation issues such as *Wilsher* v *Essex Area Health Authority* [1988] AC 1074, and

On further appeal, the majority of the House of Lords, led by Lord Mustill, decided firmly that the decisive influence test should be rejected. There was strong dissent from the minority, Lord Templeman and Lord Lloyd, who both suggested that nothing could be construed as being decisive if the insurer would not have acted differently, but their argument did not hold sway. This, we think, is highly regrettable. Had the majority been prepared to accept this line of reasoning, there would have been no need, in our opinion, for the convoluted analysis of the inducement requirement that followed and, indeed, it appears to us that the judgments given by the minority in the House of Lords, that of Lord Lloyd in particular, bear closer scrutiny than that of the majority, masterly though Lord Mustill's judgment undoubtedly is.

The main reasons given by the majority for the rejection of the 'decisive influence' test were as follows. First, Lord Mustill discusses the difficulties facing both the court, and the prospective insured and insurer, if they have to decide before the risk is underwritten whether one particular fact, if undisclosed, will be decisive on the terms of the contract.[14] This is surely to misunderstand the issue. The prospective insured does not sit down in conference with his underwriter to discuss all material facts, nor does he consciously sit down and think to himself, 'if I do not disclose this fact will it make a difference to the risk?' If every prospective insured could be relied upon to do that, then there would not be many non-disclosure actions. It is far more likely that he does not think about it at all — we are not here discussing a fraudulent or deliberate concealment, but an inadvertent one. We are assuming that he is abiding by the duty of good faith to the best of his ability; questions of whether or not he realises that one concealed fact will sway the underwriter's opinion are surely, therefore, out of place here.

Secondly, Lord Mustill says: 'The argument for Pan Atlantic demands an assumption that the prudent underwriter would have written the risk at the premium actually agreed on the basis of the disclosure that was actually made. Yet this assumption is impossible if the actual underwriter, through laziness, incompetence or a simple error of judgment, has made a bargain which no prudent underwriter would have made, full disclosure or no full disclosure. This absurdity does not arise if the duty of disclosure embraces all materials which would enter into the making of the hypothetical decision, since this does not require the bargain actually made to be taken as the starting point.'[15] This, with the greatest of respect, *must* be considered irrelevant. What can it matter what the actual underwriter would/might/should have done? The whole point of a prudent underwriter test is to bring objectivity and dispense with such subjectivity — if the prudent underwriter would not have made the bargain on the same terms without the non-disclosure, then we can surely assume that he would not have made it had the fact been disclosed. If this is the case, then the fact is material on the decisive influence test and that is an end to it (assuming, of course, that any number of prudent underwriters could ever be expected to agree on such a matter, which must surely, in itself, be overly optimistic). However, if the starting point for such a decision is not to be the bargain actually made, then where is it to be? There is surely no other place to start, nor probably to contemplate or finish!

The third reason for rejection bears greatly on the first and again assumes (wrongly, in our view) that the prospective insured weighs up the possible

Hotson v *East Berkshire Health Authority* [1987] AC 750.

14 *Pan Atlantic*, pp 600–601, paras (j), (a)– (c).

15 *ibid*, 601, at para (d).

influence of the non-disclosed fact, and then deliberately chooses to conceal it not necessarily from any fraudulent motive, but because he objectively considers it to be unimportant or not weighty enough to bother the prudent underwriter. We have already given our opinion on whether the insured normally acts in such a conscious fashion[16] — the more conscious that conduct becomes, the further away from inadvertent non-disclosure we travel, and we should keep in mind that it is only inadvertent conduct we are concerned with here.

Lord Lloyd, for the minority, has little difficulty in dismissing these arguments and presenting a different line of reasoning which leads, of course, to a different conclusion.[17] He asks what is the central question, ie the meaning of the words 'would influence the judgment of a prudent insurer,' and gives the following answer: 'If I ask myself what the phrase as a whole means, I would answer that it points to something more than what the prudent insurer would want to know or take into account. At the very least, it points to what the prudent insurer would perceive as increasing or tending to increase the risk.'[18] He goes on to tell us, correctly, that this also best ties in with the statement made by Lord Mansfield in *Carter* v *Boehm*,[19] which explicitly says that neither party is under any duty to disclose any fact which might diminish the risk. As *Carter* v *Boehm* is regarded by everybody as being the starting point for any discussion which centres on non-disclosure, we should take this point seriously. It also fits best with section 18(3)(a) of the MIA, which confirms this.

Lord Lloyd then analyses the phrase word by word, and not only reaches the same conclusion, but carries it one stage further. 'Influence,' on its ordinary meaning, is to affect or alter. Most of us would agree with this. 'Judgment' can have many meanings and is the most difficult to define out of context but, as he points out, in a commercial sense it is often used to mean 'assessment,' as in the term 'market assessment.' This usually means a judgment as to what the market is going to do, not the process of arriving at that opinion. The word 'would' does not, and, in our view, cannot mean 'might.' It is a much more positive word than 'might.' It must be observed and, indeed, Lord Mustill paid great attention to this fact when it suited his purpose to do so,[20] that Sir Mackenzie Chalmers, who drafted the 1906 Act, was an extremely precise draftsman — if he meant 'might,' we can safely assume that he would have drafted 'might.'

In short, Lord Lloyd is simply saying that nothing can be properly described as 'influencing' anything, unless it does actually have a positive effect on behaviour, and it is surely very difficult to disagree with this analysis. Nevertheless, both arguments already have their respective supporters, and a trawl through early authority, both case law and commentary, provides no ready solution to the dilemma.

The starting point for any discussion concerning misrepresentation and non-disclosure in insurance law is always Lord Mansfield's statement in *Carter* v *Boehm*[21]:

16 Although we are prepared to acknowledge that this particular point carries more force if an experienced broker is placing the risk in a large commercial contract.

17 Lord Lloyd has been very consistent on this issue. As Lloyd J he was the judge at first instance in *CTI* [1982] 2 Lloyd's Rep 178, where he presented an argument very similar to the one presented here, for the minority.

18 *Pan Atlantic*, p 626, para (e).

19 (1766) 3 Burr 1905, 97 ER 1162.

20 See Lord Mustill's later analysis of an inducement requirement, particularly pp 610 and 611, paras (j) and (a)–(f), where he considers it impossible that Chalmers could have drafted this part of the Act either thoughtlessly or carelessly.

21 (1766) 3 Burr 1905, 97 ER 1162.

> First, insurance is a contract upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only: the underwriter trusts to his representation, and proceeds upon confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that the circumstance does not exist and to induce him to underestimate the risque, as if it did not exist. The keeping back such circumstance is fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention, yet still the underwriter is deceived and the policy is void; because the risque run is actually different from the risque understood and intended to be run at the time of the agreement. The policy would equally be void against the underwriter if he concealed: as, if he insured a ship upon her voyage which he privately knew to be arrived: and an action would lie to recover the premium. The governing principle is applicable to all contracts and dealings. Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain from his ignorance of that fact, and his believing the contrary.[22]

Lord Mustill uses this statement to support the majority's rejection of the 'decisive influence' test, on the grounds that such a test is too lenient to the insured. He describes the duty of disclosure as being of the highest standard and sees no room in Lord Mansfield's judgment for any dilution of it. But this requires an acceptance of the assumption that the decisive influence test is unfair to the insurer, and we do not accept that. Why, in all fairness, should the insurer be allowed to avoid the whole contract, often causing great hardship to an innocent insured, when the insurer has effectively suffered no loss? The risk run may be different from that which he supposed, but if he would have taken it without any increase in premium, what right has he to such a drastic remedy? We would also point out that the duty of disclosure, as described by Lord Mansfield and based on his notion of good faith, in our view bears little resemblance to the incredibly wide duty English insurance law has now arrived at, which places an almost impossible burden on insureds.[23] The American courts derived their duty of disclosure from exactly the same source, and yet have managed to establish a much narrower duty which works perfectly well and is fair to both parties. That Lord Mansfield cannot possibly have meant the duty to be as wide as the one which English law has today is indisputable, because he wished that the notion of good faith on which it is based to be applicable to *all* contracts, not simply contracts of insurance. To attempt to impose upon all contracting parties such a wide duty would make a nonsense of the very essence of English contract law, particularly in the commercial sector, so to imagine that a Lord Chief Justice as commercially aware as Lord Mansfield would propose such a step is inconceivable.

However, as Lord Mustill goes on to say, Lord Mansfield's observations may not help us very much today in deciding what materiality really means, because he never mentioned the word 'influence' or spoke of 'the prudent underwriter,' both of which are the crucial parts of section 18(2) of the MIA. It appears that Lord Mustill is correct in his assumption that the origins of the word 'influence' in this context arise from early commentators on insurance law. Quoting from an early edition of *Marshall on Insurance*:

> Every fact and circumstance which can possibly influence the mind of a prudent and intelligent insurer, in determining whether he will underwrite the policy at all or at what premium he will underwrite it, is material.[24]

22 *ibid* 1165.

23 See also Hasson, 'The Doctrine of *uberrima fides* in Insurance Law: A Critical Evaluation' (1969) 32 MLR 615.

24 *Marshall on Insurance* (3rd ed, 1823) vol I, at p465.

Lord Mustill supposes (correctly)[25] that notions of influencing the mind of the insurer may have been around for longer. He then goes on to quote from several eminent nineteenth century textbook writers[26] and concludes that there is little in any of their writings on materiality which would support the decisive influence test. With respect, this is a matter of subjective interpretation. It appears to us that the words and descriptions used do support the decisive influence test, particularly the words of *Marshall* quoted above. Lord Lloyd also uses exactly the same authorities in support of the decisive influence test which he favours.[27] The whole point here is that 'influence' is not in any way defined, either in case law or by the commentators, and so the words can be interpreted in any way which suits one's own purpose. Lord Mustill is more fortunate than the rest of us in that his interpretation is now the law, but it is, at the end of the day, only one possible interpretation.

Inducement

The second aspect of the *Pan Atlantic* decision is concerned with the idea that the misrepresentation or non-disclosure must have proved an actual inducement to the innocent party to enter that particular contract, if that party wishes to avoid. This is absolutely novel in relation to non-disclosure, although not of course to misrepresentation — inducement has always been a requirement for misrepresentation, at least in the general law of contract. Their Lordships were, on this point, unanimous in deciding that there should indeed be an inducement requirement for both misrepresentation and non-disclosure in the law of insurance.

The crux of the problem is not that those of us who ever think about such matters do not recognise the probable need for a causal link between the misrepresentation or non-disclosure and the assessment of the risk — such a link may be essential if the law in this area is to be rendered 'morally correct' [28]— but that the relevant sections of the MIA contain no such requirement. Lord Mustill begins his analysis of inducement with just such an observation; that there is, strictly on the wording of the relevant sections of the MIA, no mention of a necessary causal link between the misrepresentation or non-disclosure and the writing of the risk. He then recognises that most interested observers will find this somewhat surprising:

> But for this feature, I doubt whether it would nowadays occur to anyone that it would be possible for the underwriter to escape liability even if the matter complained of had no effect on his processes of thought.[29]

He goes on to ask:

> How, then, does it happen that the 1906 Act seems to contemplate that once a material misrepresentation or non-disclosure is established, the underwriter has an invariable right to avoid?[30]

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25 The same words appear in an earlier, second edition, published in 1811.

26 eg *Philips on Insurance* (5th ed, 1857); *Parsons on Marine Insurance and General Average* (1868); *Arnould on Marine Insurance* (2nd ed, 1857); *Duer: The Law and Practice of Marine Insurance* (1846).

27 See Lord Lloyd's judgment, at pp628–630.

28 Although again, somewhat surprisingly, the Law Commission did not support this proposition either: see n 12 above.

29 See Lord Mustill's judgment, at p610, para (e).

30 *ibid* para (h).

With respect, this seems to us to be entirely self-explanatory. Plainly, nobody should envisage the underwriter being allowed to escape liability when his thought processes, and therefore surely his actions, are unaffected by the misrepresentation or non-disclosure, and we would maintain that the Act supports no such thing. The Act, a codification of the existing case law, must have supposed that the test for materiality was exactly that which Lord Mustill and the majority of the House have expended much energy telling us it was not; namely, that the fact will not be considered material unless it affects the thought processes and, therefore, the actions of the underwriter, ie the 'decisive influence' test just discarded by their Lordships.[31] If one accepts that test, what need is there for an inducement requirement? Indeed, the whole issue is better resolved by the necessary effect being confined to materiality, because then we can remain in the realms of objectivity, having only to assess the effect on the prudent underwriter and not the actual underwriter, which is where we must look if an inducement requirement is introduced.

Lord Mustill obviously disagrees, but recognises that a rejection of this interpretation and the introduction of an inducement requirement needs some justification. One possibility that has been mooted,[32] and which he considers and rejects, is that the requirement was simply omitted by the draftsman. We would also reject such a submission. Given that the draftsman of the Act was Sir Mackenzie Chalmers, it is highly improbable that a need for inducement, if the common law required it, would simply have been forgotten.[33]

Lord Mustill therefore considers that there might be three reasons why the Act took the form it did. First, the common law did not require inducement and was correctly reproduced by the Act. Secondly, the common law did require inducement but the promoters of the Act wished the law to be changed, and Parliament did change it. Thirdly, the common law did require inducement and the Act, properly understood, is to the same effect. He suggests that the way to make a choice is to look behind the Act to the developing history of marine insurance law and, in particular, to the scholarly writings.

Accepting that there is a controversy about the need for inducement, Lord Mustill refers us to *MacGillivray and Parkington on Insurance Law* (8th ed, 1988, para 577), where it is stated that at common law an innocent misrepresentation did not affect the contract or afford a defence to an action upon it, *unless there is a total failure of consideration.*[34] He goes on to say that:

> This proposition was asserted as late as 1867 in the judgment of the Court of Queen's Bench delivered by Blackburn J in *Lord Kennedy* v *Panama, New Zealand and Australia Royal Mail Co Ltd* (1867) LR 2 QB 580. Thus, in the field of life assurance, which was governed

31 We think this view is given further support by an examination of mid nineteenth century cases dealing with misrepresentation in insurance law. Because, by this time, the courts of equity had introduced a remedy for innocent misrepresentation into the general law of contract, provided there had been inducement, the courts, when dealing with insurance cases, also started to talk of the need for inducement. It seems clear, however, if one looks carefully at those judgments, that what they are really referring to is materiality in the sense of the 'decisive influence' test, rather than inducement in the strict sense: see particularly here *Traill* v *Baring* (1864) 4 DeGJ & S 318, 326 *per* LJ Knight Bruce.

32 See Kelly, 'Recent Developments in relation to Inducement in Non-Disclosure and Misrepresentation' (1988) 1 ILJ 30.

33 We would point out that this did not concern Lord Mustill quite so much when he was discussing the words of s 18(2) as they relate to materiality: see our comments, *supra* at n 20.

34 The emphasis is ours. We can neither find the italicised words in the text referred to, nor really understand how they can be relevant in this context.

> by the common law, the law on misrepresentation took a shape which was quite unrecognisable from what it is today: see, for example, the difficult case of *Anderson* v *Fitzgerald* (1853) 4 HL Cas 484, 10 ER 551. It was not until, after the Judicature Acts, that the equitable doctrines governing rescission for misrepresentation had infiltrated the general law of contract that a route to the protection of the underwriter in non-marine cases became apparent.[35]

Lord Mustill then goes on to trace the development of the law relating to misrepresentation, both in the general law of contract and the law of *marine* insurance, the latter, it has always been generally supposed, being subject to special rules on innocent misrepresentation. Whilst it may be true that marine insurance only has been subject to special rules, that this was not what Lord Mansfield intended when he was single-handedly hewing out the law on insurance, is, we think, indisputable. His seminal statement on this area, in *Carter* v *Boehm*,[36] clearly intends that a duty of good faith should apply to *all* contracts and, even if he intended that a remedy for an innocent misrepresentation or non-disclosure should be available only in insurance law, he cannot have meant only *marine* insurance law, because *Carter* v *Boehm* was not itself a marine insurance case.

How, then, was it possible for the law of insurance to take what we would regard as a wrong turning and separate not insurance from general contract, but marine insurance from both non-marine and the general law? This cannot, after all, be regarded as sensible — if insurance contracts are to be regarded as being in some way different from general contracts (and we accept that they should be so regarded), then *all* insurance contracts should be so regarded. It is the concept of risk that renders them different, not anything that could be regarded as being peculiar to marine insurance. Lord Mansfield himself made no distinction in the decided cases and it is not until much later, in the middle of the nineteenth century, that the distinction becomes apparent.[37] This can, we think, probably be best explained by observing that the courts of equity had, by this time, developed a remedy for innocent misrepresentation which the common law, outside of insurance, had never recognised. These courts would, of course, have been aware of Lord Mansfield's pronouncements on innocent misrepresentation in insurance cases, ie that there would be a remedy granted by the common law to an insurer even for an innocent misrepresentation by the insured, and a brief perusal of these cases would, of course, reveal them to be concerned with marine insurance. This is not surprising, as little other insurance was available at this time, but this should not necessarily have led the courts to make an assumption that Lord Mansfield intended his pronouncements to apply to marine insurance *exclusively*. As we have just stated, no such thing can have been intended, because *Carter* v *Boehm* is itself one of the very few early cases that is non-marine. Nevertheless, it is not difficult to see why the courts did make such an assumption and why it has now become entrenched. What is less clear is why Lord Mustill should say that the law regarding life insurance should take a different form from that regarding marine, because life insurance was 'governed by the common law.'[38] The common law as opposed to what? This seems to imply that marine insurance is governed by some

35 *Pan Atlantic*, pp 611–612, paras (h), (a).

36 (1766) 3 Burr 1905; see text relating to n 21 above.

37 See eg *Anderson* v *Fitzgerald* [1853] IV HLC 484, mentioned above in the quote from Lord Mustill's speech. This is strictly a case concerning a warranty, but it is stated by at least three of the judges that an innocent misrepresentation will only be given a remedy if the case is one of marine insurance — there is no discussion, however, of why or how this came to be so.

38 *Pan Atlantic*, at p 611, para (j).

other law, which it is not. Marine insurance is, as all other insurance, governed by the common law and we remain entirely puzzled as to what his Lordship means by this statement.

This may be, for all practical purposes, nothing other than an interesting academic point because, when one accepts that the law of insurance did divide, one must, of course, also accept that Lord Mustill is correct when he says that it was not until the Judicature Acts, and the fusion of law and equity, that the equitable remedy of rescission was imported into the law of non-marine insurance as a newly available remedy for innocent misrepresentation. It would not be surprising if inducement was then required, because it was required by the general law of contract. However, the MIA, passed 30 years later, makes no mention of inducement. As both we and Lord Mustill have discounted the possibility of this being due merely to forgetfulness on the part of Chalmers, then surely the only logical conclusion to draw is that it was considered to be unnecessary, superfluous even, in insurance law because of the insurance law requirement of materiality. If the test for materiality was then supposed to be the 'decisive influence' test, there is absolutely no need for any requirement of inducement — the law as it stood would produce an equitable enough result.

Even if one has difficulty in accepting this argument, then we have to say that we still do not understand why a principle of misrepresentation must necessarily apply to non-disclosure, other than that such a course of action provides consistency. It may be that such an objective is desirable, but any legal justification for such an action is difficult to find. Lord Mustill himself accepts that any analogy with the general common law is futile, because the general common law has no concept of non-disclosure. The best he can do is to tell us that as he has shown, at least to his own satisfaction, that inducement is a requirement of misrepresentation, then it is intolerable to suppose that such a requirement is not necessary in cases of non-disclosure. To his Lordship's credit, he bravely goes on to admit that this may involve the House in the making of new law and, if that is the case, so be it.[39] In our opinion, this does indeed involve the making of new law because there has not, to our knowledge, ever been any suggestion before, in insurance law cases or commentary, that inducement is a requirement for avoidance for non-disclosure. This development is consistent with a somewhat worrying proposition which appears to be currently running through the English appellate courts, namely, that the delivery of 'justice' will not be held back by a firm adherence to established doctrine.[40] Justice is always an admirable objective, but it is equally a rather subjective concept — the way to avoid subjectivity in this area is surely to adhere to precedent, the principle on which the English common law rests, not to throw it out of the window simply to achieve the desired result in any particular case.

As we pointed out earlier, there are difficulties involved in treating misrepresentation and non-disclosure as the same creatures. The two are often pleaded indiscriminately and this is bound to become even more common the more the legal differences between the two are blurred. Yet there are differences — for example, an innocent misrepresentation can never be an actionable non-disclosure. A misrepresentation that the law deems to be innocent is a positive statement based

39 *Pan Atlantic*, p617, para (j).

40 This has been particularly apparent in recent cases of negligently inflicted pure economic loss in torts law: see eg *Henderson* v *Merrett Syndicates* [1994] 3 All ER 506; *White* v *Jones* [1995] 1 All ER 691; and also in contract cases concerning the doctrine of consideration, *Williams* v *Roffey Brothers* [1990] 1 All ER 512, being the prime example.

upon the representor's genuine belief in its truth. A good example in insurance law is the declaring of losses by a prospective insured to his insurer. If the actual loss is more than that declared, albeit through no fault of the insured, this could as easily be termed a non-disclosure in the sense that an amount of actual loss remains hidden, and this is exactly what happened in *Pan Atlantic*. This situation cannot, however, technically be an actionable non-disclosure because, to be actionable, an innocent non-disclosure must involve the insured failing to disclose something which he knows, because he fails to realise it might be important to a prudent insurer. We must assume, in the given situation, that the insured is totally unaware of the true actual losses, otherwise the misrepresentation must be deemed to be fraudulent, a situation which the law treats very differently. It is not difficult to imagine other situations where this may arise and it surely cannot be sensible for the law to attempt to merge these doctrines when they are, legally, quite separate entities.

Another difficulty arises conceptually when one talks of an insurer being induced into a contract by a non-disclosure. How can anyone really be induced by what amounts to silence? Of course, the non-disclosure could be framed in a different way, eg had the undisclosed facts been disclosed, then the insurer would not have entered into this particular contract, but that is not quite the same as alleging that silence was the actual inducement, which is what should be proved in this situation. In our opinion, inducement does not make any real sense when non-disclosure is being alleged, unlike misrepresentation where it is easy to see how an incorrect positive statement can be an inducement. This difficulty may, in our opinion, be another nail in the coffin of a presumption that inducement was a requirement of either misrepresentation or non-disclosure in insurance law but, even if one accepts that it was a requirement of misrepresentation, it should be another argument in favour of keeping the two doctrines separate.

Conclusion

In *St Paul Fire and Marine (UK) Ltd* v *McConnell Dowell Constructors Ltd*,[41] strictly a case of misrepresentation,[42] the Court of Appeal were asked to clarify certain of the problems arising out of *Pan Atlantic*. It was argued that the test for materiality had still not been precisely determined[43] and, concerning inducement, that is was not clear whether an actual insurer benefits from a *presumption* of inducement.

Evans LJ, who delivered the principal judgment in *St Paul*, had no hesitation that the proper test for materiality had been properly determined, and was only that the prudent insurer would have wished to know; this must mean that the 'decisive influence' test has now been absolutely discounted. As to the second limb, Lord Mustill alludes to a presumption of inducement at least twice in his judgment in

41 May 1995, unreported at the time of writing.

42 But, following *Pan Atlantic*, equally applicable to non-disclosure.

43 It was argued that although the 'decisive influence' test had been discarded as the test for materiality, the exact nature of the test had not been conclusively determined by the House of Lords. Was it (a) the very broad test of whether the fact was one that might be of interest to the prudent insurer, or (b) the narrower test suggested by the Court of Appeal in *CTI*, that the fact can be material only if the prudent insurer would have regarded it as increasing the risk. The Court of Appeal here decided that the very broad test should prevail.

Pan Atlantic,[44] but it was firmly rejected by Lord Lloyd.[45] The Court of Appeal in *St Paul* decided, however, that there was such a presumption in favour of the innocent party and, moreover, that it was enough for him to show that the misrepresented fact had proved *an* inducement, but not necessarily *the* inducement. One of us has already argued that if a presumption of inducement does exist, then the misrepresented fact must be shown to be the only inducement because anything less only aids the insurer, already subject to a very lenient test on materiality[46]; however, such an argument has been firmly rejected, at least by this particular Court of Appeal.

It therefore appears that the law after *Pan Atlantic* is much the same as it was after the much criticised *CTI* decision, although it is arguable that it is worse in that it is no longer open to the insured to argue the 'increased risk' theory.[47] The introduction of an inducement requirement has served only to muddy the waters, rather than clear them, which is what the House of Lords purportedly set out to do. There must now be a very strong argument for referring this whole issue back to the House for clarification and resolution.

Law, Labour and Mental Harm

Lesley Dolding and Richard Mullender***

Introduction

Employers are under a duty (arising concurrently in tort and contract) to exercise reasonable care so as to protect their workers from reasonably foreseeable work-related mental harm. That the law comprehends this form of harm was established by Colman J in the case of *Walker* v *Northumberland County Council*,[1] in which the plaintiff suffered a permanently disabling mental breakdown having been unreasonably exposed to a 'deluge of work.'[2] In reaching this decision, the judge has addressed an issue which has recently come under scrutiny by, *inter alia*, the Health and Safety Executive,[3] the Confederation of British Industry[4] and the national press.[5] His decision is, moreover, noteworthy on account of the emphasis it gives to the balancing of plaintiff- and defendant-related interests when

44 *Pan Atlantic*, p610, para (f); p617, para (d).
45 *ibid* 637, para (c).
46 See Hird, 'Rationality in the House of Lords?' [1995] JBL 194, 196. It was also stated here that an inducement requirement, whether 'an' or 'the' inducement, could only aid the insured if the burden of proof lies with the *insurer*, and that it will so lie is not at all clear from *Pan Atlantic*.
47 For a fuller discussion of the *St Paul* case, see Hird, '*Pan Atlantic* — yet more to disclose?' [1995] JBL 608.

*Lecturer in Law, University of Exeter.
**Lecturer in Law, University of Newcastle-upon-Tyne.

1 [1995] 1 All ER 737.
2 *ibid* 756G: see also p741B, where Colman J notes that '[The plaintiff's] confidence in himself was permanently destroyed.'
3 See Health and Safety Executive, *Stress at Work: A Guide for Employers* (HSE Books, 1995) HS(G) 116.
4 See Health, Safety and Environment Bulletin, 'Stress and Common Sense' (July 1995) p9.
5 See, for example, 'Welcome Back Stakhanov', *The Independent on Sunday*, 1 January 1995, p14 (editorial comment).

SUBROGATION IN INSURANCE LAW—A CRITICAL EVALUATION

REUBEN HASSON*

1. INTRODUCTION

There can be few, if any, legal subjects, that have received less critical attention in Commonwealth countries than the law of insurance. The doctrine of subrogation, for example, is set out in most Commonwealth insurance law textbooks without a whisper of criticism.[1] To be sure, the periodical literature is a little more promising. There one finds criticisms of specific incidents of subrogation; for example in its application to the vendor-purchaser situation,[2] to employer's liability insurance[3] or to the right of health authorities to bring claims for subrogation.[4]

It is worth considering why the doctrine of subrogation has attracted so little critical attention from legal writers. In the first place, most writing in the law of insurance has been aimed at practitioners and there is a feeling (perhaps justified) that practitioners are not interested in policy debates. Second, the doctrine of subrogation is at least two centuries old[5] and it is associated with the name of Lord Mansfield who has achieved the status of legal sainthood—at least in the area of insurance law even if he is credited with having formulated rules which he did not.[6] After a doctrine has been in existence for two centuries, it becomes natural to think of that doctrine as being an indispensable part of insurance law.

*Osgoode Hall Law School, York University, Toronto. I would like to thank John Birds, Ben Geva, Harry Glasbeek, Douglas Hay, Terry Ison, Derek Morgan and David Vaver for reading an earlier draft of this paper. They are, of course, not responsible for any of my errors or opinions.

1 See e.g. McGillivray and Parkinston on *Insurance Law* (London, Sweet & Maxwell 1981) 471–512; Colinvaux, *The Law of Insurance* (London, Sweet & Maxwell 1979) 135–41; Ivamy, *General Principles of Insurance Law* (London, Butterworths 1979) 496–520; Sutton, *Insurance Law in Australia and New Zealand* (Sydney, The Law Book Co 1980) 552–69; Brown and Menezes, *Insurance Law in Canada* (Toronto, Carswell 1982) 313–41. The one exception is Birds, *Modern Insurance Law* (London, Sweet & Maxwell 1981) whose chapter on subrogation includes a brief critical discussion of the subject; see 274–5 ('The Future of Subrogation').

2 See e.g. Thompson, *Must a Purchaser Buy a Charred Ruin?* (1984) Conv 43.

3 See e.g. Glanville Williams, 'Vicarious Liability and the Master's Indemnity' 20 *Mod L Rev* 200, 437 (1957).

4 See e.g. Rendall, 'Subrogation in Medical and Hospital Insurance Schemes: Judicial Philosophy Versus Legislative Pragmatism' 6 *Ottawa L Rev* 291 (1974).

5 For an attempt to trace the doctrine of subrogation to its origins, see Marasinghe, 'An Historical Introduction to the Doctrine of Subrogation (Parts I & II) 10 *Valparaiso U L Rev* 45, 275 (1975).

6 See Hasson, 'The Doctrine of "*Uberrima Fides*" in Insurance Law—A Critical Evaluation' 32 *Mod L Rev* 615 (1969) and Hasson, 'The "Basis of the Contract" Clause' 34 *Mod L Rev* 29 (1971).

Thus, many lawyers cannot envisage the law of insurance functioning without say, the doctrines of subrogation and *uberrima fides*.

The most important factor is the very strong attachment by lawyers and judges[7] to the concept of fault that subrogation embodies.[8] To many lawyers, nothing could be more beneficial than that an insurer should penalize the wrongdoer and hold the recoveries in trust for the benefit of 'innocent' policy holders.

I will try to demonstrate that the alleged goals of subrogation do not achieve their purpose. I will argue, instead, that the results achieved by subrogation are wasteful and harmful. I will then show how courts in the United States and the Commonwealth have limited the operation of subrogation in certain areas. I will demonstrate the severe limitations of this kind of judge made law reform. Finally, I will outline a statute designed to abolish subrogation in most areas of insurance.

(a) *What is subrogation?*

When a loss occurs, it is open to the legal system to adopt one of three alternatives (i) to allow the insured party to keep *both* the insurance proceeds and to allow full recovery against the tortfeasor (or other party against whom the insured could enforce contractual rights); (ii) to allow the insured party to recover his/her own loss while the insurer is denied the right to proceed against the tortfeasor or contract breaker; or (iii) to allow the insured to recover from his/her own insurer but also to allow the insurer to use the insured's name to recover such payout from the tortfeasor or contract breaker.

It is this third option that the legal system has chosen to deal with most insured losses and which is called subrogation. This doctrine operates throughout the field of property and liability insurance—to all so-called contracts of indemnity.

This principle does not hold sway throughout the law of insurance. In the field of personal injury because life insurance and accident insurance are (strangely) not thought to be contracts of indemnity,[9] the insured person is allowed to accumulate recoveries.

7 See e.g. the views expressed by the Pearson Commission (*The Report of the Royal Commission on Civil Liability and Compensation for Personal Injury* (1978) Cmnd 7054), which included such statements as the following: 'There is elementary justice in the principle of the tort action that he who has by his fault injured his neighbour should make reparation' (Vol 1, para 262). 'In broad terms, however, there remains an important potential impact on the tortfeasor's reputation as, say, a professional or businessman. This is the more significant in that the cases attracting most publicity will tend to be those in which a tortfeasor contests his liability, and in which liability is therefore the least clear cut' (Vol 1, para 256).

8 It is true that in some cases (e.g. vendor-purchaser) negligence seems to play no part. In these cases, the English courts and those in the Commonwealth, have adopted a dogma of insurance as a personal contract, however harsh the consequences of that view.

9 As early as 1918, Professor Patterson argued that there was a considerable indemnity element in life insurance; see his article, 'Insurable Interest in Life' 18 *Col L Rev* 381 (1918).

In 1957, the same author wrote that: 'The English Courts, obedient to a statute enacted in 1774 have rather halfheartedly treated the life policy as an indemnity contract'; see his *Essentials of Insurance Law* (New York, McGraw-Hill Book Co 1957) 155.

The second option, that of allowing the insured to recover his/her loss from the insurer while denying subrogation rights to the insurer does not apply to any particular branch of insurance but courts in the United States and the Commonwealth are adopting this result by a variety of devices.[10]

Each option is said to suffer from a drawback. Option one allows the insured to be overcompensated. The second option is said to be inconsistent with the concept of the insurance contract as a personal contract between the insurer and the insured. The objection to the third option is that insurers are given a windfall by the device of subrogation, since insurance rates are not fixed in anticipation of such a recovery.[11]

The objections to options one and three would appear to be extremely powerful since the law is supposed to set its face against windfalls. The second objection turns out to be insubstantial. The reason why insurance is a personal contract between insurer and insured is simply because in England the courts said it was in *Rayner* v *Preston*.[12] The courts might just as easily have held as did the American courts in vendor-purchaser cases,[13] that insurance was not a personal contract. The social results of the American approach are far more just than the English approach.

Despite the fact that the second option has the most to commend it, it plays only a small part in the law of insurance. Options three and one dominate the field.

(b) To which insurance contracts does the doctrine of subrogation apply?

The doctrine of subrogation applies only to contracts of indemnity and in the Alice-in-Wonderland world of insurance, life insurance contracts and accident insurance contracts were held not to be contracts of indemnity,[14] despite the fact that it is clearly the intention of purchasers of these contracts to indemnify either their families (in the event of death) or, in the event of an accident, to compensate themselves for their lost earnings. Why the loss of property should be treated differently from a loss of an arm, when both result in economic losses to the person who sustains them has never been explained.

In any event, as a result of not classifying life insurance and accident insurance as contracts of indemnity, an insured victim is allowed to accumulate recoveries from as many sources as s/he can. As Fleming James,[15] Fleming,[16] and Atiyah[17]

10 See Part IV Judicial Attempts to Curb Subrogation, *infra*.

11 See Part II *(b) Subrogation is a cost saver, infra*.

12 (1881) 18 Ch D 1 (CA) (James LJ dissenting).

13 See Part IV *(a) Vendor-purchaser, infra*.

14 See *Dalby* v *India and London Life Assurance Co* (1854) 15 CB 365 (life insurance); *Bradburn* v *Great Western Railway Co* (1874) LR 10 Ex 1 (accident insurance).

15 See his article, 'Social Insurance and Tort Liability: The Problem of Alternative Remedies' 27 *New York UL Rev* 537 (1952). (Professor James uses a very wide notion of 'social insurance').

16 See his article, 'The Collateral Source Rule and Loss Allocation in Tort Law' 54 *Calif L Rev* 1478 (1966).

17 See his article, 'Collateral Benefits Again' 32 *Mod L Rev* 397 (1969).

have argued it is difficult to justify accident victims' being able to end up with enormously high recoveries, when others who are injured receive a pittance or have to depend on welfare payments.

Canadian courts (or at least some of them) seem prepared to nibble away at part of the collateral benefits principle. The area of battle is in the field of disability insurance. While the courts have accepted that they cannot call life insurance or accident insurance contracts contracts of idemnity, some have started to describe disability insurance contracts as contracts of indemnity. In *Orion Insurance Co* v *Hicks*,[18] a Manitoba court held that disability benefits of $35 a week paid for forty-one weeks were indemnity benefits since they were intended to compensate for loss of income. This decision was followed by the New Brunswick Court of Appeal in *Levesque* v *Co-operative Fire & Casualty Co*[19] and by the Ontario High Court in *Gibson* v *Sun Life Assurance Co of Canada*.[20]

On the other hand, in *Mandas* v *Thomaschke*,[21] Mr Justice Bouck of the British Columbia Supreme Court refused to deduct disability benefits because 'Negligent conduct should not be forgiven simply because the injured party took steps to provide for his future security'.[22]

Finally, in *Greenwood* v *Sparkel Janitor Service*,[23] Mr Justice Taylor said he would deduct benefits which were meant to replace wages, but he would not deduct sums that were 'properly characterized as insurance'. How this distinction is to be operated when virtually all disability benefits are meant to replace loss of wages or earnings is quite beyond me.

If we ignore the confusion in doctrine, the trend in Canada seems to be to regard disability insurance as being a contract of indemnity. From one angle this makes a lot of sense. Disability insurance is indemnity insurance just as much as life and accident insurance. What the courts are doing, however, by calling disability insurance a contract of indemnity is to draw arbitrary lines between different kinds of insurance benefits. The problem of rationalizing collateral benefits, whether provided by private or social insurance, can only be dealt with by legislation. The task of rationalizing these benefits is beyond the powers of the Supreme Court of Canada, let alone the courts of first instance who have heard most of these cases.

(c) *Fictitious Plaintiffs* v *Fictitious Defendants*

We tend today to look upon legal fictions as the product of a primitive age[24] and twentieth century lawyers are normally quick to attack fictions as being a blotch on the legal system.

18 (1972) 32 DLR (3d) 256.
19 (1976) 68 DLR (3d) 553.
20 (1984) 6 DLR (4th) 746.
21 (1983) 145 DLR (3d) 530.
22 Ibid, 536.
23 (1983) 145 DLR (3d) 711.
24 Thus, Professor Fuller's *Legal Fictions* (Stanford University Press 1967) makes no mention of subrogation or any other modern legal fiction.

Yet in the field of subrogation, the presence of fictions seems to escape notice as well as criticism. In subrogation not only do we invariably have a fictitious plaintiff who is suing in the name of the insured but very often—perhaps in the vast majority of cases—a fictitious defendant. Sometimes the courts are aware that the contest is between two insurance companies.[25] In other cases, judges speculate that the contest is between two insurance companies.[26]

Insurance companies use the device of the fictitious plaintiff because they think it will increase their chances of success in litigation.[27] Whether they do in fact increase their chances of recovery is not something that can be proved.

It may be that in at least some cases, insurers gain an advantage by suing as the XYZ company instead of suing as the XYZ insurance company. A court may be more likely to find for private uninsured individuals than for an insurer.

In the United States some defendants have successfully moved to dismiss an action on the ground that the insurer and not the insured, was the 'real party in interest'. In *Ellis Canning Co* v *International Harvester*,[28] the Supreme Court of Kansas overruled a number of previous decisions and held that: '. . . the insurer may, indeed, must bring the action if one is to be maintained'.[29] Similarly, in *Shambley* v *Jobe Blackley Plumbing*,[30] homeowners brought an action to recover damages to their home resulting from the explosion of a defective water heater which the defendants had warranted to be safe and suitable for home use. The defendant brought suit to have the insurer declared the real party in interest. Higgins J, giving the judgment of the North Carolina Supreme Court stated that: 'Defendants have the right to demand that they be sued by the real party in interest and none other.'[31]

In order to counter this development, insurance companies began to develop a device called the 'loan receipt'. Under this device, the insurer makes a payment which is technically a loan to be repaid out of proceeds of the claim against the third party, which claim is pledged to the insurer as security for the 'loan'.[32] The receipt contains a power of attorney appointing the insurer agent to collect this claim by legal action, if necessary, in the insured's name.

25 See the judgment of Laskin CJC, for the majority, in *Ross Southward Tire Ltd* v *Pyrotech Products* (1975) 57 DLR (3d) 248. In that case, his Lordship stated that: 'The existence of the policy means only that litigation which in form is between a landlord and its tenant is in substance a contest between two insurance companies'; ibid, 253.

26 See the dissenting judgment of Cooke J in *Marlborough Properties* v *Marlborough Fibreglass* [1981] 1 NZLR 464. In the course of his judgment, his Lordship said: 'It may be that the action is in effect between two insurance companies, but that is irrelevant'; ibid, 465.

27 See Keeton, *Insurance Law* (St Paul, Minn, West 1971) 156–8.

28 255 P 2d 658 (1953).

29 Ibid, 659.

30 142 SE 2d 18 (1965).

31 Ibid, 20.

32 See the excellent comment, 'The Loan Receipt and Insurers' Subrogation: How to Become the Real Party in Interest Without Really Lying' 50 *Tulane L Rev* 115 (1975).

Deplorable though this device is, it is important to realize the severe limitations of the 'real party in interest' rule. This device enables the defendant to show that the plaintiff is an insurance company. However, this shows only one side of the picture because 'the real defendant in most of these cases is also an insurance company which cannot be sued directly under prevailing practice and so also hides behind the skirts of an insured individual or business corporation'.[33] James and Hazard have aptly commented that 'the effect of this pair of rules is a spectacle even more unedifying than the classic action in ejectment where the fictitious nature of the nominal parties was at least so palpable that it could fool nobody'.[34]

So long as we have a doctrine of subrogation, there can be no justification for concealing the true identity of parties in litigation. The idea of letting insurance companies use disguises so as to influence the outcome of a case is an obscenity which should not be tolerated in a civilized legal system.

Unfortunately, there is no sign that legal scholars in the Commonwealth have begun to address this problem.

II. THE ALLEGED GOALS OF SUBROGATION

It is difficult to write about the goals of subrogation since to most commentators the doctrine appears to be so just as not to need any justification. However, various rationales have been advanced by insurance company representatives, academics and judges.

(*a*) *Subrogation is necessary for the survival of the insurance industry*

According to one insurance executive: 'Effective subrogation practices by insurers can mean the difference between an underwriting profit or a loss.'[35] There is no description of what is meant by 'effective'. Does it mean the same as aggressive? The statistics that are provided make it *extremely* unlikely that the amounts recovered through subrogation are likely to prove the difference between a profit and loss.

Thus, in 1972 fire insurance companies in the United States paid out $973,636,000. Subrogation recoveries amounted to $6,621,000 a net recovery of 0.68 per cent of paid losses.[36] Again, consider the figures for homeowners' insurance provided by the same author. In 1972, homeowners' claims paid by the insurance industry came to $1,636,147,000. Subrogation recoveries totalled $13,089,000 a net recovery of 0.80 per cent of paid loss.[37] These sums appear to be too trivial to make much difference to anything. In the absence of more compelling

33 See James & Hazard, *Civil Procedure* (Boston, Little, Brown & Co 1977) 400.

34 Ibid, 400–01.

35 See Meyers, 'Subrogation Rights and Recoveries Arising Out of First Party Contracts', 9 *Forum* 83 (1973). The author is Senior Vice President of Crum and Forster Insurance companies.

36 Ibid, 84–5.

37 Ibid, 85.

evidence it is impossible to argue that subrogation is necessary to keep insurance companies solvent.

(b) Subrogation is a cost saver

The notion that insurance companies might after taking 'net subrogation recoveries' into account be able to offer their customers lower premiums has been advanced by two authors. This argument is stated without any doubts by R. C. Horn in this book, *Subrogation in Insurance Theory and Practice*[38] and, more tentatively, by Professor McCoid in his article on the *Allocation of Loss and Property Insurance.*[39]

The difficulty with this theory is that it flies in the face of the information we have about the workings of subrogation.

In the first place as Professor Patterson pointed out in 1957, '[Subrogation] plays no part in rate schedules'.[40] This statement is unchallenged by Horn, McCoid or any other authority.

Patterson's statement is supported by evidence that insurers do not seem to take subrogation recoveries into account when fixing premiums for their policy holders. Thus, Patterson found that insurers made 'no reduction in insuring interests such as that of the secured creditor, where the subrogation rights will obviously be worth something'.[41] Another researcher found that in issuing fire insurance policies, insurers charged the same rates whether or not there was the possibility of subrogation recoveries.[42] Finally, Professor Keeton discovered that from the 1950's 'it became possible to obtain an endorsement on a lessor's fire policy by which the insurer waives any right of recovery against a tenant for loss to insured property. Ordinarily, also, no additional premium is charged for such an endorsement.'[43]

Second, if subrogation recoveries helped reduce premiums, one would expect insurance companies to pursue subrogation recoveries aggressively. But this is precisely what they do not do. In England and Canada, motor insurers pursue a 'knock-for-knock' agreement with other motor vehicle insurers.[44] In England,

38 (Homewood, Illinois, R. D. Irwin, 1964) 25.

39 39 *Indiana LJ* 647 (1964).

40 See his, *Essentials of Insurance Law*, (New York, McGraw-Hill Book Co 1957) 151–2.

41 Ibid, 152.

42 See note in 72 *Harv L Rev* 1380, 1382 (1959).

43 See Keeton, *supra*, n 28, 209.

44 In England 'knock-for-knock' agreements were first made soon after the formation of the earliest motor insurance companies at the beginning of this century; see Richard Lewis, *Insurers' Agreements Not to Enforce Strict Legal Rights: Bargaining with Government and in the Shadow of the law* 48 *Mod L Rev* 275 (1985).

In Canada, most automobile insurers are party to a multilateral agreement whereby they agree in appropriate cases to apportion loss. The agreement only applies where the vehicles involved carry valid third party liability and collision insurance. The damage to any vehicle must not exceed $10,000. If the insurers disagree on the facts, they may have recourse to arbitration under the 'Inter-Company Arbitration Agreement'. This agreement applies to collision losses of up to $2,500 in any one accident; see Brown & Menezes, *supra* n 1, 334.

there is also an agreement between members of the Fire Offices Association not to pursue subrogation recoveries,[45] and an agreement by the BIA not to pursue subrogation rights in employers' liability policies.[46]

The reason why subrogation recoveries cannot play an important part in fixing insurance premiums is because most subrogated claims are, in effect, contests between two insurers. In this state of affairs, it will not be enough to compute subrogation recoveries. One would also have to take into account subrogation liabilities. Since one would expect subrogation recoveries and subrogation liabilities to cancel each other out on a 'swings and roundabouts basis', it is difficult to see how subrogation could help lower rates.

In sum, it seems most unlikely that subrogation can have any appreciable effect on the cost of premiums. On the other hand, by requiring overlapping premiums and especially the occasional expensive lawsuit, it would seem that subrogation might well have the effect of making insurance more expensive.[47]

(c) *Subrogation is a deterrent against negligent behaviour*[48]

It is clear that subrogation is justified by some as a deterrent against negligent behaviour. It is true that few judges would be as outspoken as Viscount Simonds in *Lister* v *Romford Ice and Cold Storage*,[49] when he wrote: '. . . to grant the servant immunity from such an action would tend to create a feeling of irresponsibility in a class of persons from whom, perhaps more than any other, constant vigilance is owed to the community',[50] but I expect that very few judges in the United States and the Commonwealth would dissent from Lord Diplock's statement in *Doughty* v *Turner Manufacturing Co*[51] when he said that: 'There is no room today for mystique in the law of negligence. It represents the application of common morality and common sense to the activities of the common man.'[52]

45 'Knock-for-knock' agreements limiting both contribution and subrogation in fire insurance cases followed the decision of the English Court of Appeal in *North British & Mercantile Ins Co* v *Liverpool, London & Globe Ins Co* (1877) 5 Ch D 569. The Fire Offices Committee (representing most of the fire insurers) have revised their agreement on several occasions; see Lewis, *supra* n 44.

46 The first of these agreements was entered into after the decision in *Lister* v *Romford Ice and Cold Storage Co* [1957] AC 555. There have been subsequent revisions of the agreement; see Lewis, *supra* n 45.

47 See e.g. Kimball and Davis, 'The Extension of Insurance Subrogation' 60 *Mich L Rev* 841 (1962). The learned authors write: '. . . repeated transfer of losses is an expensive matter, and socially it is much more efficient to handle the money only once, especially if litigation costs can thereby be avoided'; ibid, 871.

48 I have drawn here, and at other parts of this article on my case note, '*Blindfolding the Courts: A Further Comment on Photo Production* v *Securicor*' 5 *Canadian Business LJ* 498 (1981).

49 [1957] AC 555.

50 Ibid, 579.

51 [1964] 1 QB 518 (CA).

52 Ibid, 531.

There are, however, formidable difficulties in using subrogation to deter negligent behaviour. In the first place, as Professor Langmaid argued in a famous article in the Harvard Law Review fifty years ago, most negligent behaviour is of such a trivial kind that deterrence makes no sense.[53] To be sure, two of the cases Langmaid offered as examples, *Mason* v *Sainsbury*[54] and *Clark* v *Inhabitants of Blything*,[55] are now only of historic interest. In those cases, an insurer was subrogated to the insured's cause of action against the hundred under the Riot Act 1720.[56] But some of Langmaid's examples are apt; he queried the utility of bringing subrogated claims against employers in respect of minor acts of negligence committed by their employees.[57] He also queried the justice of a decision in which an innocent converter was held liable in a subrogated claim.[58]

Second, if we truly believed that subrogation claims deterred negligent behaviour by corporations and individuals, the sensible step would be to ban liability insurance. The argument that subrogation claims promote safety not in the individual case but by increasing premiums for delinquent companies with bad accident records,[59] is most unlikely to be true because insurance companies very infrequently bring subrogated claims.[60]

Next, if we took the deterrence argument seriously we would not allow insurers to insure both the insured and the potential tortfeasor. We know from various sources[61] that this is a frequent occurrence. A law making sure that the insurer could not insure both sides of the bargain would not be easy to draft. But one could at least provide that the same insurer could not say, insure both vendor and purchaser, landlord and tenant, contractors and subcontractors.

The real deterrent against negligent behaviour on the part of corporations is not the possibility of subrogated claims, against which they are insured, in any event. The real deterrent against negligent behaviour in the case of a corporation is the fear of the loss of business which may follow an accident. So far as using

53 'Some Recent Subrogation Problems in the Law of Suretyship and Insurance' 47 *Harv L Rev* 976 (1934). The same theme was expressed in an influential article by King, 'Subrogation under Contracts Insuring Property' 30 *Texas L Rev* 62 (1951).

54 (1782) 3 Doug. 61.

55 (1823) 2 B & C 254.

56 For a brief description of remedies against the hundred under the Riot Act 1720, see 5 *Law Magazine* 132 (1831). (I am indebted to my colleague Douglas Hay for this reference.)

57 See *supra* n 55, 988.

58 See *Potomac Ins Co* v *Nickson* (1924) 231 P 445.

59 See e.g. Fleming, 'The Role of Negligence in Modern Tort Law' 53 *Va L Rev* 815, 825 (1967).

60 See text at ns 37–8 and 45–7, *supra*.

61 See e.g. A. V. Alexander, 'The Law of Tort and Non-Physical Loss' 12 *JSPTL* (NS) 119 (1972) 122 where the author, Managing Director, Sedgwick Collins & Co Ltd writes: 'Not infrequently one sees the rather absurd spectacle of a fire insurer seeking to exercise rights of subrogation against a third party who is insured by the liability department of the same insurance company'; see also to the same effect the *Financial Times* for 25 February 1980 quoted by Nicol and Rawlings in their note, 'Substantive Fundamental Breach Burnt Out' 43 *Mod L R* 567, 571, n 34 (1980).

subrogated claims to deter individual behaviour is concerned, I can do no better than to quote the report of the New York State Insurance Department as a means of achieving safety on the roads: 'Individual, last-moment, driver mistakes—undeterred by fear of death, injury, imprisonment, fine or loss of licence—surely cannot be deterred by fear of civil liability against which one is insured.'[62]

It is perhaps significant that no representative of the insurance industry has, to the best of my knowledge, made the claim that subrogated claims deter negligent behaviour. It would appear that judges accept the efficacy of fault notions much more readily than do representatives of the insurance industry.

III. THE REAL FUNCTIONS OF SUBROGATION

(*a*) *Subrogation and overlapping coverage*

The main function of the subrogation doctrine is that it requires overlapping insurance coverage. Thus, in a sale both the vendor and the purchaser will have to insure the same piece of property, unless the purchaser wishes to pay a substantial sum of money for 'a charred ruin'.[63] Again, in the mortgagee-mortgagor relationship, it will be prudent for the mortgagor to protect his/her interest by taking out insurance.[64] In both these cases, two policies are being taken out to cover one risk. This is the real attraction of subrogation for insurers.

The situation becomes even more promising for insurers if we consider the situation of a landlord and a commercial tenant. In this case, both the landlord and tenant will carry insurance on the same building. In addition, the tenant's employees would be well advised to carry liability insurance. Similarly, people who supply the tenant with goods would be well advised to take out liability insurance, as would people who come to effect repairs. Thus, in this situation five groups of people may well be paying insurance premiums in respect of one risk.

If the insurance companies' interest lies in being able to recover several premiums in respect of one risk, it might be asked why they bother to sue at all. One answer must be that, the occasional action is necessary to make sure that all potential tortfeasors and potential contract-breakers maintain their liability insurance. If insurers did not bring any subrogated claims, then some potential tortfeasors might cease to procure overlapping coverage.

Another answer must be that individual insurers see their interest as being different from the aggregate interest and pursue their individual interest by bringing subrogated claims.

(*b*) *Subrogation and wasteful litigation*

Three examples of wasteful subrogated cases appeared in English courts recently.

In *Harbutt's Plasticine Ltd* v *Wayne Tank and Pump Co Ltd*[65] the defendants agreed with the plaintiffs to design and install equipment for storing stearine in a

62 See their report, *Automobile Insurance . . . for Whose Benefit?* (New York, 1970) 12.

63 See Thompson, *supra* n 2.

64 The parties, in this area, can avoid overlapping coverage by using the Standard Mortgage Clause.

65 [1970] 1 QB 447 (CA).

molten state. For this purpose, the defendants specified durapipe which was wholly unsuitable because it was liable to distort at temperatures above 187°F. A fire was caused when the durapipe distorted under heat causing molten stearine to escape and ignite. Despite the presence of a broad exemption clause, the Court of Appeal, in a decision that attracted a great deal of criticism,[66] held that the defendant had been guilty of a fundamental breach and was liable to pay £172,966. Despite the fact that it had drafted a very wide exemption clause, the defendant had taken out liability insurance. In a second action, arising out of this saga, the defendant sued one of its insurers in a case which was heard by the Court of Appeal.[67] No one knows the cost of shifting the loss of £172,966 from one insurer to another but one can be certain that the cost was very high. It is in this connection that Professor Atiyah has pertinently asked 'would the decision [in *Harbutt's Plasticine*] have been much more sensible in policy even if there had been no exclusion at all?'[68]

Next, in *Home Office* v *Dorset Yacht*,[69] seven Borstal boys escaped from the supervision of three officers and damaged the plaintiff's yacht. The cost of the damage to the yacht was £1315 13s. 8d.[70] The insurer having made good the damage, now brought a subrogated claim against the Crown. In this case, it is clear that the cost of shifting the loss from the insurer to the Crown vastly exceeded the small amount of money paid out by the insurer. One might seek to justify this fiasco by arguing that their Lordships reviewed fully the system of supervision of borstal boys but as Lord Dilhorne pointed out several times in his dissent, the courts are not a suitable institution for determining rules for compensating property claims and, at the same time, trying to determine good penal policy.[71]

66 See e.g. Legh-Jones and Pickering, '*Harbutt's Plasticine Ltd* v *Wayne Tank and Pump Co*: Fundamental Breach and Exemption Clauses, Damages and Interest' 86 *Law Q Rev* 513 (1970); Coote, 'The Effect of Discharge by Breach on Exception Clauses' 28 CLJ 221 [1970] and notes by Weir 28 CLJ 189 and Baker, 33 *Mod L Rev* 441 (1970).

67 See *Wayne Tank and Pump Co Ltd* v *Employers' Liability Assurance Corp Ltd* [1974] QB 57. Wayne Tank were unsuccessful in this action but no great significance is to be given to this fact. The policy could easily have been read so as to give Wayne Tank protection.

68 See his review of Waddams, 'Products Liability' 26 *U Toronto LJ* 118, 120 (1976). For a fuller critique of the doctrine of subrogation see Atiyah, 'Property Damage and Personal Injury—Different Duties of Care?' In T. Simos (ed), *Negligence and Economic Torts: Selected Aspects* (Sydney, the Law Book Co 1980) 37 esp 41–50.

69 [1970] AC 1004.

70 Ibid, 1008.

71 Ibid, 1045, 1048, 1051. The same idea was expressed more concisely by Lord Denning MR: 'Many, many a-time has a prisoner escaped—or been let out on parole—and done damage. But there is never a case in our law books when the prison authorities have been liable for it. No householder who has been burgled, no person who has been wounded by a criminal, has ever recovered damages from the prison authorities such as to find a place in the reports. The householder has claimed on his insurance company. The injured man can now claim on the compensation fund. None has claimed against the prison authorities. Should we alter all this? I

A third case which shows the costs of trying to shift an insured loss from one insurer to another is *Photo Production Ltd* v *Securicor Transport Ltd.*[72] In that case it will be remembered that Musgrove, the patrolman employed by Securicor caused a loss by starting a small fire which got out of control and destroyed the insured factory belonging to Photo Production. Photo Production's insurers failed in their subrogated claim because the exclusion clause provided:

> under no circumstances shall the company be responsible for any injurious act or default by any employee of the company unless such act or default could have been foreseen and avoided by the exercise of due diligence on the part of the company and his employer.

Although the attempt by Photo Production's insurers to shift the loss to Securicor's insurers failed,[73] the cost of attempting to shift the loss was enormous.

It is important to note that slightly different facts in *Photo Production* might have produced a different result. Thus, suppose that: (1) the employee who caused the fire had been dismissed for recklessness from his previous employment ten years ago or; (2) that the employee who set the fire had been sent by Securicor despite Securicor's knowledge that this employee had been under great emotional strain because his wife and children had been killed a week earlier.

In either (or both) of these cases, Securicor might well be held to have acted without 'due diligence'.[74] In this case, Photo Production's insurers would have been able to shift the loss to Securicor's insurers. Moreover, Securior might have had to sue its insurers as did Wayne Tank in order to be indemnified.[75] However beneficial all this activity might be to insurance companies, lawyers, textbook and note writers, it can be seen as an activity that is scandalously wasteful. It is difficult to believe that this kind of waste would be tolerated in the public sector.

(c) *Subrogation as the destroyer of the utility of insurance contracts*

Although the most serious charges against the doctrine of subrogation are that it promotes overlapping coverage and wasteful litigation, the doctrine can also

should be reluctant to do so if, by so doing, we should hamper all the good work being done by our prison authorities' [1969] 2 QB 412, 426.

72 [1980] AC 827. It is interesting that this case like *Harbutt's Plasticine* (see text *supra* n 65), should be dealt with in contract textbooks, while *Dorset Yacht* (see text *supra* n 69) finds its way into torts textbooks. None of these cases is discussed in an insurance text, although the central problem in all three cases is one of insurance.

73 *Photo Production* were insured except for a deductible of £25,000, while *Securicor* carried liability insurance except for a deductible of £10,000; see the judgment of Lord Denning MR [1978] 1 WLR 856, 866.

74 There is a considerable body of case law on the question of whether the insured acted with 'due diligence'; see e.g. *Woolfall and Rimmer Ltd* v *Moyle* [1942] 1 KB 66 (CA); *Fraser* v *B. N. Furman (Productions) Ltd, Miller Smith & Partners Third Party* [1967] 1 WLR 898 (CA); *Hartley* v *Provincial Insurance Co Ltd* [1957] 1 Lloyd's Rep 121. How much assistance the courts will derive from this body of case law is, indeed, problemantic.

75 See *supra* n 67.

render worthless (or, at least, substantially undermine) the value of an insurance contract.

For example, in an employer's liability insurance situation, subrogation may substantially destroy the utility of the insurance contract both from the employer's point of view and that of its employees. In the first place, if the insurer brings a subrogated claim, the employer may well be faced with a strike,[76] which will end only after it has compensated the employee against whom a subrogated claim has been brought. Even if no strike occurs, the employer may well feel that it should compensate a valued employee it does not want to lose. Here, the utility of employers' liability insurance is undermined by the doctrine of subrogation.

IV. JUDICIAL ATTEMPTS TO CURB SUBROGATION

Judicial attempts to curb the doctrine of subrogation in various spheres are of considerable antiquity but it is only in the last two or three decades that the courts have begun to curb the operation of subrogation with any degree of enthusiasm. Courts in the United States have, from the beginning, been far more energetic in curbing subrogation than have courts in the Commonwealth.[77] But even in the United States, the state of legal doctrine in this area is highly problematic. In the first place, it is difficult to know what the law in many states is. Second, many decisions curbing subrogation still leave it open for the insurer to outflank these decisions by changing the language of the policy.

(a) *Vendor and purchaser*

In 1853, the Supreme Court of Pennsylvania held in *State Farm Mutual* v *Updegraff*,[78] that the doctrine of subrogation would work such 'hardship' on the vendee, that the doctrine of subrogation could not be allowed to operate. In *Reed* v *Lukens*[79] decided in 1863, the same court decided that after a contract for the sale of real estate had been executed, the purchaser became the equitable owner of the property and was 'entitled to all the advantages of the contract'.[80] In 1880, the Supreme Court of New Hampshire held that a subrogated claim by an insurer was defeated by the defence of frustration.[81]

In any event, by 1925 most US jurisdictions had adopted the rule that the vendor received insurance proceeds for the benefit of the purchaser.[82] But some jurisdictions continued to follow the prevailing English rule. Thus, in 1925 the

76 Lord Denning MR expressly referred to the possibility of a strike if an insurer brought a subrogated claim; see *Morris* v *Ford* [1973] QB 792, 798.

77 It is possible that the writings of scholars such as Patterson, Langmaid, King, Keeton and Kimball have had a considerable effect on the courts.

78 (1853) 21 Pa 513.

79 (1863) 44 Pa 200.

80 Ibid.

81 (1880) 60 NH 352.

82 See e.g. notes in 34 *Yale LJ* 87 (1924) and 25 *Col L Rev* 477 (1925).

New York Court of Appeals held in *Brownell* v *Board of Education*,[83] that it would not follow the majority US rule. The decision in *Brownell* was modified by the subsequent decision of the same court in *Raplee* v *Piper*.[84] In that case, the Court decided by a majority of 4–3 that the *Brownell* rule did not apply where the contract of purchase required the purchaser to pay the fire insurance premiums. It is difficult to see why any importance should be given to whether the purchaser paid the premiums. This seems to be no more than an accounting device. The view of Lloyd J in '*The Yasin*'[85] that it cannot matter who pays the premiums has much to commend it.[86]

But whatever the uncertainties of the American doctrine, the position in that country is preferable to the situation in the United Kingdom where the English Court of Appeal held in *Rayner* v *Preston*,[87] that the vendor did not hold the insurance proceeds for the purchaser. In *Castellain* v *Preston*,[88] the insurers added insult to injury by successfully arguing that as the vendor had not suffered a loss, the insurers could recover the proceeds. The effect of all this is, as Mr Thompson points out 'the insurers receive the benefit of a premium without having to pay on the occurrence of a specified event'.[89]

The provisions introduced by section 47 of the 1925 Law of Property Act are so obscure and uncertain,[90] that it is thought to be prudent for the purchaser to take out his/her own insurance.

The Australian Insurance Contracts Act 1984,[91] section 50 provides the simple solution to this problem. The section provides that where the purchaser agrees to purchase property, 'the purchaser shall be deemed to be an insured under the contract of insurance so far as the contract provides insurance cover in respect of loss or damage to the property.'[92]

(b) The purchaser of personal property

In at least one case, an American court has refused to apply subrogation to contracts of personal property. *In the Matter of Future Manufacturing Co-op*[93] concerned a conditional sales contract requiring the buyer of equipment to procure insurance for the benefit of the seller. The buyer failed to procure insurance but the seller did so. When the property was destroyed by fire, the insurer paid the seller and sought to be subrogated against the buyer. Chief Judge Goodman of the

83 (1925) 146 NE 330.
84 (1957) 143 NE 2d 919.
85 [1979] 2 *Lloyd's Rep* 41.
86 Ibid, 56.
87 (1881) Ch D 1 (CA).
88 (1883) 11 QBD 380 (CA).
89 See his article, *supra* n 2, 51.
90 See Thompson, *supra* n 2.
91 Law 80 of 1984.
92 S 50 (1) (c).
93 (1958) 165 F Supp 111 (ND Cal).

Northern California District Court held that the subrograted claim must fail. The judge was greatly impressed by the fact that: '[subrogation] gives the insurer a windfall, if as appears to be normally the case, its rates are not fixed in anticipation of such a collateral recovery'.[94] The judge then applied the cases on real property in which the courts had denied subrogation rights against the purchaser.[95] The weakness of the judgment is that the judge expressly stated that the result of his decision can be reversed by the insurer writing into the contract a power to claim subrogation against the purchaser.[96]

There are two serious problems with this case. In the first place, there is no indication of how many jurisdictions will follow its lead. In the one case that appears to have considered it, the New Jersey Supreme Court in *Flint Frozen Foods Inc* v *Firemen's Ins Co*[97] rejected the reasoning in *Future Manufacturing Co.*

The second problem with *Future Manufacturing Co* is that the decision can be nullified by the insurer merely writing into the policy an express right of subrogation.

(c) Mortgagor and mortgagee

The American courts seem to have done nothing to curb the operation of subrogation in the field of mortgages.[98] Fortunately, the problem now seems to have been solved by the nearly universal adoption of the standard (or union) mortgage clause.[99] Under this device both the mortgagee and the mortgagor are named as insureds and the principle that an insurer cannot claim subrogation against its own insured, virtually eliminates subrogation from this area of the law. Subrogation will be possible if some neglect on the part of the mortgagor prevents his/her recovery against the insurer on the policy. In this situation, the mortgagor will not be considered an insured and the insurer will be able to enforce subrogation rights against the mortgagor.

(d) Landlord and tenant

Probably the most drastic curtailment of subrogation rights both in the United States and in the Commonwealth has come in the field of landlord and tenant.

94 Ibid, 113. The learned judge cited in support of this proposition, King, 'Subrogation under Contracts insuring Property' 30 *Texas L Rev* 62 (1951) and a note, 'Subrogation of the Insurer to Collateral Rights of the Insured' 28 *Col L Rev* 202 (1928).

95 See text *supra* n 78–82.

96 See *supra* n 93, 116.

97 (1952) 86 A 2d 673.

98 See e.g. *City of New York Ins Co* v *Abraham* (1944) 20 So 2d 183.

99 For an excellent brief description of the Standard Mortgage clause see Keeton, *supra* n 27, 187–9.

The insurer's right to claim subrogation rights against a tenant who caused damage negligently to the landlord's property seems to have been unquestioned until 1950.[100]

In that year *General Mills* v *Goldman*[101] was decided by the Eighth Circuit Court of Appeals. In that case, the tenant negligently caused damage by fire. The clause in the lease exempted the tenant from 'loss by fire'. By a majority, the Eighth Circuit Court of Appeals held that it was clearly the landlord and tenant's intention to cover fires which were negligently begun. There are two difficulties with this argument; in the first place, the courts had previously held that if a tortfeasor is to be given exemption from negligence, this must be done by clear words.[102] Secondly, the intention of the landlord and tenant can have no bearing on the insurer's rights of subrogation. To take an extreme example: suppose that a landlord expressly exempts the tenant from liability from harm negligently caused. In this case, it is clear that the landlord will be liable to the insurer for interfering with its subrogation rights.[103] .

Whatever the technical shortcomings of the *Goldman* decision, it was followed by the Supreme Court of Illinois in *Cerny-Pickas & Co* v *C. R. Jahn & Co*[104] and by the Supreme Court of Ohio in *US Fire Insurance Co* v *Phil Mar Corp.*[105] On the other hand, in *Polosky* v *Firestone Tire and Rubber Co*[106] the Missouri Supreme Court allowed a subrogated claim against a tenant in circumstances very similar to the three cases exempting the tenant from liability against a subrogated claim.

The difficulty with the American cases is that no one knows whether they will be followed in other US jurisdictions. Moreover, since they depend on the construction of the exemption clause in the lease, they can be construed in different ways by different courts.

The assault on subrogation in the area of landlord and tenant took place also in Canada. In three decisions decided by the Supreme Court of Canada, *Cummer-Yonge Investments Ltd* v *Agnew-Surpass Shoe Stores*,[107] *Ross Southwood Tire* v *Pyrotech Products Ltd*[108] and in *T. Smith* v *Eaton Co*[109] the court held that the insurer could not be subrogated against a negligent tenant where either; (1) the landlord had covenanted to insure; and/or (2) the tenant had agreed to pay the premiums. I have criticized the decisions at some length elsewhere.[110] To

100 See Keeton, *supra* n 27, 209.
101 (1950) 184 F 2d 359 (8th Cir).
102 See 32 *Am Jur* 669 (1941); 'Landlord and Tenant' 51 *Corpus Juris Secundum*, 1162 (1947).
103 See e.g. *City of New York Ins Co* v *Abraham supra* n 103.
104 (1955) 131 NE 2d 100.
105 (1956) 139 NE 2d 330.
106 (1961) 349 SW 2d 847.
107 [1976] 2 SCR 221; (1975) 55 DLR (3d) 676.
108 [1976] 2 SCR 35; (1975) 55 DLR 3d 248.
109 [1978] SCR 749; (1977) 92 DLR (3d) 425.
110 See Hasson, 'The Supreme Court of Canada and the Law of Insurance' 14 *Osgoode Hall LJ* 769, 779–82 (1976).

make the insurer's right of subrogation depend on formal factors such as whether the landlord covenanted to insure the premises or whether the tenant paid the premiums, seemed to me to make the insurer's right of subrogation depend on arbitrary factors. A decision which held that subrogation had no application in the field of landlord and tenant because it was wasteful and because it gave the insurer an unjustified windfall would have made sense but the court chose not to take this route. In these three cases, the employees of the lessee were also sued but, in each case, they were either implicitly or explicitly exonerated.[111]

Those people who thought they had heard the last of subrogation in the field of landlord and tenant received a rude awakening with the decision of the Supreme Court of Canada in *Greenwood Shopping Plaza* v *Beattie*.[112] In that case, the landlord had covenanted to insure the premises. A fire occurred as a result of negligence on the part of the tenant's employees. Under the case law formulated by the Supreme Court,[113] the insurer could not sue the tenant and, by implication, the tenant's employees. The insurer, however, sought to bring a subrogated claim against the negligent employees who had caused the fire. This claim was rejected with some vigour by the Nova Scotia Court of Appeal.[114] Speaking for a unanimous court, McKeigan CJ NS said that to allow such an action:

> . . . would fly in the face of common sense, modern commercial practice and labour relations. I would think that an employer in a case such as this, and its employees, would take for granted the intent to protect the employees from liability and not merely the corporate entity, the employer.[115]

The Supreme Court of Canada reversed the Nova Scotia Court of Appeal in a unanimous decision. Mr Justice McIntyre, giving the judgment of the court, seemed unconcerned by its assault on common sense, commercial practice and labour relations. Instead, he relied on *Tweddle* v *Atkinson*[116] to make short work of the case.[117] The Court's opinion is devoid of any analysis. Further, it fails to

111 In *Pyrotech* v *Ross Southward* (1971) ILR 1–159, the employees were held liable by the trial court but the Supreme Court, by implication, exonerated them. In *Cummer-Yonge* v *Agnew-Surpass* (1970) ILR 1–380, Hartt J found the tenant liable in negligence but not its employees. The Supreme Court of Canada dismissed the claim against the tenant and did not impose liability on the employees. Finally, in *Green* v *T. Eaton* (1972) ILR 1–485 (later *Eaton* v *Smith*), the employees were held liable for damage negligently caused. However, the decision by the Supreme Court of Canada that subrogation did not lie against the tenant must have implicitly exonerated the employees as well.

112 [1980] 2 SCR 228; (1980) 111 DLR 3d 257. For criticisms of the decision see Armyowicz, 'Comment' 60 *Canadian Bar Rev* 467 (1982) and an article by the same author, '*Greenwood Shopping Plaza* v *Beattie and Pettipas*: Life Masquerading as a Contract case' 8 *Dalhousie LJ* 216 (1984).

113 See text *supra* n 107–09.

114 *Greenwood Shopping Plaza* v *Buchanan et al* (1979) 99 DLR 3d 289.

115 Ibid, 295.

116 (1861) 1 B & S 393.

117 The Court did not consider trust or agency arguments because these had not been argued in the courts below.

even mention the fact that in three previous decisions of the Court, actions against employees had failed.[118]

The decision in *Greenwood* is a disaster. Unlike the situation after *Lister* v *Romford Ice*,[119] Canadian insurers have not entered into a 'gentlemen's agreement' not to sue negligent employees. The situation created by this decision makes a farce of the court's earlier decisions on the subject.[120] If they had allowed subrogated claims against the tenants in the first three cases, then only two policies would have been needed. As a result of the *Greenwood* case, three policies will be required (landlord, tenant and employees). This must be a source of satisfaction to insurers but to no one else.

The three earlier Canadian Supreme Court decisions were relied on by the New Zealand Court of Appeal in *Marlborough Properties* v *Marlborough Fibreglass*.[121] In that case, the landlord owned a factory which it had leased to the tenant who manufactured fibreglass products there. In accordance with its lease, the tenant insured the premises against fire, in the name of the landlord. The tenant also paid the premiums. A fire which was begun by the tenant's negligence caused great damage to the factory. After the damage to the factory had been repaired, the insurer claimed subrogation rights against the tenant. By a majority of 2–1, the New Zealand Court of Appeal held that the insurer was not entitled to be subrogated. As Professor Yates has argued,[122] there is no effective reply to the dissenting judgment of Cooke J who pointed out:

> There is nothing positive in the lease to indicate that the parties intended to negative the lessee's liability for negligence. I doubt whether it would even have crossed the draftsman's mind that the covenant to insure in the lessor's name might have that effect. Nor can I see that an implication to that effect is necessary to give the lease business efficacy. On the contrary, if the lessee remained liable for negligence it had an added inducement to be more careful in carrying on its business—a point of some importance in the case of a hazardous business such as this.[123]

One may admire the judicial sleight of hand which has curbed subrogation in some landlord-tenant cases, but that sleight of hand has produced a body of case law which is poorly reasoned and hopelessly confused.

(e) *Contractors and subcontractors*

In a few US cases, the courts have held that where the contractor insures all property on the construction site, subrogation would not be permitted against the subcontractor. The leading decision in this field is the decision of the Louisiana

118 See *supra* n 111.

119 See *supra* n 49.

120 See text *supra* n 107–09.

121 [1981] 1 NZLR 464. But see now *Leisure Centre Ltd* v *Babytown Ltd* [1984] 1 NZLR 318 (CA).

122 See his note, *Ensuring exemption by insurance* 3 *Oxford J Legal Stud* 431, 436 (1983).

123 See n 124, 468.

Court of Appeals in *Louisiana Fire Insurance Co* v *Royal Indemnity Co.*[124] That decision was followed by the Court of Appeals for the Tenth Circuit in *Transamerica Insurance Co* v *Gage Plumbing & Heating Co*[125] and by the Louisiana Court of Appeal in *United States Fire Insurance Co* v *Beach*,[126] which in 1973 refused to overrule the decision in the *Louisiana Fire Insurance Co* case decided in 1949.[127]

Once again, two serious problems arise with these cases. In the first place, no one knows whether they will be followed in other jurisdictions. Second, in all three cases, the courts have held that the insurer can write a policy expressly preserving its rights of subrogation against the subcontractor.

There is a Canadian analogue to these US decisions; the decision of the Supreme Court of Canada in *Commonwealth Construction Ltd* v *Imperial Oil Ltd.*[128] The insurer (suing in the name of the general contractor) sought to enforce subrogation rights against the subcontractor which had negligently damaged the general contractor's property. The Supreme Court refused to allow the subrogated claim to proceed on two grounds. The first is straightforward and need not detain us long; the court held that subrogated claim could not be brought because the general contractor and the subcontractor were co-insureds on the same policy.

The Supreme Court then added a second ground for its decision. Mr Justice de Grandpré, giving the unanimous judgment of the court, pointed out that the value of 'builders' risk policies' would be undermined if there could be 'resort to litigation in case of negligence by anyone connected with the construction'.[129]

To allow subrogation would be to fail 'to recognize the realities of industrial life'.[130] Welcome though this language is, it is not clear that the court was saying that an action against a subcontractor was against public policy. Rather the language of the court suggests that it is relying on the device of the implied term. If this is so, then an express term reserving the right of subrogation against the subcontractor (or its employees)[131] could be maintained.

(f) *Employers' Liability Insurance*

The atavistic decision of the House of Lords in *Lister* v *Romford Ice*,[132] which gave full recognition in the insurer's right of subrogation has now been qualified by the decision of the English Court of Appeal in *Morris* v *Ford Motor Co Ltd.*[133] In that case, Cameron had agreed to perform certain cleaning services for Ford

124 (1949) 38 So 2d 807.
125 (1970) 433 F 2d 1051 (10th Cir).
126 (1973) 275 S 2d 473.
127 See *supra* n 127.
128 [1978] 1 SCR 317, 328; (1976) 69 DLR (3d) 558.
129 [1978] 1 SCR 317, 328; (1976) 69 DLR (3d) 558, 566.
130 Ibid.
131 See *Greenwood Shopping Plaza* v *Beattie* (see text *supra* n 111).
132 See *supra* n 51.
133 See *supra* n 76.

and to indemnify it against loss or injury therefrom, whether caused by the negligence of Ford or Cameron. The plaintiff was an employee of Cameron injured by the admitted negligent act of Ford's employee. Ford settled the plaintiff's action and brought third party proceedings against Cameron on the indemnity clause. Cameron indemnified Ford, then brought in Ford's negligent employee, claiming to be subrogated to Ford's right to recover from its negligent employee the damages and costs for which it was liable.

The Court of Appeal by a majority of 2–1 held that the subrogated claim could not proceed. Lord Denning held that it was not 'just and equitable' for the subrogated claim to proceed.[134] His Lordship admitted that this defence had never before been recognized in a case involving a subrogated claim.[135] If such a defence were to be recognized who would be able to use it? Employees;[136] members of one's family,[137] visitors to one's home, pedestrians, residential tenants? Perhaps even an ailing uninsured company could argue that it would not be 'just and equitable' to be on the receiving end of a subrogated claim. The standard is an unworkable one.

The same criticism must be made of the 'implied term' theory formulated by James LJ.[138] The question that immediately arises is, in what other cases is the 'implied term' to be used to defeat a subrogated claim? The answer must be—in those cases in which the judge dislikes the operation of subrogation. This is no standard at all. There is another difficulty with the implied term theory; presumably, it can be trumped by an express term giving the insurer an unambiguously framed right of subrogation. If this is all the protection that the implied term gives, it is very slender. Not only would insurers have no qualms about writing in express terms. In England, as Mr Birds has shown,[139] insurers have gone to the extent of providing for the right to bring subrogated claims even before they have indemnified the insured.

(g) *Evaluation*

It is clear that subrogation has fallen into some disfavour among some courts particularly in the United States and (to a lesser degree) the Commonwealth. But

134 See *supra* n 76, 800–01.

135 Ibid, 801.

136 The Australian Insurance Contracts Act (see *supra* n 91) in s 66 abolishes the insurer's right of subrogation, unless the employee was guilty of 'serious and wilful misconduct' (s 66(b)).

137 The Australian Insurance Contracts Act, s 65(c)(*i*) prevents the exercise of subrogation rights against a member of the 'family or other personal relationship between the insured and the third party'. Again, the tortfeasor must not have been guilty of 'serious and wilful misconduct' (s 65(2)(b)).

138 See *supra* n 76, 802.

139 See his article, 'Contractual Subrogation in Insurance' *J Business L* 124 (1979). Under s 65(5) of the Australian Insurance Contracts Act, a condition requiring the insured to assign rights of recovery to the insurer before the insured has been paid, is a criminal offence with a fine of $5,000.

judicial efforts have produced an enormous amount of confusion. The continued existence of that confusion has meant that the evils of subrogation—overlapping coverage[140] and wasteful litigation[141] will continue as before. Once again, the limits of judicial change when one is trying to eradicate a well established doctrine have been powerfully demonstrated.[142]

V. THE SHAPE OF A REFORMING STATUTE

Although some courts have been chipping away at the doctrine of subrogation, it must be clear to even the passionate devotees of the common law method of reform, that the doctrine will not be abolished by attrition. In fact, the only thing likely to be achieved by common law sniping is to reduce this branch of the law to a state of complete confusion.

I shall not attempt to draft a model statute but I shall outline a proposed statute.

First two general problems must be faced.

1. *The need for comprehensive reform*

If a statute is to be passed reforming subrogation, it seems clear that the reforms must be comprehensive. If this is not done, then arbitrary distinctions will remain. A good example of piecemeal reform is to be found in the Australian Insurance Contracts Act 1984.[143] In that statute, subrogation is abolished in the case of vendor and purchaser in the context of real[144] but not personal property.

Subrogation is abolished in respect of an employer's subrogated claim but only where the employee is employed by the insured.[145] Thus, claims against other employees would still be possible.[146] Finally, subrogated claims may not be brought against members of the insured's family.[147] But subrogated claims against the insured's business visitors would seem to be maintainable.[148]

2. *The role of fault in the revised law of subrogation*

Sweden has abrogated subrogation in indemnity insurance in cases of ordinary negligence but retains it in cases of intentional torts and gross negligence.[149] This

140 See *supra* section 3(a).
141 *Supra* section 3(b).
142 See e.g. the attempts to get rid of the doctrine of common employment.
143 See *supra* n 96.
144 Ibid, s 50.
145 Ibid, s 66.
146 See *Greenwood Shopping Plaza* v *Beattie supra* n 116.
147 See *supra* n 91, s 65.
148 See *supra* n 91, s 65 which speaks 'of family or other personal relationships'.
149 See Hellner, *Försäkringsgivarens Regressratt* (The Insurer's Right of Subrogation) 260–1 (English summary).

solution commends itself to Mr Birds in his treatise on insurance law.[150] I fear that this approach would still leave the courts with an enormous amount of discretion. For example, one can argue endlessly (and at great cost) as to whether *Wayne Tank*[151] were guilty of 'gross' negligence or ordinary negligence. This uncertainty would necessitate the continuance of overlapping coverage—probably the greatest of the evils of subrogation.

It seems preferable to limit subrogation to a few cases of intentional wrongdoing. Thus, in a case where a bank has insured against losses by forgery, there would be no objection to a bank bringing a subrogated claim against the forger.[152] Again, in a fidelity insurance policy, there would seem to be little objection to allowing the insurer to proceed against an employee who had been convicted of dishonesty. These claims would not usually be worth pursuing but there can be no objection to them. In the first place, the difficulty of overlapping coverage does not arise since the wrongdoer cannot obtain liability insurance against wrongdoing of this kind. Secondly, losses of this kind are difficult to distinguish from theft from an insurer.

I have great difficulty in deciding whether to allow subrogated claims against arsonists. My hesitation derives from the fact that in many cases it is either someone who is mentally disturbed[153] or else is a child who sets fire to someone else's property. An enquiry into the arsonist's sanity or an infant's ability to understand his/her acts does not appear to be an edifying prospect.

• • •

The following changes in the law of subrogation seem to be desirable.

1. It should be made clear whether disability insurance benefits fall within the definition of indemnity or not. The present situation in Canada of distinguishing between disability benefits on one hand and life and accident benefits on the other, is intolerable.[154]

2. Both the assignment of claims, as well as subrogated claims are to be abolished with the very minor exceptions for forgery insurance and fidelity insurance.

3. It is important to make sure that after the action for subrogation has been abolished, the insured cannot bring an action to recover the deductible. The

150 See his *Modern Insurance Law*, *supra* n 1, 274–5.

151 See text *supra* n 65.

152 See e.g. Farnsworth, 'Insurance against Check Forgery' 60 *Col L Rev* 284 (1960).

153 See e.g. *Gosselin* v *State Farm Fire & Casualty Co* (1983) 147 DLR (3d) 226, affirmed (1984) 8 DLR (4th) 318. In this case, the plaintiff's wife set fire to the house of which she was joint tenant when she was seriously intoxicated. She was found dead in the house; Keith J of the Ontario High Court refused to find that the plaintiff's wife was guilty of a 'wilful and criminal act'.

154 See text *supra* ns 18–23.

deductible may be large[155] in which case the problem of overlapping coverage remains. Even where the deductible is small, the waste caused by these actions is indefensible.

4. It is essential that those people who have underinsured should have to bear their own losses. Unless this is done, everyone who presently carries liability insurance will continue to do so.

5. The problem of those who cannot obtain insurance either because of poverty or because of 'redlining'[156] will have to be tackled. To allow these groups to sue in tort for damage to their property is undesirable. First, many of the people who would wish to sue could not afford to do so. Second, and more important, once a certain group is allowed to sue, the advantages of abolishing subrogation would be lost. The question then becomes whether one assigns uninsurable risks to private insurers or to the government. It seems clear that there are great difficulties in devising and operating an assigned risk scheme.[157] Moreover, a government run scheme can be more cheaply run than a private insurance scheme.

6. There is a very good case for dealing with the vendor-purchaser problem separately. The sections should be drafted so as to cover real and personal property. They should provide that whether it is the vendor or purchaser who insures, that person holds the insurance proceeds to protect his/her own interests. Any surplus will be held in trust for the vendor or purchaser, as the case may be.

VI. CONCLUSION

It is tempting, when one is permitted to find out so little about the workings of the insurance industry,[158] to leave things unchanged. But the defects of some parts of the law of insurance such as subrogation are so striking that it would be the height of irresponsibility not to point them out and to advocate radical change.

155 Even when the deductible is small, the insured may be tempted, for other reasons, to sue; see e.g. *Hobbs* v *Marlowe*, [1977] 2 All ER 241 (HL) noted by Birds, *Motor Insurance and the Knock for Knock Agreements* 41 *MLR* 201 (1978).

156 No one knows how serious a problem 'redlining' is in the Commonwealth. The problem is a serious one in the United States; see e.g. Badain, *Insurance Redlining and The Future of the Urban Core*, 16 *Colum J Law & Social Problems* 1 (1980).

157 The difficulties in operating assigned risk plans in the field of motor vehicle insurance are fully canvassed in US Dept of Transportation, Automobile Insurance and Compensation Study, *A Study of Assigned Risk Plans* (Washington, US Government Print Office 1970).

158 This is certainly true of the situation in the Commonwealth. The situation is more satisfactory in the United States because of the information obtained by various Congressional and Senate Committees and by various Superintendents of Insurance.

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FRAUDULENT INSURANCE CLAIMS: RECENT LEGAL DEVELOPMENTS

Julie-Anne R. Tarr.

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Abstract: Considers, with reference to case law from various common law jurisdictions, fraudulent insurance claims, and the difficulty for the insurance industry in proving fraud. Discusses exaggerated claims, or "padding ", claims where the insured deliberately caused the loss, the use of a fraudulent device in support of a genuine claim, and remedies.

139 Introduction

Insurance fraud continues to be a major problem worldwide. [FN1] This article will canvass recent legal developments in relation to selected issues and matters of particular concern to the insurance industry. [FN2] Cases from the United Kingdom, Australia, New Zealand and the United States will be focused upon.

"Fraud" in the context of this paper embraces all claims where an insured intends to deceive an insurer by getting out of it money to which the insured knew he had no right. [FN3] Fraud therefore requires an intention to deceive as fraud will not *140 be established upon proof of mere error, carelessness or stupid mistake. [FN4] In the classic statement by Lord Buckley in London and Globe Finance Corp (Winding Up), Re [FN5]:

> "To deceive is, I apprehend, to induce a man to believe that a thing is true which is false, and which the person practicing the deceit knows or believes to be false." [FN6]

Fraudulent insurance claims continue to cost the insurance market huge amounts of money each year. It is estimated that in the United States property and casualty insurance fraud cost insurers about US $30 billion in 2004 with "padding", submitting claims for injuries or damage that never occurred, and "staged" accidents all on the rise. [FN7] Predictions are that the hurricanes of 2005, especially Katrina, will result in a further surge of insurance fraud [FN8]:

"In addition to schemes where homeowners or renters make claims for ste reos, televisions or other expensive items they never purchased, and other where they inflate claims for items actually destroyed, home arsons have risen. Dozens of fires broke out in New Orleans and other affected communi ies after Hurricane Katrina. Some of these may be the result of arson com- mitted by flood victims who did not have flood coverage." [FN9]

The picture in the United Kingdom and Australia is no different, with abundar industry data and case law evidencing the widespread problem of dishonest in- surance claims. [FN10]

*141 This article will examine fraudulent insurance claims [FN11] by focus ing on particular aspects or issues that emerge in practice.

Exaggerated or padded claims

The opportunistic "padding" or exaggeration of an otherwise legitimate cla is believed by insurers to be the most widespread variety of fraudulent or di honest claim. As the IAG Insurance Group [FN12] points out:

"The exaggeration of genuine personal lines insurance claims, such as vehicle and household insurance is believed to be the most common type of fraud. It is also the hardest to detect. Not only do personal insurance products generate a large number of small-value claims, making it tough fo insurance companies to investigate all but the most spurious, but it can b difficult to differentiate between the genuine and the fabricated elements of an exaggerated claim. Large claims on commercial insurance products, by contrast, are more likely to attract the attention of fraud investigators, making such a deceit more risky and more difficult to perpetrate."

It is clear that in all jurisdictions exaggeration or overvaluation by an in- sured of the amount of his loss or damage does not necessarily amount to frau

For example, in Dawson v Monarch Insurance Co of NZ Ltd [FN13] the insured claimed $6,000 under an insurance policy for the total loss of an inflatable rabbit and attachments thereto. The rabbit, which was part of the paraphernal of a fairground proprietor, was unique and consequently its value was difficu to assess, there being (not surprisingly) no ready market for inflatable rab- bits. The insurer denied liability and sought to rely, inter alia, on a condi tion in the policy which provided that "all benefit ... shall be forfeited if ... any claim ... be in any respect fraudulent or intentionally exaggerated ...". However, Somers J. was of the opinion that an exaggeration could not be intentional if the insured did not know of the exaggeration. This, the learne judge concluded, was the situation in the case before him and he ordered that the insurer pay the insured $3,500 in respect of the rabbit. He did observe, obiter, that in some cases where the amount of the claim is greatly exaggerat it may justify the inference that it was not honestly made and in such a case the exaggeration is fraudulent. [FN14]

*142 This was clearly the position in the US case of Pogo Holding Co v New York Property Insurance Underwriting Association, [FN15] where the insured brought an action to recover on a policy of fire insurance covering buildings which sustained fire damage. The insured valued the buildings for the purpose

claiming insurance proceeds from the insurer at a figure approximately five mes greater than the appraised value of the buildings set by the insurer's luer and the price of the property when purchased by the insured two years rlier; moreover, the buildings were located in a deteriorating neighbourhood. ile the Court did not treat the fact of gross overvaluation as dispositive, e manifestly excessive valuation, when taken with other evidence, was suffi- ent to sustain an allegation of fraud. [FN16]

Similarly, recent case law in the United Kingdom has emphasised that exag- eration of the amount of loss by an insured is potentially fraud which allows e insurer to refuse the entirety of the claim unless the degree of exaggera- on is so small that it can be regarded as the adoption of a bargaining posi- on by the insured. [FN17] Thus in Danepoint Ltd v Underwriting Insurance Ltd FN18] an insured claimed for loss of rent in relation to a property divided up nto 13 flats, each of which had been sublet to various tenants. The insured laimed that all flats had been vacated following a fire at the property and he loss of rent claim was based on all of the flats being unoccupied. This was lainly untrue. H.H. Judge Coulson Q.C. concluded that the evidence in favour f fraud was overwhelming as the exaggerated claim for loss of rent was excess ve. He held that an exaggerated claim would be categorised as fraudulent where hree requirements were satis-fied. First, the fraud had to be substantial and his requirement meant that the exaggeration must be more than trivial. econdly, the insured had to be dishonest and mere exaggeration of the claim id not establish dishonesty; there had to be *143 an intention to deceive the nsurer, or recklessness. Thirdly, the fraud must have been material, in that t had a decisive effect on the readiness of the insurers to make payment. FN19] He drew a crucial distinction between a repair claim which was also be- ore the court and the loss of rent claim. In the case of the repair claim the earned judge observed that there was a clear opportunity for the insurer's oss adjuster to exercise careful scrutiny and independent review by scrutin- sing the property before any payments were authorised; conversely, in the cas f the loss of rent claim, similar scrutiny was not possible and the claim ould depend in large measure upon the documents provided by the insured. learly in this latter case inducement was easier to demonstrate as the in- urers were unable themselves to readily determine the correctness of the laim. [FN20]

In Australia, at least in relation to the broad category of insurance con- racts subject to the Insurance Contracts Act 1984 (Cth), [FN21] this matter o adding or exaggeration of claims is dealt with legislatively. The Act provide s follows:

> "In any proceedings in relation to [a fraudulent] claim, the court may, if only a minimal or insignificant part of the claim is made fraudulently and non-payment of the remainder of the claim would be harsh and unfair, or der the insurer to pay, in relation to the claim, such amount (if any) as i just and equitable in the circumstances." [FN22]

n exercising the power conferred by this subsection the court is directed to ave regard to the need to deter fraudulent conduct in relation to insurance nd is given a discretion to have regard to any other relevant matter. There

are serious conceptual and practical difficulties with this provision for equitable relief. Conceptually, the "saving" subsection is very difficult to reconcile with ss.12 and 13 of the Insurance Contracts Act whereby the duty utmost good faith is expressed to be the paramount obligation between the parties and where it is expressed that Pt II of the Act [FN23] is not limite or restricted in any way by any other law, including the subsequent provisio of the Act. All frauds, no matter how great or small, are totally irreconcil able with the duty of utmost good faith. Practically, Marks and Balla [FN24] point out:

> "This provision [for equitable relief] presupposes that it is possible dissect the claim which is made fraudulently so as to be able to determin that some part of it only involved fraudulent conduct. That part must be 'minimal' or 'insignificant'. It is difficult to see how it could be sugg ted that there was *144 only a 'little fraud'. It seems akin to describin someone as being only a 'little pregnant'."

Of course, it is possible to construct examples that fit the circumstances f the provision of equitable relief; for example, in an explanatory memorandum the Act, the Attorney-General said that:

> "... [I]t would be unfair for an insured to have the whole of a legiti ate claim for the loss of contents worth $100,000 disallowed merely becau he fraudulently claimed for the loss of a non-existent watch worth $50."

An example of successful reliance on s.56(2) is Entwells Pty Ltd v National General Insurance Co Ltd. [FN25] The insured fraudulently inflated stock val in relation to losses sustained in a supermarket fire. By inserting fictitio items into stock lists the claim was inflated by approximately $27,000 out o total claim worth as much as $528,000. Ipp J. held that the fraudulent part the claim was "relatively small" and that non-payment of the entire claim wo be harsh and unfair. In his view, it was appropriate to disallow the insured claim for loss of stock completely (which totalled $94,000) but permit the i sured to recover the balance of the claim. [FN26]

Exaggerated or padded claims are a major problem but it is understandable that in certain circumstances judges are reluctant to draw an inference of fraud notwithstanding great overvaluation or exaggeration. This is a perfect reasonable attitude to adopt in circumstances where the valuation of the sub ject matter of the claim is difficult to ascertain; for example, as in the Dawson case, [FN27] or where the measurement of value of a large number of goods lost in a fire is a difficult and uncertain task, and where some discr ancies are to be expected. However, less supportable is the approach as exem plified by the decision in Ewer v National Employers' Mutual General Assuran Association Ltd, [FN28] where a "preposterously extravagant" claim was put f ward for the cost price of new goods as the value of second-hand goods des- troyed in an accidental fire, in respect of which loss the insured sought in demnity under the policy of insurance. McKinnon J. rejected the contention o the insurer that the claim was false and fraudulent, saying:

> "The plaintiff knew the claim would be discussed, and probably drastic ally criticized, by the assessors; he had been asked for invoices, and he started the bargaining with them by putting down the cost price of his ar icles as if they were new. Though I admit the resulting figure is prepost

ously extravagant, I do not think there was any fraud in putting it forward." [FN29]

Thus, if the claim is knowingly inflated by the insured for purposes of negotiation, or as a bargaining device, the claim may not be categorised as fraudulent. In *145 these circumstances it may be perceived as not being made with intention to deceive and defraud the insurer by getting out of it money to which the insured knew he had no right. [FN30] However, there are problems associated with any judicial leniency towards the stratagem of exaggerating the value of claims. The insurer may, for instance, make payment in excess of the actual loss in reliance upon the information contained in the insured's claim. This consequence is unlikely on the facts of a case like Ewer where the goods destroyed were obviously second hand, but the spectre does emerge of an insured settling for more than a full indemnity in less informed or less transparent circumstances. Moreover, difficult questions of motive are introduced. Did the insured grossly overvalue the subject matter of insurance as a basis for negotiation, or did the insured intend to defraud the insurer? If the motive of negotiation is too readily available as a refuge for an insured who is shown to have submitted a grossly exaggerated claim, the dishonest claimant is given a "green light" to become very expansive as to the extent of loss sustained.

A final comment in relation to padded or exaggerated claims is this: as a practical matter the insurer has a difficult task in identifying and proving fraud; accordingly there must be some sympathy for the view that, as a matter of public policy, an insured should lose all standing in a court of justice where he knowingly makes false statements of losses he did not sustain, in addition to those actually sustained. [FN31]

Deliberate causing of loss

As a general rule the insured may not recover under a policy where the insured has by his own intentional act caused the loss or event upon which the insurance moneys were expressed to be payable. As a matter of construction of any policy, leaving aside express coverage and exception clauses, it is presumed that the insurer has not agreed to pay on that happening. [FN32] Therefore, where an insured sets fire to *146 his own property for the sole purpose of recovering under a fire insurance policy, there can be no recovery because as a matter of construction, it is presumed that the insurers have not agreed to cover intended loss. The presumption may be rebutted if the policy concerned provides expressly, or by clear implications, that deliberate losses are covered. [FN33]

Where the insurer alleges fraud, such as arson, the onus of proof is on the insurer. [FN34] The standard of proof to be applied is that applicable to civil actions generally, namely, proof on a balance of probabilities, and not the higher standard of proof beyond all reasonable doubt in criminal cases. [FN35] However there is no absolute standard of proof and where fraud is alleged a higher degree of probability is required; that is, the standard required by the criminal law does not have to be reached but, having regard to the seriousness of the allegation and recognising that there are degrees of proof within the standard of a preponderance of probability, the courts require a degree of

probability that is commensurate with the occasion.

Direct evidence of fraud is unlikely. The Washington Court of Appeals observed in Great American Insurance Co v KW Log Inc [FN36] that arson, for instance, is most often proved by circumstantial evidence. Arson, like most frauds, involves secret preparation and commission and it is seldom that an insurer can furnish eyewitness testimony as to the setting of a fire. However, arson and any other fraud can be proven entirely by circumstantial evidence. Consider the case of Engel v South British Insurance Co Ltd. [FN37] At about 01.00 on April 1, 1982 the insured, who was a taxi driver, returned to his home. He left again at 02.00, making sure that the premises were securely locked. After doing a couple of jobs and refuelling his taxi he went to pick his relief driver. He arrived at her home at about 03.20. Meanwhile, a fire h broken out at his home; the fire brigade had been called at about 02.30 and t insured discovered on his return that the house had been badly damaged. Later that day the insured reported the fire to the police. The house was insured b South British under a homesurance policy, originally taken out on January 14, 1982 for the sum of $50,000, but increased on March 4, 1982 *147 to $75,000. The contents and personal effects were also insured by South British under a policy issued on January 14, 1982 to a limit of $10,000. The insurer denied l ability on the ground, inter alia, that the fire was caused by the deliberate act of the insured. The insurer adduced the following circumstantial evidence the insured had substantial debts and had been trying unsuccessfully to sell the house since April 1978; he had increased the insurance cover by $25,000 less than amonth before the fire and had only paid the increased premium two days before the fire; goods, furniture and various personal effects had been removed from the premises, leaving only cheap furniture; the refrigerator was unplugged and contained only a small amount of food; no personal items of not were left in the bathroom where they might have been expected to be; the insured's account of events of the night of the fire might be suggested as bein tailored to having him away from the house when the fire was discovered and t give him a witness or witnesses to establish the fact that he was elsewhere; his only explanation for the fire had been a cigarette, but the evidence did not support that or any other accidental cause; the property had been secure the time, and the insured himself had discounted the possibility of a third person starting the fire; the fire started at about 02.00 which would have en abled the insured to have started it before he left; two experts called by th insurer were of the opinion that the fire had been deliberately lit, and the insured had chosen not to give evidence to deny the allegations. Davison C.J. accepted on the basis of this circumstantial evidence, including the evidence of motive and opportunity, that on the balance of probabilities by applying t higher degree of probability required in this case, the fire was started by t deliberate act of the insured. [FN38] Unfortunately, many insureds who take t pathway to fraud are more cautious and devious in concealing their tracks and do not, like the insured in Engel's case, leave marker beacons along the way. In these more complex cases all the insurer can hope is that the coalescence motive, opportunity, scientific evidence and other relevant factors (such as the timing of an increase in cover) will amount to an established case of fraud.

In addition, it is difficult in certain cases to determine whether the deliberate act is the cause of the loss or liability or merely part of the circumstances in which the real cause operates. For example, in the recent case KR v Royal and Sun Alliance Plc [FN39] a liability policy excluded liability for loss that resulted from any "deliberate act or omission of the insured". Civil claims had been brought against child's care homes operated by a compar in respect of indecent assault offences committed by the senior manager durir the relevant period. The claims had been framed in terms of negligent failure by the company to monitor the conduct of its employees, and judgment was give for the claimants on that basis. In a subsequent action by the claimants against the insurers based on the terms of the insurance *148 policy, [FN40] the trial judge held that judgment had been given against the company on the basis of its negligence so that the policy exclusion in respect of negligent acts did not apply. The Court of Appeal reversed this ruling, holding that tl manner in which the action against the company had been framed was immaterial and that what mattered was whether there had actually been deliberate miscon duct on the part of the company. This was found to be the case, given that tl acts of the senior manager could be attributed to the company itself. By con trast, in Patrick v Royal London Mutual Insurance Society, [FN41] P, at the time aged 11, built a den with a friend in the corner of a mill which housed commercial premises. The two decided to burn down the den and the fire sprea causing extensive damage to the mill and to the stock of a company operating the mill. This company's insurers provided an indemnity in relation to the stock loss and then brought a subrogated claim against the wrongdoer. P's mo er had a liability policy covering her and her family against third party claims, excluding claims arising from "any wilful, malicious or criminal act: The Court held that the exception did not apply. For an act to be "wilful" i had to be shown either that the consequences were intended or that there was reckless disregard for the possible consequences. P had not intended to burn down the mill even though he had intended to set the fire. Less supportable the Court's conclusion that the conduct was not "reckless". However, it was held that the policy covered the loss and that the exception did not encompa the conduct.

Similar difficulties arise in the context of illegal conduct in determini whether that conduct is the cause of the loss or merely part of the circumstances in which the cause operates. [FN42] This topic is too broad to be ca vassed here, but the gravity of the antisocial act and the extent to which i would be encouraged must as public policy considerations be weighed in the b ance by the court against the social harm if the right is not enforced. [FN4

Many acts of deliberate destruction have their foundation in the insured' poor business performance or desperate financial circumstances. For instance it was widely believed that the spate of deliberate sinkings of fishing vess in Australian waters in the 1980s was attributable to an overpopulated and d pressed fishing industry--when finance payments on a boat became too difficu to service, the prospect of an insurance payout became too attractive an esc route. [FN44] Marine underwriters and other insurers have sought to counter fraud in this context by introducing more searching proposal forms designed

solicit more comprehensive financial information about amounts owing on property or in *149 respect of a business, other financial commitments, and the ability of the insured to service these debts. In the event of a loss, the insured's financial position may be checked against the information given in the proposal form. [FN45] By paying more attention to the financial circumstances of the prospective insured, the insurer may be able to reduce its exposure to fraud--either by refusing cover in the first place, or by storing up ammuniti to avoid payment of a claim on the basis of fraudulent misrepresentation or non-disclosure.

Insurers may detect fraud involving the deliberate destruction of property through the employment of sophisticated investigatory techniques and personne [FN46] Moreover, advances of information technology and the internet have enhanced the insurers' ability to identify dishonest prospective insureds and claimants, and to uncover fraudulent schemes. [FN47] However, the fact remain that fraud is difficult to prove and in the United States additional difficul arises out of the prospect of exposure to extra-contractual damages where fra investigations are unable to sustain original submissions with admissible evi ence. [FN48]

Fraudulent evidence

In Agapitos v Agnew [FN49] Mance L.J. stated that the use of a fraudulent device to further a genuine claim was a sub-species of making a fraudulent claim, at least as regards the forfeiture of the claim itself. Relevant in th regard was:

> "... any lie, directly related to the claim to which the fraudulent device relates, which is intended to improve the insured's prospect of obtaining a settlement or winning the case, and which would, if believed, tend, objectively, prior to any final determination at trial of the partie rights, to yield a not insignificant improvement in the insured's prospect -whether they be prospects of obtaining a settlement, or a better settlement, or of winning at trial ..." [FN50]

*150 The Court held further that the common law rules governing the making of fraudulent claim (including the use of a fraudulent device) and the duty of u most good faith are quite distinct. [FN51] Accordingly, there was no basis fo avoidance ab initio and the use of a fraudulent device would result in forfei ure of the claim itself in relation to which the fraudulent device or means i used. This case involved breach of duty [FN52] that had occurred after litiga tion had commenced. The ratio of the case was that once proceedings had started, any disclosure was a matter for the rules of court and the duty of good faith and attendant disclosure obligations [FN53] are superseded by the rules of litigation. The insurers' case depended on the assertion of lying in breac of either a common law duty or a duty under s.17 (of the Marine Insurance Act 1906) continuing after the commencement of litigation. The appeal was dismissed.

Agapitos establishes certain general principles regarding fraudulent claim including that sub-species where fraudulent devices or means have been utilis to support an otherwise valid claim. However, many uncertainties remain. In I

terpart Comerciao E Gestao SA v Lexington Insurance Co, [FN54] H.H. Judge Ch bers Q.C. declined summary judgment in a case involving false entries in a c tificate of inspection that formed an integral part of a damaged cargo claim He was of the view that the law on the promotion of claims by fraudulent mea was "uncertain" [FN55]; in particular, the degree of nexus that there has to between the fraudulent conduct and the promotion of the claim against insure was unclear. It was said in Agapitos that a statement is fraudulent if it wa designed to improve the assured's prospects of recovery and objectively capa of having that effect, but it is unclear whether there is any need for an ac al effect on the insurer. There is authority for the proposition that there no fraud if the insurer is able *151 to discover the truth very easily, [FN5 whereas in Agapitos itself it was commented that fraud remains fraud even though it subsequently unravels. [FN57] Similarly in Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV [FN58] Cooke J. refused to strike out a defence by insurers who pleaded that failure to disclose material fact in the claims process amounted to a breach of the duty of utmost good faith, set out in s.17 of the Marine Insurance Act 1906. While disposed to follow t analysis in Agapitos [FN59] at trial, he declined to strike out a defence th could be outside the ratio of Agapitos which, as stated above, deals with a breach of duty after litigation had commenced. [FN60]

The leading Australian case in this area is Tiep Thi To v Australian Asso ated Motor Insurers Ltd. [FN61] The insured owned a Toyota Landcruiser which was comprehensively insured with the insurer. Her 15-year old son drove the vehicle without her consent and, while he was driving the car, it was damage in an accident. The insured on returning home discovered the damaged vehicle She moved the vehicle a short distance and three days later reported to the lice that the vehicle had been stolen and damaged when her son was set upon a gang of youths. On the following day she claimed upon the insurance policy repeating the false story she had told the police. The insured lied about th circumstances in which the vehicle was damaged because she incorrectly belie that the policy did not cover damage when the car was being driven by an unl censed person without the insured's consent. It was held that she was not en titled to recover. Her claim was fraudulent because she dishonestly intended deceive the insurer into giving her a benefit which she believed she was not entitled to under the policy. Buchanan J.A. stated:

> "The existence of an underlying valid claim does not render fraud irre evant; the dishonest intention required for fraud is at least one to indu a false belief in the insurer for the purpose of obtaining payment or som other benefit under the policy, with or without belief or knowledge of a lack of entitlement; and fraud which relates to the claim made with the r quisite intent will disentitle the claimant even if made subsequent to th first presentation of the claim." [FN62]

*152 The Court did not agree with the conclusion reached in GRE Insurance Lt Ormsby, [FN63] where the Supreme Court of South Australia held that an insur who had produced false evidence to support an otherwise valid claim could re cover under a policy of insurance. The policy covered loss of stock on shop premises caused by theft consequent upon entry into the building by forcible and violent means. The lock on the insured's shop was forced, the shop was

broken into and a number of items were stolen. However, the insurer refused t indemnify the insured, alleging that the insured had attempted to bolster his claim by causing further damage to the door and lock at a later time. Photographs of the door in this heightened state of disrepair were sent by the insured to the insurer in support of the claim. The Supreme Court did not reach any conclusion as to whether it was the insured who had tampered with the doo and lock after the break-in, but, for purposes of the appeal proceeded as if the insured was responsible. The Court held that the insured could recover as distinction should be drawn between a valid claim supported by false evidence and a fraudulent claim. A fraudulent claim, it was asserted, involved situations where the insured had suffered no loss under the policy, or loss which is not of the kind covered under the policy, or a claim where the insured attempts, by deception, to get money which the insured knows he is not entitled to. Walters J. observed that the insured may have been "morally wrong" in bol stering up the story to support the claim, but there was no intention to defraud the insurer. [FN64] The Court stated that where a policy contained a clause entitling the insurer to avoid the policy where a claim was fraudulent or supported by fabricated evidence, then the insurer could rely on the polic condition to defeat the claim. However, the policy in question was silent on the matter of false statements or evidence in support of claims, and with the advent of the Insurance Contracts Act 1984 any such clause would in any event have to overcome the potential obstacle posed by s.54 of the then new legisla tion. [FN65] Finally the Court considered the question as to whether the insurer could rely upon the uberrimae fidei doctrine to deny the insured's clai under the policy. Cox J. concluded that while the doctrine applied to precontract statements, and to representations by the insured as to the existenc of a proper claim under the policy and also to his representation about the kind or extent of loss sustained, the doctrine did not extend to cover conduc subsequent to the claim of the kind involved in this case. [FN66]

The decision in Ormsby has been widely criticised [FN67] as the insured's intention in falsifying evidence was clearly to deceive the insurer into maki a payment *153 it would not otherwise have made. The New Zealand Court of Appeal in New Zealand Insurance Co Ltd v Forbes [FN68] categorised Ormsby as an "exceptional case decided on its own facts". [FN69] Accordingly it will be ra in Australia or New Zealand that a claim supported by fraudulent evidence, devices or means will be a valid claim. [FN70]

Remedies

Given the difficulties associated with identifying and then proving fraudu lent claims, it is appropriate that the fraudulent maintenance of an initiall honest claim is on the same footing as one which the insured knows from the outset to be dishonest. As Mance L.J. observes in Agapitos v Agnew [FN71]:

> "As a matter of principle, it would be strange if an insured who though at the time of his initial claim that he had lost property in a theft, but then discovered it in a drawer, could happily maintain both the genuine ar the now knowingly false part of his claim, without risk of application of the rule."

Moreover, that the use of fraudulent devices or means is regarded as a sub-species of fraudulent claim is consistent with the rationale to discourage fraud in all its guises. [FN72] The same can be said for the rule that where there is a fraudulent claim, the law forfeits not only that which is known t be fraudulent but also any genuine part of the claim. [FN73] More difficult reconcile with the deterrence of fraud is s.56(2) of the Insurance Contracts Act 1984 (Australia) permitting the court to grant equitable relief in respe of "little frauds", i.e. those where "only a minimal or insignificant part o the claim is made fraudulently" and where "non-payment of the remainder of t claim would be harsh and unfair". [FN74] However, judicial control over the scope and circumstances in which relief is granted, and in particular the st utory requirement in s.56(2) that courts must "have regard to the need to de fraudulent conduct in relation to insurance", has ensured that this does not serve *154 as a source of encouragement to insureds to exaggerate or "pad" claims. [FN75] It is unlikely that the s.56(2) principle in practice operate any differently from the position in the United Kingdom: a small amount of p ding in Australia is treated as fraudulent in Australia but capable of being excused under s.56(2), [FN76] whereas in the United Kingdom a small amount o padding is not regarded as fraud at all. The two jurisdictions appear to rea the same result but by different means.

In the absence of express contractual or legislative provisions to the co trary, if a claim is fraudulent or partly fraudulent, the insurer is entitle to avoid liability for the whole claim. [FN77] This remedy does not contempl avoidance ab initio and, as a result, does not permit the insurers to refuse payment of prior valid claims. [FN78] In Australia this position is enshrine in the Insurance Contracts Act 1984 (Australia) [FN79] where it is provided that where a claim is made fraudulently "the insurer may not avoid the contr but may refuse payment of the claim". The Australian Law Reform Commission [FN80] disapproved of avoidance ab initio in that it might entitle an insure to deny a prior claim untainted by fraud--as in Moraitis v Harvey Trinder (Q Pty Ltd [FN81]--or permit an insurer to require repayment of moneys paid by in connection with such claim. In accordance with the Commission's recommend tion, s.56, by only permitting the insurer to refuse the claim which is frau lently made, prevents the insurer from denying non-fraudulent claims made be fore or after the fraudulent claim. Of course, the insurer may avoid liabili for any subsequent claim by exercising its right to give 14 days' notice of cancellation pursuant to s.60(1)(e) of the Insurance Contracts Act; such can cellation only operates prospectively from the date on which the notice of c cellation expires [FN82] and if it is not exercised the policy remains in fu force other than in respect of the claim itself. [FN83] As noted above, in A tralia there remains an argument that a fraudulent claim constitutes a breac of the insured's general duty of utmost good faith imposed by s.13 of the In surance Contracts Act 1984, although the Australian authorities have adopted the view that the duty to refrain from making a fraudulent claim is entirely distinct from the duty to act *155 with the utmost good faith, so that the r edies available for the latter are not available for the former. [FN84] The Australian courts have also held that the principle in s.54 of the 1984 Act, which precludes reliance by insurers on policy terms where there is no causa

link between the breach and the loss, does not operate to relieve the assured of the effects of a fraudulent claim. [FN85]

The utmost good faith provision in the Marine Insurance Acts, being s.17 o the Marine Insurance Act 1906 (UK), provides that "if utmost good faith is no observed by either party, the contract may be avoided by the other party". Th courts have therefore been faced with a difficult task in defining and confin ing the scope of the obligations this duty imposes upon parties in the post- contract environment--in relation to contracts to which the Marine Insurance Act 1906 (UK) applies, or pursuant to the common law duty of utmost good fait [FN86] There can prima facie be no clearer breach of this duty than the lodgi of a fraudulent claim and accordingly avoidance ab initio would be the remedy However in Agapitos v Agnew [FN87] Mance L.J. proffers the "acceptable solu- tion" that the common law rules governing the making of a fraudulent claim should be treated as falling outside the scope of s.17--on this basis no ques tion of avoidance ab initio would arise. [FN88] Thus in AXA General Insurance Ltd v Gottlieb [FN89] Mance L.J. and the Court of Appeal confirmed that the making of a fraudulent claim does not have a retrospective effect on prior, separate claims which have already been settled under the same policy before any fraud occurs. However, where interim payments have been made in respect o a claim which was genuine at the outset, but were subsequently exaggerated in order to secure further payment, the whole claim was forfeited. Therefore, post-loss fraud could in these circumstances have a retroactive effect in re- spect of the claim itself, allowing recovery of interim payments. No guidance is provided in relation to the effect of fraud on the future of the policy it self.

Clearly the parties by their contract and express terms can make the con- sequences of fraud more severe than those prescribed by law [FN90] and it is common industry practice for express provisions relating to dishonest claims oe inserted into policies by insurers with a view towards alleviating eviden- tiary burdens or to *156 provide express remedies. [FN91] Finally it should b noted that in Super Chem Products Ltd v American Life and General Insurance C Ltd [FN92] the Privy Council held that an insurer's reliance on fraud did not preclude other policy defences. Lord Steyn dismissed the insured's arguments that because the insurer had alleged arson they were not entitled to rely on the limitation and claims co-operation provisions. The learned judge stated that:

> "It would be contrary to principle and business common sense, which un- derpin our commercial law, to require an insurer to choose between allegin fraud, thereby abandoning the right to invoke other conditions of the policy, or to rely on those provisions, thereby giving up the right to al- lege fraud." [FN93]

Conclusion

The abundance of case law in relation to fraudulent claims is testimony to the magnitude of the problem facing insurers and, indirectly, the wider com- munities in which they operate.

Generally speaking the cases discussed above may be said to comply with t rationale given by Lord Hobhouse in The Star Sea [FN94]:

"The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing. The courts have to maintain a careful balance as there are public policy con siderations, issues of fairness, good faith and pragmatic claims handling is sues to be considered. Nowhere is this better exemplified than in the case o exaggerated claims or padding. The deliberate inflation of an otherwise vali claim through the inclusion of items that the insured never had or were not stolen or lost is readily distinguishable from a claim that is inflated for genuine negotiation purposes where there is a reasonable basis for dispute a to value. It is submitted, with respect, that the Court in Danepoint Ltd v U derwriting Insurance Ltd [FN95] achieves this balance by requiring, in the c of exaggeration, that the exaggeration be more than trivial, that it was mad with an intention to deceive and that it was material. These requirements ar consistent with the rationale enunciated by Lord Hobhouse and are fair to in surer and insured.

As far as remedies are concerned Mance L.J. observes in Agapitos v Angew [FN96] that:

*157 "The waves of insurance litigation over the last 20 years have in volved repeated examination of the scope and application of any post-contractual duty of good faith. The opacity of the relevant principles--whether originating in venerable but cryptically reasoned common law cas or enshrined, apparently immutably, in section 17 of the Marine Insurance Act 1906--is matched only by the stringency of the sanctions assigned. No surprisingly, recent clarification of aspects of these principles has bee influenced by this stringency, particularly in the context of section 17. [FN97]

Avoidance ab initio is certainly a stringent sanction and accordingly it is submitted that the legislative [FN98] and judicial substitution of forfeitur of the fraudulent claim is a more balanced outcome--thereby leaving any prio valid claim under the policy unaffected by a subsequent fraudulent claim.

In conclusion, fraud and its manifestations in the insurance environment diverse, complex and widespread. The courts will continue to grapple with fraudulent claim cases within the framework of legislation, [FN99] common la rules and the express and implied terms of contracts. While cases like Agapi [FN100] bring a welcome order to this complicated matrix there are still unc tainties to be resolved. In a broader sense a reduction in the number of fra ulent claims will require a comprehensive public education campaign, industr wide collaboration on the collection of intelligence and legislative changes [FN101]

FN Julie-Anne R. Tarr, B.A. (Wisconsin), J.D. (Cornell), LL.M. (Monash), Ph.D (Queensland).

FN1. See also Dr A.A. Tarr, "Dishonest Insurance Claims" (1998) 1 Insurance Journal 42; A.A. Tarr and J.R. Tarr, "The insured's non-disclosure in the fo ation of insurance contracts: a comparative perspective" (2001) 50 Internati

al and Comparative Law Quarterly 577; A.A. Tarr and J.R. Tarr, "Some Critical Legal Issues Affecting Insurance Transactions Globally" [2001] J.B.L. 661.

FN2. This article is confined to fraudulent claims. Fraud may arise at variou points in the insurance relationship, including initial fraud on placement ar fraudulent breach of contract by the assured. Fraud at the outset by the assured is treated differently from innocent or negligent conduct: in Australia insurers have the right to avoid in the case of fraud but not in other cases (Insurance Contracts Act 1984 s.28, with a limited and little explored modification in s.31 where avoidance would be harsh and unfair); in the UK(and in Australia in the context of marine insurance only), the right to avoid is retain in all cases but the insured is stripped of his right to return of premium in the case of fraud (Marine Insurance Act 1906 s.84). Fraudulent breach of contract, including fraud in the claims co-operation process before a claim is actually made, does not give the insurers any additional rights over and above those that they possess for non-fraudulent breaches: for the position in Australia, see s.54 of the Insurance Contracts Act 1984, and for the position in the UK, see K/S Merc-Scandia XXXXII v Lloyd's Underwriters (The Mercandian Continent) [2001] EWCA Civ 1275; [2001] Lloyd's Rep. I.R. 802.

FN3. See, for example, Norton v Royal Fire and Accident Life Assurance Co (1885) 1 T.L.R. 460 at 461, per Lord Coleridge C.J.; Agapitos v Agnew (The Aegeon) (No.1) [2002] EWCA Civ 247; [2003] Q.B. 556; AXA General Insurance Ltd Gottlieb [2005] EWCA Civ 112; [2005] Lloyd's Rep. I.R. 369; GRE Insurance Ltd Ormsby (1982) 29 S.A.S.R. 498 at 503-504, per Walters J.; SAFECO Insurance Company of America v Sharma 160 Cal. App. 3d 1060, 207 Cal. Rptr 104 (1984).

FN4. Lahman v Phoenix Insurance Co (1889) 7 N.Z.L.R. 271 at 273; Foster v Standard Insurance Co of New Zealand Ltd [1924] N.Z.L.R. 1093 at 1099; FAME Insurance Co Ltd v McFadyen [1961] N.Z.L.R. 1070; Purcell v State Insurance Office (1982) 2 A.N.Z. Ins. Cas. 50-495; Mourad v NRMA Insurance Ltd (2003) 12 A.N.Z. Ins. Cas. 61-560. See also the definition of fraud in ss.2 and 3 of the Fraud Act 2006 (UK), which requires an act of dishonesty. There is no statute definition of fraud in the Australian Insurance Contracts Act 1984, and common law principles remain applicable.

FN5. London and Globe Finance Corp (Winding Up), Re [1903] 1 Ch. 728 at 732-733.

FN6. In the leading case on the meaning of fraud, Derry v Peek (1889) L.R. 14 App. Cas. 337 at 374-375, Lord Herschell pointed out that a person who makes a statement "recklessly, careless whether it be true or false" can have no real belief in the truth of what he states and this would be fraudulent. See also Maye v CML Assurance Society Ltd (1924) 35 C.L.R. 14 at 30; Public Trustee v Guardian Trust and Executors Co (NZ) Ltd [1939] N.Z.L.R. 613 at 674-675; Australian Specialist Underwriters Pty Ltd v Pierpoint (1986) 4 A.N.Z. Ins. Cas 60-702; Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea) [2001] UKHL 1; [2001] 1 Lloyd's Rep. 389.

FN7. See Insurance Information Institute, September 2006: http://www.iii.org

FN8. See Insurance Information Institute, September 2006: http://www.iii.org

FN9. See Insurance Information Institute, available at http://www.iii.org/media/hottopics/insurance/fraud/ [Accessed December 12, 2007].

FN10. See, for example, the Association of British Insurers, available at http://www.abi.org.uk/Newsreleases (fraudulent claims of £400 million in 2005) [Accessed December 12, 2007]; IAG Insurance Group Australia, Hidden Costs: Insurance Fraud in Australia (2004) (estimated cost of fraudulent claims around AUS $2.1 billion). See also the cases discussed in the text below.

FN11. In Agapitos [2002] EWCA Civ 247; [2003] Q.B. 556; [2002] Lloyd's Rep. I.R. 573 at 581, Mance L.J. states:

> "A fraudulent claim exists where the insured claims, knowing that he has suffered no loss, or only a lesser loss than that which he claims (or is reckless as to whether this is the case). A fraudulent device is used if the insured believes that he has suffered the loss claimed, but seeks to improve or embellish the facts surrounding the claim, by some lie."

FN12. IAG Insurance Group Australia, Hidden Costs (2004), p.3.

FN13. Dawson v Monarch Insurance Co of NZ Ltd [1977] 1 N.Z.L.R. 372.

FN14. Dawson [1977] 1 N.Z.L.R. 372 at 378. A claim of nearly double the value as assessed by the court might be thought to be a gross exaggeration, but having regard to the unique nature of the subject matter of insurance it was accepted that the insured honestly had put forward the $6,000 claim. See also Mustapha Ally v Hand-in-Hand Fire Insurance Co Ltd (1968) 13 W.I.R. 210 at 2

FN15. Pogo Holding Co v New York Property Insurance Underwriting Association 467 N.Y.S. 2d 872 (1983).

FN16. See also Safeco Insurance Co of America v Sharma 160 Ca. App. 3d 1060, 207 Cal Rptr 104 (Court of Appeal of California, Second District, 1984).

FN17. See Tonkin v UK Insurance Ltd [2006] EWHC 1120 (TCC) where it was held that even if there was fraud, the alleged fraud was no more than £2,000 which represented 0.3% of the total claim. Fraud of that degree was insufficient to vitiate the entire claim and at most would have precluded recovery of that s See also Insurance Law Monthly, October 2006, Vol.18, No.10, pp.8-10.

FN18. Danepoint Ltd v Allied Underwriting Insurance Ltd [2005] EWHC 2318; [2006] Lloyd's Rep. I.R. 429. See also London Assurance v Clare (1937) 57 Ll L.R. 254; O'Connell v Pearl Assurance Plc [1995] 2 Lloyd's Rep. 479; Orakpo Barclays Insurance Services Ltd [1995] L.R.L.R. 443; Transthene Packaging Co Ltd v Royal Insurance (UK) Ltd [1996] L.R.L.R. 32; Insurance Corp of the Channel Islands Ltd v McHugh (No.1) [1997] L.R.L.R. 94; Nsubuga v Commercial Uni Assurance Co Plc [1998] 2 Lloyd's Rep. 682; Galloway v Guardian Royal Exchan (UK) Ltd [1999] L.R.L.R. 209; Baghbadrani v Commercial Union Assurance Co Pl [2000] Lloyd's Rep. I.R. 94; Direct Line v Khan [2002] Lloyd's Rep. I.R. 151 Micro Design Group Ltd v Norwich Union Insurance Ltd [2005] EWHC 3093 (TCC);

Axa Insurance Ltd [2005] Lloyd's Rep. I.R. 369.

FN19. Danepoint [2006] Lloyd's Rep. I.R. 429 at 439. See below for discussio of the inducement issue.

FN20. See also discussion in Insurance Law Monthly, July 2006, Vol.18, No.7, pp.5-7.

FN21. See the Insurance Contracts Act 1984 (Cth) s.9. Notable exceptions fro the ambit of the Act are marine insurance contracts, workers compensation an compulsory third party motor vehicle liability insurance.

FN22. Insurance Contracts Act 1984 (Cth) s.56(2).

FN23. Comprising ss.12-15.

FN24. Guidebook to Insurance Law in Australia, 2nd edn (1987), p.334.

FN25. Entwells Pty Ltd v National and General Insurance Co Ltd (1991) 6 W.A. 68.

FN26. See also Tiep Thi To v AAMI Ltd (2001) 161 F.L.R. 61.

FN27. Dawson [1977] 1 N.Z.L.R. 372.

FN28. Ewer v National Employers' Mutual General Assurance Association Ltd [1937] 2 All E.R. 193.

FN29. Ewer [1937] 2 All E.R. 193 at 203.

FN30. Norton v Royal Fire and Accident Life Assurance Co (19885) 1 T.L.R. 46 at 461; GRE Insurance Ltd v Ormsby (1982) 29 S.A.S.R. 498 at 504; Strive Shi ping Corp v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Grecia press) [2002] EWHC 203 (Comm); [2002] Lloyd's Rep. I.R. 669.

FN31. See the comments of Chilwell J. in Gibbs v New Zealand Insurance Co Lt unreported, December 6, 1983, High Court, Auckland, New Zealand, A 173/80, a 204-205.

FN32. Beresford v Royal Insurance Co Ltd [1938] A.C. 586, per Lord Atkin at 595; Fire & All Risks Insurance Co Ltd v Powell [1966] V.R. 513, FC, per O'Bryan and Pape JJ. at 517; Gray v Barr [1971] 2Q.B. 554, per Phillimore L. at 587. In Keefe v State Insurance General Manager (1987) 5 A.N.Z. Ins. Cas. 60-845, HC NZ, an executrix made a claim under a policy in respect of damage a house which had been bequeathed by the deceased insured to three beneficia ies. It was established that one of the beneficiaries had deliberately lit t fire causing the damage. The Court held that the claim by the executrix coul still properly be made: the terms of the policy provided that a claim would be paid if the insured, or anyone acting on his behalf, used fraudulent mean to obtain any benefit, however, the executrix was not implicated in the fire and therefore could still make a claim. See also McQuade v Sun Alliance Insu ance Co (1992) 7 A.N.Z. Ins. Cas. 61-136, HC NZ.

FN33. Legislative rebuttals of the general rule excluding deliberate acts als exist. For example, the Life Insurance Act 1995 (Australia) s.228 provides th a life company may only avoid a life policy on the ground that the person who life is insured by the policy committed suicide if the policy expressly ex- cludes liability in case of suicide. In any event, a life policy not uncommon includes a clause to the following or like effect: "The policy shall become void if the life insured dies by his/her own hand or act whether sane or insa within 13 calendar months of the commencement date of the policy."

FN34. See, for example, The Star Sea [2001] 2 W.L.R. 170; Agapitos [2002] Lloyds I.R. 573; Moustakos v Federation Insurance Ltd (1984) 3 A.N.Z. Ins. Ca 60-587; Mourad v NRMA Insurance Ltd (2003) 12 A.N.Z. Ins. Cas. 61-560.

FN35. See, for example, cases cited above, and Hornal v Neuberger Products Lt [1957] 1 Q.B. 247. at 258; Watkins and Davis Ltd v Legal and General Insuranc Ltd [1981] 1 Lloyd's Rep. 674. at 677; Burnett v Lloyds of London 710 F. 2d 4 at 489 (1983); Nagel-Taylor Automotive Supplies Inc v Aetna Casualty and Sure Co 402 N.E. 2d 302 (1980); Neat Holding Pty Ltd v Karajan Holdings (1992) 67 A.L.J.R. 170.

FN36. American Insurance Co v KW Log Inc 591 P. 2d 457 at 460 (1979).

FN37. Engel v South British Insurance Co Ltd (1983) 2 A.N.Z. Ins. Cas. 60-516

FN38. See also Lockamy v United States Fidelity and Guaranty Co 652 F. 2d 753 (1981); Moustakos (1984) 3 A.N.Z. Ins. Cas. 60-587; Winstanley v AlliANZ Insu ance Co Ltd (1984) 3 A.N.Z. Ins. Cas. 60-567; cf. Mercantile Mutual Insurance Co Ltd v Hewitt (1985) 3 A.N.Z. Ins. Cas. 60-611.

FN39. KR v Royal and Sun Alliance Plc [2006] Lloyd's Rep I.R. 327, reversed [2006] EWCA Civ 1354.

FN40. The company had become insolvent and the action was brought under the Third Parties (Rights against Insurers) Act 1930.

FN41. Patrick v Royal London Mutual Insurance Society [2007] Lloyd's Rep. I.R 85, affirming the first instance decision: [2006] Lloyd's Rep. I.R. 194.

FN42. See, for example, Fire and All Risks Insurance Co Ltd v Powell [1966] V.R. 513; Gray v Barr [1971] 2 Q.B. 554; Charlton v Fisher [2001] Lloyd's Rep I.R. 387.

FN43. See The Laws of Australia, Title 22.1 Insurance, para.191.

FN44. See Michael Meagher, "Red Faces when the Boat Comes In", The Bulletin, November 13, 1984, p.59.

FN45. Meagher, "Red Faces when the Boat Comes In", The Bulletin, November 13, 1984, p.59. See also Halcome v Cincinnati Insurance Co 778 F. 2d 606 (11th Ci 1985).

FN46. For example, in 1984 McKinnon MacErlane Booker Pty Ltd, a Sydney under-

writing agency, hired a mini-submarine Platypus I to look for a sunken fishir vessel off the Queensland coast; the boat was then filmed. This insurer also used a remote piloted robot to film vessels (The Bulletin, November 13, 1984)

FN47. For example in Antico v CE Heath Casualty and General Insurance Ltd (1996) 9 A.N.Z. Ins. Cas. 61-304 at 76,399, Kirby P. (as he then was) stated that:

> "... with many advances in information technology, persons dealing with large insurers are entitled to expect that information provided to them wi be circulated to all relevant divisions."

Attribution of knowledge contained in files may be the other edge of the swor in the information age.

FN48. See, for example, Chavers v National Security Fire and Casualty Co 405 So. 2d 1 (Ala. 1981); reversed 456 So. 2d 293 (1984).

FN49. Agapitos [2002] Lloyd's Rep. I.R. 573, CA.

FN50. Agapitos [2002] Lloyd's Rep. I.R. 573, CA, at 585.

FN51. Agapito [2002] Lloyd's Rep. I.R. 573, CA, at 585.

FN52. The insurer asserted that the insured after litigation had commenced fraudulently misrepresented that no "hot works" in breach of warranty had bee carried out on a ferry undergoing repair.

FN53. As Mance L.J. observes (Agapitos [2002] Lloyd's Rep. I.R. 573 at 585-586):

> "It cannot be disputed that there are important changes in the parties' relationship that come about when the litigation starts. There is no longe a community of interest. The parties are in dispute and their interests ar opposed. Their relationship and rights are now governed by the rules of pr cedure and the orders which the Court makes on the application of one or other party. The battle lines have been drawn and new remedies are availab to the parties. The disclosure of documents and facts are provided for wit appropriate sanctions; the orders are discretionary within the parameters laid down by the procedural rules. Certain immunities from disclosure are conferred under the rules of privilege. If a party is not happy with his o ponent's response to his requests he can seek an order from the Court. If judgment has been obtained by perjured evidence remedies are available to the aggrieved party. The situation therefore changes significantly. There no longer the need for the remedy of avoidance under section 17; other mor appropriate remedies are available. The same points have been persuasively made by Callahan AJ sitting in the Supreme Court of Connecticut in Reg v Connecticut Ins Placement Facility (1991) 593 A2d 491 at 497."

FN54. Interpart Comerciao E Gestao SA v Lexington Insurance Co [2004] Lloyd's Rep. 690.

FN55. Interpart [2004] Lloyd's Rep. 690 at 695.

FN56. Danepoint [2006] Lloyd's Rep. I.R. 429.

FN57. An approach confirmed by the Privy Council in Stemson v AMP General Insurance (NZ) Ltd [2006] Lloyd's Rep. I.R. 852.

FN58. Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV [2004] EWHC 2632; [2005] Lloyd's Rep. I.R. 396.

FN59. Agapitos [2002] Lloyd's Rep. I.R. 573, CA. For a clear-cut illustration of fraudulent statements in the claims process, see Eagle Star Insurance Co Ltd v Games Video Co (GVC) SA (The Game Boy) [2004] Lloyd's Rep. I.R. 867.

FN60. The cases can be reconciled on the ground that the making of fraudulent statements in the course of pursuing a claim amounts to a fraudulent claim, whereas deliberate failure to disclose relevant information to the insurers concerning the claim may not amount to the making of a fraudulent claim as this would reintroduce the post-contractual duty of disclosure by back-door means.

FN61. Tiep Thi To [2001] 161 F.L.R. 61, Court of Appeal Victoria.

FN62. Tiep Thi To [2001] 161 F.L.R. 61 at 66.

FN63. GRE Insurance Ltd (1982) 29 S.A.S.R. 498.

FN64. GRE Insurance (1982) 29 S.A.S.R. 498 at 504.

FN65. Insurance Contracts Act 1984 (Australia) s.54 imposes a concept of caution, or prejudice to the insurer, to restrict the insurer's reliance upon certain contractual terms to avoid liability for claims. See The Laws of Australia, Title 22.1. Insurance paras 147-149.

FN66. GRE Insurance (1982) 29 S.A.S.R. 498 at 504-507. See also Forbes v New Zealand Insurance Co Ltd (1986) 4 A.N.Z. Ins. Cas. 60-731.

FN67. See, for example, Vermeulen v SIMU Mutual Insurance Association (1987) A.N.Z. Ins. Cas. 60-812; Back v National Insurance Co of New Zealand Ltd [1993] N.Z.L.R. 363; Mourad v NRMA Insurance Ltd (2003) 12 A.N.Z. Ins. Cas. 61-56

FN68. New Zealand Insurance Co Ltd v Forbes (1988) 5 A.N.Z. Ins. Cas. 60-871

FN69. Forbes (1988) 5 A.N.Z. Ins. Cas. 60-871 at 75,455.

FN70. See Insurance Manufacturers of Australia Pty Ltd v Heron [2005] V.S.C. 482, where there was no fraud found on the facts.

FN71. Agapitos [2002] Lloyd's Rep. I.R. 573 at 578.

FN72. Agapitos [2002] Lloyd's Rep. I.R. 573 at 585.

FN73. See, for example, Danepoint [2006] Lloyd's Rep. I.R. 429. There had been suggestions before Agapitos v Agnew that the non-fraudulent part of a claim could be severed and recovery granted: Staughton L.J. in Orakpo v Barclays Insurance Services Ltd [1995] L.R.L.R. 433; Transthene Packaging Co Ltd v Roya

lnsurance (UK) Ltd [1996] L.R.L.R. 32. This approach gives no incentive to a insured to refrain from the temptation to submit a padded claim.

FN74. The Australian Law Reform Commission in their Report on Insurance Contracts No.20 (1982), para.243, advocated that where the total loss of the insured's claim would be seriously disproportionate to the harm which the insured's conduct has or might have caused, a court should be entitled to orde the insurer to pay to the insured an amount which is just and equitable in t circumstances.

FN75. Gugliotti v Commercial Union Assurance Co of Australia (1992) 7 A.N.Z. Ins. Cas. 61-104; Tiep Thi To (2001) 161 F.L.R. 61; Riccardi v Suncorp Metwa Insurance Ltd (2001) 11 A.N.Z. Ins. Cas. 61-493.

FN76. Entwells (1991) 6 W.A.R. 68, discussed above.

FN77. See, for example, Agapitos [2002] Lloyd's Rep. I.R. 573; Insurance Contracts Act 1984 (Australia) s.56.

FN78. Agapitos [2002] Lloyd's Rep. I.R. 573; Insurance Contracts Act 1984 (Australia) s.56. See also AXA General Insurance Ltd [2005] Lloyd's Rep. I.R 369, CA.

FN79. Insurance Contracts Act s.56(1).

FN80. Report on Insurance Contracts (1982), para.243.

FN81. Moraitis v Harvey Trinder (QLD) Pty Ltd [1969] Qd R. 226

FN82. Insurance Contracts Act s.59(2): this means that if there is a genuine loss in the period of notice of cancellation, the insurers have to pay it. T right to cancel extends also to any other contracts between the insured and insurers, on the basis that the insurers are not to be required to maintain contractual relationship between themselves and a fraudster.

FN83. Barroora Pty Ltd v Provincial Insurance (Australia) Ltd (1992) 7 A.N.Z Ins. Cas. 61-103; C E Heath Casualty and General Insurance Ltd v Grey (1993) N.S.W.L.R. 25.

FN84. GRE Insurance Ltd (1982) 29 S.A.S.R. 498.

FN85. Entwells (1991) 6 W.A.R. 68; Gugliotti (1992) 7 A.N.Z. Ins. Cas. 61-10 Tiep Thi To (2001) 161 F.L.R. 61; Walton v The Colonial Mutual Life Assuranc Society Ltd [2004] N.S.W.S.C. 616.

FN86. See, for example, Manifest Shipping Co [2001] Lloyd's Rep. I.R. 493; K Merc-Scandia XXXXII v Lloyd's Underwriters (The Mercandian Continent) [2001] Lloyd's Rep. 563; A.A. Tarr and J.R. Tarr, "Utmost Good Faith in Insurance: form Overdue?" (2002) 10 Asia Pacific Law Review 171.

FN87. Agapitos [2002] Lloyd's Rep. I.R. 573.

FN88. Agapitos [2002] Lloyd's Rep. I.R. 573 at 584-585.

FN89. AXA General Insurance [2005] Lloyd's Rep. I.R. 369.

FN90. See, for example, M. Clarke, The Law of Insurance Contracts, 5th edn (2006), para.27-2c1. The standard wording used in the London market is that t insured is to "forfeit all benefit" under the policy. This has been said to r flect the common law Britton v Royal Insurance Co (1866) 4 F. & F. 905--which is unhelpful given the uncertainties surrounding the common law.

FN91. See, for example, Purcell v State Fire Office (1982) 2 A.N.Z. Ins. Cas. 60-495; Nagel-Taylor Automotive Supplies Inc v Aetna Casualty and Surety Co 4 N.E. 2d 302 (1980); Insurance Corp of the Channel Islands Ltd v McHugh [1997] Lloyd's Rep. 94.

FN92. Super Chem Products Ltd v American Life and General Insurance Co Ltd [2004] Lloyd's Rep. I.R. 446.

FN93. Super Chem [2004] Lloyd's Rep. I.R. 446 at 452.

FN94. The Star Sea [2001] Lloyd's Rep. I.R. 493 at [63].

FN95. Danepoint [2006] Lloyd's Rep. I.R. 429.

FN96. Agapitos [2002] Lloyd's Rep. I.R. 573.

FN97. Agapitos [2002] Lloyd's Rep. I.R. 573 at 575.

FN98. Insurance Contracts Act 1984 (Australia) s.56.

FN99. Old and more recent, as in the cases of the Marine Insurance Acts 1906 (UK), 1908 (Australia), 1909 (New Zealand) and the Insurance Contracts Act 19 (Australia).

FN100. Agapitos [2002] Lloyd's Rep. I.R. 573.

FN101. IAG Insurance Group Australia, Hidden Costs (2004), p.18.

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CONSUMER PROTECTION IN LIFE INSURANCE SECTOR

DR. ASHOK R. PATIL*

1. Introduction

In a period of less than half a century, the insurance sector in the country has come in a full circle, from being an open competitive market to complete nationalization and then back to a liberalized market. The entry of private players in the Indian insurance market has changed the nature of competition.

The winds of liberalization have initiated vast changes in the functioning of the insurance industry. Therefore Insurance Regulatory and Development Authority Act, 1999 (IRDA Act) came into force and due to that earlier monopoly of LIC and GIC was removed and allowed private insurance companies including foreign insurance companies in India. Majority of all new private insurers are joint ventures with foreign partners. The IRDA Act limits foreign insurers to 26% equity participation. Under this Act "Insurance Regulatory and Development Authority" (Authority) has been established under the provisions of section 3 to control the insurance business.

* Associate Professor in Law, Chairman of 'Consumer Law & Practice', NATIONAL LAW SCHOOL OF INDIA UNIVERSITY, Bangalore.

Life insurance is one of the primitive forms of insurance business across the globe. Life insurance helps to ensure that the family is protected against financial difficulties in the event of a premature death. Combined with investments, retirement and estate planning, life insurance is the fundamental part of a sound financial plan.

Every insurer promises customer satisfaction. But to what extent this promise is being translated into reality is the million-dollar question. Basically, the problem arises because several insurers are not aware of what the customer really wants, or even though they understand, they cannot deliver because of organizational constraints. The insurers need to shift focus on customer needs. Although it is difficult for them to adopt to the changing needs of the customer, they cannot survive otherwise and are sure to be the victims of marketing myopia.[1]

With the development of insurance sector the expectations of the consumers have also increased. Again, the consumers in case of the insurance sector are the society at large. It provides services to the members of the society and acts as a safety net. Therefore, in public interest, it becomes important that there is no fraud or unfair trade practice undertaken by insurance companies against the insured.

In India, the need for consumer protection is paramount in view of the fact that there is an ever-increasing population and the need for many goods and services of which is no matching supply. In India the consumer exploitation is more because of lack of education, poverty, illiteracy, lack of information, traditional outlook of Indians to suffer in silence and ignorance of their legal rights against the remedy available in such cases. It was therefore necessary that a forum be created where a consumer not satisfied with the goods supplied or services (including insurance) rendered may ventilate his grievance and machinery devised to afford him adequate protection. The new law in the form of the Consumer Protection Act, 1986 (COPRA) was enacted with this end in view. The provisions of COPRA shall be in addition to and not in derogation of the provisions of any other law for the time being in force.[2] The Consumer Protection Rules, 1987 are framed by the Central Government under the power conferred by sec. 30 (1) of the COPRA and came into force on April 15, 1987. The COPRA has been amended three times, i.e., in 1991, 1993 and 2002. And in exercise of the powers conferred by section 30A of the COPRA, the National Consumer Disputes Redressal Commission with the previous approval of the Central Government makes the regulations, called Consumer Protection Regulations, 2005.[3]

The insured/policy holder is considered as a consumer under the COPRA. The "consumer" means, 'any person who hires or avails of any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who 'hires or avails of the services for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person but does not include a person who avails of such services for any commercial purposes;'[4] and "commercial purpose" does not include use by a person of goods bought and used by him and services availed by him exclusively for the purposes of earning his livelihood by means of self-employment.[5] Here, insured and beneficiaries like nominee, assignee and legal hairs are considered as a consumer under this definition.

If any act of the insurer is without due diligence, and without any valid reason, exploiting the insured (consumer) it is deemed to be

1. Lawrence W. Borgen, "Customer Centric Approach, Insurance series,

2. Consumer Protection Act, 1986: Sec. 4.
3. W.e.f. 31st May, 2005.
4. *Supra* note 2, Sec. 2(1)(d)(ii).

deficiency in service. The "deficiency"[6] means 'any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.'

The service provided by insurer to the insured is a 'service' as defined under the COPRA. The "service"[7] means service of 'any description which is made available to potential users and includes, but not limited to, the provision of facilities in connection with banking, financing, *insurance*, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the surveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal service.'

In this article, I have tried to explain how far Insurance legislations, rules, regulations and amendment Bills, have succeeded in achieving the Insured's protection especially in Life Insurance business.

2. The Insurance Regulatory and Development Authority Act, 1999

In the open insurance market, IRDA shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business.[8] The Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business. It protects the interests of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts

6. *Id*, Sec. 2(1)(g).
7. *Id*, Sec. 2(1)(o).

of insurance. It controls and regulates the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business not so controlled and regulated by the Tariff Advisory Committee under section 64U of the Insurance Act, 1938. It adjudicates the disputes between insurers and intermediaries or insurance intermediaries and supervises the functioning of the Tariff Advisory Committee;

3. The Insurance Regulatory and Development Authority (Protection of Policyholders Interests) Regulations, 2002

To ensure protection of the interests of the policy holders, the Authority, in consultation with the Insurance Advisory Committee, makes the following regulations by exercising powers conferred by clause (zc) of sub-section (2) of section 114A of the Insurance Act, 1938 (4 of 1938) read with sections 14 and 26 of the Insurance Regulatory and Development Authority Act, 1999. These regulations apply to all insurers, insurance agents, insurance intermediaries and policyholders. They lay down provisions regarding various aspects of consumer services. It lays down requirements regarding proposal form, matters to be mentioned in the policy, claim procedure, maximum time duration provided for processing of claims and grievance redressal system.

A person who wants to take policy, the proposal form and prospectus are the introductory documents to know about the insurance company and the terms and conditions of the policy. "Proposal form"[9] means a form to be filled in by the proposer for insurance, for furnishing all material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to accept or decline, to undertake the risk, and in the event of acceptance of the risk, to determine the rates, terms and conditions of a cover to be granted. "Material" for the purpose of these regulations shall mean and include all important, essential and relevant

9. The Insurance Regulatory and Development Authority (P

information in the context of underwriting the risk to be covered by the insurer. And "Prospectus"[10] means a document issued by the insurer or on its behalf to the prospective buyers of insurance, and should contain such particulars as are mentioned in Rule 11 of Insurance Rules, 1939 and includes a brochure or leaflet serving the purpose. Such a document should also specify the type and character of riders on the main product indicating the nature of benefits flowing thereupon.

(a) Point of Sale[11]

Notwithstanding anything mentioned in regulation 2(e), a prospectus of any insurance product shall clearly state the scope of benefits, the extent of insurance cover and in an explicit manner explain the warranties, exceptions and conditions of the insurance cover and, in case of life insurance, whether the product is participating (with-profits) or non-participating (without-profits). The allowable rider or riders on the product shall be clearly spelt out with regard to their scope of benefits, and in no case, the premium relatable to health related or critical illness riders in case of term or group products shall exceed 100% of premium under the basic product. All other riders put together shall be subject to a ceiling of 30% of the premium of the basic product. Any benefit arising under each of the riders shall not exceed the sum assured under the basic product. Provided that the benefit amount under riders shall be subject to section 2(11) of the Insurance Act, 1938. And the rider or riders attached to a life policy shall bear the nature and character of the main policy, viz. participating or non-participating and accordingly the life insurer shall make provisions, etc., in its books.[12]

10. *Id.* Regulation 2(e).

11. *Id.* Regulation 3.

An insurer or its agent or other intermediary shall provide all material information in respect of a proposed cover to the prospect to enable the prospect to decide on the best cover that would be in his or her interest. Where the prospect depends upon the advice of the insurer or his agent or an insurance intermediary, such a person must advise the prospect dispassionately. Where, for any reason, the proposal and other connected papers are not filled by the prospect, a certificate may be incorporated at the end of proposal form from the prospect that the contents of the form and documents have been fully explained to him and that he has fully understood the significance of the proposed contract. In the process of sale, the insurer or its agent or any intermediary shall act according to the code of conduct prescribed by the Authority; the Councils that have been established under section 64C of the Insurance Act, 1938 and the recognized professional body or association of which the agent or intermediary or insurance intermediary is a member.

(b) Proposal for insurance[13]

Except in cases of a marine insurance cover, where current market practices do not insist on a written proposal form, in all cases, a proposal for grant of a cover, either for life business or for general business, must be evidenced by a written document. It is the duty of an insurer to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form.

The Forms and documents used in the grant of cover may, depending upon the circumstances of each case, be made available in languages recognised under the Constitution of India. In filling the form of proposal, the prospect is to be

guided by the provision of Section 45 of the Act. Any proposal form seeking information for grant of life cover may prominently state therein the requirements of Section 45 of the Act. Where a proposal form is not used, the insurer shall record the information obtained orally or in writing, and confirm it within a period of 15 days thereof with the proposer and incorporate the information in its cover note or policy. The onus of proof shall rest with the insurer in respect of any information not so recorded, where the insurer claims that the proposer suppressed any material information or provided misleading or false information on any matter material to the grant of a cover. Wherever the benefit of nomination is available to the proposer, in terms of the Act or the conditions of policy, the insurer shall draw the attention of the proposer to it and encourage the prospect to avail the facility. The Proposals shall be processed by the insurer with speed and efficiency and all decisions thereof shall be communicated by it in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer.

(c) **Grievance reddressal procedure**[14]

Every insurer shall have in place proper procedures and effective mechanism to address complaints and grievances of policyholders efficiently and with speed and the same along-with the information in respect of Insurance Ombudsman shall be communicated to the policyholder along-with the policy document and as may be found necessary.

(d) **Matters to be stated in life insurance policy**[15]

A life insurance policy shall clearly state: the name of the plan governing the policy, its terms and conditions; whether it is participating in profits or not; the basis of participation

14. *Id.* Regulation 5.

in profits such as cash bonus, deferred bonus, simple or compound reversionary bonus; the benefits payable and the contingencies upon which these are payable and the other terms and conditions of the insurance contract; the details of the riders attaching to the main policy; the date of commencement of risk and the date of maturity or date(s) on which the benefits are payable; the premiums payable, periodicity of payment, grace period allowed for payment of the premium, the date of the last instalment of premium, the implication of discontinuing the payment of an instalment(s) of premium and also the provisions of a guaranteed surrender value; the age at entry and whether the same has been admitted; the policy requirements for conversion of the policy into paid up policy, surrender, non-forfeiture and revival of lapsed policies; contingencies excluded from the scope of the cover, both in respect of the main policy and the riders; the provisions for nomination, assignment, and loans on security of the policy and a statement that the rate of interest payable on such loan amount shall be as prescribed by the insurer at the time of taking the loan; any special clauses or conditions, such as, first pregnancy clause, suicide clause etc.; and the address of the insurer to which all communications in respect of the policy shall be sent; the documents that are normally required to be submitted by a claimant in support of a claim under the policy.

While acting under this regulation in forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions, he has the option to return the policy stating the reasons for his objection, when he shall be entitled to a refund of the premium paid, subject only to a

deduction of a proportionate risk premium for the period on cover and the expenses incurred by the insurer on medical examination of the proposer and stamp duty charges. In respect of a unit linked policy, in addition to the above deductions, the insurer shall also be entitled to repurchase the unit at the price of the units on the date of cancellation. In respect of a cover, where premium charged is dependent on age, the insurer shall ensure that the age is admitted as far as possible before issuance of the policy document. In case where age has not been admitted by the time the policy is issued, the insurer shall make efforts to obtain proof of age and admit the same as soon as possible.

(e) Claims procedure in respect of a life insurance policy[16]

A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim. A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible, shall be raised all at once and not in a piece-meal manner, within a period of 15 days of the receipt of the claim. A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. However, where the circumstances of a claim warrant an investigation in the opinion of the insurance company, it shall initiate and complete such investigation at the earliest. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.

16. *Id.* Regulation 8.

Subject to the provision of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information). Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered above, the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

(f) Claim procedure in respect of a general insurance policy[17]

An insured or the claimant shall give notice to the insurer of any loss arising under contract of insurance at the earliest or within such extended time as may be allowed by the insurer. On receipt of such a communication, a general insurer shall respond immediately and give clear indication to the insured on the procedures that he should follow. In cases where a surveyor has to be appointed for assessing a loss/ claim, it shall be so done within 72 hours of the receipt of intimation from the insured. Where the insured is unable to furnish all the particulars required by the surveyor or where the surveyor does not receive the full cooperation of the insured, the insurer or the surveyor as the case may be, shall inform in writing the insured about the delay that may result in the assessment of the claim. The surveyor shall be subjected to the code of conduct laid down by the Authority while assessing the loss, and shall communicate his findings to the insurer within 30 days of his appointment with a copy of the report being furnished to the insured, if he so desires. Where,

17. *Id.* Regulation 9.

in special circumstances of the case, either due to its special and complicated nature, the surveyor shall under intimation to the insured, seek an extension from the insurer for submission of his report. In no case shall a surveyor take more than six months from the date of his appointment to furnish his report. If an insurer, on the receipt of a survey report, finds that it is incomplete in any respect, he shall require the surveyor under intimation to the insured, to furnish an additional report on certain specific issues as may be required by the insurer. Such a request may be made by the insurer within 15 days of the receipt of the original survey report. Provided that the facility of calling for an additional report by the insurer shall not be resorted to more than once in the case of a claim. The surveyor on receipt of this communication shall furnish an additional report within three weeks of the date of receipt of communication from the insurer.

On receipt of the survey report or the additional survey report, as the case may be, an insurer shall within a period of 30 days offer a settlement of the claim to the insured. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the receipt of the survey report or the additional survey report, as the case may be. Upon acceptance of an offer of settlement as stated in above by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the cases of delay in the payment, the insurer shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

(g) **Policyholders' Servicing**[18]

An insurer carrying on life or general business, as the case

receipt of any communication from its policyholders in all matters, such as: recording change of address; noting a new nomination or change of nomination under a policy; noting an assignment on the policy; providing information on the current status of a policy indicating matters, such as, accrued bonus, surrender value and entitlement to a loan; processing papers and disbursal of a loan on security of policy; issuance of duplicate policy; issuance of an endorsement under the policy; noting a change of interest or sum assured or perils insured, financial interest of a bank and other interests; and guidance on the procedure for registering a claim and early settlement thereof.

The requirements of disclosure of "material information" regarding a proposal or policy, apply under these regulations, both to the insurer and the insured. The policyholder shall assist the insurer, if the latter so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the insurer has against third parties. The policyholder shall furnish all information that is sought from him by the insurer and also any other information which the insurer considers as having a bearing on the risk to enable the latter to assess properly the risk sought to be covered by a policy. Any breaches of the obligations cast on an insurer or insurance agent or insurance intermediary in terms of these regulations may enable the Authority to initiate action against each or all of them, jointly or severally, under the Act and/or the Insurance Regulatory and Development Authority Act, 1999.[19]

4. Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000

With new concepts of trade including insurance, the need for consumer protection has increased like never before. The growing

size of production and distribution systems and advertising, mass marketing methods and emergence of e-commerce has resulted in reduction of personal interaction between buyers and sellers has contributed to the increased need of consumer protection. From the womb to the tomb we are influenced by business world where each of its participant's promises to give or deliver something or promises to sell or render quality services, but fails in reality.

Therefore, in exercise of the powers conferred by section 26 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999), the Authority in consultation with the Insurance Advisory Committee, makes the regulations called Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000 (IRDA Reg. 2000). These regulations apply to all insurers, insurance agents and insurance intermediaries. The regulations on advertisement are intended to protect the policy holders by preventing misleading or unfair advertisements and promotional material. The regulations define and lay down the criteria for an advertisement and also define a misleading advertisement.

"Insurance Advertisement"[20] means and includes any communication directly or indirectly related to a policy and intended to result in the eventual sale or solicitation of a policy from the members of the public, and shall include all forms of printed and published materials or any material using the print and or electronic medium for public communication such as: newspapers, magazines and sales talks; billboards, hoardings, panels; radio, television, website, e-mail, portals; representations by intermediaries; leaflets; descriptive literature/ circulars; sales aids flyers; illustrations form letters; telephone solicitations; business cards; videos; faxes; or any other communication with a prospect or a policyholder that urges him to purchase, renew, increase, retain, or modify a policy of insurance. And the following materials shall not be considered to be an advertisement provided they are not used to induce the purchase, increase, modification, or retention of a policy of insurance: materials used by an insurance company within its own organization and not meant for distribution to the public; communications with policyholders other than materials urging them to purchase, increase, modify surrender or retain a policy; materials used solely for the training, recruitment, and education of an insurer's personnel, intermediaries, counselors, and solicitors, provided they are not used to induce the public to purchase, increase, modify, or retain a policy of insurance; any general announcement sent by a group policyholder to members of the eligible group that policy has been written or arranged.

Every insurance company shall be required to prominently disclose in the advertisement and that part of the advertisement that is required to be returned to the company or insurance intermediary or insurance agent by a prospect or an insured the full particulars of the insurance company, and not merely any trade name or monogram or logo. Where benefits are more than briefly described, the form number of the policy and the type of coverage shall be disclosed fully.[21] Every advertisement for insurance shall state clearly and unequivocally that insurance is the subject matter of the solicitation and state the full registered name of the insurer/ intermediary/ insurance agent.[22]

Every insurer or intermediary's web site or portal shall include disclosure statements which outline the site's specific policies *vis-à-vis* the privacy of personal information for the protection of both their own businesses and the consumers they serve and display their registration/ license numbers on their web sites. For the purposes of these regulations, except where otherwise specifically excluded or restricted, no form or policy otherwise permissible for use shall be

deemed invalid or impermissible if such form or policy accurately reflects the intentions of the parties in such form or policy as published electronically or transmitted electronically between parties.[23] Every insurer or intermediary shall follow recognised standards of professional conduct as prescribed by the Advertisement Standards Council of India (ASCI) and discharge its functions in the interest of the policyholders.[24]

If an advertisement is not in accordance with these regulations the Authority may take action in one or more of the following ways: issue a letter to the advertiser seeking information within a specific time, not being more than ten days from the date of issue of the letter; direct the advertiser to correct or modify the advertisement already issued in a manner suggested by the Authority with a stipulation that the corrected or modified advertisement shall receive the same type of publicity as the one sought to be corrected or modified; direct the advertiser to discontinue the advertisement forthwith; any other action deemed fit by the Authority, keeping in view the circumstances of the case, to ensure that the interests of the public are protected. If there is any failure on the part of the advertiser to comply with the directions of the Authority it may entail the Authority to take such action as deemed necessary including levy of penalty.[25]

Every proposal for an insurance product shall carry the following stipulation, as prescribed in section 41 of the Insurance Act, 1938: "No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the insurer." If any person fails to comply with the same, he shall be liable to payment of a fine which may extend to rupees five hundred.[26]

23. *Id.* Regulation 8.

24. *Id.* Regulation 12.

25. *Id.* Regulation 11.

26. *Id.* Regulation 13.

27. Redressal of Public Grievances Rules, 1998; Rule 2.

5. Insurance Ombudsman

As the insurance sector has opened up in the country, a need has been felt for a dispute settlement mechanism focusing exclusively on the insurance sector. In recognition of this need, the Central Government created the institution of the Insurance Ombudsman. The Government of India framed the "Redressal of Public Grievances Rules, 1998" (Rules), in exercise of powers conferred on it under Section 114(1) of Insurance Act, 1938. These Rules came into force with effect from 11th November, 1998. The Insurance Ombudsman was established under these rules. These Rules aim at resolving insured's complaints relating to the settlement of disputes, delay, repudiation etc., with insurance companies in a cost effective, efficient and impartial manner. The Rules apply to all insurance companies, whether they are operating in the general insurance business or the life insurance business.[27] These Rules apply to companies in both the public and the private sectors. The Ombudsman functions within a set geographical jurisdiction.[28] It adjudicate only an insurance policy taken on personal lines. The maximum limit for the award is Rs.20 lakhs. There is no appeal against a decision given by the Ombudsman, but complainant may exercise the right to take recourse to the normal process of law against the insurance company. Further, dismissal of a complaint by the Insurance Ombudsman does not vitiate the complainant's right to seek remedy against the insurer, as per normal process of law.

But the object of establishing the Insurance Ombudsman has not been achieved completely. It was recently reported that insurance

companies are not taking the institution of Ombudsman seriously in dispute resolution with the customers as well as execution of awards.[29] This was the opinion expressed by a majority of the 12 Insurance Ombudsmen in the country in the operational reports for the last five years, submitted to the Insurance Regulatory and Development Authority (IRDA). Some of the issues identified by the Ombudsmen were that the insurance companies are negligent, there is a delay in response, speedy responses lack substance, etc. It is also generally found that most of the documents lie in the hands of the insurance companies at the complaint stage, making disposal of complaints extremely difficult. The Ombudsmen also pointed out that officials representing the case for insurance companies are not well-versed with the contents of the file. In many cases, the officers representing on behalf of the insurers are not pleading the case properly.[30] There have been many suggestions regarding improvement of the institution of Ombudsman; for instance, the Law Commission of India, in its "190th Report on the Revision of the Insurance Act, 1938 and the Insurance Regulatory and Development Authority Act, 1999"[31]. Therefore, insured is opting Consumer Forum instead of Ombudsman for settlement of the disputes against the insurer.

6. Section 45 of Insurance Act 1938 and Proposed Amendment to Sec 45 under the Insurance Laws (Amendment) Bill 2008

The Insurance Laws (Amendment) Bill, 2008[32] is yet to be introduced in the parliament to amend the Insurance Act 1938, the General Insurance Business (Nationalisation) Act, 1972 and the Insurance Regulatory and Development Authority Act, 1999. Here, I am discussing only special provision section 45 of Insurance Act, 1938.

One of the essential elements of insurance contract is a contract of utmost good faith and therefore if the insured or insurer has not disclosed all the material facts, the aggrieved party can avoid the contract. Even though this principle is applicable to both insured and insurer, it is utilized maximum by the insurer to avoid the contract.

It has become the practice of the insurers to insert a clause in the policies and proposal forms to declare that all the answers stated in the proposal form shall form the basis and form part of the terms of the contract in the policy. By such a declaration, for any variation of the state of things from the representations in the proposal form, whether in fact such a fact is material or not, and however slight the variation may be the insurer gets a right to avoid the policy.

Section 45 of Insurance Act, 1938 explains about the policy not to be called in Question on Ground of Misstatement after two years. Section 45 modified old rule materially and mitigated the rigour of the rule of utmost good faith. It lays down that no policy can be challenged after two years from the date of the policy on the ground that any statement made in the proposal or in any report of the medical officer or any document was inaccurate or false, ***unless insurer shows*** that, (i) it is material to disclose, (ii) it was fraudulently made and (iii) the policy holder knows at the time that it was false or he suppressed the fact material to be disclosed, *provided* that nothing in that section prevents the insurer from calling for proof of age of the assured or to adjust the rate of premium according to the correct age proved subsequently.

In a landmark judgment *Mithoolal v. Life Insurance*

29. The Hindu Business Line, *Insurance cos not taking Ombudsman seriously*, (March 12, 2009), http://www.thehindubusinessline.com (visited on April 12, 2009).

30. *Id.*

31. Law Commission of India, "190th Report on the Revision of the Insurance Act, 1938 and the Insurance Regulatory and Development

that the LIC can avoid the contract even after two years from the date of the policy, if it proves three essential elements of section 45 with evidence that the assured fraudulently suppressed the facts.

In *Life Insurance Corporation of India Vs. Smt. G.M. Channabasamma*[34], Supreme Court was again examining the evidence in that case with reference to Section 45 of the Insurance Act. It observed that burden of proving that insured had made false representation and a suppressed material fact, was undoubtedly on the Life Insurance Corporation of India.

(a) **Law Commission of India One Hundred and Twelth Report on Section 45 of the Insurance Act, 1938 (June 1985)**

Under the Chairmanship of Justice K.K. Mathew, 112th Report of the Law Commission of India on section 45 of the Insurance Act 1938 submitted on June 1985. The Report referred to many judgments and observed (in para 2.2) that "whenever claims are repudiated or disputes come to courts of law, the LIC should not put up fight on the pattern of ordinary litigants. But it must be on a higher plane so as to inspire confidence in the public that claims are not resisted on frivolous pleas and reckless allegations. All the relevant materials gathered by the LIC in the course of its investigation of a particular claim shall be placed before the court to enable it to judge the truth. There shall be a frank and full disclosure of all the material evidence and no attempt should be made to suppress or withhold the same."

Finally, after elaborate discussion on this section and also compared with UK and USA, had given recommendation to change three years from two years in section 45. But this recommendation has not been implemented.

(b) **Report of K.P.Narasinhan Committee on Provisions of Insurance Act, 1938, (July 2005)**

Report of K.P.Narasinhan Committee on Provisions of Insurance Act, 1938, was submitted on July 2005. This Committee's observation on section 45 (para 7.45) was as follows: "The Committee noted the elaborate consideration given in the Law Commission Report and the recommendations made with regard to amendments to the provisions on the policy of life insurance being called in question on account of any misstatements in the proposal for other papers leading to the issue of the policy. The Law Commission Report has referred to several Court rulings, including those of the Supreme Court, and the Committee considered that there was a quite well settled case law on the subject that insurers did appreciate, making any amendment of the present Act for amending the un-necessary provisions and for an equitable and adequate protection of the interest of policyholders or of other beneficiary claimants."

This report clearly shows that there is no necessity of amendment to the section 45 of Insurance Act, 1938.

(c) **The Insurance Laws (Amendment) Bill, 2008**[35]

The Insurance Laws (Amendment) Bill, 2008 is ready to be introduced to amend the Insurance Act 1938 along with other Acts. The proposed amendment to section 45 is not consumer friendly. This amendment is completely one sided, i.e, in favour of Insurer. If this amendment came into force then, there will be a lot of exploitation on consumers (insured/policy holder) by the insurers. In this proposed amendment, they have not considered the observations made in 112th Report of the Law Commission of India and as well as report of K.P.Narasinhan Committee.

Under the Insurance Laws (Amendment) Bill 2008, the proposed amendment to section 45 of Insurance Act, 1938, is as follows:

Section 45 (1) No policy of life insurance shall be called in

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 five 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 will 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 in 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 the 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

there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer.

***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 five 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 will 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 mis- statement 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 mis-statement of or suppression of fact will 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.*

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 new proposed amendment to section 45 of Insurance Act, 1938 is not consumer friendly because of the following reasons:

(*i*) The period during which the insurer's can repudiate the contract on any ground whatsoever is increased to 5 years (*Presently it is two years*).

(*ii*) That five years period is being proposed to be counted 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 (*Presently the policy period is counted from the date of issuance of the policy*) .

(*iii*) Burden of Proof is shifted to insured to prove that insured has not done fraud (*presently Burdon of Proof is on Insurer*).

(*iv*) In case of repudiation of the policy within five years on the ground of mis-statement 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 [*Presently insurer can't have a right to repudiate the contract on the ground that insured's statement or suppression of a material fact, which he himself did not know at the time of entering into the contract* (*i.e. which was not fraud*)].

6. Important Case Laws

Some of the important judgments are discussed below:

(*a*) In Delhi Electric Supply Undertaking v. Basanti Devi[36], the LIC floated a "Salary Savings Scheme" under which Bhim

Singh, an employee of DESU took an insurance policy for an amount of Rs. 50,000/- with the LIC. Insurance policy was to commence on January 28, 1992. Bhim Singh had paid Rs. 636/- as premium for two months to the LIC. Premium for the third month was payable by March 29, 1992. The amount of the premium was deducted by the DESU from the salary of Bhim Singh and remitted by it to the LIC. It appears that premium for the subsequent months was deducted by DESU from the salary of Bhim Singh but was not remitted to LIC. In the meantime Bhim Singh died on August 17, 1992. Basanti Devi, widow of Bhim Singh informed LIC of the death of her husband and requested for payment of the amount due under the policy. LIC disclaimed any liability for payment under the policy as the instalments of premium after June, 1992 were not received by it. LIC, therefore, repudiated claim of Basanti Devi. LIC said that since default had been committed in payment of premium the policy taken out by Bhim Singh lapsed. This led Basanti Devi to file a complaint before the State Commission against LIC and DESU. Then appeal to National Commission and lastly before SC. In this case SC held that the court is not concerned with the insurance agent. It is not the case of the LIC that DESU could be permitted as an insurance agent within the meaning of Insurance Act and the Regulations. *DESU is not procuring or soliciting any business for the LIC. DESU is certainly not an insurance agent within the meaning of aforesaid Insurance Act and the Regulations but DESU is certainly an agent as defined in Section 182 of the Contract Act.* Mode of collection of premium has been indicated in the scheme itself and employer has been assigned the role of collecting premium

concerned, employer will be agent of the LIC. It is a matter of common knowledge that Insurance Companies employ agents. When there is no insurance agent as defined in Regulations, in the Regulations and the Insurance Act, general principles of the law of agency as contained in the Contract Act are to be applied.[37]

Then SC observed in this case that Agent in Section 182 means a person employed to do any act for another, or to represent other in dealings with third persons and the person for whom such act is done, or who is so represented, is called the principal. Under Section 185 no consideration is necessary to create an agency. As far as Bhim Singh is concerned, there was no obligation cast on him to pay premium direct to LIC. Under the agreement between LIC and DESU, premium was payable to DESU who was to deduct every month from the salary of Bhim Singh and to transmit the same to LIC. DESU had, therefore, implied authority to collect premium from Bhim Singh on behalf of LIC. There was, thus, valid payment of premium by Bhim Singh. Authority of DESU to collect premium on behalf of LIC is implied. In any case, DESU had ostensible authority to collect premium from Bhim Singh on behalf of LIC. So far as Bhim Singh is concerned DESU was agent of LIC to collect premium on its behalf.[38] Therefore, SC directed that LIC shall pay to Basanti Devi insurance amount of Rs. 50,000/- with interest at the rate of 15% per annum from December 17, 1992 till payment, thus substituting Life Insurance Corporation of India for Delhi Electric Supply Undertaking, as ordered by the State Commission and upheld by the

National Commission. For suffering which Basanti Devi had to undergo for the default committed by DESU in not remitting the premium to LIC we would direct that DESU will pay cost of these proceedings, which we quantify at Rs. 25,000/-.

(*b*) LIC has repudiated the claim on the ground that the insured has suppressed the material facts about his health. Then insured filed a complaint against LIC. National Commission held that there is no evidence to show treatment taken by insured in any hospital about their allegation and also LIC has issued this policy after medical examination. Hence the repudiation is not justified and insurer is held liable to pay the claim.[39]

(c) The insured had submitted his proposal on 24-06-1988 but LIC had not issued the policy till the death of insured on 01-11-1988 without any valid reason. LIC rejected the claim on the ground that the contract is not completed. National Commission held that the plea of unconcluded contract cannot be accepted as the issuance of policy was delayed due to mistake of the insurance corporation.[40]

(*d*) Complainant's wife took life insurance policy and died after delivery due to cardiac arrest. The claim repudiated alleging concealment of pregnancy at the time of taking policy. Deceased not examined by any doctor at the time of issuance of policy. LMP not mentioned in form by agent of insurers. No evidence on record that deceased was aware of pregnancy. 3rd month of pregnancy can be missed by a lady. Insurers liable

39. *Laxman Prasad Pandey v Life Insurance Corporation of India* (DD.30-08-

to pay claim along with interest @ 12% p.a. The Revision Petition dismissed on this ground.[41]

(e) Insured died due to cancer. Diseases like bronchitis and TB for which treatment was taken for about four or five years ago were not disclosed due to which claim was repudiated. Concealment of said diseases cannot be made the ground of repudiation of claim as death of insured was caused by cancer. National Commission held that Insurer is liable for deficiency in service.[42]

(f) Insured was suffering from cough and breathlessness which found no mention in proposal form. No doctor produced to confirm the information collected from hospital in support of evidence of disease. Death of insured had no nexus with bronchitis and breathlessness. Doctor of company failed to give nature of ailment. National Commission held that repudiation of claim on ground of concealment of disease unjustified.[43]

7. Conclusion

The establishment of IRDA and formulation of regulations by it is a very good effort to protect not only the policyholders and to control, encourage healthy environment in insurance business. But there is a need for better and proper implementation of these regulations. Under some of the regulations like regulations on protection of the interests of the policyholders, most of the times there is no effective check to ensure that the regulations are being followed. Even though the policyholders are more aware and informed than earlier, when

41. *Life Insurance Corporation of India v. Jasbir Singh* (DD. 31-01-2003), 2003 (2) CPJ 0114, para 7.

42. *Life Insurance Corporation of India v.Kamala Devi Gupta*, (DD.16-01-2007),2007 (1) CPC 0473, para 3.

43. *Life Insurance Corporation of India v.*

they did not know all their rights. Hence, there is a need to make certain amendments to ensure better implementation of these regulations

As regards Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000, it is important to increase the punishment for violation of the regulations as such a low punishment will not be sufficient to deter large companies from publishing advertisements which are not in accordance with the rules.

The Insurance Ombudsman was established in 1998, but the achievement is very less because of many reasons. This is partly due to lack of awareness about the existence of this system and mostly due to the vast jurisdiction covered by the Ombudsman. There may be a case for creating this post in each State Headquarters and to give wide publicity about the role of the Ombudsman. And also there is a need for active participation in real sense of insurers in the dispute settlement process.

The additional solution for insured is to settle the dispute by approaching Consumer Dispute Reddressal Forum at the different level i.e, District Forum, State Commission and National Commission depending on the territorial jurisdiction and pecuniary jurisdiction. Consumer Forum decides the dispute with nominal fees, quickly and summarily.

Lastly, amendment to section 45 of the Insurance Act 1938 under the Insurance Laws (Amendment) Bill, 2008 is not necessary because as we know that, in India majority of people are uneducated, poor, and unaware of their rights. By looking into the present Indian scenario the existing section 45 is perfect. It is balanced one and there is no need of amendment. Even the Law Commission Report,

well settled case law on the subject that insurers did appreciate, making any amendment of the present Insurance Act, 1938 section 45 unnecessary for an equitable and adequate protection of the interest of policyholders or of other beneficiary claimants.

PART – C : INSURANCE

Pink v. *Fleming*
(1890) 25 Q.B.D. 396

LORD FISHER, J. - It is well settled that by the law of England there is a distinction in this respect between cases of marine insurance and those of other liabilities. In cases of marine insurance the liability of the underwriters depends upon the proximate cause of the loss. In the case of an action for damages on an ordinary contract, the defendant may be liable for damage, of which the breach is an efficient cause or *causa causans*; but in cases of marine insurance only the *causa proxima* can be regarded. This question can only arise where there is a succession of causes, which must have existed in order to produce the result. Where that is the case, according to the law of marine insurance, the last cause only must be looked to and the others rejected, although the result would not have been produced without them. Here there was such a succession of causes. First, there was the collision. Without that no doubt the loss would not have happened. But would such loss have resulted from the collision alone? Is it the natural result of a collision that the ship should be taken to a port for repairs, and that the cargo should be removed for the purposes of the repairs, and that, the cargo being of a kind that must be injured by handling, it should be injured in such removal? A collision might happen without any of these consequences. If it had not been for the repairs, and for the removal of the cargo for the purposes of such repairs, and for the consequent delay and handling of the fruit, the loss would not have happened. The collision may be said to have been a cause, and an effective cause, of the ship's putting into a port and of repairs being necessary. For the purpose of such repairs, it was necessary to remove the fruit, and such removal necessarily caused damage to it. The agent, however, which proximately caused the damage to the fruit was the handling, though no doubt the cause of the handling was the repairs, and the cause of the repairs was the collision. According to the English law of marine insurance only the last cause may be regarded. There is nothing in the policy to say that the underwriters will be liable for loss occasioned by that. To connect the loss with any peril mentioned in the policy, the plaintiffs must go back two steps, and that, according to English law, they are not entitled to do.

For these reasons I think that the judgment of Mathew, J., was right. The case of *Taylor* v. *Dunbar* [LR 4 C.P. 206], seems to me to have been decided upon substantially the same view as that which I have endeavoured in somewhat different terms to state, and it appears to me to be really an express authority in favour of our decision. With regard to the American authorities, the American law on the subject seems to differ materially from our law, and therefore it is not necessary to consider them.

LINDLEY, J. - It appears to me that the judgment of Mathew, J., was correct. It has long been the settled rule of English law with regard to marine insurance that only the *causa proxima* or immediate cause of the loss must be regarded. The rule is well known, and people must be taken to have contracted on that footing. In principle the case appears to me to be governed by the decision in *Taylor* v. *Dunbar*. The evidence shows that the damage to the fruit was due to the joint operation of the handling and the delay.

Mithoolal Nayak v. *Life Insurance Corporation of India*
AIR 1962 SC 814

S.K. DAS, J. - The appellant is Mithoolal Nayak, who took an assignment on 18-10-1945 of a life insurance policy on the life of one Mahajan Deolal for a sum of Rs 25,000 in circumstances that we shall presently state. Mahajan Deolal died on 12-11-1946. Thereafter, the appellant made a demand against the respondent Company for a sum of Rs 26,000 and odd on the basis of the life insurance policy, which had been assigned, to him. This claim or demand of the appellant was repudiated by the respondent Company by a letter dated 10-10-1947, which in substance stated that the insured Mahajan Deolal had been guilty of deliberate misstatements and fraudulent suppression of material information in answers to questions in the proposal form and the personal statement, which formed the basis of the contract between the insurer and the insured. On the repudiation of his claim, the appellant brought the suit out of which this appeal has arisen. The suit was originally instituted against the Oriental Government Security Life Assurance Co. Ltd., Bombay, which issued the policy in favour of Mahajan Deolal on 13-3-1945. Later, on the passing of the Life Insurance Corporation Act, 1956, there was a statutory transfer of the assets and liabilities of the controlled (life) business of all insurance companies and insurers operating in India to a Corporation known as the Life Insurance Corporation of India. By an order of this Court made on 16-2-1960 the said Corporation was substituted in place of the original respondent. For brevity and convenience we shall ignore the distinction between the original respondent and the said Corporation and refer to the respondent in this judgment as the respondent Company. The suit was decreed by the learned Additional District Judge of Jabalpur by his judgment dated 7-5-1949. The respondent Company then preferred an appeal to the High Court of Madhya Pradesh. This appeal was heard by a Division Bench of the said High Court and by a judgment dated 28-8-1956, the appeal was allowed and the suit was dismissed with costs.

2. We now proceed to state some of the relevant facts relating to the appeal and the contentions urged on behalf of the appellant. Mahajan Deolal was a resident of Village Singhpur, Tahsil Narsinghpur. It appears that he was a small landholder and possessed several acres of land. Sometime in December 1942, Mahajan Deolal submitted a proposal through one Rahatullah Khan, an agent of the respondent Company at Narsinghpur, for the insurance of his life with the respondent Company for a sum of Rs 10,000 only. Mahajan Deolal's age at that time was about 45 as stated by him. In the proposal form that was submitted to the respondent Company, Mahajan Deolal mentioned the name of one Motilal Nayak, by profession a doctor, as a personal friend who best knew the state of the health and habits etc. of the insured. This Motilal Nayak, be it noted, is a brother of the appellant, the evidence in the record showing that the two brothers lived together in the same house. When Mahajan Deolal made the proposal for insurance of his life in December 1942, a doctor named Dr D.D. Desai examined him. This doctor submitted two reports about Mahajan Deolal: one report, it appears, was submitted with the proposal form through the agent of the respondent Company; another report was sent in a confidential cover along with a letter from the doctor. In this letter the doctor explained why he was submitting two medical reports. In substance he said that the report submitted with the proposal form at the instance of the agent,

Rahatullah Khan, was not a correct report and the correct report was the one that he enclosed in the confidential cover. In that report Dr Desai said that Mahajan Deolal was anaemic, looked about 55 years old, had a dilated heart and his right lung showed indications of an old attack of pneumonia or pleurisy. The doctor further said that the general health of Mahajan Deolal was very much run down and he was a total physical wreck. The doctor opined that Mahajan Deolal's life was an uninsurable life. It appears that nothing came out of the proposal made by Mahajan Deolal for the insurance of his life in December 1942. The evidence of the Inspector of the respondent Company shows that on receipt of Dr Desai's reports, the respondent Company directed that Mahajan Deolal should be further examined by the Civil Surgeon, Hoshangabad and District Medical Officer, Railways at Jabalpur. Mahajan Deolal could not, however, be examined by the two doctors aforesaid and according to the rules of the respondent Company the proposal lapsed on the expiry of six months for want of completion of the medical examination as required by the respondent Company. Then, on 16-7-1944, a second proposal was made through the same agent of the respondent Company for the insurance of the life of Mahajan Deolal, this time for a sum of Rs 25,000. The Inspector of the respondent Company said in his evidence that this second proposal was made at the instance of the same agent, Rahatullah Khan, inasmuch as the proposal of 1942 had not been rejected but had only lapsed. It appears that at the time of the first proposal in 1942 Mahajan Deolal had paid a sum of Rs 571 and odd towards the first premium due in case the proposal was accepted. In the personal statement accompanying the second proposal of 16-7-1944, it was stated that an earlier proposal for insuring the life of Mahajan Deolal was pending with the respondent Company. Now, in the proposal form there was a question to the following effect:

> "Have you within the past five years consulted any medical man for any ailment, not necessarily confining you to your house? If so, give details and state names and addresses of medical men consulted."

The answer given to the question was - "No". This answer, according to the case of the respondent, was false and deliberately false, because, according to the evidence of one Dr P.N. Lakshmanan, Consulting Physician at Jabalpur, Mahajan Deolal was examined and treated by the said doctor between the dates 7-9-1943, and 6-10-1943, when the doctor found that Mahajan Deolal was suffering from anaemia, oedema of the feet, diarrhoea and panting on exertion. We shall advert in greater detail to the evidence of Dr Lakshmanan at a later stage. In his personal statement accompanying the second proposal Mahajan Deolal answered in the negative Question 12(*b*), the question being as to when he was last under medical treatment and for what ailment and how long. In the same personal statement with regard to questions, for example, Question 5(*a*), 5(*b*) etc., as to whether he suffered from shortness of breath, anaemia, and asthma etc., Mahajan Deolal gave negative answers. The contention on behalf of the respondent Company was that these answers in the personal statement were also deliberately false and constituted a fraudulent suppression of material particulars relating to the health of the insured. With regard to the second proposal and the personal statement accompanying it, Dr Motilal Nayak, brother of the appellant, gave a friend's report, in which he said that Mahajan Pedal's health was good and that he had never heard that Mahajan Deolal suffered from any illness. It is worthy of note here that Dr Motilal Nayak himself took

Mahajan Deolal to Dr Lakshmanan for treatment at Jabalpur in September-October, 1943. On receipt of the second proposal in July 1944, Mahajan Deolal was examined by Dr Kapadia, who was the District Medical Officer of the Railways at Jabalpur. Dr Kapadia reported that Mahajan Deolal was a healthy man and looked about 52 to 54 years old. He recommended that Mahajan Deolal might be given a policy for fourteen years. In his report Dr Kapadia noted that Mahajan Deolal had stated that he had suffered from pneumonia four or five years ago, and that he had also cholera some years ago. No mention, however, was made of anaemia, asthma, shortness of breath etc. On 29-12-1944 Mahajan Deolal, made a further declaration of his good health and so also on 12-2-1945. On 13-3-1945, the respondent Company issued the policy. It contained the usual terms of such life insurance policies, one of which was that in case it would appear that any untrue or incorrect averment had been made in the proposal form or personal statement, the policy would be void. The first premium due on the policy was taken from the amount that was already in deposit with the respondent Company in connection with the proposal made in 1942. Then, on 22-5-1945, Mahajan Deolal wrote a letter to the respondent Company in which he said that his financial condition had become suddenly worse and that he would not be able to pay the premium for the policy. He requested that the policy be cancelled. In the meantime the premium for 1945 not having been paid, the policy lapsed. Then, on 28-10-1945 Mahajan Deolal made a request for revival of the policy, but a few days before that, namely on 18-10-1945, the policy was assigned in favour of the appellant, by an endorsement made on the policy itself. This assignment was duly registered by the respondent Company by means of its letter dated 1-11-1945 in which the respondent Company said that it accepted the assignment without expressing any opinion as to its validity or effect.

The respondent Company also made an enquiry from the appellant as to whether the latter had any insurable interest in the life of the insured and what consideration had passed from him to the insured. To this the appellant replied that he had no insurable interest in the life of Mahajan Deolal, except that the latter was a friend and he (the appellant) had purchased the policy for a sum of Rs 427.12 n.p. being the premium paid by him so far, because Mahajan Deolal did not wish to continue the policy. On his request for a revival of the policy Mahajan Deolal was again medically examined, this time by one Dr Belapurkar. Later on 25-2-1946 he was examined by Dr Clarke. The policy was then revived on payment of all arrears of premium, these arrears having been paid by the present appellant. On receipt of the revival fee, the policy appears to have been revived some time in July 1946. We have already stated that Mahajan Deolal died in November, 1946. The certificate of Dr Clarke, who was the medical attendant at the time when Mahajan Deolal died, showed that the primary cause of death of Mahajan Deolal was malaria followed by severe type of diarrhoea; the secondary cause was anaemia, chronic bronchitis and enlargement of liver. In the certificate that Dr Clarke gave there was mention of certain other medical practitioners who had attended Mahajan Deolal at the time of his death. One of such medical practitioners mentioned in the certificate was Dr Lakshmanan. On receipt of this certificate the respondent Company got into touch with Dr Lakshmanan and discovered from him that Mahajan Deolal had been treated in September-October 1943 by Dr Lakshmanan for ailments which, according to the doctor, were of a serious nature.

3. Several issues were tried between the parties in the trial court. But the four questions which were argued in the High Court and on which the fate of the appeal depends were these:

(*1*) Whether the policy was vitiated by fraudulent suppression of material facts by Mahajan Deolal?

(2) Whether the present appellant had no insurable interest in the life of the insured, and if so, can he sue on the policy?

(*3*) Whether the respondent Company had issued the policy with full knowledge of the facts relating to the health of the insured and if so, is it estopped from contesting the validity of the policy? and

(*4*) Whether in any event the appellant is entitled to refund of the money he had paid to the respondent Company?

5. So far as the first question is concerned, the learned trial Judge found that though Mahajan Deolal had given a negative answer to Question 13 in the proposal form and to Questions 5(*a*), 5(*b*), 5(*f*) and 12(*b*) in the personal statement, these answers though not strictly accurate, furnished no grounds for repudiating the claim of the appellant by the respondent Company, inasmuch as Section 45 of the Insurance Act, 1938 (Act 4 of 1938) applied and the answers did not amount to a fraudulent suppression of material facts by the policy-holder within the meaning of that section. The learned trial Judge found that the ailments for which Dr Lakshmanan treated Mahajan Deolal in September-October 1943 were of a casual or trivial nature and the failure of the policy-holder to disclose those ailments did not attract the second part of Section 45 of the Insurance Act. The High Court came to a contrary conclusion and held that even applying Section 45 of the Insurance Act, the policy-holder was guilty of a fraudulent suppression of material facts relating to his health within the meaning of that section and the respondent Company was entitled to avoid the contract on that ground.

7. We shall presently consider the evidence, but it may be advantageous to read first Section 45 of the Insurance Act, 1938, as it stood at the relevant time. The section, so far as it is relevant for our purpose, is in these terms:

> "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 policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose...."

It would be noticed that the operating part of Section 45 states in effect that no policy of life insurance effected after the coming into force of the 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; the second part of the section is in the nature of a proviso which creates an exception. It says in effect that if 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 policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose, then the insurer can call in question the policy effected as a result of such inaccurate or false statement. In the case before us the policy was issued on 13-3-1945 and it was to come into effect from 15-1-1945. The amount insured was payable after 15-1-1968 or at the death of the insured, if earlier. The respondent Company repudiated the claim by its letter dated 10-10-1947. Obviously, therefore, two years had expired from the date on which the policy was affected. We are clearly of the opinion that Section 45 of the Insurance Act applies in the present case in view of the clear terms in which the section is worded, though learned counsel for the respondent Company sought, at one stage, to argue that the revival of the policy some time in July 1946 constituted in law a new contract between the parties and if two years were to be counted from July, 1946, then the period of two years had not expired from the date of the revival. Whether the revival of a lapsed policy constitutes a new contract or not for other purposes, it is clear from the wording of the operative part of Section 45 that the period of two years for the purpose of the section has to be calculated from the date on which the policy was originally effected; in the present case this can only mean the date on which the policy (Ex. P-2) was effected. From that date a period of two years had clearly expired when the respondent Company repudiated the claim. As we think that Section 45 of the Insurance Act applies in the present case, we are relieved of the task of examining the legal position that would follow as a result of inaccurate statements made by the insured in the proposal form or the personal statement etc. in a case where Section 45 does not apply and where the averments made in the proposal form and in the personal statement are made the basis of the contract.

8. The three conditions for the application of the second part of Section 45 are -

(*a*) the statement must be on a material matter or must suppress facts which it was material to disclose;

(*b*) the suppression must be fraudulently made by the policy-holder; and

(*c*) the policy-holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose.

The crucial question before us is whether these three conditions were fulfilled in the present case. We think that they were. We are unable to agree with the learned trial Judge that the ailments for which Mahajan Deolal was treated by Dr Lakshmanan in September-October 1943 were trivial or casual ailments. Nor do we think that Mahajan Deolal was likely to forget in July 1944 that he had been treated by Dr Lakshmanan for certain serious ailments only a few months before that date. This brings us to a consideration of the evidence of Dr Lakshmanan. That evidence is clear and unequivocal. Dr Lakshmanan says that Dr Motilal Nayak brought the patient to him at Jabalpur. We have already referred to the fact that Dr Motilal Nayak had himself made a false statement in his friend's report dated 17-7-1944,

when he said that he had never heard that the insured had suffered from any illness. It is impossible to believe that Dr Motilal Nayak would not remember that he had himself taken the insured to Jabalpur for treatment by Dr Lakshmanan who was an experienced consulting physician. Dr Lakshmanan said that when he first examined Mahajan Deolal on 7-9-1943 he found that his condition was serious as a result of the impoverished condition of his blood, and that Mahajan Deolal was suffering from anaemia, oedema of the feet, diarrhoea and panting on exertion. The doctor asked for an examination of the blood. The pathological report supported the diagnosis that Mahajan Deolal was suffering from secondary anaemia meaning thereby that anaemia was due to lack of iron and malnutrition. Dr Lakshmanan further found that from the symptoms disclosed the disease was a major one. Mahajan Deolal had also cardiac asthma, which was a symptom of anaemia and due to dilatation of heart. Dr Lakshmanan saw the patient again on 9-9-1943, and then again on 16-9-1943. On 6-10-1943, Mahajan Deolal himself went to Dr Lakshmanan. On that date Dr Lakshmanan found that anaemia had very greatly disappeared. In cross-examination Dr Lakshmanan admitted that the anaemia, dilatation of heart and cardiac asthma from which Mahajan Deolal was suffering constituted a passing phase that might disappear by treatment. He further admitted that he did not mention cardiac asthma in his letter addressed to the respondent Company. We have given our very earnest consideration to the evidence of Dr Lakshmanan and we are unable to hold that the ailments from which Mahajan Deolal was then suffering were either trivial or casual in nature. The ailments were serious though amenable to treatment. Mahajan Deolal's son gave evidence in the case and he said in his evidence that though Dr Lakshmanan prescribed some medicine, his father did not take it. He further said that his father was a strict vegetarian. This evidence was given by the son with regard to what the doctor had said that he prescribed fresh liver juice made at home according to his directions three times a day. He also prescribed iron sulphate in tablet form with plenty of water. The son further said that during his stay at Jabalpur his father felt weak, though he used to move about freely and was never confined to bed. The son tried to make it appear in his evidence that his father was suffering from nothing serious. Dr Lakshmanan said in his evidence that his fees for visiting a patient at Jabalpur were Rs 16 per visit. We agree with the High Court that if Mahajan Deolal was not suffering from any serious ailment, he would not have been taken by his physician, Dr Motilal Nayak, from his village to Jabalpur nor would he have consulted Dr Lakshmanan, a consulting physician of repute, for so many days on payment of Rs. 16 per visit. No doubt, Mahajan Deolal's son now tries to make light of the illness of his father, but Dr Lakshmanan's evidence shows clearly enough that in September-October 1943 Mahajan Deolal was suffering from a serious type of anaemia for which he was treated by Dr Lakshmanan. Mahajan Deolal could not have forgotten in July, 1944 that he was so treated only a few months earlier and furthermore, Mahajan Deolal must have known that it was material to disclose this fact to the respondent Company. In his answers to the questions put to him he not only failed to disclose what it was material for him to disclose, but he made a false statement to the effect that he had not been treated by any doctor for any such serious ailment as anaemia or shortness of breath or asthma. In other words, there was a deliberate suppression fraudulently made by Mahajan Deolal.

9. We may here dispose of the third question. Learned counsel for the appellant has argued before us that Mahajan Deolal was examined under the direction of the respondent

Company by as many as four doctors, namely, Dr Desai, Dr Kapadia, Dr Belapurkar and Dr Clarke. It is further pointed out that Mahajan Deolal had correctly disclosed that he had suffered previously from malaria, pneumonia and cholera. Dr Kapadia, it is pointed out, was specifically asked to examine Mahajan Deolal in view of the conflicting reports that Dr Desai had earlier submitted. On these facts, the argument has been that the respondent Company had full knowledge of all facts relevant to the state of health of Mahajan Deolal and having knowledge of the full facts, it was not open to the respondent Company to call the policy in question on the basis of the answers given by Mahajan Deolal in the proposal form and the personal statement, even though those answers were inaccurate. Learned counsel for the appellant has referred us to the Explanation to Section 19 of the Indian Contract Act in support of his argument. We are unable to accept this argument as correct. It is indeed true that Mahajan Deolal was examined by as many as four doctors. It is also true that the respondent Company had before it the conflicting reports of Dr Desai and it specially asked Dr Kapadia to examine Mahajan Deolal in view of the reports submitted by Dr Desai.

Yet, it must be pointed out that the respondent Company had no means of knowing that Mahajan Deolal had been treated for the serious ailment of secondary anaemia followed by dilatation of heart, etc., in September-October 1943 by Dr Lakshmanan. Nor can it be said that if the respondent Company had knowledge of those facts, they would not have made any difference. The principle underlying the Explanation to Section 19 of the Contract Act is that a false representation, whether fraudulent or innocent, is irrelevant if it has not induced the party to whom it is made to act upon it by entering into a contract. We do not think that that principle applies in the present case. The terms of the policy make it clear that the averments made as to the state of health of the insured in the proposal form and the personal statement were the basis of the contract between the parties, and the circumstance that Mahajan Deolal had taken pains to falsify or conceal that he had been treated for a serious ailment by Dr Lakshmanan only a few months before the policy was taken shows that the falsification or concealment had an important bearing in obtaining the other party's consent. A man who has so acted cannot afterwards turn round and say: "It could have made no difference if you had known the truth." In our opinion, no question of waiver arises in the circumstances of this case, nor can the appellant take advantage of the Explanation to Section 19 of the Indian Contract Act.

10. Our finding on the first question makes it unnecessary for us to decide the second question, namely, whether the present appellant merely gambled on the life of Mahajan Deolal when he took the assignment on 18-10-1945. The contention of the respondent Company was that the appellant had no insurable interest in the life of Mahajan Deolal and when he took the assignment of the policy on 18-10-1945 he was merely indulging in a gamble on Mahajan Deolal's life; the contract was, therefore, void by reason of Section 30 of the Indian Contract Act. On behalf of the appellant, however, the contention was that Section 38 of the Insurance Act provided a complete code for assignment and transfer of insurance policies and the assignment made in favour of the appellant by Mahajan Deolal was a valid assignment in accordance with the provisions of Section 38 aforesaid. The High Court, it appears, proceeded on the footing that from the very inception the policy was taken for the benefit of the appellant on the basis of a gamble on the life of Mahajan Deolal; it said that the

appellant and his brother, Dr Motilal Nayak, knew very well that Mahajan Deolal was not likely to live very long and when the policy was taken out in 1944, it was really for the benefit of the present appellant, who soon after took an assignment on payment of the premium already paid by Mahajan Deolal and such arrears of premium as were then outstanding. It is unnecessary for us to give our decision on these contentions; because if Mahajan Deolal was himself guilty of a fraudulent suppression of material facts on which the respondent Company was discharged from performing its part of the contract, the appellant who holds an assignment of the policy cannot stand on a better footing than Mahajan Deolal himself. It was argued before us that if the policy was valid in its inception, that is to say, if it was in fact effected for the use and benefit of Mahajan Deolal, who undoubtedly had an insurable interest in his own life, it could not afterwards be invalidated by assignment to a person who had no interest but who merely took it as a speculation. As we have stated earlier, on our conclusion on the first question, the appellant is clearly out of Court and cannot claim the benefit of a contract which had been entered into as a result of a fraudulent suppression of material facts by Mahajan Deolal.

11. This brings us to the last question, namely, whether the appellant is entitled to a refund of the money he had paid to the respondent Company. Here again one of the terms of the policy was that all moneys that had been paid in consequence of the policy would belong to the Company if the policy was vitiated by reason of a fraudulent suppression of material facts by the insured. We agree with the High Court that where the contract is bad on the ground of fraud, the party who has been guilty of fraud or a person who claims under him cannot ask for a refund of the money paid. It is a well-established principle that courts will not entertain an action for money had and received, where, in order to succeed, the plaintiff has to prove his own fraud. We are further in agreement with the High Court that in cases in which there is a stipulation that by reason of a breach of warranty by one of the parties to the contract, the other party shall be discharged from the performance of his part of the contract, neither Section 65 nor Section 64 of the Indian Contract Act has any application.

12. For the reasons given above we have come to the conclusion that there is no merit in the appeal. The appeal is accordingly dismissed with costs.

* * * * *

Smt. Dipashri v. *Life Insurance Corporation of India*

AIR 1985 Bom. 192

PENDSE, J. – The unfurling of the facts would disclose the sorrow plight of a young widow who had to bring up three minor children when her husband died in an unfortunate accident. The petitioner's husband was employed as a Clerk in Mackinnon Mackenzie Private Limited for about 19 years. The deceased husband of the petitioner took out a double benefit policy while in the employment. The deceased husband submitted to respondent 1 a proposal for issue of an Endowment Policy under Table 25 for 20 years for Rs. 30,000/- on July 5, 1975. The monthly premiums of the said policy were to be paid directly through the salary saving scheme of Messrs. Mackinnon Mackenzie. The policy was taken out by the deceased husband as "Provision for future" and the monthly premiums were paid regularly as per the contract of Insurance. Prior to the acceptance of the Policy by the Life Insurance Corporation, the deceased husband of the petitioner was examined by doctors on the panel of the Corporation and after the doctors certified about the sound health of the petitioner's husband, the proposal was accepted by the Corporation and the policy was issued on July 7, 1975. On Oct. 4, 1977, the petitioner's husband while lighting the Stove in the Kitchen, accidentally sustained severe burns. The petitioner's husband was removed to the Nursing Home and from there to Cooper Hospital but succumbed to his injuries on Oct. 8, 1977. The Coroner issued a certificate certifying that the death occurred due to toxaemia following 50% burns sustained accidentally by the deceased. It is not in dispute that the burns were suffered in an accident when the Stove caught fire.

3. On Oct. 24, 1977, the petitioner addressed a letter to the Senior Divisional Manager - respondent 2 - requesting to settle the Insurance claim under the policy. The Agent of the Corporation who had insured the deceased also requested respondent 2 to pay the amount under the Policy. The Senior Divisional Manager called upon the petitioner to fill up certain forms and return the same along with original Policy. The petitioner was nominated by her husband as the person entitled to receive the amount. The petitioner carried the requirements of the Corporation but was informed by the Senior Divisional Manager by letter D/- Aug. 25, 1978 that the Corporation repudiates all liabilities under the policy as the deceased had deliberately made misstatements and withheld material information regarding the health at the time of effecting assurance with the Life Insurance Corporation. The letter, inter alia, recites that the answers to the following questions given by the deceased were incorrect and false:

	Answers
Q. No. 4(d): Have you consulted a medical practitioner within the last five years? If so, give details	*No*
Q. No. 6: Have you ever suffered from any of the following ailments?	
Q. No. 6(a): Giddiness, fits, neurasthenia, paralysis, insanity, nervous breakdown or any other disease of the brain or the nervous system	*No*
Q. No. 6(d): Sprue, Jaundice, Anaemia, Dysentery, Cholera, Abdominal pain, Appendicitis or any disease of the stomach, liver, spleen or intestine?	*No*

Q. No. 8(b): Have you remained absent from your work on grounds of health during the last two years?
If so, when, how long and what ailments? *No*

The letter further recites that the answers to the questions set out hereinabove were false and the Corporation holds indisputable evidence to establish that before the date of proposal, the deceased suffered from bleeding from fissure cuts, inflamed piles and rectum in April-May 1972, from low blood-pressure, giddiness and weakness in Dec. 1972 and from Influenza in July 1973, Nov. 1973, Sept. 1974, Nov. 1974 and Feb. 1975 for which the deceased was under treatment of doctors and had also availed of leave on Medical grounds. It was claimed by the Corporation that as the deceased did not disclose these facts in the personal Statement form and instead gave false answers in terms of Policy contract and the declaration contained in the form of proposal for assurance and personal statement, the Corporation repudiates the claim and accordingly are not liable for any payment under the policy and all moneys paid as premiums under the policy stand forfeited. The petitioner appealed to the Corporation that the Corporation should not repudiate the contract and decline to pay the amount to the poor widow who had to bring up three minor children, including two daughters, in life. The petitioner pointed out that her husband died at a very young age of 43 years and the Corporation should not jump to the conclusion that the deceased was suffering from piles, giddiness and Influenza merely from the fact that the deceased had taken sick leave from his office.

"Sick Leave	30 days	14-4-72	to	14-5-72
"	8 days	18-12-72	to	26-12-72
Sick	6 days	24-7-73	to	29-7-73
"	3 days	17-9-73	to	19-9-73
"	9 days	20-11-73	to	28-11-73
"	14 days	9-9-74	to	22-9-74
"	2 days	5-11-74	to	6-11-74
"	7 days	26-11-74	to	1-12-74
"	7 days	17-2-75	to	23-2-75
"	2 days	21-7-75	to	22-7-75
"	7 days	15-9-75	to	21-9-75
"	2 days	17-11-75	to	18-11-75

4. At this juncture, it would be convenient to make reference to a certificate given by the Assistant Manager of Messrs. Mackinnon Mackenzie Private Limited and which was forwarded by the petitioner to the Corporation in pursuance of the demand made by the Corporation. The certificate sets out the sick leave obtained by the deceased while in employment and it would be convenient to set out the relevant portion of the certificate:

Pain on a/c.	*Medical certificate*	*Pain on a/c.*	*Medical certificate*
Piles	produced	Fever	produced
Hypertension	Yes	Influenza	Yes
Influenza	Yes	Influenza	Yes
Dysentery	Yes	Diarrhoea	Yes

Influenza	Yes	Sprain in leg	Yes
Influenza	Yes	Fever	Yes

For privilege leave, staff is not required to submit any reasons. Casual leave and privilege leave are not granted when the staff becomes sick. They take sick leave as per the Company's rules".

As the appeals made by the petitioner for grant of the amount under the policy fell on the deaf ears, the petitioner was driven to file the present petition under Art. 226 of the Constitution of India in this Court on April 19, 1980 for writ of mandamus directing the respondents to pay the petitioner the amount due under the Policy including all the benefits and bonuses accruing thereon.

5. In an answer to the petition, the respondents filed a return dt. July 31, 1980 sworn by Naresh Chander Gautam, Administrative Officer of the Corporation. The Corporation claims that the dispute pertains to contractual obligations and as such a right cannot be enforced in the writ petition. It is claimed that it would be a gross abuse to issue a high prerogative writ as claimed by the petitioner. It is further claimed that the remedy of the petitioner is to file a suit. On merits, it is claimed that the Corporation was perfectly justified in repudiating the contract as the deceased had made false statements as regards his health and in case the deceased had disclosed the correct facts of his ailments at the time of submitting the proposal papers, then the Corporation would not have entered on the risk. The Corporation further pleads that although the Corporation had in its possession undisputable evidence to hold that the deceased made false and inaccurate statements, the Corporation is not willing to give inspection of the evidence in its possession because it is extremely dangerous to disclose such evidence as it could be spirited away or destroyed. The Corporation declines to produce the evidence even in this petition and claims that the same would be produced from the proper custody when evidence is led in a suit, which the petitioner should file. The Corporation, therefore, claims that the petition should be dismissed with costs.

6. Mrs. Singhvi, learned counsel appearing on behalf of the petitioner, submitted that the entire conduct of the Corporation, right from the inception till the hearing of the petition, smacks of high-handedness and the public body like the Corporation should not indulge in raising false defences and defeating the claim of an unfortunate young widow with three minor children. The learned counsel urged that it is a common knowledge that while submitting the proposal, the insured does not refer to the trivial or minor ailments and it is futile on the part of the Corporation to claim that the amount under the policy cannot be claimed by the petitioner and the Corporation can repudiate the contract merely on the ground that the Corporation finds some material which possibly might indicate that the statements were inaccurate. Mrs. Singhvi submits, and in my judgment with considerable merit, that the mere fact that the sick leave was obtained by the deceased by producing medical certificate cannot lead to the conclusion that the deceased was suffering from serious ailments and such ailments would have reduced his life span. It was also urged that the deceased died due to accidental fire and the ailment, which the Corporation claims the deceased was suffering, had no nexus to the death of the husband of the petitioner. Mrs. Singhvi placed strong reliance upon S. 45 of the Insurance Act, which, inter alia, provides that the Policy cannot be called in question on the ground of mis-statement after two years. Shri Taleyarkhan, learned counsel

appearing on behalf of the Corporation, on the other hand, submitted that the basis of the contract is the statement made by the insured and once it is found that the statements were not correct, then the contract is void and the Corporation is perfectly justified in repudiating the same. Shri Taleyarkhan places strong reliance upon the declaration made by the insured at the time of submitting the proposal form.

7. The first submission of Shri Taleyarkhan that it would be a gross abuse to issue a writ in favour of the petitioner is required to be repelled with the contempt it deserves. The Life Insurance Corporation is a public body and it is regrettable that such contentions are raised to defeat the claim of a poor widow. It has been repeatedly pointed out that the writ jurisdiction is exercised by the Courts for advancing the cause of justice and the public body like the Corporation should not raise frivolous defence to defeat the claim of a citizen on technical consideration. The contention that the dispute pertains to contractual obligations and, therefore, the petitioner should be driven to file a suit is repeatedly raised by the public Corporations and it would be advantageous to refer to certain observations of the Supreme Court in the case of *Gujarat State Financial Corporation* v. *Lotus Hotels Pvt. Ltd.* [AIR 1983 SC 848]. Shri Justic Desai speaking for the Bench observed (at p. 851):

> "It is next contended that the dispute between the parties is in the realm of contract and even if there was a concluded contract between the parties about grant and acceptance of loan, the failure of the Corporation to carry out its part, of the obligation may amount to breach of contract for which a remedy lies elsewhere but a writ of mandamus cannot be issued compelling the Corporation to specifically perform the contract. It is too late in the day to contend that the instrumentality of the State which would be 'other authority' under Art. 12 of the Constitution can commit breach of a solemn undertaking on which other side has acted and then contend that the party suffering by the breach of contract may sue for damages but cannot compel specific performance of the contract".

8. In spite of the dictum laid down by the Supreme Court on more than one occasion, it is unfortunate that the Corporation should raise such defense to refuse the claim. It is high time that the Corporation should mend its ways and desist from raising such technical contentions and wasting the time of the Court. The contention of the Corporation that the grant of relief to the petitioner would be a gross abuse of the powers is entirely misconceived. The Corporation may very well choose to deny the relief to the citizen and defeat the justice, but in my judgment, the refusal of the Corporation to pay a pittance of an amount to the widow is, in fact, the gross abuse of the powers.

9. Shri Taleyarkhan submitted that the printed form of proposal contains a declaration of the proposal and it reads as under:-

> "I, Shri Anandrao Talpade the person, whose life is hereinbefore proposed to be assured, do hereby declare that the foregoing statements and answers are true in every particular and agree and declare that those statements and this declaration along with the further statements made or to be made before the Medical Examiner and the declaration relative thereto shall be the basis of the contract of assurance between me and the Life Insurance Corporation of India and that if any untrue

averment be contained therein the said contract shall be absolutely null and void and all moneys which shall have been paid in respect thereof shall stand forfeited to the Corporation."

The learned counsel urged that the contract between the Corporation and the deceased husband makes it clear that if any untrue averments are contained in the proposal, then the contract should be absolutely null and void and the amount of premium can be forfeited. It was urged that the deceased husband of the petitioner had made false statement as regards his health and before considering whether any such false statements were at all made, it would be appropriate to make reference to S. 45 of the Insurance Act, 1938. Section 43 of the Life Insurance Corporation of India Act, 1956, inter alia, provides that S. 45 of the Insurance Act shall apply to the Corporation as it applies to any other insurer Shri Taleyarkhan did not dispute that under the provisions of S. 45 of the Insurance Act, it is not open for the Corporation to question any policy on the ground that the statement made in the proposal was inaccurate or false. Shri Taleyarkhan submits that the Corporation can repudiate the policy provided it is shown that such statement by the policyholder was on a material matter and was fraudulently made. It is obvious that in view of the statutory provisions of S. 45 of the Insurance Act, it is not permissible for the Corporation to repudiate the policy merely on the ground that an inaccurate or false statement was made by the policy-holder at the time of taking out the policy. The power of the Corporation is repudiate the contract comes to an end after the expiry of two years from the date of commencement of the policy. The policy was taken out by the deceased husband of the petitioner on July 7, 1975 and the deceased died after the passage of two years from the date and obviously the provisions of S. 45 of the Insurance Act come into play.

10. The Supreme Court considered the ambit of S. 45 of the Insurance Act in ***Mithoolal Nayak v. Life Insurance Corporation of India*** [AIR 1962 SC 814] and laid down that the three conditions for the application of the second part of S. 43 are:

(a) the statement must be on a material matter or must suppress facts which it was material to disclose,
(b) the suppression must be fraudulently made by the policy holder, and
(c) the policy holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose.

It is necessary now to ascertain whether the deceased made any inaccurate or false statement in the proposal submitted to the Corporation and even assuming that such statement was made whether the second part of S. 45 of the Insurance Act has application to the facts of the case. Column 4 of the proposal form requires the deceased to state what is the usual state of his health and the deceased had answered that it was good. The deceased had also answered that he had not consulted the Medical Practitioner within the last five years prior to the date of making the proposal. The deceased had also stated in Col. 8 that he had not remained absent from the work on the ground of health during previous two years. The Corporation claims that all these statements were false or inaccurate and in support of the claim, the sole reliance by Shri Taleyarkhan is on the certificate issued by the employer and forwarded by the petitioner to the Corporation. It was urged that the certificate sets out in detail the ailments suffered by the deceased from April 14, 1972 onwards till Nov. 18, 1975

and the sick leave secured by the deceased from his office. Shri Taleyarkhan submits that the deceased had taken sick leave on production of medical certificate and that clearly establishes that the deceased was suffering from ailment and had consulted Medical Practitioner. It is impossible to accept the contention of Shri Taleyarkhan that the deceased had made deliberate false statements. In the first instance, it must be remembered that before the Corporation accepted the proposal of the deceased, a confidential report of the Medical Examiner was secured by the Corporation. The Medical Officer, Dr. Sahil Dipchand, is a Doctorate in Medicine and is attached to the General Hospital at Borivli and is on the panel of the Corporation.The confidential report submitted by the Medical Examiner was made available by Shri Taleyarkhan after I called upon the learned counsel to produce the original and the report unmistakably establishes that the deceased was enjoying sound health. The report was made by the Medical Examiner after examining the deceased thoroughly and it is obvious that the Corporation has not proceeded to accept the proposal of the deceased only on the statements made in the printed form but on the basis of the report received from the Medical Officer. Secondly, the deceased had disclosed in the proposal form that he was operated for appendicitis in the year 1959 and had not hidden the fact of operation from the Corporation. What is urged by Shri Taleyarkhan is that the deceased did not disclose that he was suffering from bleeding piles, hypertension and influenza.

11. Now, even assuming that the certificate issued by the employer is correct and the deceased had in fact secured sick leave on the relevant dates by production of Medical Certificate, it cannot be concluded that the deceased was in fact suffering from the bleeding piles or hypertension. In my judgment, the ailment of bleeding piles, influenza and dysentery are very minor and trivial ailments and the failure to disclose such ailments in the proposal form cannot be treated as a suppression of the relevant particulars. The deceased might have very well felt that it is not necessary to state that he had suffered from flue, dysentery or common cold because such ailment has no bearing whatsoever to the longevity of the person. It is well known that people in Bombay do not consult Medical Practitioners for such petty ailments like flue, fever or dysentery but the medical certificates are required to be produced before the employer in accordance with the service conditions and the mere fact that the medical certificate is produced for obtaining sick-leave cannot lead to the conclusion that the deceased had taken treatment from the Medical Practitioner.Shri Taleyarkhan made reference to paragraph 11 of the return wherein it is claimed that the deceased was suffering from low blood pressure, giddiness and weakness in Dec. 1972 .There is no material on record whatsoever to substantiate this claim. The reliance on the certificate issued by the employer would not help the Corporation because the medical certificate issued in Dec. 1972 merely recites that the deceased was suffering from hypertension. It nowhere refers to the deceased suffering from giddiness or blood pressure or weakness. The certificate discloses only one occasion in 1972 when leave was secured on ground of hypertension and piles. The Corporation has stoutly claimed that it is not bound to produce any material which it holds in support of the claim that the deceased had made false and inaccurate statements and the excuse given for such non-production of evidence is that the disclosure may lead to the destruction or spiriting away of the said material. The Corporation cannot take shield behind such vague excuses and sustain its claim that it holds undisputable evidence in its custody. It is obvious that the Corporation has no material in its custody save and except the certificate

issued by the employer of the deceased. The action of the Corporation in concluding from that certificate that the deceased was suffering from serious ailments or illness and thereby repudiating the contract is wholly illegal. The Corporation has raised false bogie of inaccurate statements only to defeat the just claim of the poor widow and the action of the Corporation deserves to be deplored.

12. Even assuming that the deceased had made incorrect or false statements about his ailment, still that fact itself would not be suffice for the Corporation to repudiate the contract in view of the clear-cut provisions of S. 45 of the Insurance Act. Realizing this position, Shri Taleyarkhan urged that the suppression of ailment was a material matter and the deceased suppressed that fact fraudulently. It was urged that the deceased knew at the time of making the statement that it was false and, therefore, it is open for the Corporation to repudiate the contract. In my judgment, the submission is entirely misconceived. In the first instance, there was no suppression whatsoever by the deceased. It was not necessary for the deceased to disclose trivial ailments like fever, flu or dysentery. There is nothing to warrant the conclusion that the deceased had consulted Medical Practitioner within five years prior to the taking out of the Policy. The concept of consultation with the Medical Practitioner is entirely different from securing medical certificate on the ground that the person is down with fever. The perusal of the proposal form leaves no manner of doubt that it is not each and every petty ailment which has to be disclosed by the proposor and what it required to be disclosed is a serious ailment. The deceased was not suffering from any serious ailment and was a young man of 41 years age at the time of taking out of the policy. The Medical Practitioner on the panel of the Corporation had examined him and in these circumstances, it is futile for the Corporation to claim that the deceased was suffering from any serious ailment. In my judgment, the non-disclosure of the fact that the deceased was suffering from fever or down with flue on some occasions is not material matter and, therefore, the failure to disclose the same cannot be construed as suppression of the relevant fact. As laid down by the Supreme Court, it is not suppression of the fact which is sufficient to attract second part of S. 45 of the Insurance Act but what is required is that such suppression should be fraudulently made by the policyholder. The expression "fraudulently" connotes deliberate and intentional falsehood or suppression and some strong material is required before concluding that the policyholder had played a fraud on the Corporation. In my judgment on the facts and circumstances of the present case, it is impossible to come to the conclusion that the deceased had suppressed any material facts and such suppression was done fraudulently. The Corporation cannot deny its liability by a raising hopeless defence that the deceased was suffering from fever, flu and dysentery from time to time. In my judgment, the second part of S. 45 of the Insurance Act is not, at all, attracted to the facts of the case and it is not open for the Corporation to repudiate the contract. The petitioner is entitled to the claim under the policy along with the bonuses and other benefits accrued thereon.

13. In my judgment, the request made by the learned counsel is correct and deserves acceptance. The petitioner husband died on Oct. 8, 1977 and the claim was lodged by the petitioner on Oct. 24, 1977. The Corporation raised false and frivolous pleas to deny the claim of the petitioner who has deprived the petitioner of a small amount though it is quite large to the petitioner, what I am told, is serving as a maid servant to bear up her three minor

children. The Corporation has enjoyed the advantage of the amount which was due to the petitioner and the Corporation is duty bound to pay the said amount with interest to the petitioner who was deprived her just dues. In my judgment, the Corporation should pay the amount due under the policy along with interest at the rate of 15% from the date of lodging of the claim i.e. Oct. 24, 1977 till payment. The Corporation has not only denied payment to the petitioner but has also raised frivolous pleas in answer to the petition and has persisted in defending the petition without any just reasons. In my judgment, this is a fit case to award compensatory costs of Rs. 1,000/- to the petitioner in addition to the normal costs.

14. Accordingly, rule is made absolute and the respondents are directed to pay to the petitioner the amount due under Policy No. 18251483 issued on July 7, 1975 including all the bonuses and other benefits accrued thereon.

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Kasim Ali Bulbul v. *New India Assurance Co.*

AIR 1968 J & K 39

J.N. BHAT, J. – The plaintiff, Kasim Ali Bulbul, carries on business in wood carving and paper machine under the name and style of K.A. Bulbul in Lambert Lane, Residency Road, Srinagar. On 8th June 60 he got his stock-in-trade consisting of wood carving, paper machine, business furniture and two pieces of carpet contained in the shop insured with the defendant company for one year from 8th June 60 to 8th June 61 for a sum of Rs. 30,000.

A policy No. 155860356 was issued in his favour by the defendant company. The plaintiff's shop caught fire on the night between 4/5th February 1961 while he was asleep in Zadaibal. Next morning he came on the scene and found that the shop had been taken possession by the local officials of the defendant company and the police. It was sealed. The plaintiff gave tentative information of this fire to the defendant company. The plaintiff's books were seized by the police. The police inquired into the matter and declared the fire accidental. Later on a Surveyor was deputed by the defendant company who made a report. The loss that he sustained on this account was Rs. 27340.31.

2. The shop remained in possession of the defendant company when on the night of 3rd November 61 another fire broke out which destroyed the remaining articles in the shop. There were some un-insured goods of the value of Rs. 564.50. The total claim of the plaintiff thus comes to Rs. 27,904.81.

3. According to the plaintiff, on the basis of the insurance effected on his goods, the defendant company was liable to make good the loss to him, but did not do so. As the keys of the shop remained with the defendant upto 3rd November 61, the defendant was further liable for the loss of uninsured goods valuing Rs. 564.50. The plaintiff therefore claimed a decree for the above-mentioned amount, i.e., Rs. 27,904.81.

4. In defence the defendant company has taken a number of pleas. They are that the defendant has not been properly sued; the plaint is not properly verified and the suit is time-barred. All the benefits under the policy and the suit stand forfeited because (1) the claim is fraudulent; (2) A false declaration has been made in support of the claim; (3) the loss or damage was occasioned by the wilful act and connivance of the plaintiff; (4) the plaintiff has not complied with the terms and conditions of the policy; (5) the plaintiff is not entitled to any relief as the suit was not commenced within three months after the rejection of his claim by the defendant company; and (6) the plaintiff did not comply with condition 11 of the policy and did not submit any claim within the period of 15 days from the date of the alleged loss. Condition 11 is quoted in extenso in the written statement. The plaintiff was notified by letter dated 25-2-61 that as the claim was not submitted in accordance with this condition, his claim could not be entertained.

5. On facts the defendant did not deny the insurance of the articles of the plaintiff with the defendant company as alleged by the plaintiff. But the defendant alleged that this contract was entered into by the defendant on the basis of false representation and suppression of material facts by the plaintiff which vitiated the whole contract. It was admitted that the plaintiff informed the defendant company at Srinagar on 5.2.61 that his shop had been gutted

on the night between 4/5th February 61. On 5.2.61 the plaintiff was asked to submit his claim, account books, pass books and submit his claim form. He was reminded by another letter dated 16.2.61. But the plaintiff did not do anything. It is admitted that the defendant company locked the shop but the plaintiff's lock also was there. On 25.2.61, the defendant rejected the claim of the plaintiff. The plaintiff did not submit his account books, nor submit his claim in writing. The plaintiff replied the letter of the defendant of 25.2.61 that he could not ascertain the damages as the account books and other documents were lying with the police. By letter dated 28.2.61 the plaintiff was again referred to the letter of the defendant dated 25.2.61. On 27.6.61 the Chief Regional Manager of the defendant company New Delhi notified the plaintiff that he had forfeited all benefits under the policy and his claim stood rejected. The conclusion of the police that the fire was accidental was not correct. Mr. Sarin of Messrs. V.N. Sarin and Co. was appointed as the Surveyor. The survey report was also against the plaintiff. There was further correspondence between the parties. On 9-5-61 the plaintiff submitted a list of goods destroyed by fire but that was beyond time. The plaintiff had been guilty of suppression of facts in the proposal form while replying questions 8(a) and (b) in the proposal form. He had formerly insured the same goods in the year 1957 with the Ruby General Insurance Co. Ltd. and the shop was gutted in that year and the plaintiff's claim which was a huge amount was settled by that company at Rs. 14860/-. The plaintiff had not complied with conditions 11 and 13 of the policy. Therefore he was not entitled to any amount. The presence of the uninsured goods in the shop was also denied. Even if there were any such goods the defendant was not liable for the loss alleged to have been caused to the plaintiff by the fire of 5.11.61.

6. On these pleadings my learned predecessor-in-office framed the following issues in the case:

(1) Is the suit properly stamped? OPP

(2) Is the plaint properly verified? OPP

(3) What was the value of the goods lying in the shop of the plaintiff at the time of the fire on the night of 4/5th February 1961 and what was the value of the goods damaged or destroyed by the fire?

(4) Is the plaintiff's right to claim extinguished by lapse of time?

(5) Is the plaintiff's suit not within time?

(6) Has the plaintiff been guilty of suppression of material facts and false representation at the time of obtaining the policy from the defendant and as such is the policy of insurance void and unenforceable and not binding on the defendant?

(7) Has the plaintiff not filed claim within the time stipulated in the policy and as such he has forfeited all rights and claims under the policy?

(8) Is the claim of the plaintiff fraudulent?

(9) Was the fire occasioned by the connivance or wilful act of the plaintiff?

(10) Has the plaintiff's goods of the value of Rs. 500/- been damaged or destroyed in the fire of November 1962 in the same premises and if so, is he entitled to get the sum of Rs. 500 from the defendant?

(11) Is the plaintiff not entitled to any relief as he has not filed the suit within 3 months of the rejection of his claim by the defendant as provided in the policy?

(12) To what relief is the plaintiff entitled?

7. One additional issue was framed by order of this court dated 4.10.62 which is to the following effect:

(13) Is the declaration made in support of the suit claim made by the plaintiff true and correct and if not has he forfeited all the benefits under the policy?

11. Before me some of the issues were not at all pressed. For instance, issues 1 and 2 were not at all discussed before me. Therefore, they will be deemed to have been waived. The third issue relates to the value of the goods lying in the shop of the plaintiff at the time of the fire on the night between 4/5th February 61 and the value of the goods damaged or destroyed by fire. The plaintiff in support of this issue has produced the following witnesses:

12. Ama Shah states that the value of goods which were gutted by fire on the night between 4/5th February 1961 in the shop of the plaintiff at Lambert Lane was of the value of thirty to thirty-two to thirty-five thousand rupees. This witness states that he has been carrying on the polishing of the wood carving articles of the plaintiff for a number of years. Mohd. Shaban, who is a broker, states that the goods that were gutted by fire on the relevant night were worth about Rs. 30,000/-. Similarly G.M. Mir who supplied paper machine goods to the plaintiff states that the value of the goods destroyed by fire in the shop of the plaintiff was between Rs. 25 to 30 thousand rupees. The plaintiff's son also places the value of the gutted goods between 25 to 30 thousand rupees. The plaintiff also in his own statement places the same valuation. The evidence of these witnesses is based on their own estimate of the valuation of the goods. No witness has or could possibly state the correct value of the goods gutted. The plaintiff has produced some books, i.e., the sale book, the stock book and the Counter-foils of certain cash memos. According to the plaintiff on the basis of these documents he has fixed the valuation of the goods gutted as given by him in the plaint. Although this evidence is not full proof, yet there is no direct evidence produced by the defendant to contradict this evidence. The surveyor produced by the defendant Mr. V.N. Sarin proprietor of Messrs. V.N. Sarin and Co. puts the estimated loss of goods at Rs. 6508.20, and the furniture at Rs. 150/-.

13. The learned counsel for the defendant has criticized the account books produced by the plaintiff and has stated that they were not genuine. They were prepared for the sake of this case. The plaintiff from the very beginning had an evil design of setting fire to this shop which contained a small quantity of goods, and to inflate and bolster up his false claim he got those account books prepared. He has argued that the account books start right from the date the insurance was effected. He has at length cross-examined the plaintiff's son who has admitted that he writes the accounts of the plaintiff alongwith another clerk, Mohd. Ishaq. According to the learned counsel for the defendant the accounts have been prepared at one time, being in the same ink and hand though covering a sufficiently long period of time. This argument of the learned counsel for the defendant is not without force, but in view of the ultimate fate that the case is to meet at any hands, I do not think I should very seriously probe into the matter of the valuation of the goods that were gutted. I must therefore accept the figure of loss sustained by the plaintiff as put by him as correct. Therefore issue 3 is decided in favour of the plaintiff.

15. The case of the defendant is that under the terms of the policy of insurance the plaintiff had to intimate the details of the loss to the defendant company within 15 days of its occurrence. Further he had to institute a suit within three months of the rejection of the claim by the defendant. The fire broke out admittedly on the night of 4/5th February. 61 The plaintiff did in fact inform the defendant company's branch at Srinagar on the morning of 5th February. The then SHO Kothibagh Mr. Abdul Rashid seized the books of the plaintiff from his house on 5-2-61 and prepared a seizure list Ex. PW2/2. The books remained in the custody of the police till 5-5-61. When the plaintiff moved the ADM Srinagar on 3-6-61; the books were returned to him by means of a receipt Ex. PW 1/2 on 5-5-61, vide the statement of Shambu Nath Head Constable Thana Kothibagh PW 1. It is therefore conceivable that the plaintiff was not in a position to give a detailed list of the articles which were burnt to the defendant company within 15 days. The plaintiff has however given a detailed list of the loss caused to him on 9th May 61. The defendant's contention was based on condition 11 of the policy which runs as under:

> "On the happening of any loss or damage the insured shall forthwith give notice thereof to the company and shall within 15 days after the loss or damage or such further time as the company may in writing allow in that behalf, deliver to the Company.
>
> (a) A claim in writing for the loss or damage containing as particulars an account as may be reasonably practicable of all the several articles or items of property damaged or destroyed, and of the amount of the loss and damage thereto respectively, having regard to their value at time of the loss or damage not including the profit of any kind.
>
> (b) Particulars of all other insurances, if any the insured shall also at all time at his own expense produce, procure and give to the company all such further particulars, plans, specifications, books, vouchers, invoices, duplicate or copies thereof, documents, proof and informations with respect to the claim and the origin and cause of the fire and the circumstances under which the loss or damage occurred, and any matter touching the liability or the amount of the liability of the company as any, be reasonably required by or on behalf of the company together with a declaration on oath or in other legal form of the truth of the claim and of any matters connected therewith.
>
> No claim under this policy shall be payable unless the terms of this condition have been complied with."

16. According to the defendant the plaintiff did not supply the detailed list within 15 days of the occurrence of the fire, and therefore the plaintiff forfeited his right under the policy. Emphasis was laid on the last portion of this condition which says that no claim under this policy shall be payable unless the terms of this condition have been complied with. But I think it was physically impossible for the plaintiff till the 5th of May 61, to give a complete and detailed list of the loss sustained by him as his books were with the police. Therefore to that extent the plaintiff has an explanation or a justification in not supplying the detailed list to the company within 15 days of the damage. But there is the second part of this matter which is covered by condition 13 of the policy. This condition runs as under:

"If the claim be in any respect fraudulent or if any false declaration be made or used by the insured or anyone acting on his behalf to obtain any benefit under this policy, or if the loss or damage be occasioned by the wilful act or with the connivance of the insured, or if the claim be made and rejected and an action or suit be not commenced within three months of such rejection, or in case of an arbitration taking place in pursuance of the 18th condition of this policy within three months after the arbitrator or arbitrators or umpire shall have made their award, all benefits under this policy shall be forfeited."

17. In this case we have it in the evidence of Mr. Jaipal Bahadur D.W. 2 Chief Regional Manager of the defendant company Northern India that the claim of the plaintiff was rejected by means of a letter of the company dated 25.2.61. The same thing has been testified to by Mr. R.N. Dubash D.W. 5 who has been an employee in this concern from 1957 and is now the O/c of the Company at Srinagar. According to him the company rejected the claim of the plaintiff on 25.2.61. There are a number of letters also which reiterate and refer to the initial letter of the defendant dated 25.2.61. All these letters are signed by Mr. K.B. Pestonjee who was then incharge of the Srinagar branch and is now in Manila and therefore incapable of appearing before the court. His signatures have been identified by Mr. R.N. Dubash.

18. The suit was instituted on 1-2-62 which is clearly about a year after the rejection of the claim of the plaintiff by the defendant. Therefore in terms of this policy the right of the plaintiff to recover the suit amount is extinguished. In the proposal form Ex. D.W. 4/1 the condition is that the declaration made in this form shall be the basis of the contract between the parties. The insurance company agrees to compensate the insured only subject to the conditions mentioned in the policy which appear on the back of the policy.

19. An argument has been advanced that the condition of instituting legal proceedings within three months of the rejection of the claim of the insured by the insurance company is against section 23 and 28 of the Contract Act. Section 28 reads as under:

"Every agreement, by which any party thereto is restricted absolutely from enforcing his rights under or in respect of any contract, by the usual legal proceedings in the ordinary tribunals, or which limits the time within which he may thus enforce his rights, is void to that extent."

20. Section 23 of the Contract Act makes the following agreements as unlawful: If they are forbidden by law or are of such a nature that if permitted would defeat the provisions of any law, or are fraudulent, or involve or imply injury to the person or property of another, or if the court regards them as immoral or opposed to public policy. A list of illustrations is appended to this section.

22. Section 28 makes all agreements in restraint of legal proceedings void.

23. It is argued that such an agreement is immoral and opposed to public policy and further it curtails the ordinary period of limitation. I need not consider these sections in detail because the matter is completely covered by authority. It will surely be a waste of time to embark on a discussion of the points raised. The following authorities may be mentioned:

In Porter's *Law of Insurance* (6th Edn.) page 195 it is stated that insurance may lawfully limit the time within which an action may be brought to a period less than that allowed by the statute of limitation and that the true ground, on which the clause limiting the time of claim rests and is maintainable is that, by the contract of the parties the right to indemnity in case of loss and the liability of the Company therefor do not become absolute, unless the remedy is sought within the time fixed by the condition in the policy. In AIR 1924 Cal 186 some English cases were discussed and condition No. 13 of the policy as in the present case was there. The condition amongst other things stated:

> "If the claim be made and rejected and an action or suit be not commenced within 3 months after such rejection and in the case of arbitration taking place in pursuance of the 18th condition of this policy within three months of the arbitration when the arbitrator or the umpire shall have made the award, all benefits under the policy shall be forfeited."

In this case an action commenced after the stipulated period of three months was held to contravene neither section 23 nor section 28 of the Contract Act.

27. The latest authority on the subject is AIR 1966 All 385 wherein according to a clause in the loss-cum-fire insurance policy the insured had to file within 15 days of the loss a complete claim giving full particulars. The loss occurred on 18-8-47. Insured sent a telegram on 21-8-1947 as "sugar is looted. Please note." The company replied on 25.8.47 asking for policy number and circumstances of loss. The insured sent reply on 8.9.47 giving some particulars. Even this did not give all particulars. The company ultimately rejected the claim. On these facts it was held that the communication was beyond 15 days. The mere fact that the application under section 13 of the Displaced Persons (Debts Adjustment) Act 1951 regarding the claim of the insured who was a displaced person was within time, would not entitled him to get any relief in respect of the loss.

28. In this case even if the plaintiff was entitled to any relief he had forfeited all rights under the policy when he failed to bring his suit within three months of 25th February 61 when his claim was rejected by the insurance company. The claim was not rejected only once, but the basic stand taken by the company in its letter of 25.2.61 was repeated in a number of letters, for instance, D.W. 5/2 dated 28.2.61, D.W. 5/3 dated 27.12.61, D.W. 5/4 dated 21.11.61 and D.W. 2/1 dated 27.6.61. The plaintiff had no justification to wait till 1.2.62 to file the suit. By that time his right had been completely extinguished.

29. In this way issues 4, 5, 7 and 11 are decided against the plaintiff. His suit is clearly time-barred.

30. The second group of issues that can be conveniently taken up together is Nos. 6, 8, and 13. The case of the defendant is that the plaintiff has been guilty of suppression of material facts and has made a false representation at the time of obtaining the policy from the defendant. His claim cannot therefore be entertained. Emphasis on this aspect of the case is laid on the reply of the plaintiff to question 8(a) and 8(b) of the proposal Ex. D.W. 4/1 which is as under:

> 8 (a) Has the property been insured in the past or at the present time? If so, give full particulars.

8(b) Have you sustained loss. Give full particulars.

To both these queries the plaintiff has said 'No.'

31. The contention of the learned counsel for the defendant is that the plaintiff had insured the goods of his shop with another insurance company in the year 1957 namely, the Ruby General Insurance Co. During that year also his shop was gutted by fire. He made a claim for Rupees 25,000/- from the Insurance Company, but his claim was settled at Rs. 14807/-. According to the Manager of the Ruby General Insurance Co., Mr. D.N. Chopra, the settlement was arrived at on 24.2.58. The shop of the plaintiff had caught fire on 24.4.57 and the policy of insurance with that company had come into force for one year from 9.10.56 to 9.10.57. The plaintiff and his son admitted this previous insurance, but their case was that the plaintiff is an illiterate person who does not know English. He only know how to sign 'K.A. Bulbul' and at the time of entering into the present contract he was not explained the terms of the proposal form or of the insurance policy. D.W. 4 Abdul Ahad Sheikh, Inspector of the New India Assurance Co. has deposed on solemn affirmation that he filed in the form Ex. D.W. 4/1 on 5th June 60 and the answer that he entered against each query in the proposal form was at the instance of the plaintiff. He made the plaintiff understand all the questions and recorded his answers. Col. No. 8 was also filled at the instance of the plaintiff. The plaintiff signed the proposal form after knowing the contents thereof. The plaintiff however tried to negative this evidence by the statement of Gulla Khan who says that the plaintiff is an illiterate person. In view of the statement of Abdul Ahad Sheikh and reading in between the lines the statement of the plaintiff himself, it is difficult to hold that the plaintiff was not put a specific question whether he had not insured this property with another insurance company earlier. I feel that the plaintiff purposely withheld this information from the insurance agent because when previously he had insured the goods of the shop with the Ruby G. Insurance Co. and his shop had caught fire he had claimed Rs. 25000 but was given only Rs. 14000 and odd. Feeling somewhat apprehensive about the state of affairs then, he wilfully suppressed this fact from the defendant insurance company. So on facts it is proved that the plaintiff has made a false statement in reply to question No. 8.

32. Now we have to see what is the legal effect of this false statement. The law on this point is so well settled both in England and India that it does not require any elaborate discussion. Anyhow the following authorities may be mentioned.

33. The effect of non-disclosure or misrepresentation is that the insurers have the right to repudiate, that is to say, to avoid contract.

34. Where, however, insurers answer a claim by repudiating the policy on the ground of fraud, misrepresentation or non-disclosure, they are not bound to offer a return of premium

39. The matter has again been fully discussed in AIR 1962 SC 814 where a policy holder who had been treated a few months before he submitted his proposal for the insurance of his life with the insurance company by a physician of repute for certain serious ailments as anaemia, shortness of breath and asthma, not only failed to disclose in his answers to the questions put to him by the insurance company that he suffered from these ailments but he made a false statement to the effect that he had not been treated by any doctor of any such serious ailment, it was held that judged by the standards laid down in section 17 Contract Act,

the policy holder was guilty of a fraudulent suppression of material facts when he made his statements, which he must have known were deliberately false and hence the policy issued to him relying on those statements was vitiated. In the circumstances of the case it was held that no advantage could be taken of the Explanation to section 19 of the Contract Act. In this case it was further held:

> "Where, according to terms of the life insurance policy, all moneys that had been paid in consequence of policy would belong to the insurance company if the policy was vitiated by reason of a fraudulent suppression of material facts by the insured, and the contract is bad on the ground of fraud, the party who has been guilty of fraud or a person who claims under him cannot ask for a refund of the money paid. It is a well established principle that courts will not entertain an action for money had and received where, in order to succeed, the plaintiff has to prove his own fraud. Further in cases where there is a stipulation that by reason of a breach of warranty by one of the parties to the contract, the other party shall be discharged from the performance of his part of the contract, neither S. 65 nor S. 64 of the Contract Act has any application."

40. In view of all these authorities, it is clear that the plaintiff simply on the ground that he gave a false reply to questions 8(a) and (b) in the proposal form cannot claim any compensation for fire having been caught by the goods in his shop. In this case the question was very material and withholding of the real information from the insurance company would automatically absolve the insurance company from any liability under the contract. As already remarked, the Privy Council has gone to the length of holding that the answers to a question being material or immaterial, would not make any difference. The plaintiff's suit would therefore fail on this account alone.

41. Issue 8 is not very clear but I have grouped it with issues 6 and 13. In my opinion this issue is based on the fraud alleged to have been committed by the plaintiff in suppressing the material information regarding the previous insurance of the goods of his shop with the Ruby General Insurance Co. in the year 1957. But if this issue is construed as suggesting that the claim of the plaintiff is not bonafide, I have given my finding already that all the weaknesses that the plaintiff's case may have, it can be safely held that it is proved that he lost goods of the valuation mentioned in the plaint during the fire. So these observations dispose of issues 6, 8 and 13.

42. The learned counsel for the defendant has laid great stress on the fact that the fire was caused by the wilful act of the plaintiff. No doubt the plaintiff's conduct is somewhat not above suspicion. According to the plaintiff and his witness Ama Shah, his son Safdar Ali and the plaintiff himself they closed the shop as usual at about 7.30 in the evening. The shop caught fire in the night. The plaintiff or anybody on his behalf did not repair to the scene of occurrence till 10 the next morning. The plaintiff says that he did not know about the occurrence. Although this statement would seem improbable, but there is nothing on the file to clearly contradict this statement of the plaintiff. The police registered the case as a suspicious one and conducted investigation but later on the police also discovered that the fire was accidental (Vide the statement of Abdul Rashid P.W. 2). The defendant has led no positive evidence to show that the plaintiff himself set the goods of his shop on fire. The

defendant's case is based on certain suspicious entries in the account books of the plaintiff and on the conduct of the plaintiff. But that by itself is not sufficient to hold that the plaintiff himself wilfully set his shop on fire or connived at it. In my opinion this issue should be decided against the defendant.

43. The plaintiff claims Rs. 564.50 as the value of uninsured goods which caught fire on November 3, 1961 because according to him the keys of the shop were still with the defendant company. In the first place the plea of the plaintiff that the shop remained under the possession and lock and key of the defendant up to 3rd November 61 is not established. Apart from that fact unless it is shown that the destruction by fire of this uninsured goods was the result of the negligence of the defendant, no responsibility can be fastened upon the defendant. If the plaintiff's case were that he was present on the scene of occurrence on November 3, 1961 to salvage his merchandize, but for the fact that the shop was locked by the defendant, there was some case for the plaintiff. But there is no such suggestion on the part of the plaintiff. Even if the shop was under the lock and key of the defendant and it caught fire which was accidental the defendant would not by the mere fact of the destruction of the goods therein be liable for the damage. Therefore, in my opinion, the plaintiff cannot even claim this amount.

44. From the finding on the issues recorded above, the plaintiff's suit has to be dismissed and is hereby dismissed.

* * * * *

Smt. Krishna Wanti Puri v. *Life Insurance Corporation of India*

AIR 1975 Del. 19

AVADH BEHARI ROHTAGI, J. – On February 19, 1968, Smt. Krishna Wanti Puri, widow of Late Dharam Pal Puri instituted an action against the Life Insurance Corporation for the recovery of Rs. 85,000/- and profits and interest on the four policies.

2. Dharam Pal Puri when he was alive insured his life with the Corporation and took out four policies.

3. Dharam Pal Puri died on 5th August 1964. The widow claims the amount of the four policies from the Corporation on the ground that she is the assignee. The Corporation resists the suit. The main ground of defence is that Dharam Pal Puri was suffering from heart disease, that he know about his ailment, that he had consulted doctors about his disease but fraudulently suppressed these facts. In the proposal forms and the personal statements, he made declarations knowing them to be false because he never disclosed to the Corporation that he was suffering from heart disease.

4. On the pleadings of the parties the following issues were framed on merits on 19th August, 1969:

(1) Is the plaintiff entitled to recover the amount, if any, due to her on the policies mentioned in the plaint on the allegations made in the plaint? O.P.P.

(2) Who is the assignee of these policies? O.P.P.

(3) Are the defendants entitled to deny payment to the plaintiff on the grounds stated in the written statement? O.P.D.

(4) Relief?

Issue No. 3:

5. The only question that arises for decision is whether the widow is entitled to recover the amount of the four policies from the defendant Corporation or whether the Corporation is entitled to avoid the policies and refuse to pay the amount to her on the ground that the deceased fraudulently concealed and suppressed material facts which were necessary for the insurer to know.

6. The chief issue in the case is Issue No. 3 and clearly the onus of this issue was on the defendant Corporation to prove fraudulent concealment and material suppression of facts. In support of their case, the Corporation examined three doctors. They are Dr. Santosh Singh who was examined on commission. Dr. (Miss) S. Padmavati (D.W. 3) and Dr. V.K. Dewan (D.W. 10). In order to appreciate their evidence, it is necessary to set out the relevant questions which were required to be answered by the deceased in the personal statements and the answers given by him thereto.

Question	*Answer*
What has been your usual state of health?	Good
Have you consulted a medical practitioner within the last five Years? If so, give details	No
Have you ever suffered from any of the following ailments -	No

Fainting attacks, pain in chest, breathlessness, palpitation or any disease of the heart?	No
Any other illness within the last five years requiring treatment for more than a week	No
Have you ever had any electric cardiogram, X-ray or fluoroscopic examination made or your blood examined. If so, give details.	No
Have you ever been in any hospital, asylum or sanatorium, check up, observation, treatment or an operation.	No

7. In identical terms were the answers of the deceased in all the four policies. On the basis of these statements the Corporation issued the policies.

8. On the death of Dharam Pal Puri the widow made a claim and gave to the Corporation the certificate of death of her husband. From the certificate the Corporation came to know that the deceased was admitted in Sir Ganga Ram Hospital on 4th August, 1964 and died there on 5th August 1964. The Corporation also learnt that the deceased was suffering from Mitral Stenosis with auricular fibrillation and that he died of this disease in the hospital. The Corporation made certain investigations and as a result came to the conclusion that Dharam Pal Puri was suffering from this heart disease since 1959 in any case, if not earlier. The Corporation contacted the three doctors named above and took from them certificates stating that the deceased was suffering from this heart disease.

9. Dharam Pal Puri consulted Dr. (Miss) S. Padmavati on 29th May, 1959 and 25th of September, 1959. Dr. Padmavati appeared in the witness-box and deposed to this effect. She had at the request of the Corporation issued a certificate on 11th December, 1964, in which she had stated that the deceased was examined by her on these two occasions and that he suffered from Mitral Stenosis with auricular fibrillation. In the certificate she had also said that the deceased was suffering since 1946 according to the statement of the patient himself which was made to her. The Doctor never saw the patient after 25th September, 1959. When Dr. Padmavati was examined in court on 9th October, 1970 she said that she verified the contents of certificate (D-6) issued by her from the records of the Lady Harding Hospital which were supplied to her. It appears that on 11th December, 1964, when she gave the certificate the records of the Lady Harding Hospital were available to her. She was Professor of Medicine in Lady Harding Medical College at that time. She is F.R.C.P. of London and F.R.C.P. of Edinburgh. She also deposed that before she signed the document she verified the name, address and age of the patient from the record. As regards the nature of the disease, she said this:

> "Mitral stenosis is a type of rheumatic heart disease. Auricular Fibrillation is a complication of mitral stenosis in which an abnormal rhythm is supers-imposed. According to entry made in Col. 5 the patient's case was a case of serious form of heart disease. This disease can be checked without doing the electro cardiogram. This disease can be checked by a stethoscope. Normally a general medical practitioner should be able to check this disease."

10. The next medical man who was approached by the Corporation to find out the nature of the disease from which Dharam Pal Puri was suffering was Dr. V.K. Dewan. He had also

similarly certified on 17th November, 1964, that Dharam Pal Puri suffered from the very ailment of which Dr. Padmavati deposed. He also said that deceased had been suffering from this disease for about five or seven years before his death. Dr. Dewan is an honorary physician in Sir Ganga Ram Hospital. He attended on the deceased when he was admitted to the hospital on 4th August, 1964. In his evidence before the court he stated that the contents of his certificate (D-7) were correct and the entire form had been filled up by him in his own hand. He derived the information from the hospital record where the patient was admitted.

11. Dr. Santosh Singh was examined on commission at Ranchi. When the deceased was admitted to the hospital in August 1964, Dr. Santosh Singh was the Registrar of Sir Ganga Ram Hospital. He also attended on the deceased on the 4th and 5th of August, 1964, and similarly gave two certificates regarding the hospital treatment. In the two certificates (B-2 and B-3) Dr. Santosh Singh stated that Dharam Pal Puri was suffering from Mitral stenosis and died as a result of heart failure. He said that the deceased had been suffering from this disease for about seven years before his death and the symptoms of this illness were first observed by the deceased about seven years ago. Both these certificates were signed by Dr. Santosh Singh. He solemnly declared that the foregoing statements were true and correct to the best of his knowledge and that the information was correct as per records of the hospital. These certificates are dated 31st October, 1964. Dr. Santosh Singh also signed a report regarding the deceased wherein too he stated that the deceased was suffering from this ailment for the last 7½ years. These certificates and report were obtained by Shri P.C. Puri, the brother of the deceased, and were passed on to the Corporation. These certificates set the Corporation thinking and put the officials on enquiry regarding the cause, place and the date of his death.

12. Later on it appears that Dr. Santosh Singh was prevailed upon by the relatives of the deceased and he issued another certificate of hospital treatment dated 24th October, 1964 and a report dated 28th November, 1964. In the certificate and report Dr. Santosh Singh stated that some attendant on the deceased had reported to him that Dharam Pal Puri had been suffering from the disease only for the last years. The relative also procured another medical attendant certificate dated 30th October 1964, purported to be signed by Dr. Santosh Singh wherein it was stated that the deceased had been suffering from this disease for about 1½ years before his death. A photostat copy of this certificate dated 30th October, 1964, was produced during the examination of Dr. Santosh Singh on commission. The original of this document has not been placed on the record. In his examination Dr. Santosh Singh admitted the correctness of all the documents. He also admitted that Dr. V.K. Dewan was the physician incharge who was attending on the deceased in the hospital. He admitted that the records of the hospital were available to him at the time of signing the two certificates (B-2 and B-3). When it was pointed out to the witness that in some certificates he had given the duration of the disease 7½ years and in some 1½ years, the witness said:

> "It appears that certain entries in Exhibit B-2 and Exhibit 'E' different. I cannot assign any reason unless I see the original records. Without reference to the original record it is not possible to say whether the entries in the certificates are correctly made."

13. This is the evidence of the three doctors and the counsel for the Corporation strongly relies on their evidence to show that the deceased had been suffering from heart disease since 1946 and, as has been proved in the evidence of Dr. Padmavati, that Dharam Pal knew about the same and that is the very disease of which he ultimately died. On the ground of fraud and suppression of material facts, the counsel urges that the Corporation is entitled to avoid all the four policies.

15. In *Mithoolal Nayak* v. *Life Insurance Corporation of India* [AIR 1962 SC 814], it was held that the three conditions for the application of the second part of Section 45 are:

(a) the statement must be on a material matter or must suppress facts which it was material to disclose;

(b) the suppression must be fraudulently made by the policy holder; and

(c) the policy holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose.

16. The crucial question before me is whether these three conditions were fulfilled in the present case.

17. Now what is the nature of a contract of insurance? Contracts of insurance are ***uberrima fides*** and therefore the insured owes a duty to disclose before the contract is made every material fact of which he knows or ought to know. If a material fact is not so disclosed, the insurers have the right at any time to avoid the contract. As Lord Mansfield demonstrated in ***Carter*** v. ***Boehm*** [(1763) Sm 5 KC 546, 550], insurance is a contract upon speculation where the special facts upon which the contingent chance is to be computed lie generally in the knowledge of the assured only, so that good faith requires that he should not keep back anything which might influence the insurer in deciding whether to accept or reject the risk. A fact is material if it is one that would affect the mind of a prudent man, even though the assured does not appreciate the materiality. In the words of Bayloy, J.:

"I think that in all cases of insurance whether on ships, houses or lives, the underwriter should be informed of every material circumstance within the knowledge of the assured; and that the proper question is, whether any particular circumstance was in fact material, and not whether the party believed it to be so. The contrary doctrine would lead to frequent suppression of information, and it would often be extremely difficult to show that the party neglecting to give the information thought it material. But if it be held that all material facts must be disclosed, it will be in the interest of the assured to make a full and fair disclosure of all the information within their reach."

18. In India, the duty of disclosure in the case of marine insurance is prescribed as follows in the Marine Insurance Act, 1963:

"S. 20(1) Subject to the provisions of this section, the assured must disclose to the insurer before the contract is concluded, every material circumstance which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known to him. If the assured fails to make such disclosure, the insurer may avoid the contract.

(2) Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk."

19. A similar duty of disclosure exists in the case of non-marine insurances. Whether the policy is taken out for a life, fire, burglary, fidelity or accidental risk, it is the duty of the assured to give full information of every material fact; and it has been held by the Court of Appeal in England that the definition of "material" contained in the Marine Insurance Act, 1906 namely, every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk is applicable to all forms of insurance.

20. Life Insurance stands on the same footing. The provisions of Marine Insurance Act in India are in *par materia* with the English Act in this respect. I would, therefore, similarly hold that the test of what is a material fact and the degree of good faith, which is required, is otherwise the same in all classes of insurance.

23. Any material fact that comes to the knowledge of the proposer; the would-be assured, before the contract is made must be disclosed. The duty to disclose all material facts to the insurer arises from the fact that many of the relevant circumstances are within the exclusive knowledge of one party, and it would be impossible for the insurer to obtain the facts necessary for him to make a proper calculation of the risk he is asked to assume without this knowledge. It has been for centuries in England the law in connection with insurance of all sorts, marine, fire, life, guarantee and every kind of policy, that, as the underwriter knows nothing and the would-be assured knows everything, it is the duty of the assured to make a full disclosure to the underwriters of all the material circumstances.

24. The words 'prudent insurer' in Section 20(2) of Marine Insurance Act should be noted. They mean that in a dispute the court must apply the objective standard of business usage and disregard the exacting standard of a particular insurer. Circumstances that need not be disclosed include those diminishing the risk and matters of common knowledge generally or in the insurer's business. The prospective assured must disclose material circumstances that he knows or ought to know: (See Section 20, Marine Insurance Act, 1963).

25. Whether the omission to disclose any particular circumstance is material so as to render the contract voidable is a question of fact in each case.

26. The present case, however, presents no difficulty. If the assured had truly disclosed his illness that fact would have certainly influenced "the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk."

27. If the insured makes a statement containing certain information and the policy contains a term to the effect that the proposal form constitutes the "basis of the contract," the insurers are entitled to avoid liability if any answer in the proposal form is incorrect, whether it is material or not. The insurers are entitled to avoid liability if any answer in the proposal form is incorrect irrespective of whether the insured made the answers fraudulently or innocently and irrespective of whether the answer relates to a material fact.

31. In India, the Legislature has enacted in Section 45 of the Insurance Act that no policy of life insurance shall be called in question by an insurer on the ground that a statement made

in the proposal form "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 policy holder and that the policy holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose." The statute therefore, superimposes the test of materiality on the terms and conditions of the proposal. The contractual freedom of the insurers has been severely restricted by the Indian Legislature. The insured has thus been sufficiently protected and the resulting contract cannot be rescinded merely upon proof that the information is inaccurate, unless all the three conditions of Section 45 are satisfied. In this sense Indian Law is a distinct advance upon the English Law.

32. In this case it is clearly provided in the proposal form of the Corporation that the declarations of the assured shall be the "basis of the contract" and that

> "If any untrue averment be contained therein the said contract shall be absolutely null and void and all moneys which shall have been paid in respect thereof shall stand forfeited to the Corporation."

33. In view of the term of the policy the insurer is entitled to avoid the contract as there was misrepresentation and concealment by the assured. No one will doubt that the questions in the proposal form regarding state of health were on a material matter and that the answers given by the assured were fraudulent and false. Insurers are generally well able to take care of their own interests by requiring a prospective insured to complete an application form giving information on a wide range of matters. But the important thing is that answers to material questions must be accurate and true. From the very necessity of the case, the assured alone possessed full knowledge of all the material facts and the law required him to show *uberrima fides*. The insurer contracts on the basis that all material facts have been communicated to him; and it is a condition of the contract that the disclosure shall be made and that if there has been a non-disclosure, he shall be entitled to avoid.

35. To use the language of the Indian Statute, a contract of insurance is a "contract based upon the utmost good faith, and if the utmost good faith be not observed by either party, the contract may be avoided by the opposite party" (Section 19, Marine Insurance Act).

36. The general principle of good faith governing insurance is tersely stated by Lord Chorley:

> "The general principle governing insurance is that of good faith. In a sense this applies to all contracts, but an insurer can insist on a more stringent requirement - utmost good faith. The terminology is unfortunate, for good faith, in ordinary parlance, is an absolute term; it cannot be graded. Ordinarily a person has acted either in good faith or in bad faith. But in insurance law utmost good faith has a precise meaning and a genuine purpose.
>
> In negotiations for an ordinary contract no party must say anything that misleads the other party. If he does the other party can avoid the contract... In insurance, however, the cards are stacked against the insurer. The buyer can inspect the goods, and the employer can obtain references about a candidate for employment, but the insurer has very few means of discovering the nature and magnitude of the risk.

> Accordingly, in law prospective assured refrain from actively misleading the insurer he must also disclose all material circumstances".

37. Dharam Pal Puri must have known that it was material to disclose the fact of his ailment to the Corporation. In the answers to the questions put to him he not only failed to disclose what it was material for him to disclose, but he made a false statement to the effect that he had never suffered from any disease of the heart. In other words, there was a deliberate suppression fraudulently made by Dharam Pal. Fraud, according to Section 17 of the Indian Contract Act, means and includes *inter alia* any of the following acts committed by a party to a contract with intent to deceive another party or to induce him to enter into a contract.

> (1) The suggestion as to a fact of that which is not true by one who does not believe it to be true; and (2) The active concealment of a fact by one having knowledge or belief of the fact.

Judged by the standard laid down in Section 17, Dharam Pal Puri was clearly guilty of a fraudulent suppression of material facts when he made declarations in the proposal form, statements, which he must have known, were deliberately false.

38. The counsel for the plaintiff has argued that the statement of Dr. (Miss) Padmavati should not be believed as the original record of the Lady Hardinge Medical College and Hospital was not produced in court at the time she made her statement. This is true that she gave her deposition in court with the help of the certificate that she had issued in 1964, though she was examined on November 9, 1970. In the course of arguments I ordered that the original record of the hospital should be produced. Today the medical record keeper appeared in court and stated that the record of outdoor patients was maintained in the hospital only for a period of five years and was destroyed thereafter. Dharam Pal Puri was examined by Dr. (Miss) S. Padmavati as an outdoor patient obviously. Dr. (Miss) S. Padmavati did not depose that Dharam Pal Puri was admitted to the hospital. The record of outdoor patients, therefore, could not be produced. Probably by 1970 when Dr. (Miss) S. Padmavati was examined in court the record of the hospital had been destroyed because she examined the patients in 1959. The fact of the destruction of the record does not destroy the probative value of Dr. (Miss) S. Padmavati's evidence. In her statement she unequivocally stated that she examined Dharam Pal Puri on two occasions and had referred to the record before signing the statement and that the deceased was suffering from heart disease. I have not reason to disbelieve the testimony of a doctor of the eminence of Dr. (Miss) S. Padmavati. What axe she had to grind, what motive to perjure herself? I feel confident to base my conclusion on her evidence because similar was the evidence of Dr. V.K. Dewan and of Dr. Santosh Singh in his two earlier certificates dated October 31, 1964, and the report dated August 4, 1964.

39. The Plaintiff's counsel then argued that no reliance should be placed on the testimony of Dr. V.K. Dewan and Dr. Santosh Singh as they were never told by the deceased that he was suffering from heart trouble for the last seven years. It is true, as appears from the evidence, that Dharam Pal Puri was unconscious when he was admitted to the hospital on August 4, 1964, and his brother who accompanied him gave his past medical history. It is so stated in Exhibit B-2, certificate dated October 31, 1964, of Dr. Santosh Singh. When the

deceased was unconscious, his brother was the best person to give the past history of his brother. At that time his brother was telling the truth because he was interested in saving somehow the life of Dharam Pal his brother. He knew that without disclosing correctly the illness and its past history doctors in the hospital would not be able to give treatment to his brother. It is only later on that Dr. Santosh Singh was prevailed upon to issue certificate and report wherein the doctor changed his stand and said that the illness was of only 1½ years standing before the death. Since I had some doubts on the veracity of the certificates issued by Dr. Santosh Singh for he issued as many as five certificates and reports, I ordered that the original record of Sir Ganga Ram Hospital be produced before me. Today Shanti Swarup Sharma (P.W. 3) brought the original record. I have examined the original record and found that some one had written on the case sheet 7½ years originally. This figure of 7½ was obliterated and in its place 1½ years was written. The two writings are quite different. The entire case-sheet, it is in the evidence of Shanti Swarup Sharma (P.W. 3) is in the hand of Dr. Santosh Singh, who actually made this obliteration is not clear because Dr. Santosh Singh could not be examined with reference to the original case-sheet which I have today before me and which the witness did not have at the time of making his statement on commission. On a consideration of the entire evidence, no doubt is left in my mind that the deceased was suffering from this heart disease since 1946 as deposed by Dr. (Miss) S. Padmavati, for five or seven years as deposed by Dr. V.K. Dewan or for about seven years as was certified by Dr. Santosh Singh in his two certificates and 7½ years as stated by him in his report. In view of the incontrovertible evidence on the record I will discard from consideration the certificate dated August 24, 1964, and the report dated November 28, 1964 of Dr. Santosh Singh. Similarly, the photostat copy of the certificate dated October 31, 1964 is no piece of evidence in this case as the original was never produced in court.

40. On behalf of the plaintiff two witnesses were examined. The first was P.C. Puri, the brother of the deceased. He merely stated that his brother died on August 5, 1964 and that he entered into correspondence with the Corporation after the death of his brother for the purpose of claiming the amount from them. The insurance agents who had come to insure the deceased, he said, filled the proposal forms for these policies, in his presence.

41. The next witness examined by the plaintiff was the widow Krishna Wanti Puri. She completely denied that her husband ever consulted Dr. (Miss) S. Padmavati prior to his death. She also said that she did not know the name of the doctor who attended on the deceased at the time of his death and what was the result of the doctor's examination. As regards the deceased's illness, she simply said that her husband developed pain in the hip on the morning of August 4, 1964, and he had to be removed to the hospital. As regards other questions put to her she stated that the deceased's elder brother was dealing with the matter of insurance and that she knew nothing about these matters. The cumulative result of the evidence adduced on both sides is that there is no evidence of the doctors examined on behalf of the Corporation to show that the deceased's illness was of the heart and that he suffered from the same since 1946 and that he actually died of it. There is no rebuttal to this evidence on behalf of the plaintiff. Mere denial by the widow takes us nowhere. The brother of the deceased who, according to the widow, knew everything about his own brother said nothing in evidence to disprove the testimony of the doctors. The main plank of the plaintiff's claim is

the certificate and the report of Dr. Santosh Singh wherein the doctor had given the period of illness as 1½ years. The certificates and the report, I have already said, are not worth relying upon for the rest of the evidence on the record which in my opinion is overwhelming, contradicts the correctness of the certificate and the report dated November 24, 1964 and November 28, 1964, respectively.

42. The plaintiff's counsel lastly urged that before the deceased was insured he was examined by as many as three doctors of the Corporation Dr. Uppal, Dr. R.N. Rohtagi and Dr. Kartar Singh. All these doctors appeared in the witness-box on behalf of the Corporation. It is true that all of them deposed that in their opinion the deceased was fit to be insured at the time of their examination but their evidence does not advance the case of the plaintiff. The corporation did not know that there was a fraudulent suppression of facts by the deceased. The terms of the policy make it clear that the averments made as to the state of health of the insured in the proposal form and the personal statement were the basis of contract between the parties and the circumstances that Dharam Pal Puri had taken pains to conceal that he had ever been treated for this serious ailment by Dr. (Miss) S. Padmavati when in fact he had been treated only a few months before he took out the first policy dated October 12, 1959, shows that the fraudulent suppression and concealment had an important bearing in obtaining the consent of the Corporation.

43. On the whole case my conclusion is that the declarations made by the deceased in the personal statement were on a material matter and that he suppressed fraudulently facts which were material to disclose and that the deceased knew at the time of making the statement that it was false and that he suppressed facts which it was his duty to disclose.

44. I, therefore, hold that the Corporation is entitled to avoid the policies on the grounds available to the insurers under Section 45 of the Act, which I have reproduced above.

Issue No. 2:

45. In view of my decision on Issue No. 3, this issue does not arise.

Issue No. 1:

46. I have already held that the Corporation is entitled to avoid the policies and therefore, the plaintiff is not entitled to claim the amount on the four policies from them.

Issue No. 4:

47. As a result of my finding on Issue No. 3, I dismiss the suit of the plaintiff, leaving the parties to bear their own costs.

48. As regards the premium paid by the deceased on the four policies, the rule of law is that if the policy is voidable owing to fraudulent misrepresentation, the insurer can have the policy set aside without having to return the premiums. The Supreme Court has held in *Mithoolal Nayak* that in a case of fraud the plaintiff cannot claim or ask for the refund of the money paid. It was held that the courts would not entertain an action for money had and received where in order to succeed the plaintiff has to prove his own fraud. Above all the policy contains the term that if the policy is void the premium shall be forfeited and this term will prevent the premiums from being recoverable.

LIC of India v. *Smt. G.M. Channabasamma*
(1991) 1 SCC 357

L.M. SHARMA, J. - This appeal by special leave arises out of a suit filed by the plaintiff-respondent for a money decree for a sum of Rs 77,805.85 being the amount due for four insurance policies held by her deceased husband. The defendant-appellant Life Insurance Corporation denied the claim on the plea that the deceased, while filling up the proposal forms for the policies, was guilty of fraudulent misrepresentations and suppression of material facts with regard to his health. The trial court accepted the defence and dismissed the suit. On appeal by the plaintiff, the High Court reversed the decision and passed a decree.

2. The deceased husband of the plaintiff was described in the policies as T.R. Gurupadaiah but in the plaint his name has been mentioned as Gurupadappa. However, since in our view the correct spelling of the name is not material for purposes of the present case, it is not necessary to give further details in regard to the difference in the two names. We agree with the Corporation that the correct name was Gurupadaiah and since the policies under which the claim in the suit has been made bear the said name, it is immaterial if he was also known by a slightly different name. After the receipt of the claim from the plaintiff, the Corporation, feeling suspicious, made an inquiry through its Administrative Officer Sri V.V. Narasimhan (DW 1) who according to the defence collected sufficient material to establish fraudulent misrepresentation and suppression of material facts by the insured at the time of taking out the policies. The insured died on October 14, 1961 in a hospital for tubercular patients. According to the case of the Corporation the deceased was suffering from acute diabetes and diseased of the lungs of which he was fully aware at the time of taking out the policies in question, and fraudulently denied the same in the proposal forms.

3. The four policies were respectively taken out for Rs 20,000 on July 30, 1959, for Rs 20,000 on July 16, 1960, for Rs 10,000 on July 16, 1960 and for Rs 25,000 on August 23, 1961. It has been contended by the learned counsel for the appellant that since the last policy was of a date only about two months before the death of the insured it cannot be believed that he did not know about his illness. Even the earlier three policies had been taken out only a short time earlier, and having regard to the nature of the diseases it must be assumed that the insured was fraudulently suppressing the relevant fact. The questions on the proposal forms which the insured had to fill up have been placed before us and it has been argued that several answers submitted by the insured were definitely false to his own knowledge. It was claimed that the Administrative Officer of the Corporation was, on inquiry, informed by several doctors about the chronic illness of the insured and this information was corroborated by documentary evidence.

4. The learned counsel of the respondent has contended that it is true that her husband died of tuberculosis but he nor any member of the family had any knowledge of his illness at the time of taking out the policies. He was keeping good health and actively taking part in his business and the discovery of the disease which accounted for his early demise was made very late. The allegations of fraudulent misrepresentation and suppression of material facts made in the written statement were emphatically denied on behalf of the plaintiff at the trial. The trial court, however, accepted the defence and dismissed the suit.

5. On appeal the High Court, on a consideration of the evidence led by the parties and the arguments addressed on their behalf, held that the defendant had failed to prove that the insured was suffering from diabetes or tuberculosis at the time of filling of the proposals for the insurance policies or that he had given any false answer in his statements or suppressed any material fact which he was under a duty to disclose. The finding of the trial court that the assured had committed fraud on the defendant Corporation in taking out the policies was reversed. In the result, the appeal was allowed and the suit was decreed. This decision is under challenge in the present appeal by special leave.

6. Mr Vasudev, appearing in support of the appeal, has strenuously contended that in view of the evidence on the record and the circumstances, the findings of the High Court are erroneous and fit to be set aside. He has emphasised the fact that the policies in question were taken within a short span of time and that the insured died only about two months from the last policy. The argument is that the evidence of the witnesses examined on behalf of the defendant is fit to be accepted as reliable and is adequate to prove the defence case. We have gone through the entire evidence in this case with the learned counsel for the parties, and do not find ourselves in a position to take a view different from that of the High Court. Since we concur with the impugned judgment, it is not necessary to deal with the evidence at great length. We, however, proceed to briefly indicate our reasons.

7. The principle as to when an insurer can validly repudiate a contract of insurance on the ground of misrepresentation or suppression of material facts is not in controversy in the present appeal. Mr Vasudev, the learned counsel for the appellant has, however, placed a number of decisions both English and Indian dealing with this aspect, but we do not consider it necessary to discuss them here. It is well settled that a contract of insurance is contract *uberrima fides* and there must be complete good faith on the part of the assured. The assured is thus under a solemn obligation to make full disclosure of material facts which may be relevant for the insurer to take into account while deciding whether the proposal should be accepted or not. While making a disclosure of the relevant facts, the duty of the insured to state them correctly cannot be diluted. Section 45 of the Act has made special provisions for a life insurance policy if it is called in question by the insurer after the expiry of two years from the date on which it was affected. Having regard to the facts of the present case, learned counsel for the parties have rightly stated that this distinction is not material in the present appeal. If the allegations of fact made on behalf of the appellant Company are found to be correct, all the three conditions mentioned in the section and discussed in ***Mithoolal Nayak*** **v.** ***Life Insurance Corporation of India*** [AIR 1962 SC 814] must be held to have been satisfied. We must, therefore, proceed to examine the evidence led by the parties in the case.

8. The burden of providing that the insured had made false representations and suppressed material facts is undoubtedly on the Corporation. According to Mr Vasudev the defence has discharged its duty by examining a number of doctors to establish that the insured was, at the time of taking out the policies, suffering from diabetes and other diseases. The appellant has heavily relied upon the evidence of DW 4 Dr M.S. Kumar, who has deposed that he was giving Gurupadaiah injections of insulin, anacobia and vetabion and was also examining his urine daily which contained sugar. The witness has been disbelieved by the High Court on the ground of his enmity with Gurupadaiah's father-in-law G.B.

Mallikarjunaih. In his statement before the court in September 1966 he claimed to have treated Gurupadaiah from 1953 to 1957. He was charging fee for his services but on a concessional rate as he was a tenant in the house belonging to Mallikarjunaih. According to the plaintiff's case, certain dispute had arisen between the two which ultimately led to Dr Kumar's vacating the house in 1959. The witness has denied the dispute but has admitted the tenancy and the fact that he left the house in 1959. In support of his claim to have treated the insured, he produced a chit Ex. D-33, containing an account of the payments from patients. The document is a single loose sheet of paper containing the accounts of 8 patients out of whom only Gurupadaiah's name finds place therein. No other patient's name is mentioned in the slip. The witness has not offered any explanation for this exceptional treatment given to Gurupadaiah in mentioning his name in Ex. D-33. There is also an obvious discrepancy in the sheet with respect to the dates which the witness has explained by saying that it was a mistake. According to his further evidence Gurupadaiah again contacted him in 1960, but he has not produced any document similar to Ex. D-33. In answer to a question as to why he had struck off some other name at the top of Ex. D-33 and had written the name of Mallikarjunaih, Dr Kumar stated that he did so as at that time he might not have any other paper with him. Having regard to all the circumstances pointed out by the High Court, we agree with its conclusion that the evidence of DW 4 cannot be relied upon for holding that Gurupadaiah was under his treatment in 1957, 1960 or at any point of time.

9. Another medical practitioner Dr H.N. Gangadhar was examined as DW 2. He was the family doctor of Mallikarjuniah and denied that Gurupadaiah was his patient. He, however, stated that he had given to Gurupadaiah two injections of anacobin in October 1958 and another in November 1958. According to his evidence anacobin injections are harmless and can be given even to healthy men as tonic; and generally they are given for general weakness, ananemia, sprain and a number of other diseases including diabetes. There is no reason to disbelieve Dr Gangadhar. But his evidence does not take us beyond showing that the insured had taken in 1958 three injections of anacobin which, according to the doctor's evidence, does not lead to any conclusion about the disease. The next witness Dr Siddalingaih DW 3 was working in the T.B. Hospital, Tumkur, where Gurupadaiah was admitted as an indoor patient with severe cough trouble and chest pain. The doctor was an LMP, but did not hold any special diploma for treatment of tuberculosis. According to the witness, Gurupadaiah had lost weight and was weak and died there on October 14, 1961. Having regard to the condition of the patient, the doctor opined that he might have been ill for more than six months before his admission in the hospital. He, however, accepted in cross-examination that if a man is weak and not in a position to resist infection from outside, galloping tuberculosis may attack him, and in such a case the duration for the symptoms to come out may be from a month to three months. His evidence also does not necessarily lead to the conclusion that Gurupadaiah was inflicted by a serious disease for a long time.

10. According to the evidence of three other doctors DW 5, DW 6 and DW 10, they had examined and treated a person bearing the name Gurupadayya or Gurupadaiah or Gurupadappa. But none of them is in a position to say that it was the same person as the deceased husband of the present plaintiff. They are not in a position to indicate anything whereby the identity of the patient can be proved or inferred. There is no mention of the

father's name or residence of the patient and their depositions can be of evidentiary value only if the statement of Dr Kumar DW 4 is accepted. If the evidence of DW 4 is rejected, as we have already done, the evidence of the other three doctors by themselves is not of any help. As against this, the evidence of the Corporation's doctors who had certified the good health of the insured at the time of taking out the insurance policies and who have been examined as defence witnesses disproves the case of illness. It has not been suggested that these doctors were either won over by the insured or were negligent in performing their duty. They had submitted confidential reports about the health of the insured and were of the opinion that he was in good health. We, therefore, agree with the High Court that the defendant Corporation has failed to discharge the burden of proving the defence story about the serious illness of the insured at the time of taking out the insurance policies and knowingly suppressing the material information.

11. Before concluding we would like to say a few words about the role of V.V. Narsimhan, DW 11, who was the Administrative Officer of the Corporation and was in charge of the investigation of the death claims. The learned counsel for the appellant has contended that certain observations in the judgment of the High Court amount to a criticism of the Administrative Officer. We do not think that the observations can be described as strictures, but, in any event, we would like to clarify the position that in our view no exception can be taken against the conduct of the officer in the matter of investigation of the present case. He was under a duty to have made a thorough inquiry in the circumstances, which certainly on the face appeared to be suspicious, and he was performing his duty with all seriousness as he ought to have done.For the reasons mentioned above, the appeal is dismissed.

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MEDICAL EXAMINATION AND SUPPRESSION

AIR 1986 KERALA 201

CASE NO.: Appeal Suit No 105 of 1979

PETITIONER: P.SAROJAM

RESPONDENT: L.I.C of India

KERALA HIGH COURT

Coram : 2 P. C. BALAKRISHNA MENON AND K. SUKUMARAN, JJ. (Division Bench)

Life Insurance Corporation of India Act (31 of 1956), S.6 and S.43(1) - Insurance Act (4 of 1938), S.45 - INSURANCE - CONTRACT - Insurance Policy - Person seeking insurance is bound to disclose all material facts - Questions in proposal form relating to state of health - False answers given by assured - Insurer is entitled to repudiate policy and decline payment - *Fact that Medical Offices of Corporation had certified life assured as good is not material.*

Contract Act (9 of 1872), S.19.

A contract of insurance is uberrima fides and the person seeking insurance is bound to disclose all material facts relating to the risk involved in the policy of insurance. Where the assured was suffering from a serious heart ailment not only when the proposal was made for insurance on his life but also for several years prior to that, he was bound to disclose all material facts relating to his state of health. The assured gave false answers to the questions in the proposal form relating to his state of health inducing the insurer the Life Insurance Corporation to accept the proposal. The assured died of the heart ailment shortly after the date of the policy even before the premium for the second quarter had fallen due. In such case, the mere fact that the Medical Officer of the Corporation had certified the life assured as good would not be of much consequence. The false answers to the questions in the proposal form given by the assured relating to the state of his health vitiate the contract of insurance and the Corporation is entitled to repudiate the policy and decline payment thereunder. (1766) 3 Burr. 1905. (1974) 1 Lloyd's Rep 147, AIR 1962 SC 814 and 1983 Ker LT 492, Rel. on; (1908) 2 KB 863, Considered. (Paras 5, 8)

LIC – Non-disclosure - AIR 2010 ORISSA 19 "Kuni Lata Sahoo v. Senior Divi Manager, LIC of India"

ORISSA HIGH COURT

Coram : 2 I. M. QUDDUSI, Actg. C.J. AND S. C. PARIJA, J. (Division Bench)

Kuni Lata Sahoo v. Senior Divisional Manager, LIC of India, Cuttack and Anr.

W.P. (C) No. 3552 of 2003, D/- 6 -8 -2009.

Insurance Act (4 of 1938), S.45 - INSURANCE - LIFE INSURANCE CORPORA - Life insurance policy - Repudiation of policy - Validity - Suppression of material Insured suffering from Gastritis with superficial stomach ulcer - However, insure of Viral Encephalitis and Cardio Respiratory arrest and suffered from same only 10 before his death as per medical certificate - Insured being suffering from minor ail not a serious disease having any bearing on risk undertaken by LIC - Non-disclos same cannot be said to be material especially when same did not affect life expecta deceased-insured - Moreover-cause of death was different from previous ailm Repudiation of policy and rejection of claim - Not justified.

AIR 2007 Ori 19; AIR 1968 Mad 324 and AIR 2008 SC 424, Rel. on.(Paras 14, 16,

Cases Referred : Chronological Paras

AIR 2008 SC 424 : 2007 AIR SCW 7179 (Rel. on) 13

AIR 2007 Ori 19 (Rel. on) 12

AIR 2001 SC 549 : 2001 AIR SCW 161 11

AIR 1968 Mad 324 (Rel. on) 10, 12

AIR 1961 Punj 253 9

AIR 1960 Cal 696 8

M/s. M.R. Tripathy, for Petitioner; M/s. S.K. Das, S. Swain, S.R. Subudh Respondents.

LIC Repudiated claim - Non-disclosure: Medical Leave - AIR 2010 JHARKHAND 5 "Ram Dulari Devi v. Life Insurance Corporation of India"

JHARKAND HIGH COURT
Coram : 1 AJIT KUMAR SINHA, J. (Single Bench)
Ram Dulari Devi v. Life Insurance Corporation of India and Ors.
W. P. No. 4060 of 2004, D/- 23 -6 -2009.

Insurance Act (4 of 1938), Pre., S.45 - INSURANCE - PREAMBLE - LIFE INSURANCE CORPORATION - LIC policy - Death claim - Respondent/LIC repudiated claim of petitioner based on certificate given by Medical Officer for period on leave which is treated as material mis-statement of fact - Deceased policy holder was under treatment for said period - It was not a case of concealment of any serious operation undergone of a fraudulent suppression of material facts - Being on medical leave by itself cannot amount to suppression of material facts - Moreover, policy cannot be called in question on ground of mis-statement after lapse of two years - Impugned order rejecting petitioner's claim is liable to be quashed.

AIR 2008 SC 424, Rel. on. (Paras 7, 11, 14, 15)

Cases Referred : Chronological Paras

AIR 2008 SC 424 : 2007 AIR SCW 7179 (Rel. on) 13
AIR 2001 SC 549 : 2001 AIR SCW 161 5, 12
AIR 1999 MP 13 10
AIR 1993 Ori 103 10
AIR 1991 SC 392 : 1991 AIR SCW 26 5
AIR 1962 SC 814 5, 9
AIR 1959 Pat 413 5, 8

Dhananjay Kumar Pathak, Ajit Kumar, for Petitioner; Sachin Kumar, for Respondents.

LIC – Nondisclosure of Minor ailments - AIR 2010 ORISSA 93 "Anupama B v. Divisional Manager, L.I.C. of India"

ORISSA HIGH COURT

Coram : 2 B. P. DAS AND S. C. PARIJA, JJ. (Division Bench)

Anupama Behera and Ors. v. Divisional Manager, L.I.C. of India, Cuttack and Anr.

W.P. (C) No.6994 of 2005, D/- 29 -1 -2010.

Insurance Act (4 of 1938), S.45 - INSURANCE - Repudiation of claim under p Grounds, withholding of material information regarding health - Insured died o failure - Minor ailments of casual nature like back pain which insured had complai much prior to taking of Insurance Policies - Has no nexus with ultimate cause of his - Non-disclosure of minor ailments in proposal form - Cannot be construed as frau suppression of material facts - Repudiation of Insurance Policy - Not proper.

The test to determine materiality is whether the fact not disclosed has any bearing risk undertaken by the insurer. If the fact has any bearing on the risk, it is a materi If the insured failed to disclose in the proposal form trivial ailments suffered b temporarily on some occasions, the same cannot be construed as fraudulent suppr of material facts, so as to repudiate the contract of insurance. The Insurance Policy from its special feature, is a contract between a person seeking to be insured a insurer. In interpreting the terms of contract of insurance, they should receiv reasonable and sensible construction in consonance with the purpose of the cont intended by the parties. Emphasis in such cases is laid more upon a practic reasonable, rather than, on a literal and strained construction. In interpreting the c of insurance neither the coverage under a Policy should be unnecessarily broadene should the Policy be rendered ineffective in consequence of unnatural or unreas construction. An attempt should be to construe a contract in liberal manner so accomplish the purpose or the object for which it is made. In the absence of amb neither party can be favoured but where the construction is doubtful, the Court strongly against the party who prepared the contract. Where there is a susceptibi two interpretations, the one favourable to the insured is to be preferred. (Paras 1

In the present case, the insured admittedly died due to heart failure and there is no material on record or any medical evidence to show that the insured had suffered from any serious disease affecting his life expectancy in any manner, prior to his taking three L.I.C. Policies. The medical book maintained by the employer of the insured disclosed that he had complained of lower back pain in some five years prior to his death, which was non-specific and no neurological disorder or deficiency was noticed and the insured did not suffer from any serious disease or illness during his service period. Merely because the insured had not disclosed in the proposal form some minor ailments of trivial nature suffered by him temporarily on some occasions, as has been reflected in the medical book of the insured, which had no material bearing on the risk undertaken by the LIC or even any remote nexus with the ultimate cause of his death, the same cannot be construed as fraudulent suppression of material facts, so as to authorise the LIC to repudiate its liabilities under the contract of insurance. Accordingly, the repudiation of the Insurance Policies and rejection of the claim by the LIC was not proper and justified.

(Para 17)

Cases Referred :	**Chronological Paras**
AIR 2010 Ori 19	14
AIR 2008 SC 424 : 2007 AIR SCW 7179	13
AIR 2001 SC 549 : 2001 AIR SCW 161	12
AIR 1968 Mad 324	11
AIR 1962 SC 814	8
AIR 1961 Punj 253	10
AIR 1960 Cal 696	9

M/s. J.M. Mohanty, K.C. Mishra, T.R. Mohanty and P.C. Moharana, for Petitioners; M/s. A.R. Dash, R.N. Behera and S.N. Nanda-1, for Opp. Parties.

Life Insurance Corporation of India v. *Ajit Gangadhar Shanbhag*

AIR 1997 Kant. 157

S. RAJENDRA BABU AND B. PADMARAJ, JJ. -

One Anil Gangadhar Shanbhag had taken out six policies of Insurance on his life for Rs. 15,000/-, Rs. 10,000/-, Rs. 10,000/-, Rs. 10,000/- Rs. 10,000/- and Rs. 25,000/- on 21-9-72, 28-12-75, 28-12-75, 18-3-76, 20-3-76 and 10-8-78 respectively from the respondent – Life Insurance Corporation of India and he died on 10-12-80. The claim made by the mother of the deceased for payment of the amount under the aforesaid policies taken out by the deceased, after his death, was repudiated or denied by the appellant on the ground that the deceased while filling-up the proposal forms for the policies, was guilty of fraudulent, misrepresentation and suppression of material facts, with regard to his health. The respondent filed a writ petition under Art. 226 of the Constitution before this Court in seeking the following reliefs:

> "(i) Issue direction of writ to the respondents to produce the material on the basis of which the claim of the petitioner made on Policy Nos. 40469599, 40384083, 40384001, 40380276/77 and 40196022 have been rejected.
>
> (ii) Issue writ or direction in the nature of mandamus directing the respondents to settle the claim of the petitioner by made payments under the policies 40469599, 40384083, 40384001, 40380276/77, 40196022."

2. The learned Single Judge of this Court, by his order dated 5-6-92, allowed the writ petition in the following terms:

> "Accordingly, I allow this petition and direct the respondent-Corporation to honour its obligations in terms of the policies issued and settle the claims of the petitioner and make payment of all the amounts due under the respective policies after satisfying itself that the petitioner is the sole legal heir of the insured."

5. It was mainly argued on behalf of the appellants that the nature of the claim made by the respondent arises out of a contract qua contract and that further the matter involves serious disputed questions of fact, which needs thorough investigation and cannot be decided in the writ jurisdiction. There is no public law element involved in it. Thus a writ will not issue in relation to the nature of the claim made in respect of the policy of insurance issued by the Corporation, especially when the matter involves serious disputed questions of fact, which needs thorough investigation. In support of his contention, learned Counsel for the appellants has relied upon the decision of the Supreme Court in ***Kulchhinder Singh*** v. ***Hardayal Singh Brar*** [AIR 1976 SC 2216].

7. In para 5 of the Writ Petition filed by the respondent, it is stated as under:

> "The respondent No. 1 has stated in replies Annexures 'C' to 'F' that the deceased Anil did not disclose that he suffered from Atrial Septral defect and that he had consulted medical men and he had taken treatment in the Hospital in the year 1973. The respondent 1 stated in its reply Annexure-B that the deceased Anil had made a false statement that his proposal for insurance had not been rejected by the respondent 1 at any time before

and that the information revealed that the proposal of the deceased Anil for Insurance had been declined by the Bangalore office of the respondent in the year 1971. Thereafter the petitioner sought from the respondent 1 the material on which the respondent 1 had made the statements contained in Annexures-B to E. The petitioner made a representation to the Office of the Respondent-1 at Bombay to verify from the record and find out, the real nature of the case. As far as the petitioner is aware the deceased Anil had not made any proposal in the year 1971 to the Bangalore office of the respondent 1 for insurance. As far as the petitioner is aware the deceased Anil had not suffered from any disease in 1973. Had he consulted any Doctor and the deceased Anil had not taken any treatment in any hospital in that year for the disease which the deceased Anil alleged to have suffered. The respondent 1 has not disclosed any material on the basis of which the respondent 1 can say that the deceased Anil has made false declarations in his proposals for insurance on the policies mentioned above. The request made by the petitioner to the Head Office of the Bombay has been rejected. A true copy of the respondent 2 refusing to revise the decision taken by the respondent 1 is annexed hereto and marked as Annexure-G."

9. In the Statement of Objections filed by the appellants in the writ petition filed before the learned single Judge, the appellants have stated in Para 8 as under:

"It is therefore evident that the Life Assured had made incorrect statements and withheld vital information from this respondent regarding his health at the time of submitting his proposals dated 26-12-1975, 28-2-1976, 8-3-1976 and 3-8-1978. In respect of proposals dated 23-8-1972 the deceased Life Assured had withheld material information regarding declinature of his proposal submitted to Bangalore Divisional Office in the year 1971. The Life Assured did not disclose the above material facts which are essential and required for undertaking the risk in the said proposals of the deceased Life Assured. Instead he gave false answers therein. A contract of Insurance is a contract of 'Uberriamafide' i.e., Utmost good faith. The proposer has a duty cast on him to disclose all facts and information relating to the health, however, unimportant it may appear to him. It is not for the proposer to Judge whether they are relevant material and significant to the risk proposed. The Life Assured ought to have furnished the details regarding declinature of his proposal submitted to Bangalore office, which is essential to assess the risk in accepting his proposal dated 23-8-1972. The fact that the deceased Life Assured having knowledge of his ailment by deliberately suppressing the facts of his health and the declinature of the proposal, prior to taking insurance committed fraud on the respondent Corporation is clear from the answers given by him in the Personal Statement of the respective proposals at the time of submitting the proposals for life insurance. The respondent therefore, in terms of the policy contract and the declaration contained in the Personal Statement at the time of submitting his proposals for insurance repudiated the claim under the above mentioned policies and accordingly this respondent by its letter Ref: PHS/DC/VRD, dated 21-6-82, Ref: PHS/DC/VRD, dated 14-5-82 conveyed its decision to repudiate the claim under the six suit policies to Shri Gangadhar Shanbhag, the nominee under suit insurance policies."

10. It is further contended in Para 10 of the Objection Statement filed by the appellants before the learned single Judge as under:

"This respondent has indisputable proof to establish that the deceased was not keeping good health and took treatment from a reputed hospital before submitting his proposals for insurance. This respondent has also proof to show that the deceased life assured had withheld material information regarding declinature of his proposal submitted to Bangalore Divisional Office in the year 1971, when he submitted his proposal dated 23-8-1972, which resulted into policy bearing No. 40196022."

11. It has to be mentioned in the above context that an Insurer can validly repudiate a contract of Insurance on the ground of misrepresentation or suppression of material facts. It is well settled that a contract of insurance is contract Uberriamafide and there must be complete good faith on the part of the assured. The assured is thus under a solemn obligation to make full disclosure of the material facts, which may be relevant for the Insurer to take into account, while deciding whether the proposal should be accepted or not. While making a disclosure of the relevant facts, the duty of the Insured to state them correctly cannot be diluted. Section 45 of the Insurance Act has made special provisions for a life insurance policy, if it is called in question by the Insurer after the expiry of 2 years from the date on which it was effected. Having regard to the facts of the present case, the learned Counsel for the appellants rightly submitted that the matter involves serious questions of disputed facts, which cannot be decided in the writ jurisdiction and they have to be examined on the basis of the evidence to be adduced by the parties at a trial. In fact, learned single Judge himself would observe in the course of his order that in view of the fact that in cases of fraudulent suppression of material facts, the burden of proof rests heavily on the party alleging fraud. Having so stated about the burden of proof, the learned single Judge proceeded to observe that the appellant Corporation cannot escape its obligations under the policies by merely stating that the deceased-Insured at the time of making proposals had suppressed the material facts. With this view, he held that the respondent herein has to succeed. At the very outset, it has to be stated that the matter involves serious disputed questions of fact, which needs thorough investigation and cannot be decided in the manner in which it is sought to be done by the learned single Judge in the writ petition filed before him. Further, we are at loss to understand as to which statutory duty is not performed by the appellant-Insurance Company in repudiating the claim of the respondent. On the other hand, the appellants sought to repudiate or deny the claim of the respondent by taking recourse to Section 45 of the Act and on the basis of the principles involved in such type of contracts. In view of the facts and circumstances narrated herein above, apart from the fact that the matter in issue has arisen out of the contract between the Insured and the Insurer there are disputed questions of fact which could be decided only in a regularly drawn trial between the parties. In '*Food Corporation of India* v. *Jagnannath Dutta*, AIR 1993 SC 1494: it has been observed that question of contractual obligations cannot be gone into in writ jurisdiction.

12. In ***Kulchhinder Singh* v. *Hardayal Singh Brar***, relied upon by the learned Counsel for the appellants, it is held as under at Page 2218:

"The remedy of Article 226 is unavailable to enforce a contract qua contract. A mere contract agreeing to a quota of promotions, cannot be exalted into a service rule or statutory duty. Private law may involve a State, a statutory body, or a public body in contractual or tortious actions. But they cannot be siphoned off into the writ jurisdiction.

Although Art. 226 is of wide amplitude to correct manifest injustice, but contractual obligations in the ordinary course, without even statutory complexion cannot be enforced by this short, though, wrong cut. Hence, a writ petition merely to enforce an agreement entered into between the employees and the co-operative Bank about giving certain percentage of promotions to existing employees is not maintainable."

13. In the case relied upon by the learned Counsel for the respondent stated supra, writ jurisdiction was invoked to enforce a provision to advance a loan. The Supreme Court upheld the issuance of the writ because the Court held that there was a statutory duty to perform the terms of the contract to advance the loan. There can hardly be any quarrel with the principles laid down in the aforesaid decision of the Apex Court. When an organ of the State/Statutory Authority is functioning, it is bound to be fair and just in the exercise of its statutory duties. If the Court finds that there is violation of the statutory duty or unfairness on the part of the statutory authority or an Organ of the State, the Court would readily come down to exercise its power under Art. 226 of the Constitution. But that is not the situation forthcoming in the case before us. Thus, the decision relied upon by the learned Counsel for the respondent is not helpful to the facts of the present case. In the present case, not only that there is no violation of any statutory duty on the part of the appellants, but in view of the facts and circumstances of the case, apart from the fact that the matter arises out of the contract between the Insurer and the Insured, there are several disputed questions of fact, which cannot be gone into in writ jurisdiction. In our Judgment, therefore, this was not a case worth the name to invoke exercise of the extraordinary discretionary remedy under Art. 226 of the Constitution.

16. It cannot be said that the remedy sought for by the petitioner was misconceived because a mandamus can be issued to the statutory authority to perform the statutory duty. Now if a suit is filed by the petitioner the same will be barred by limitation. Therefore, I direct that the respondent shall not raise the question of limitation if the suit is filed within three months from today and that the Court shall go into the merits of the case and dispose of the matter in accordance with law.

17. In the present case also, it cannot be said that the claim made by the respondent is either misconceived or untenable, but since it involves disputed questions of facts, this Court cannot go into the question of disputed facts and which could only be decided in a regularly drawn trial between the parties before a competent Civil Court and this Court cannot grant the relief sought by the respondent in the writ petition. The respondent is at liberty to institute a Civil Suit to enforce her rights and if such a suit is filed by the respondent within 3 months from the date of this order, the appellants shall not raise the question of limitation and the Court before which such a suit is validly instituted shall dispose of the case on merits in accordance with law. The appeal is accordingly allowed.

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Life Insurance Corporation of India v. *Asha Goel*

(2001) 2 SCC 160 : AIR 2001 SC 549

D.P. MOHAPATRA, J. - These appeals, filed by Life Insurance Corporation of India ("the Corporation"), are directed against the judgment of a Division Bench of the Bombay High Court in Writ Appeal No. 843 of 1985 allowing the appeal on the ground that the appellant should have had an opportunity of leading evidence relevant to their contention that the insurance policy was obtained by misrepresentation, and therefore, avoidable at the instance of the Corporation, and remitting the writ petition to the writ court for fresh decision after allowing the Corporation to lead evidence. The Division Bench did not accept the objection raised by the Corporation against maintainability of the writ petition on the ground that the case involves enforcement of contractual rights for adjudication of which a proceeding under Article 226 of the Constitution is not the proper forum. The contention on behalf of the Corporation was that the writ petition should be dismissed as not maintainable leaving it to the writ petitioner, Respondent 1 herein, to file a civil suit for enforcement of her claim.

2. Late Naval Kishore Goel, husband of Smt Asha Goel - Respondent 1, was an employee of M/s Digvijay Woollen Mills Limited at Jamnagar as a Labour Officer. He submitted a proposal for a life insurance policy at Meerut in the State of U.P. on 29-5-1979 which was accepted and the policy bearing No. 48264637 for a sum of Rs 1,00,000 (Rs one lakh) was issued by the Corporation in his favour. The insured passed away on 12-12-1980 at the age of 46 leaving behind his wife, a daughter and a son. The cause of death was certified as acute myocardial infarction and cardiac arrest. Respondent 1 being nominee of the deceased under the policy informed the Divisional Manager, Meerut City, about the death of her husband, submitted the claim along with other papers as instructed by the Divisional Manager and requested for consideration of her claim and for making payment. The Divisional Manager by his letter dated 8-6-1981 repudiated any liability under the policy and refused to make any payment on the ground that the deceased had withheld correct information regarding his health at the time of effecting the insurance with the Corporation. The Divisional Manager drew the attention of the claimant that at the time of submitting the proposal for insurance on 29-5-1979 the deceased had stated his usual state of health as good; that he had not consulted a medical petitioner within the last five years for any ailment requiring treatment for more than a week; and had answered the question if remained absent from place of your work on ground of health during the last five years in the negative. According to the Divisional Manager, the answers given by the deceased as aforementioned were false. Since Respondent 1 failed to get any relief from the authorities of the Corporation despite best efforts, she filed the writ petition seeking a writ of mandamus directing the Corporation and its officers to pay the sum assured and other accruing benefits with interest.

10. Article 226 of the Constitution confers extraordinary 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 extraordinary 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 bypass 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 Court 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.

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 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.

12. Coming to the question of scope of repudiation of claim of the insured or nominee by the Corporation, the provisions of Section 45 of the Insurance Act is of relevance in the matter. The section provides, inter alia, that 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 policy-holder and that the policy-holder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose. The proviso which deals with proof of age of the insured is not relevant for the purpose of the present proceeding. On a fair reading of the section it is clear that it is restrictive in nature. It lays down three conditions for applicability of the second part of the section namely: (*a*) the statement must be on a material matter or must suppress facts which it was material to disclose; (*b*) the suppression must be fraudulently made by the policy-holder; and (*c*) the policy-holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose. Mere inaccuracy or falsity in respect of some recitals or items in the proposal is not sufficient. The burden of proof is on the insurer to establish these circumstances and unless the insurer is able to do so there is no question of the policy being avoided on ground of misstatement of facts. The contracts of insurance including the contract of life assurance are contracts uberrima fides and every fact of material (*sic* material fact) must be disclosed, otherwise, there is good ground for rescission of the contract. The duty to disclose material facts continues right up to the conclusion of the contract and also implies any material alteration in the character of the risk which may take place between the proposal and its acceptance. If there are any misstatements or suppression of material facts, the policy can be called into question. For determination of the question whether there has been suppression of any material facts it may be necessary to also examine whether the suppression relates to a fact which is in the exclusive knowledge of the person intending to take the policy and it could not be ascertained by reasonable enquiry by a prudent person.

15. Life Insurance Corporation was created by the Life Insurance Corporation Act, 1956 with a view to provide for nationalisation of life insurance business in India by transferring all such business to a corporation established for the purpose and to provide for the regulation and control of the business of the Corporation and for matters connected therewith or incidental thereto. The said Act contains various provisions regarding establishment of Life Insurance Corporation of India; the functions of the Corporation, the transfer of existing life insurance business to the Corporation, the management of the establishment of the Corporation, the finance, accounts and audit of the Corporation and certain other related matters. Section 30 of the Act provides that except to the extent otherwise expressly provided in this Act, on and from the appointed day the Corporation shall have the exclusive privilege of carrying on life insurance business in India; and on and from the said day any certificate of

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registration under the Insurance Act held by any insurer immediately before the said day shall cease to have effect insofar as it authorises him to carry on life insurance business in India.

16. In course of time the Corporation has grown in size and at present it is one of the largest public sector financial undertakings. The public in general and crores of policy-holders in particular, look forward to prompt and efficient service from the Corporation. Therefore, the authorities in charge of management of the affairs of the Corporation should bear in mind that its credibility and reputation depend on its prompt and efficient service. Therefore, the approach of the Corporation in the matter of repudiation of a policy admittedly issued by it, should be one of extreme care and caution. It should not be dealt with in a mechanical and routine manner.

17. With the above discussions and observations regarding the questions raised before us, we dispose of the appeals with the direction that the sum, as directed by the learned Single Judge in favour of the claimant, will be paid by the Corporation expeditiously, if it has not already been paid. In view of the above order/direction, it is not necessary to proceed with the case pending before the High Court any further.

* * * * *

M/s. Krisna Food & Baking Industry P. Ltd. v. *M/s. New India Assurance Co. Ltd.*

2008 (13) SCALE 747

C.K. THAKKER, J. -. All these appeals have been filed against a common judgment and order dated June 01, 2001 passed by the National Consumer Disputes Redressal Commission (`National Commission') in Original Petition No. 194 of 1994 and companion matters. These appeals are filed under Section 23 of the Consumer Protection Act, 1986 (`the Act').

3. M/s Krishna Flour and Oil Mills (`Mill') is a partnership firm while M/s Krishna Food and Baking Industry Pvt. Ltd. ('Company') is a company registered under the Companies Act, 1956 as applicable to the State of Jammu & Kashmir. Both the units were located in Nawab Bazar, Srinagar, in the State of Jammu & Kashmir. Both were sister concerns. Rajendra Kumar Sawhney was Chairman of the Company as also main partner of the Mill. The Company was dealing in manufacturing bread, biscuits, cakes and other bakery items. It is the case of the complainants that during the period of disturbances caused by militancy in early nineties of the last century, Mr. Praneet Sawhney, only son of Rajendra Kumar Sawhney was shot dead by the terrorists on March 27, 1990 in his office. Immediately thereafter, operations of both the units were suspended and the complainants had to migrate to Delhi. It was stated that there was `watch and ward staff' as also some other personnel who looked after the premises and stocks and raw materials lying in the units. It was also stated in the complaints that the complainants were able to transfer records from Srinagar to Delhi.

4. According to the complainants, they had obtained three separate insurance policies from M/s New India Assurance Co. Ltd. ('Insurance Company'), the details of which are as under; S No. Policy No. Sum Case No. Items covered Assured

S.No.	*Policy No.*	*Sum Assured*	*Case No.*	*Items covered*
1.	112119000249	Rs.40 Lakhs	194/94	Stock of Wheat, Wheat Lakh Products and Packing material and Goods of like nature of Krishna Flour & Oil Mills
2.	113119000312	Rs.25 Lakhs	210/94	Stocks of Raw Material Lakh like Flour, Maida, Ghee, chemicals etc. in godowns belonging to Krishna Food & Baking Industries
3.	113119000313	Rs.53 Lakhs	209/94	Plant & Machinery Lakhs installed in Krishna Food & Baking Industries. (a) Factory Building Rs.21 lakhs (b) Electric fittings Rs.4 lakhs (c) Plant & Machinery Rs.28 lakhs

5. It was the say of the complainants that in the morning of November 12, 1991, certain terrorists attacked the Company as well as the Mill and set them on fire. Substantial damage had been caused to building, plant, machinery and electricity fittings; the raw materials lying

in the units were destroyed stocks which were in both the units were also either destroyed or substantially damaged. In view of the insurance coverage, a demand was made by the complainants to the Insurance Company to get the survey done and to pay the amount of loss sustained by the complainants.

The Insurance Company, however, did not do anything in the matter for quite long time.

The complainants got the survey done through their surveyors and demanded the amount to which they were entitled to. The Insurance Company, however, did not make payment which constrained the complainants to approach National Commission by filing three complaints being Complaint Nos. 194, 209 and 210 of 1994. The prayer made in the complaints and the demand in respect of policies and sums was as given in the above Table.

7. The Insurance Company repudiated the claim of the complainants. At a belated stage, survey had been carried out by the Insurance Company through its Surveyors wherein it was observed that substantial damage had not been caused to building, plant, machinery and electricity fittings and the complainants were not entitled to the amount demanded by them under the said head. The Insurance Company also assessed the damage to the building, plant, machinery and electricity fittings to the extent of Rs.31,373/- and nothing more.

8. With regard to raw-materials and stocks, the amount was substantially curtailed by the Insurance Company inter alia on the grounds that the stocks were perishable in nature and had become unfit for human consumption and the same had been badly affected by bacterial growth. It had become worthless at the time of mishap in 1991. It was also contended that in absence of proper `watch and ward staff', there was pilferage of stocks and raw materials by intruders as well as by staff members of the complainants' Company and Mill. It was, therefore, submitted that the complainants were not entitled to the amount claimed in the complaints.

9. The National Commission went into the merits of the matter and held that the complainants were entitled to certain reliefs.

With regard to stocks kept in the godown of the Mill, it observed that it was covered by policy No. 1131190000249. The policy was for an amount of Rs. forty lakhs and premium of Rs.5,814/- was paid. The claim put forward by the complainants was for Rs.37,78,618/-. According to the complainants, the stocks which were lying in the units were as under:

Commodity	*Quantity*	*Rate*	*Amount (Rs.)*
Wheat	2138.48 Qtls.	Rs.400/Qtl.	8,55,392
Maida	4676 Bags (90 Kg.)	Rs.450/bag	21,04,200
Krishna 271	Bags (80 Kg.)	Rs.400/bag	1,08,400
Bhog Atta Super	5952 Bags (10 Kg)	Rs.55/bag	3,27,360
Fine Atta Bran	2090 Bag (10 Kg)	Rs.100/bag	2,09,000
Bardana (Packing Material)	(Total value as per Books		1,74,267
Total			**37,78,619**

10. The National Commission held that surveyors of the complainants had prepared a report and submitted to the Insurance Company, but the claim was repudiated on the ground that there were no stock worth its while as there was pilferage since the units remained closed for about twenty months. It was also contended by the Insurance Company that the stock was not fit for human consumption. The final survey report at the instance of the Insurance Company recommended to settle the claim of the complainants at Rs.5,18,619/-. The figure was communicated by the Insurance Company to the complainants.

11. The National Commission noted that respondent No. 2 Grindlays Bank supported the case of the complainants and prayed that the amount claimed by the complainants be given to them as the complainants executed mortgage documents in the favour of the Bank.

12. The National Commission considered the evidence of Mr. Ghulam Rasool Wani, the only witness examined on behalf of the complainants who was an illiterate staff member. On behalf of the Insurance Company, two surveyors, Mr. Andrasabi and Mr. A.K. Gupta were examined. The Insurance Company also examined Mr. V.K. Malik and Mr. M.R. Grover. The National Commission considered the relevant documentary and oral evidence and observed that the risk was covered by the terms and conditions of the insurance policy. It also held that the units could not work in view of militancy in the area and the units were required to be closed down. It believed the case of the complainants that there was terrorist attack on both the units on November 12, 1991 and the militants set on fire the units. It further recorded a finding that there was no evidence whatsoever to conclude that there was pilferage either by the intruders or by the staff members of any of the units. It, however, held that stocks were worthless, and as such, the complainants were not entitled to the amount claimed. According to the National Commission, an amount of Rs.5,18,619/- as recommended by the surveyors of the Insurance Company was a reasonable figure and ought to have been accepted by the Insurance Company. Accordingly, it held that the complainants were entitled to the said amount.

13. With regard to the raw material, it was covered by policy No.1131190000312 and the coverage was for Rs. 25 lakhs. Premium of Rs.4,821/- was paid and the policy was subsisting.

14. The break up given for such claim was as under:

Raw Materials	Rs. 11,52,248-00
Packing Materials	Rs. 05,40,079-00
Interest @ 18%	Rs. 08,66,471-00
TOTAL	**Rs. 25,58,798-00**

15. Thus, according to the complainants, total loss in respect of raw materials and allied perils was to the extent of Rs. 25,58,798/-. On the said claim, the Insurance Company appointed three investigators, i.e. Mr. Hamdani, Andrasabi and Adarsh Associates. The surveyors, in their report, narrated the facts and circumstances of the case and left the amount of valuation of raw materials to the opposite party. In a subsequent report, however, they gave a figure of Rs.4,33,122/- for settlement of the claim and asked the complainants whether they were ready to accept the amount. Upon the query by the complainants, however, the

Insurance Company, instead of giving response to the query, repudiated the claim vide letter dated April 19, 1995 on the ground that there was pilferage and hence, the Insurance Company was not liable. Moreover, though there was destruction of raw material due to fire in the units, since the raw materials were unfit for human consumption, the complainants' claim was not well-founded. It was, therefore, held that the complainants were not entitled to the claim.

16. The National Commission considered the question and observed that there was no pilferage and taking into account the weather condition in Srinagar, it could not be held that the raw materials had become worthless or unfit for human consumption. Considering the reports, it was held by the National Commission that as per the Surveyors Report at the instance of the Insurance Company, the claimants were entitled to Rs.4,53,122/-.

17. In respect of building, plant, machinery and electricity fittings, the claim was covered by policy No.1131190000313. It was for Rs. 53 lakhs. The break-up was as follows:

i)	Factory Building	Rs. 21,00,000
ii)	Electric fittings including Transformer etc.	Rs. 4,00,000
iii)	Machinery of all kinds used for Manufacture of Biscuits, Bread etc.	Rs. 28,00,000
		Rs. 53,00,000

18. The Insurance company, on the other hand, stated that the complainants were entitled only to Rs.31,373/- and nothing more.

19. The National Commission considered the question and observed that the complaint relating to the said policy was required to be allowed in part. The Insurance Company was directed to make payment of Rs.31,373/- towards damage to building with interest at the rate of 12 per cent and the complaints were accordingly disposed of.

20. Being aggrieved by the order passed by the National Commission, three appeals have been filed by the complainants. The grievance of the complainants is that though the complainants were entitled to the amount which had been claimed by them, based on evidence and Surveyors' Reports, the National Commission committed an error of fact and of law in not granting the prayer and in not allowing the complaints in their entirety. It was, therefore, submitted that the appeals deserve to be allowed by directing the Insurance Company to pay full amount with interest at the rate of 18 per cent from November 12, 1991 and costs. The prayer was also made to pay appropriate amount towards harassment caused to the complainants.

21. Two appeals are filed by the Insurance Company. In the appeals, it was contended by the Insurance Company that the National Commission was in error in granting relief in favour of the complainants. The complainants were not entitled to any relief since in absence of the Managing Director and other responsible persons, there was pilferage by intruders and staff members themselves for which the Insurance Company cannot be held liable nor it can be directed to make payment.

Similarly, raw materials and stocks had become unfit for human consumption and the complainants were not entitled to the amount claimed by the complainants from the Insurance Company. The amount which was offered by the Insurance Company was adequate and sufficient. The amount on account of poor quality of goods and materials had been rightly deducted. The order passed by the National Commission, therefore, deserves interference by allowing the appeals of the Insurance Company.

22. Grindlays Bank has not challenged the order passed by the National Commission. Canara Bank, however, has filed two appeals by obtaining special leave from this Court against orders passed in Original Petition Nos. 209 of 1994 and 210 of 1994. It has supported the case of the complainants. According to the Canara Bank, the claim put forward by the complainants was well-founded and ought to have been allowed in toto by directing the Insurance Company to pay full amount towards loss and damage claimed by the complainants. It, however, submitted that the entire amount to which the complainants were entitled ought to have been ordered to be paid to the Bank in view of the fact that the Insurance Policies had been assigned in favour of the Bank. In law, such an assignment amounts to transfer of actionable claim in favour of the Bank. The Insurance Company is, therefore, bound to pay the amount to Canara Bank. Reliance in this connection was placed on behalf of the Bank on Section 38 of the Insurance Act, 1938; Sections 130 and 135 of the Transfer of Property Act, 1882 and a decision of this Court in ***Chief Executive Officer & Vice Chairman, Gujarat Maritime Board*** **v.** ***Haji Daud Haji Harun Abu*** [(1996) 11 SCC 23]. It was, therefore, submitted that appeals filed by the complainants should be allowed but the entire amount in relation to two policies be ordered to be paid to Canara Bank.

23. We have heard the learned counsel for the parties. Learned counsel for the complainants contended that the National Commission committed an error of fact and of law in not allowing the complaints and the claims put forward by the complainants in their entirety. It was submitted that the National Commission recorded a finding that the claims were covered by policies which were operative. Claims were lodged by the complainants on the basis of damage sustained by them. In support of such claims, survey was made and Surveyors' Reports were duly forwarded to the Insurance Company. The defence of the Insurance Company that there was pilferage by the intruders as well as by staff members of the complainants was not believed. Regarding adverse affect on raw materials and stocks, the National Commission observed that keeping in view the climatic conditions of Srinagar, it could not be said that the entire stock and raw material was unfit for human consumption. It, therefore, allowed part of the claim of the complainants.

According to them, however, the National Commission was not right in deducting the claim of the complainants. Apart from favourable climatic conditions in Jammu & Kashmir, the National Commission ought to have appreciated the fact that the complainants could not carry on their business activities of preparing biscuits, breads, cakes and other items not because of inaction on their part, but because of terrorist activities and militancy in the area. It was, therefore, not a case of voluntary omission to carry on trade, but it was compulsion that they could not produce goods. It was contended that terrorism was one of the terms covered by the Insurance Policy and since the business could not be carried on because of terrorism, the complainants had to suspend operations of both the units. The complainants

cannot be held even partly responsible for such suspension of operation of units and stoppage of business. The National Commission ought to have appreciated these facts and ought to have allowed the claim of the complainants.

24. It was also submitted that in spite of continuous requests by the complainants to the Insurance Company to get the survey done, no action was taken by the Insurance Company for a pretty long time. Moreover, even after the survey was got done by the Insurance Company through its own Surveyors and as per their reports, certain amounts were required to be paid, the said amount was also not paid by the Insurance Company. Regarding certain items, there was no response whatsoever by the Insurance Company. The National Commission also took into account those facts, but allowed the claim of the complainants only in part.

The order of the National Commission to that extent, therefore, requires to be modified by granting full claim of the complainants.

25. It was submitted that in the facts and circumstances and entitlement of the complainants for full claim, appeals filed by the Insurance Company are liable to be dismissed.

26. Regarding to appeals filed by Canara Bank, it was submitted that the appeals are not maintainable. The National Commission was, therefore, wholly right in not directing the Insurance Company to pay the claim amount to the Bank. It was also submitted that such claim lodged by the Canara bank was even otherwise not tenable. It was urged that under Section 3 of the Jammu & Kashmir Migrants (Stay of Proceedings) Act, 1997, no such claim could have been lodged by the Bank against the complainants by approaching a Civil Court by filing a suit and no order could have been made or a decree could have been passed by a competent Court in view of the provisions of the said Act. Since no such claim is maintainable in the light of statutory provisions, the Bank cannot by this indirect method, obtain a decree and get it executed which it could not have otherwise got in view of the suspension of such claims. It was, therefore, submitted that both the appeals filed by the Canara Bank are also liable to be dismissed.

27. The learned counsel for the respondent Insurance Company contended that the National Commission was not right in partly allowing the claims of the complainants. It was stated that the Insurance Company got the survey done through its surveyors and the amount to which the complainants were found entitled was offered to them. But the complainants wanted more amount and approached the National Commission. It was also submitted that from the Survey Reports, it was clearly proved that stocks and raw materials had become unfit for human consumption. The National Commission was, therefore, right in reducing the claim to that extent. According to the counsel, however, the National Commission was not right in observing and recording a finding that there was no pilferage. It was stated that it was not in dispute that after Praneet Sawhney was shot dead by the terrorists, the operation in both the units stood suspended and Managing Director of the Company (Rajendra Kumar Sawhney) left Srinagar and went to Delhi and only employees were there. It was, therefore, obvious that in absence of any responsible officer belonging to Sawhney family, there was pilferage as stated by the Insurance Company and the National Commission could not have

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recorded a finding to the contrary. To that extent, therefore, their appeals deserve to be allowed.

28. The learned counsel for the Canara Bank, on the one hand, supported the claim of the complainants and submitted that once the operation of the units became impossible due to terrorist activities which was covered by a clause in Insurance Policy and the complainants could not carry on business, the National Commission was not justified in rejecting any part of the claim of the complainants. On the basis of survey reports substantial loss to the building, plant, machinery and electricity fittings had been proved and the complainants were entitled to the entire amount. Similarly, with regard to raw materials and stocks, nothing could have been deducted by the National Commission as it was impossible for the complainants to carry on production. The only reason why the units could not operate was militancy activities in the area. If it were so, the National Commission was not justified in taking into account the fact as to suspension of business for reduction of claim and consideration of the aspect that certain items were unfit for human consumption and the amount was liable to be reduced.

29. It was, however, submitted that indisputably substantial advance was made to the complainants by the Bank and it was having charge over the property of the Company and of the Mill. It had also a right of lien. It was, therefore incumbent on the National Commission to uphold the claim of the Bank by directing the Insurance Company to pay the amount to the Bank directly and not to the complainants. The counsel submitted that the provisions of Section 38 of the Insurance Act, 1938 and Sections 130 and 135 of the Transfer of Property Act are clear on the point. The point is also covered by a decision of this Court.

The National Commission was, therefore, wrong in rejecting the prayer of the Bank and both the appeals of the Bank should be allowed.

30. Regarding the provisions of 1997 Act, it was submitted that the contention of the complainants is ill-founded. This is not a case wherein the Bank becomes a plaintiff and in that capacity, it files a suit against the complainants-defendants for recovery of amount. Once there is an `actionable claim' and the Bank is having charge over the property of the complainants, it ipso facto entitles the Bank to recover such amount directly from the debtor, i.e. Insurance Company. The 1997 Act has no application to such cases. It was asserted that as on date, the amount to which the Bank is entitled and the complainants are liable to pay, exceeds Rs. five crores. The Bank, therefore, has right to get the entire amount to which the complainants are held entitled to. It was, hence, submitted that the appeals filed by the Bank deserve to be allowed.

31. Having heard the learned counsel for the parties and having gone through the records and proceedings as also the judgment of the National Commission, it is clear that the complainants were able to establish the claims put forward by them. It is not in dispute by and between the parties that the Insurance Policy covered several acts including terrorism and fire. It has come in evidence and has been believed by National Commission that the son of the Managing Director was killed in March, 1990 by terrorist attack. It is in the light of the said incident that the Managing Director had to leave Srinagar and to return to Delhi. It was because of the said incident that the operation of both the units was suspended. Thus, it was

not a case wherein the complainants did not undertake the activities which were required to be undertaken by them, but they could not operate the units and carry on business. No fault, therefore, can be found against the complainants for suspending the operation of both the units. The complainants obviously cannot suffer because of non-production in the Mill as well as in the Company. The National Commission was, therefore, not right in reducing any amount on the ground that certain stocks and raw materials were unfit for human consumption. It was not intentional or deliberate act on the part of the complainants in stopping production and allowing the stocks and raw materials to get spoiled or damaged and by making them unfit for human consumption. It was because of the militant activities and terrorism that the Company and the Mill could not do business and produce goods. Reduction of amount by the National Commission on that count was, therefore, unjustified and in our opinion, that part of the order requires interference by this Court.

32. As regards pilferage by intruders and staff members, except ipse dixit on the part of the Insurance Company, no material whatsoever has been placed on record in support of such allegation. The National Commission, in our opinion, was justified in not accepting such bare assertion without any evidence or concrete material in support of such plea. In fact, a finding has been recorded by the National Commission that the godowns were `full' when they were set on fire. `Watch and ward staff' were protecting the Mill and the Company. There was also a `Police post' nearby both the units. Further, the report submitted by Mr. Andrasabi as to pilferage was not reliable. In ***Shyam Sunder Narang* v. *United India Insurance Co.*** [(1997) 111 CPJ 599], an adverse comment had been made by the National Commission against the report submitted by Mr. Andrasabi. Hence, in our opinion, the National Commission was right in not believing `pilferage theory' advanced by the Insurance Company.

33. The matter, however, did not end there. Even before us, nothing has been shown from which such an inference could be drawn by a reasonable and prudent man as to pilferage by intruders or staff members. The National Commission, in our judgment, was wholly right in negativing the contention of the Insurance Company that substantial part of stocks and raw materials had been taken away by intruders or staff members. No reduction, therefore, could be allowed on that count.

34. The National Commission was also right in observing that no payment was made by the Insurance Company even as per the survey conducted by the Surveyor appointed by the Insurance Company. Taking into consideration the entire facts and circumstances, in our opinion, the complainants are entitled to claim compensation towards building, plant, machinery and electricity fittings, raw materials and stocks.

35. Accordingly, the complainants are held to be entitled to the following:

Policy No.	*Amount entitled to be awarded in favour of the appellant-insured*
113119000249	Rs. 37,78,619/-
113119000312	Rs. 23,79,195/-
113119000313	Rs. 25,81,600/-

35. In view of the fact that the appeals filed by the complainants are allowed, the appeals filed by the Insurance Company must necessarily fail. Accordingly, the appeals filed by the Insurance Company are dismissed.

36. In respect of Policy No. 113119000249, no appeal has been filed by the Grindlays Bank. It was observed by the National Commission in the impugned judgment that the matter appears to have been settled between the parties. In any case, there is no appeal by a financial institution so far as the said policy is concerned.

37. But as far as the appeals by Canara Bank are concerned, in our opinion, the claim put forward by the Bank is well founded.

Section 38 of the Insurance Act reads thus;

Section 38 - ***Assignment and transfer of insurance policies.-***

(1) A transfer or assignment of a policy of life insurance, whether with or without consideration may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the transferor or by the assignor his duly authorised agent and attested by at least one witness, specifically setting forth the fact of transfer or assignment.

(2) The transfer or assignment shall be complete and effectual upon the execution of such endorsement or instrument duly attested but except where the transfer or assignment is in favour of the insurer shall not be operative as against an insurer and shall not confer upon the transferee or assignee, or his legal representative, and right to sue for the amount of such policy or the moneys secured thereby until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or a copy thereof certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer:

Provided that where the insurer maintains one or more places of business in India, such notice shall be delivered only at the place in [India] mentioned in the policy for the purpose or at his principal place of business in India.

(3) The date on which the notice referred to in sub-section (2) is delivered to the insurer shall regulate the priority of all claims under a transfer or assignment as between persons interested in the policy; and where there is more than one instrument of transfer or assignment the priority of the claims under such instruments shall be governed by the order in which the notices referred to in sub-section (2) are delivered.

(4) Upon the receipt of the notice referred to in sub-section (2), the insurer shall record the fact of such transfer or assignment together with the date thereof and the name of the transferee or the assignee and shall, on the request of the person by whom the notice was given, or of the transferee or assignee, on payment of a fee not exceeding one rupee, grant a written acknowledgement of the receipt of such notice; and any such acknowledgement shall be conclusive evidence against the insurer that he has duly received the notice to which such acknowledgement relates.

(5) Subject to the terms and conditions of the transfer or assignment, the insurer shall, from the date of receipt of the notice referred to in sub-section (2)], recognise the transferee or assignee named in the notice as the only person entitled to benefit under the policy, and such person shall be subject to all liabilities and equities to which the transferor or assignor was subject at the date of the transfer or assignment and may

institute any proceedings in relation to the policy without obtaining the consent of the transferor or assignor or making him a party to such proceedings.

(6) Any rights and remedies of an assignee or transferee of a policy of life insurance under an assignment or transfer effected prior to the commencement of this Act shall not be affected by the provisions of this section.

(7) Notwithstanding any law or custom having the force of law to the contrary, an assignment in favour of a person made with the condition that it shall be inoperative or that the interest shall pass to some other person on the happening of a specified event during the lifetime of the person whose life is insured, and an assignment in favour of the survivor or survivors of a number of persons, shall be valid.

38. Likewise, both the sections, i.e. Sections 130 and 135 of the Transfer of Property Act, 1882 are explicitly clear and they read as under;

Section 130 - ***Transfer of actionable claim.-***

(1) The transfer of an actionable claim whether with or without consideration shall be effected only by the execution of an instrument in writing signed by the transferor or his duly authorized agent, shall be complete and effectual upon the execution of such instrument, and thereupon all the rights and remedies of the transferor, whether by way of damages or otherwise, shall vest in the transferee, whether such notice of the transfer as is hereinafter provided be given or not:

Provided that every dealing with the debt or other actionable claim by the debtor or other person from or against whom the transfer would, but for such instrument of transfer as aforesaid, have been entitled to recover or enforce such debt or other actionable claim, shall (save where the debtor or other person is a party to the transfer or has received express notice thereof as hereinafter provided) be valid as against such transfer.

(2) The transferee of an actionable claim may, upon the execution of such instrument of transfer as aforesaid, sue or institute proceedings for the same in his own name without obtaining the transferor's consent to such suit or proceedings and without making him a part thereto.

Exception.-Nothing in this section applies to the transfer of a marine or fire policy of insurance or affects the provisions of section 38 of the Insurance Act, 1938.

Section 135 - ***Assignment of rights under policy of insurance against fire.-***

Every assignee by endorsement or other writing, of a policy of insurance against fire, in whom the property in the subject insured shall be absolutely vested at the date of the assignment, shall have transferred and vested in him all rights of suit as if the contract contained in the policy had been made with himself.

39. In our opinion, therefore, the submission of the learned counsel for the Bank that as soon as a decree is passed or order is made in favour of the complainants, the Bank is entitled to the said amount is well founded. For such a relief, it is not necessary for the Bank to become a plaintiff by filing a suit in a competent Court of law and obtain a decree in its favour. It is true that had it been the position, the provisions of 1997 Act would get attracted and such suit would be stayed and no decree could have been passed by a competent Court in favour of the creditor. But in the light of the statutory provisions in the Insurance Act and in

the Transfer of Property Act, the Bank is entitled to the amount directly from the Insurance Company.

40. In our opinion, the learned counsel for the Bank is also right in relying upon the decision in ***Gujarat Maritime Board.*** In that case, a similar question came up for consideration before this Court. There one B was financed by A for purchase of vessel. The vessel so purchased was mortgaged in favour of A. As per the Finance Agreement between the parties, B was required to take out a comprehensive risk insurance policy and assign it in favour of Director of Ports representing Government of Gujarat. The insurance also contained an endorsement in terms of the agreement. The vessel on its voyage sunk in the sea. B filed a complaint before the National Commission claiming the insurance amount from the Insurance Company. A brought to the notice of the Commission that it had an interest in the vessel as a mortgagee. The Commission, however, directed the Insurance Company to pay entire amount to B. A approached this Court. This Court held that the directions of the National Commission that the entire insurance amount be paid to B was unsustainable in law. Accordingly, the appeal filed by the Maritime Board was allowed and the order passed by the National Commission was set aside.

41. In our opinion, the point is directly concluded by the above decision of this Court in ***Gujarat Maritime Board*** and the National Commission was not right in rejecting the claim of the Bank. The appeals of the Bank are, therefore, required to be allowed.

42. For the foregoing reasons, the appeals filed by the Insurance Company are ordered to be dismissed. The appeals filed by the complainants are required to be allowed to the extent indicated above with interest at the rate of 9 per cent per annum from the date of filing of complaints before the National Commission, i.e. from the date of payment. So far as Appeal concerning Policy No.11319000249 relating to stocks is concerned, the complainants are entitled to get the entire amount of Rs.37,78,619/- since there is no appeal in respect of the said policy. Canara Bank is not concerned with the said policy.

Grindlays Bank has not approached this Court and had supported the complainants before the National Commission. The two appeals of Canara Bank are in regard to two policies, 113190000312 and 113190000313, raw materials policy and plant policy. Both the appeals of Canara Bank are allowed and the Insurance Company is directed to make payment to Canara Bank and not to the complainants in respect of the amount to be paid to the complainants.

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New India Assurance Company Ltd. v. *M/s. Zuari industries Ltd.*

(2009) 9 SCC 70

MARKANDEY KATJU, J. - This appeal has been filed against the impugned judgment of the National Consumer Disputes Redressal Commission, New Delhi dated 26.3.2004 in Original Petition No.196 of 2001.

3. The facts of the case were that the complainant (respondent in this appeal) had taken Insurance Policies from the appellant on 1.4.1998 in respect of its factory situated in Jauhri Nagar, Goa.

One policy was a fire policy and the other was a consequential loss due to fire policy.

4. On 8.1.1999 at about 3.20 p.m. there was a short circuiting in the main switch board installed in the sub-station receiving electricity from the State Electricity Board, which resulted in a flashover producing over currents. The flashover and over currents generated excessive heat. The paint on the panel board was charred by this excessive heat producing smoke and soot and the partition of the adjoining feeder developed a hole. The smoke /soot along with the ionized air traveled to the generator compartment where also there was short circuiting and the generator power also tripped. As a result, the entire electric supply to the plant stopped and due to the stoppage of electric supply, the supply of water/steam to the waste heat boiler by the flue gases at high temperature continued to be fed into the boiler, which resulted in damage to the boiler.

5. As a result the respondent - complainant approached the Insurance Company informing it about the accident and making its claim. Surveyors were appointed who submitted their report but the appellant-Insurance Company vide letter dated 4.9.2000 rejected the claim. Hence the petition before the National Commission.

6. The claimant-respondent made two claims (i) Rs.1,35,17,709/- for material loss due to the damage to the boiler and other equipments and (ii) Rs.19,11,10,000/- in respect of loss of profit for the period the plant remained closed.

7. The stand of the appellant- Insurance Company was that the loss to the boiler and other equipments was not caused by the fire, but by the stoppage of electric supply due to the short circuiting in the switch board. It was submitted that the cause of the loss to the boiler and the equipments was the thermal shock caused due to stoppage of electricity and not due to any fire. It was submitted that the proximate cause has to be seen for settling an insurance claim, which in the present case, was the thermal shock caused due to stoppage of electricity. However, the National Commission allowed the claim of the respondent and hence this appeal.

8. Ms. Meenakshi Midha who argued this case with great ability submitted that the loss to the boiler and to the equipments did not occur due to any fire. Hence she submitted that the claim of damages did not fall under the cover of the Insurance Policy. She submitted that for a claim relating to fire insurance policy to succeed it is necessary that there must be a fire in the first place. In the absence of fire the claim cannot succeed. She submitted that in the

present case (1) there was no fire and (2) in any case it was not the proximate cause of the damage.

9. On the other hand, Shri K.K. Venugopal, learned senior counsel, supported the judgment of the National Commission and stated that the judgment was correct.

10. We have therefore to first determine whether there was a fire. Admittedly there was a short circuit which caused a flashover.

11.. Wikipedia defines flashover as follows :

> "A flashover is the near simultaneous ignition of all combustible material in an enclosed area. When certain materials are heated they undergo thermal decomposition and release flammable gases. Flashover occurs when the majority of surface in a space is heated to the autoignition temperature of the flammable gases."

12. In this connection, it is admitted that the short circuit in the main switch board caused a flashover. The surveyor Shri M.N. Khandeparkar in his report has observed :

> "Flashover, can be defined as a phenomenon of a developing fire (or radiant heat source) radiant energy at wall and ceiling surfaces within a compartment.... In the present case, the paint had burnt due to the said flashover ... Such high energy levels, would undoubtedly, have resulted in a fire, causing melting of the panel board...."

13. The other surveyor P.C. Gandhi Associates has stated that "Fire of such a short duration cannot be called a `sustained fire' as contemplated under the policy".

14. In our opinion the duration of the fire is not relevant. As long as there is a fire which caused the damage the claim is maintainable, even if the fire is for a fraction of a second. The term `Fire' in clause (1) of the Fire Policy `C' is not qualified by the word 'sustained'. It is well settled that the Court cannot add words to statute or to a document and must read it as it is. Hence repudiation of the policy on the ground that there was no `sustained fire' in our opinion is not justified.

15. We have perused the fire policy in question which is annexure P-1 to this appeal. The word used therein is 'fire' and not 'sustained fire'. Hence the stand of the Insurance Company in this connection is not acceptable.

16. Shri K.K. Venugopal invited our attention to exclusion (g) of the Insurance Policy which stated that the insurance does not cover :

> "(g) Loss of or damage to any electrical machine, apparatus, fixture or fitting (including electric fans, electric household or domestic appliances, wireless sets, television sets and radios) or to any portion of the electrical installation, arising from or occasioned by over running, excessive pressure short circuiting, arcing self-heating or leakage of electricity from what ever cause (lightning included), provided that this exemption shall apply only to the particular electrical machine apparatus, fixtures, fittings or portion of the electrical installation so affected and not to other machines, apparatus, fixture, fittings or portion of the electrical installation which may be destroyed or damaged by fire so set up."

17. A perusal of the exclusion clause (g) shows that the main part of the exclusion clause which protects the insurer from liability under the policy covers loss of damage to any electrical machinery, apparatus, fixture or fittings including wireless sets, television sets, radio and so on which themselves are a total loss or a damage or damaged due to short circuiting, arcing, self heating or leakage of electricity. However, the proviso to the said clause through inclusion of any other machinery, apparatus, fixture or fitting being destroyed or damaged by the fire which has affected any other appliances such as television sets, radio, etc. or electrical machines or apparatus are clearly included within the scope of the Fire Policy for whatever damage or destruction caused by the fire. If for example the short circuiting results in damage in a television set through fire created by the short circuiting in it the claim for it is excluded under the fire policy. However, if from the same fire there is a damage to the rest of the house or other appliances, the same is included within the scope of the Fire Policy by virtue of the proviso. In other words, if the proximate cause of the loss or destruction to any other including other machines, apparatus, fixtures, fittings etc. or part of the electrical installation is due to the fire which is started in an electrical machine or apparatus all such losses because of the fire in other machinery or apparatus is covered by the Policy.

18. The main question before us now is whether the flashover and fire was the proximate cause of the damage in question.

19. To understand this we have to first know the necessary facts. The insurance company pointed out the chain or sequence of events as under :

> "Short-circuiting takes place in the INCOMER 2 of the main switchboard receiving electricity from the State Electricity Board possibly due to the entry of a vermin. ? Short-circuiting results in a flashover. Short-circuiting and flashover produced over-currents to the tune of 8000 amperes, which in turn produced enormous heat. The over currents and the heat produced resulted in the expansion and ionization of the surrounding air.
>
> The electricity supply from the State Electricity Board got tripped. The paint of the Panel Board charred by the enormous heat produced above and the MS partition of the adjoining feeder connected to the generator power developed a hole. It also resulted in formation of smoke/soot. The smoke/soot and the ionized air crossed over the MS partition and entered into the compartment receiving electricity from the generator.
>
> Consequently the generator power supply also got tripped. The tripping of purchased power and generator power resulted in total stoppage of electricity supply to the plant. The power failure resulted in stoppage of water/steam in the waste heat boiler. The flue gases at high temperature continued to enter the boiler, which resulted in thermal shock causing damage to the boiler tubes."

20. In this connection, it may be noted that in its written submission before the National Commission the appellant has admitted that there was a flashover and fire. The relevant portion of the written statement of the appellant before the National Commission is as follows:

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(a) Para 1 of the Preliminary Objections wherein it is stated: ... On 8th January, 99, there was a short circuiting... which resulted in flash over.... The cause of loss to the boiler and equipment is the thermal shock caused due to stoppage of electricity.... The stoppage of electricity was due to the fire... short circuiting results in a flash over....

(b) Para 3(iv) of the Preliminary Objections wherein it is stated: ... Due to this flash over and over currents excessive heat energy was generated which resulted in the evolution of marginal fire....

(c) Para 3(vi) of the Preliminary Objections wherein it is stated: ... The surveyors observed that the experts in all the reports submitted by the complainant admitted that a flash over took place ...;

(d) Para 3(viii) of the Preliminary Objections wherein it is stated: ... Fire of extremely short duration followed and preceded by short circuit...;

(e) Para 7 of the reply wherein it is stated: ... It is correct that on 8th January, 1999, short circuit occurred on INCOMER-2 of the 3.3 KV main switch board in the electrical sub station which resulted in a flash over.....

(f) Para 10 of the reply wherein it is stated: ... Due to this flash over and over currents excessive heat energy was generated which resulted in the evolution of marginal fire....

(g) Para 21 of the reply wherein it is stated: ... A reference of fire, as opposed to sustained fire, in the opinion of M/s. P.C. Gandhi & Associates has been made.... It is in this context that M/s. P.C. Gandhi & Associates have referred to the possible fire after the flash over being of a very short duration.

21. Thus it is admitted in the written statement of the appellant before the National Commission that it was the flashover/fire which started the chain of events which resulted in the damage.

22. Apparently there is no direct decision of this Court on this point as to the meaning of proximate cause, but there are decisions of foreign Courts, and the predominant view appears to be that the proximate cause is not the cause which is nearest in time or place but the active and efficient cause that sets in motion a train or chain of events which brings about the ultimate result without the intervention of any other force working from an independent source.

23. Thus in ***Lynn Gas and Electric Company v. Meriden Fire Insurance Company*** [158 Mass. 570; 33 N.E. 690; 1893 Mass. LEXIS 345] Supreme Court of Massachusetts was concerned with a case where a fire occurred in the wire tower of the plaintiff's building, through which the wires of electric lighting were carried from the building. The fire was speedily extinguished, without contact with other parts of the building and contents, and with slight damage to the tower or its contents. However, in a part of the building remote from the fire and untouched thereby, there occurred a disruption by centrifugal force of the fly wheel of the engine and their pulleys connected therewith, and by this disruption the plaintiff's building and machinery were damaged to a large extent. It was held that the proximate cause was not the cause nearest in time or place, and it may operate through successive instruments,

as an article at the end of a chain may be moved by a force applied to the other end. The question always is :

Was there an unbroken connection between the wrongful act and the injury, a continuous operation? In other words, did the facts constitute a continuous succession of events, so linked together as to make a natural whole, or there was some new and independent cause intervening between the wrong and the injury?

24. The same view was taken in ***Krenie C. Frontis et al.*** **v.** ***Milwaukee Insurance Company*** [156 Conn. 492; 242 A.2d 749; 1968 Conn. LEXIS 629]. The facts in that case were that the plaintiffs owned the northerly half of a building that shared a common wall with a factory next door. A fire broke out in the factory and damaged that building. Minimal fire damage occurred to the plaintiffs' building. However, due to the damage next door, the building inspector ordered the removal of the three upper stories of the factory building, which left the common wall insufficiently supported. Due to the safety issue, the inspector ordered the third and fourth floors of plaintiffs' building to be demolished. On this fact it was held that the fire was the active and efficient cause that set in motion a chain of events which brought about the result without the intervention of any new and independent source, and hence was the proximate cause of the damage.

25. In ***Farmers Union Mutual Insurance Company*** **v.** ***Blankenship*** [231 Ark.127; 328 S.W..2d 360; 1959 Ark. LEXIS 474; 76 A.L.R..2d 1133] the claimant's goods were damaged after a fire originated in his place of business. The goods were not damaged by the flames but by a gaseous vapour caused by the use of a fire extinguisher in an effort to put out the fire. On these facts the Supreme Court of Arkansas upheld the claim of the claimant.

26. In ***Leyland Shipping Company Limited*** **v.** ***Norwich Union Fire Insurance Society Limited*** [(1917) 1 K.B. 873] the facts of the case were that a ship was insured against perils of the sea during the first world war by a time policy containing a warranty against all consequences of hostilities. The ship was torpedoed by a German submarine twenty five miles from Havre. With the aid of tugs she was brought to Havre on the same day. A gale sprang up, causing her to bump against the quay and finally she sank. The House of Lords upheld the claim for damages observing that the torpedoing was the proximate cause of the loss even though not the last in the chain of event after which she sank.

27. In ***Yorkshire Dale Steamship Company Ltd.*** **v.** ***Minister of War Transport*** **(*The Coxwold*)** [(1942) AC 691 : [1942] 2 All ER 6] during the Second World War a ship in convoy was sailing carrying petrol for use of the armed forces. There was an alteration of the course of the ship to avoid enemy action, and an unexpected and unexplained tidal set carried away the ship and she was stranded at about 2.45 a.m. It was held that the loss was the direct consequence of the warlike operation on which the vessel was engaged.

28. In ***The Matter of an Arbitration between Etherington and the Lancashire and Yorkshire Accident Insurance Company*** [(1909) 1 K.B. 591] by the terms of the policy (an accident) the insurance company undertook that if the insured should sustain any bodily injury caused by violent, accidental, external and visible means, then, in case such injuries should, within three calendar months of the causing of such injury, directly cause the death of the insured, damages would be paid to his legal heirs. There was a proviso in the policy that

this policy only insured against death where the accident was the proximate cause of the death. The assured while hunting had a fall and the ground being very wet he was wetted to the skin. The effect of the shock lowered the vitality of his system and being obliged to ride home afterwards, while wet, still further lowered his vitality. As a result he developed pneumonia and died. The Court of Appeal uphold the claim holding that the accident was the proximate cause of death.

29. In the present case, it is evident from the chain of events that the fire was the efficient and active cause of the damage. Had the fire not occurred, the damage was also would not have occurred and there was no intervening agency which was an independent source of the damage.

30. Hence we cannot agree with the conclusion of the surveyors that the fire was not the cause of the damage to the machinery of the claimant.

31. Moreover, in ***General Assurance Society Ltd. v. Chandmull Jain*** [AIR 1966 SC 1644] it was observed by a Constitution Bench of this Court that in case of ambiguity in a contract of insurance the ambiguity should be resolved in favour of the claimant and against the insurance company.

32. Learned counsel for the appellant relied on the decision of the British High Court in ***Everett v. The London Assurance*** [S.C. 34 L.J.C.P. 299; 11 Jur. N.S. 546; 13 W.R. 862]. By the terms of the policy the premises in question was insured against "such loss or damage by fire to the property." It was held by the High Court that this did not cover damage resulting from the disturbance of the atmosphere by the explosion of a gunpowder magazine a mile distant from the premises insured. We are in respectful disagreement with the said judgment as the predominant view of most Courts is to the contrary.

33. For the reasons given above, we see no merit in this appeal and it is dismissed.

* * * * *

Simmonds v. *Cockell*

(1920) All ER Rep. 162

ROCHE, J. – The plaintiff sues one of the underwriting members of Lloyd's under a Lloyd's policy of insurance against burglary, housebreaking and theft, dated May 1, 1919. During the currency of the policy the premises were broken into, and about £475 worth of the plaintiff's goods were stolen. The action is brought to establish the liability of the defendant and the other underwriter of the policy. The defence is a short one, and turns on one point only - not an easy one to decide.

The policy contains the following clause: "Warranted that the premises are always occupied." I have to decide whether that warranty has been broken by the plaintiff. It is alleged that the warranty has been broken in this case, and that therefore the underwriters are not liable. The facts are that on June 22 the premises were broken into. The plaintiff and his wife, who were the only persons resident on the premises, were absent from the premises on the afternoon of the day of the burglary. The plaintiff was away partly on business, and his wife spent the afternoon at a garden party and fete, where she was joined later by the plaintiff, and they both spent the evening at the fete. During their absence the shop and premises were left unattended between 2.30 p.m. and 11.30 p.m., except for an interval about seven o'clock p.m. when the plaintiff himself returned to change his clothes. If the warranty means, as the defendant contends, that the premises are never to be left unattended, and that there must be some continuous attendance on the premises, then there has undoubtedly been a breach of the warranty for both the plaintiff and his wife were absent from the premises for some hours on the day in question. But, in my judgment, that is not the meaning of the warranty. I think it means that the premises are to be used, continuously and without interruption, for occupation, that is to say, as a residence, and not merely as a lock-up shop which is left unoccupied after business hours. That is the construction I should put on the words, and I am fortified in arriving at this conclusion by the judgment of Bray, J., in ***Winicofski*** v. ***Army and Navy General Assurance Association, Ltd.*** [(1919) 88 J.K.B. 1171] and by the American decisions cited by counsel for the plaintiff, most of which are collected in Mr. Macgilliavray's most useful book on Insurance Law, at p. 887.

But the matter does not rest there, for if the warranty does not bear the meaning which I have given to it, I should hold, that the language used is very ambiguous; and it is a well-known principle of insurance law and other matters, that if the language of a clause drawn by a party himself for his own protection is ambiguous it must be construed against him, and if the words of a warranty in a policy are ambiguous they must be construed against the underwriter who has inserted the warranty in it for his own protection. Therefore the defence, on the whole, fails. The only materiality which attached to the question whether the plaintiff returned to the premises about seven o'clock is that it fixes the time when the burglary happened, because the premises were all right then. It was contended for the defendant that if the warranty is to be construed in a way I suggest, it affords very little protection to the underwriters. I do not agree. If the premises are used for residential as well as for business purposes, it is obvious that a thief would never know at what moment the occupier might return from a temporary absence and disturb his operations. It is that kind of occupation

which this warranty requires and which has been secured. The defendant has not stipulated for the continuous presence of some one in the premises, which he could have done by providing that the premises were never to be left unattended. I therefore give judgment for the plaintiff with costs.

* * * * *

Harris v. *Poland*

(1941) All ER 204

ATKINSON, J. - The plaintiff lives in a flat at 4, Chartfield Avenue, London. In Jan., 1939, she took out a Lloyds comprehensive policy insuring her against loss by fire, burglary and housebreaking and other causes at her flat. There was an attempted burglary at her flat during the summer, which made her nervous about the safety of her jewellery while she was out and the flat was empty. She had jewellery worth about £500. On Dec. 2, she was going out for the day. She had over £100 in banknotes, and, therefore, felt more uneasy than usual about the safety of her empty flat. It occurred to her that perhaps the least likely place which a burglar would suspect as a hiding-place would be in the fireplace in the sitting-room amongst the paper and sticks under the coalite. She was probably quite right. She got a piece of newspaper and wrapped the money and the jewellery in it. Particulars of the latter are given in the statement of claim. The notes were in a registered envelope, the pearl necklace was in a soft leather *suit* case, the wrist-watch was wrapped in tissue paper, the watch set in diamonds was in a grey leather case lined with velvet, the links were in tissue paper, and were in a cotton bag along with the wrist-watch, while the rings were in tissue paper. She wrapped the articles in a newspaper and hid the parcel in the fireplace under the coalite, mixed up with the paper already there. It may be observed that this care was very much in the interests of the under-writers on whom would fall any loss suffered from burglary.

The plaintiff returned home late in the afternoon, and, feeling cold, lighted the fire, forgetting all about what she had done. Early the following morning, she remembered the hiding of her jewellery and money. Two of the pieces were repairable, but the rest of them and the notes had been completely destroyed by fire. The plaintiff seeks to recover the loss – agreed at £460 – from the underwriters. The relevant words in the policy are to insure her "from loss or damage caused by fire... burglary, housebreaking, theft or larceny" and various other causes. The plaintiff says that the loss she has suffered comes within that plain and simple language. Goods insured against loss by fire have been unintentionally either totally destroyed or badly damaged by fire, and, therefore, she says, her claim comes exactly within the language used.

The view presented on her behalf is that, while the burning of something intended to be consumed by fire is, of course, not fire under the policy, the moment one gets the accidental burning of something not intended to be consumed by fire, there is damage by fire within the meaning of the policy, and, therefore, if insured property not intended to be consumed by fire is ignited and thereby damaged or lost, or if insured property is damaged by heat, smoke, water or demolition caused by the burning of property not intended to be consumed by fire, there is loss or damage by fire within the meaning of the policy.

The underwriters very properly want it to be made quite clear that they are not disputing liability on the ground of negligence, or on the ground that the loss was due to an act of forgetfulness on the part of the plaintiff, or on the ground that the loss was the inevitable result of her own act. In their view, the position is just the same as if a maid instructed by the plaintiff not to light the fire had forgotten or misunderstood her instructions and lighted it and so caused the loss. They agree that there has been accidental loss which would be covered by

an all risks policy, but they dispute that this loss is a loss by fire within the meaning of the policy. Their case and the principle they seek through the defendant to establish is that, where damage is done to insured property by a fire in a place where fire is intended to be – where fire has not broken bounds – the loss is not covered, because such a fire is not a fire within the meaning of the policy. It is said that there must be ignition where no ignition ought to be in order to create liability. The argument is that there must be a fortuitous fire somewhere where fire ought not to be, that it is only damage caused by such an accidental fire which comes within the policy, and that the actual burning of the insured property does not in itself constitute fire within the meaning of the policy. The idea presented is that there must be an unintentional coming of fire from its proper place to the insured property and that the policy is not concerned with the coming of insured property to a fire which is behaving itself with perfect propriety in a place where it is intended to be.

Counsel for the defendant urges that the first question which I ought to ask myself is whether there was a fire within the meaning of the policy, and that only if I find that there was does there arise the question whether or not such fire caused damage to insured property, and he contends that it is impossible to hold that the fire, intentionally lighted, and burning quite properly in the grate, was a fire within the meaning of the policy. According to this view, the short and simple words in the policy against "loss or damage caused by fire" mean loss or damage caused to insured property by a fortuitous fire of something not intended to be consumed by fire in a place where fire is not intended to be.

The whole difference between the parties lies in those last few words. Unless there is spontaneous combustion, and apart from fires caused by electricity or lighting, the unintentional burning of insured property must, I suppose, always be caused directly or indirectly by, or must be due to, fire created intentionally of matter intended to be consumed, as, for example, domestic fires, lighted candles, oil lamps, gas jets, matches, tapers, cigarettes. Of course, one does not insure against the happening of such intended fires. One insures against the risk of insured property getting burned by unintentional contact with some such fire, or with fire started by some such fire. A householder has of necessity to make use of fire in his house for heating and lighting. He knows that fire is a source of danger, not merely from the escape of fire from its legitimate place but also from things coming in contact with it in its legitimate place in any of the forms I have just enumerated. I have no doubt that, when the ordinary man insures against loss by fire, he believes that he is insuring against every kind of loss which he may suffer from the more or less compulsory use of fire by himself or his neighbour. If he were told that the words in a Lloyds policy meant only loss from contact with fire where no fire ought to be, many questions would spring his mind, as they spring to mine. Am I not covered, he would ask, if the wind blows something – say a valuable manuscript or a sheet of foreign stamps – into the fire in the grate, or if a careless servant drops something into the fire, or if my wife stumbles and causes her lace scarf or silver fox tie to get caught by a flame in the fire grate? To all these questions the answers of counsel for the defendant is: "No." But what if part of the scarf is consumed in the grate and the rest of it is consumed outside the grate on the hearth-rug? Do I get compensation for the part burnt outside the grate, though not for the part burnt in the grate? Also, what if the burning scarf burns a hole in the carpet? That is not the fault of the fire in the grate, which has

not broken bounds. Am I covered for that? Again, what is the position if the lace catches fire by coming in contact with a lighted candle on the dinner-table? The flame of the candle is in the exact place where it is intended to be. Is it on a par with the fire in the grate? Moreover, what if the wind blows a curtain against a lighted gas jet and the curtain catches fire? I imagine that the ordinary man would say: "Your policy is no use to me. I shall never know where I am. I want an underwriter who knows what he means and says what he means." There certainly ought to be some clear understanding as to the meaning of these apparently simple words, so that persons insuring may know where they stand, and – if the defendant is right – not continue in a fool's paradise believing that they have a protection which in fact they have not.

There are one or two well-settled rules of construction with regard to policies. One is that the construction depends, not upon the presumed intention of the parties, but upon the meaning of the words used. In ***Nelson Line (Liverpool), Ltd.*** **v.** ***Nelson & Sons, Ltd.*** [(1908) AC 16], LORD LOREBURN, L.C., said, at p. 20:

> I know of only one standard of construction, except where words have acquired a special conventional meaning, namely, what do the words mean on a fair reading, having regard to the whole document.

There is another rule which I find summarised in ***Hamlyn & Co.*** **v.** ***Wood & Co.*** [(1891) 2 Q.B. 488], where LORD ESHER, M.R., said, at p. 491:

> I have for a long time understood that rule to be that the court has no right to imply in a written contract any such stipulation, unless, on considering the terms of the contract in a reasonable and business manner, an implication necessarily arises that the parties must have intended that the suggested stipulation should exist. It is not enough to say that it would be a reasonable thing to make such an implication. It must be a necessary implication in the sense that I have mentioned.

Another rule of construction is that, as a policy is prepared by the underwriters, any ambiguity therein must be taken most strongly against the underwriters by whom it has been prepared. If a policy is reasonably susceptible of two constructions, that one which is more favourable to the insured will be adopted. Again, **in** ***West India Telegraph Co.*** **v.** ***Home & Colonial Insurance Co.***[(1880) 6 Q.B.D. 51], BRETT, L.J., said, at p. 58:

> An English policy is to be construed according to the same rules of construction; which are applied by English courts to the construction of every other mercantile instrument. Each term in the policy, and each phrase in the policy, is *prima facie* to be construed according to its ordinary meaning.

Guided by these principles, I can see no reason whatever for limiting the indemnity given by the policy in the way claimed by the defendant. In my judgment, the risks against which the plaintiff is insured include the risk of insured property coming unintentionally in contact with fire and being thereby destroyed or damaged, and it matters not whether that fire comes to the insured property or the insured property comes to the fire. The words of the policy are just as descriptive of one as they are of the other, and I cannot read into the contract a limitation which is not there. To enable me to accept the contention of the underwriters, I should have to read something into the contract, some such words as "unless the insured

property is burned by coming in contract with fire in a place where fire is intended to be." Why should I? What justification can there be for so doing? To what absurdities would it lead? A red hot cinder jumps from the fire and sets on fire some paper of value. Admittedly, there is liability. A draught from the window blows the same paper into the same fire. Is that any less an accidental loss by fire? Are the words in the policy any less applicable to the latter than they are to the former? A draught blows the flame of a candle against a curtain. Admittedly, there is liability. What if the curtain is blown against the flame of the candle, however? Surely the result must be the same. If it is not the same, the result is an absurdity. If it is the same, why should the result be different if one substitutes a fire in a grate for the lighted candle in a candlestick? Unless I am bound by authority to the contrary, or unless I can find a consensus of opinion to the contrary among textbook writers indicating a generally accepted interpretation of these words, I must give effect to the view I have formed.

Counsel for the defendant relies and it is his only prop upon ***Austin* v. *Drewe*** [(1816) 4 Camp. 360], not, indeed, upon the actual decision, which gives him no help, but upon two sentences to be found in the summing up to the jury by GIBBS, C.J. The facts of that case were very simple [p. 360]:

> This was an action on a policy of insurance against fire. The premises insured were used as a manufactory for sugar baking. The building was divided into seven or eight storey's. On the ground floor were pans for boiling the sugar, and a stove to heat them. From the stove a chimney or flue went to the top of the building, and as it passed each floor, there was a register in it with an aperture into the rooms, whereby more or less heat might be introduced at pleasure. The upper floors were used for drying the baked sugars. One morning the fire being lighted as usual below, the servant whose duty it was to have opened the register in the highest storey forgot to do so. The consequence was that the smoke, sparks, and heat, were completely intercepted in their progress through the flue, and were forced into the room where the sugars were drying. The smoke being perceived below, the alarm was given. One or two men were suffocated in attempting to open the register; but at last it was opened, and the mischief remedied. Had it remained shut much longer, the premises would probably have been burnt down: but in point of fact there never was more fire than was necessary to carry on the manufacture, and the flame never got beyond the flue. The sugars, however, were very much damaged by the smoke, and still more by the heat. The loss amounted to several thousand pounds. The question was whether this was a loss for which the insurance office was liable.

The head note is as follows:

> From the negligence of a servant of the assured in not opening a register, smoke and heat from a stove used in the manufactory are forced into a room and greatly damage goods, without actually burning any, the fire not being greater than it ought to have been had there been free vent for the smoke and heat. This held not to be a loss within the policy.

Judging from the head note, the grounds of the decision were the negligence of the plaintiff's servant and the absence of any burning of any of the insured property. Nowadays

it is well-established that negligence is immaterial, and, in the case with which I have to deal, there was burning of the insured property. In the direction to the jury, however, GIBBS, C.J., said, at p. 362:

> If there is a fire, it is no answer that it was occasioned by the negligence or misconduct of servants; but in this case there was no fire except in the stove and the flue, as there ought to have been, and the loss was occasioned by the confinement of heat. Had the fire been brought out of the flue, and anything had been burnt, the company would have been liable. But can this be said, where the fire never was at all excessive, and was always confined within its proper limits? This is not a fire within the meaning of the policy.

There are several sources of damage from fire. There are the flames, the heat generated, and the smoke and sparks produced. Some might find it difficult to see how it could be said, when in fact smoke, sparks and excessive heat were forced into the room, that the fire was always confined within its proper limits. It could only be true of the actual flames. I asked counsel for the defendant what the position would be if the excessive heat had caused some of the bags to ignite, and the answer was that the loss would be within the policy – and yet it would have been just as true to say that the fire had not been brought out of the flue. I might put the question in a more awkward way. Suppose that some bags ignited and some were merely ruined by the heat. There would be liability for the former, but not for the latter, according to his view, yet the only distinction would be that in the one case there was ignition and in the other there was not.

The next report of this case to which I will refer is in Holt 126. There one can find little, if any, reference to this point about the fire escaping from its proper place. According to that report, I think that the ground upon which GIBBS, C.J., directed the jury was this [pp. 127, 128]:

> As no substance, therefore, was taken possession of by the fire, which was not intended to be fuel for it, as the sparks and smoke caused no mischief, but as the damage arose from an excess of heat in the rooms, occasioned by the register being shut, I am of opinion that the plaintiffs are not entitled to recover.

The main point, and the point in the forefront there, is surely that no substance was taken possession of by the fire which was not intended to be fuel for it.

The editor's note about that case is as follows, at p. 128:

> It is not to be concluded from this case that an insurer on a policy against fire is exempt from a loss occasioned thereby, on the ground that the servants of the assured have been careless or unskillful, and that the fire was occasioned by their negligence and misconduct. An insurer would unquestionably be answerable in such a case. The spirit of the decision of the present case is this: that there was no loss by fire, by whatever cause or misconduct produced. The injury arose from the misdirection of heat, occasioned by the unskillful management of the machinery in the sugar house. It was not, therefore, in any fair and reasonable construction of the policy, one of those accidents against which the defendant had engaged to indemnify the plaintiffs.

Therefore, the test of liability according to that report and according to that note is surely whether or not something has been consumed by fire which was not intended to be consumed.

There was a motion for a new trial in the Court of Common Pleas, and I turn to the report of that motion in 6 Taunt 436. It is interesting to read the arguments in that case and see how it was dealt with. The Solicitor-General, said this, among other things, at p. 438:

> If actual flame was the cause of the damage, it matters not whether the fire was properly or improperly lighted, but the question is whether fire occasioned the damage. If any other criterion be taken, it would in many cases of policies against fire introduce nice and intricate questions. It cannot be necessary that the fire, to produce a loss within the policy, should be only such fire as is communicated to some substance not contained in the intended and proper receptacle of fire.

Then he goes on to give other illustrations. He has put the very point for which counsel for the defendant contends. GIBBS, C.J., is reported to have said this, at pp. 438, 439:

> I think it is not necessary to determine any of those extreme questions. In the present case, I think no loss was sustained by any of the risks in the policy. The loss was occasioned by the extreme mismanagement by the plaintiffs of their register. I so directed the jury, and I have no reason to alter the opinion I then formed.

Then DALLAS, J., said, at p. 439:

> I am of the same opinion. The only cause of the damage appears to me to have been the unskillful management of the machinery by the plaintiffs' own servants, and it is therefore not a loss within the meaning of the policy.

The rule was refused, apparently on the ground of negligence. Be that as it may, it is very difficult to argue that this case is an authority for the construction put upon it by counsel for the defendant, when it is said by GIBBS, C.J., in terms, "I think it is not necessary to determine any of those extreme questions", one of them being this very question whether or not it is necessary that the fire should have taken place in some place other than the place where the fire was intended to be.

There was fourth report of this same case. It is in 2 Marsh. 130, GIBBS, C.J., is reported, at p. 132, in the same language as I have just read, and DALLAS, J., said:

> His Lordship's direction appears to me to have been perfectly right, and the jury have drawn a perfectly correct conclusion from it. There was nothing on fire which ought not to have been on fire; and the loss was occasioned by the carelessness of the plaintiffs' themselves.

Then PARK, J., concurred. The words "There was nothing on fire which ought not to have been on fire" suggests that the test of liability is that there must be the ignition of something which ought not to be ignited. In that case, there was no ignition of anything but the fuel, and, therefore, there was no liability, and no fire within the policy. The test is there laid down by DALLAS, J., and concurred in by PARK, J. That is exactly the case for which the plaintiff here contends - namely, that there was ignition here of something which ought not to

have been ignited, newspaper, sticks of wood, banknotes, cotton, leather, jewellery, and so on.

The next case to which I was referred was *Everett* v. *London Assurance* (1865) 19 CBNS 126. That was a claim on a policy of insurance against fire. There had been an explosion about a quarter of a mile away which had damaged the plaintiff's premises, so that the windows had been blown in and other damage sustained, and a claim was made that this was damage caused by fire within the meaning of the policy. The argument as to the effect of *Austin* v. *Drewe* is not without interest. It took the form of a quotation from MARSHALL ON *INSURANCE,* Vol. 2, Book IV (a), p. 790, which is as follows:

In MARSHALL ON *INSURANCE,* Vol. 2, Book IV (a), p. 790 (Edn. 1823), it is said that

> "by the terms of the usual policy, the insurers undertake to pay, make good, and satisfy to the insured all loss or damage which may happen by fire during the term specified in the policy... In order, therefore, to bring the loss within the risk insured against, it must appear to have been occasioned by actual ignition; and no damage occasioned by mere heat, however intense, will be within the policy.

In support of that proposition, ***Austin* v. *Drewe*** was relied upon. It ended up with a quotation with reference to ***Austin* v. *Drewe*** that the sugar was damaged "not by the smoke but by the excessive heat: but *nothing took fire."* Those last words, "nothing took fire", are in italics, showing that those were the words intended to be taken as the test. In that case, BYLES, J., said, at p. 134:

> The expression in the policy which we have to construe is "loss or damage occasioned by fire."

That is exactly the expression which I have to construe in this case, except that I have the word "caused" instead of the wood "occasioned." Then BYLES, J., continues as follows, at p. 134:

> Those words are to be construed as ordinary people would construe them. They mean loss or damage either by ignition of the article consumed, or by ignition of part of the premises where the article is: in the one case, there is a loss, in the other damage, occasioned by fire. LORD BACON says: "It were infinite for the law to judge the causes of causes, and their impulsions one of another; therefore it contented itself with the immediate cause, and judged the acts by that, without looking to any further degree."

It is a little too wide, because it is clear that there need not be ignition of part of the premises where the article is if the loss is, occasioned by the ignition of premises in the near neighbourhood, but the result is the same.

There is one other case to which I was referred, and that is ***Upjohn* v. *Hitchens*** [(1918) 2 K.B. 48]. During the argument in that case, SCRUTTON, L.J., said, at p. 61:

> It has been held, however, that "fire" within the meaning of a fire policy means fire which has broken bounds, so that damage caused by excess of fire heat in an ordinary grate is not damage by fire within the policy.

I do not think that I can attach very much weight to an intervention of that kind with no argument about it, but there is something which I think is a little more relevant in the judgment of PICKFORD, L.J., at p. 53. In that case, there was a covenant to insure premises against loss or damage by fire, and the question was whether such damage was within, a policy which did not cover the premises for damage caused by enemy aircraft. PICKFORD, L.J., said,

> Nor am I impressed by the other case put where it has been held that the ordinary policy against fire does not cover damage caused by overheating from a fire in an ordinary grate. There the damage was held not to be damage by fire, but damage by heating, damage caused by an ordinary domestic fire not being covered unless it sets fire to the house.

He must have used the word "house" because he was dealing with a case of fire in a house.

Substituting the words "insured property", again I find the same test laid down by HALLETT, J., in a similar case. The weight of authority seems to me to be strongly in favour of the test contended for by counsel for the plaintiff, and I think that the true test is whether or not there has been an ignition of the insured property which was not intended to be ignited. If there has been, the loss is one caused by fire. That is to say, has insured property been damaged otherwise than by burning as a direct consequence of the ignition of other property not intended to be ignited? In other words, I base my view in substance on what DALLAS, J., said in ***Austin* v. *Drewe***.

I was referred to textbooks, including one very old one, MARSHALL ON INSURANCE, a quotation from which I read in ***Everett's*** case. The next, I think, was BUNYON ON INSURANCE. There is no suggestion in Bunyon's book of this limitation about the fire being restricted to places where fire is not intended to be. There is a paragraph describing his view of the risk insured against, at p. 161:

> The "risk" must now be construed as applicable not only to loss by fire, but also to loss by the agency of the other perils insured against. In the case of loss by fire, there must, of course, be actual ignition, not necessarily of the property itself, but of some substance near to it.

He refers to ***Austin* v. *Drewe*** and continues as follows, at p. 162:

> It is not, of course, necessary that the property must be itself on fire, since losses by smoke and water, when the fire has not touched the objects insured, are familiar to all managers of insurance offices. All that appears to be necessary is, that something should have caught fire, and damage have been thereby occasioned to the insured property.

The next was MACGILLIVRAY ON ***INSURANCE,*** which was the one textbook in which counsel for the defendant could find any support for his contention, because the author says, at p. 809:

> Fire within the meaning of a fire policy means fire which has broken bounds. There must be actual ignition where no ignition ought to be. Damage caused by

> excess of fire-heat in its proper place, or by smoke from a fire in its proper place, is not damage by fire. Thus, where articles are destroyed in process of manufacture by the excessive application of heat, whether by negligence or pure misadventure, the damage cannot be recovered as damage by fire, unless they have actually ignited.

I do not know exactly what that means, but at any rate there is some suggestion there on the lines of the argument of counsel for the defendant. In my view, however, a careful examination of the one authority on which that rests really negatives his argument that that case is an authority for his proposition.

Then, as a matter of interest, I was referred to WELFORD AND OTTER BARRY ON *FIRE INSURANCE*, 2nd Edn., p. 61:

> Any loss, therefore, occasioned by such a fire, whether by the burning of any property in the fire itself, or by the scorching or cracking of any property adjacent to it owing to its intense heat, if unaccompanied by ignition, is not covered by the contract, since the cause of the loss cannot be regarded as a peril insured against.

That line in particular, "whether by the burning of any property in the fire itself", was strongly relied upon by counsel for the defendant. However, the answer was to refer to WELFORD AND OTTER BARRY ON *FIRE INSURANCE*, 3rd Erd., p. 59. Before one refers to what is said there. I want to refer to the preface to the third edition:

> Many questions in fire insurance are not covered by direct authority, and may still be regarded as open. In discussing such questions, an attempt has been made to answer them... Another example, which is discussed for the first time in this edition, is the question whether an article which accidentally falls into a domestic fire and is burned there is destroyed by fire within the meaning of a fire policy.

There is a statement by an author that whatever may have been said in the second edition was not the result of a discussion or consideration of this particular question, and then he says, at p. 59:

> So long as the fire is burning in the grate or furnace, it is fulfilling the purpose for which it was lighted. If, therefore, property adjacent to the fire is merely damaged by scorching or cracking, owing to its proximity to the fire, the loss is not covered; though the element of accident may be present, there is no ignition of the property, and nothing is on fire which ought not to be on fire. If, however, the fire breaks its bounds and, by throwing out sparks or otherwise, causes ignition to take place outside the grate or furnace, there is at once a loss by fire within the meaning of the contract. The question then arises, what is the position where property is accidentally burned in an ordinary fire, such as a domestic fire: the fire never breaks its bounds, but something which was never intended to be burned falls or is thrown by accident into the grate and is burned. In this case, equally with the case where the fire breaks its bounds, there is an accident and something is burned which ought not to have been burned. The only distinction between them is that in the one case it is the fire which escapes out of its proper place and comes into contract with the property destroyed, whereas in the other case it is the property which gets out of its proper place and comes in contact with the fire. This distinction does not appear to be

sufficient to make any difference in the result. The object of the contract is to indemnify the assured against accidental loss by fire, and so long as the property is accidentally burnt, the precise nature of the accident seems to be immaterial. It may be therefore concluded that the loss in both cases falls equally within the contract.

In the textbooks, there is no clear consensus as to the meaning of these words which might force one to say that they have acquired an authorised meaning to which one can give effect. The most which counsel for the defendant can get out of the textbooks is perhaps a difference of opinion or an ambiguity. However, ambiguity is not his case, because the interpretation of those words which is most favourable to the insured must be adopted, and it seems to me that, if the underwriters wish to avoid liability, they must put words to that effect in their policy. In my judgment, the plaintiff is entitled to succeed. It is, of course, an unusual case. It has not been suggested that the loss was due to the negligence of the plaintiff. The underwriters have made it clear that they wish to stand or fall on the principle for which they have contended. I give judgment for the plaintiff for the agreed amount of £460.

* * * * *

UNCONCLUDED CONTRACT

1984 AIR 1014, 1984(3)SCR 350, 1984(2)SCC 719, 1984(1)SCALE561 ,

PETITIONER: LIFE INSURANCE CORPORATION OF INDIA

Vs.

RESPONDENT: RAJA VASIREDDY KOMALLAVALLI KAMBA & OTHERS

DATE OF JUDGMENT27/03/1984

BENCH: MUKHARJI, SABYASACHI (J) ERADI, V. BALAKRISHNA (J)

CITATION: 1984 AIR 1014 1984 SCR (3) 350,1984 SCC (2) 719,1984 SCALE (1)561

ACT:

Insurance Law-Contract of Insurance-Proposal and acceptance-Insured filling up the proposal for insurance for Rs.50,000 on 27.12.1960 and after undergoing medical examination on the same date issues two cheques of Rs. 300 and Rs 220 toward consideration by way first premium-The Insurance Corporation encash the cheques on 11.1.1961 and the insured dies on 12.1.1961 whether there is a concluded contract of Insurance-When is the acceptance said to be complete in case of contract of Insurance-contract of Act Section 2(h) and 4.

HEADNOTE:

One Late Raja Vasireddi Chandra Dhara Prasaddied intestate on 12th January, 1961 He had filled a proposal for insurance for Rs.50,000 on 27th December 1960. There was medical examination by the doctor on the life of the deceased on 27th, December, 1960 The deceased issued two cheques being the consideration towards the first premium for Rs.300 and Rs.220 respectively which were encashed by the appellant on 29th December 1960 and 11th January 1961. On 16th January 1961, the widow of the deceased wrote to the appellant intimating the death of the deceased and demanded payment of Rs. 50,000 the Divisional Manager, Masulipatam Branch denied liability on behalf of the appellant on 28th January, 1961.Thereafter there was correspondence between the parties between Ist February 1961 and 23rd December 1963. On 10th January 1964, the respondents filed a suit in the Court of Subordinate Judge, Masulipatam. The trial court dismissed the suit holding, inter alia, that there was no concluded contract, that the proposal was not accepted by the Divisional Manager for some reason or the other by the time the deceased had died, that neither the encashment of the two cheques created a contract of insurance. In appeal,the High Court after ordering certain other additional documents set aside the Trial Court Judgment. Hence the appeal by the Corporation after obtaining the special leaves.

LAPSED POLICY

2006 AIR 2366, 2006(1) Suppl.SCR854, 2006(5) SCC258, 2006(5) SCALE375, 2006(5) JT484

CASE NO.: Appeal (civil) 4492 of 2000

PETITIONER: Life Insurance Corporation of India & Anr.

RESPONDENT Smt. S Sindhu

DATE OF JUDGMENT: 04/05/2006

BENCH: B N Srikrishna & R V Raveendran

JUDGMENT

Allowing the appeal, the Court

HELD : 1. The amount that is paid by LIC in regard to a lapsed policy, is not "refund of the premium paid on various dates", but a reduced lump sum (calculated as per condition no. 4 of the policy) instead of the assured sum. When what is paid by LIC is not refund of premiums, the question of treating the amount paid by LIC as refund of premiums paid and then directing payment of interest thereon from the respective dates of payment of premium does not arise. That would amount to treating the premiums paid in respect of a policy which lapsed by default, as fixed deposits repayable with a hefty rate of interest. Surely, the intention is not to reward defaulting policy holders. Moreover, the courts and Tribunals cannot rewrite contracts and direct payment contrary to the terms of the contract, that too to the defaulting party.

2. It is now well-settled that interest prior to the date of suit/claim (as contrasted to pendente-lite interest and future interest) Can be awarded in the following circumstances

(a) Where the contract provides for payment of interest; or

(b) Where a statue applicable to the transaction/ liability, provides for payment of interest; or

(c) Where interest is payable as per the provisions of the Interest Act, 1978. [859-d, e, f]

3. The contract, that is the insurance policy, provides that if the premium is not paid (after regularly paying premiums for a period of three full years), the policy shall subsist only as a paid up policy for a reduced sum (calculated as per Table given in Condition No. (4) of the policy) payable on the date of maturity or at the prior death of the life assured. It does not provide for payment of interest on the premiums paid. In fact, the operative portion of the policy specifically provides that no interest will be paid. Payment of

interest on the premium amounts, from the respective dates of remittance of premiums, is alien to the concept of life insurance. Therefore, under the contract, no interest is payable by LIC.

4. Where a statute provide for payment of interest, such interest will have to be paid in accordance with the provisions of such statute. Admittedly there is no enactment, or rules made under any enactment, either relating to contracts in general or insurance in particular, which provides for payment of interest in regard to amount payable under such a policy.

5.1. The Interest Act, 1978 was enacted to consolidate and amend the law relating to the allowance of interest in certain cases. The objects and reasons state that the Act was enacted to prescribe the general law of interest in a comprehensive and precise manner which becomes applicable in the absence of any contractual or statutory provision specifically dealing with interest. A claim for interest on the amount of premiun paid from the respective dates of payment to date of settlement of claim, does not find support from any of the provisions of the Act.

5.2. The Court does not propose to examine the question as to whether interest can be awarded at all, on equitable grounds, in view of the enactment of Interest Act, 1978 making a significant departure from the old Interest Act (of 1839).

Satinder Singh v. Umaro Singh etc., AIR (1961) SC 908; Hirachand Kothari (D) by LRs v. State of Rajasthan & Anr., [1985] Supp, SCC 17 and Bengal Nagpur Railway Co. Ltd v. Rultanji Ramji, AIR (1938) PC. 67, referred to.

6. The reduced sum calculated as per the Table in Condition No. (4) of the Policy became due only on the death of the assured. No interest is payable either under the contract of insurance, or under any statue, or under the Interest Act, 1978 from the respective dates of payment of premium to date of settlement of claim. Therefore the District Forum, the State Commission and the National Commission committed a serious error in awarding such interest LIC. is not liable to pay any interest on the sum of Rs 1,13,750/-. Harshad J. Shah v. L.I.C. of India, [1997] 5 SCC 64, distinguished.

7. This decision does not render the respondent liable to refund any amount already received in pursuance of the order of the consumer forum. Even though it has been held that the respondent is not entitled to any interest on Rs. 1,13,750/- in view of the concession made on 7.8.2000.

WARRANTY

CASE NO.: Appeal (civil) 5322 of 2007

PETITIONER: P.C. Chacko and another

RESPONDENT: Chairman, Life Insurance Corporation of India and others

DATE OF JUDGMENT: 20/11/2007

BENCH: S.B. SINHA & HARJIT SINGH BEDI

JUDGMENT (Arising out of SLP (C) No. 23951 of 2005)

Dismissing the appeal, the Court

HELD: 1.1. An insurance policy should not be obtained with a fraudulent act by the insured. Proposal can be repudiated if a fraudulent act is discovered. The proposer must show that his intention was bona fide. It must appear from the face of the record. A deliberate wrong answer which has a great bearing on the contract of insurance, if discovered may lead to the policy being vitiated in law. If a person makes a wrong statement with knowledge of consequence thereof, he would ordinarily be estopped from pleading that even if such a fact had been disclosed, it would not have made any material change. [Para 15 and 16] [359-A-C; 358-G-H]

1.2. In the instant case, the basic fact of the matter is not in dispute. The insured had undergone an operation for Adenoma Thyroid. It was a major operation. Although the said operation was undergone by him four years prior to the date of the proposal made by him, he did not disclose thereabout prior to obtaining the insurance policy. He died within six months from the date of taking of the policy. In a case of this nature it was not necessary for the insurer to establish that the suppression was fraudulently made by the policy holder or that he must have been aware at the time of making the statement that the same was false or that the fact was suppressed which was material to disclose.
[Para 10 and 16] [357-B-C; 359-B-C]

Mithoolal Nayak v. Life Insurance Corporation of India, [1962] Suppl. 2 SCR 571 and Life Insurance Corpn. of India & Ors. v. Asha Goel (Smt) & Anr., [2001] SCC 160, relied on.

All India General Insurance Co. Ltd. and Anr. v. S.P. Maheshwari, AIR (1960) Madras 484, held inapplicable.

Allianz Und Stuttgarter Life Insurance Bank Ltd. v. Hemanta Kumar Das AIR (1938) CAL 641, cited.

Ratan Lal & Anr. v. Metropolitan Insurance Co. Ltd. AIR (1959) PAT 413, referred to.

1.3. Section 45 of the Insurance Act, 1938 postulates repudiation of the policy within period of two years. The Statute, therefore, itself provides for the limitation for val repudiation of an insurance policy. It takes into account the social security aspect of t matter. It has not been shown in the instant case that repudiation of the contract insurance was not done by the respondent with extreme care and caution or w otherwise invalid in law. [Para 12 and 21] [358-A-C; 361-G]

1.4. Life Insurance Corporation being a State within the meaning of Article 12 of t Constitution of India, its action must be fair, just and equitable. This is not a case whe the contract of insurance or a clause thereof is unreasonable, unfair or irrational. It is al not the case of the appellants that in framing the questionnaire in the application/propos form, the respondents had acted unjustifiably or the conditions imposed a unconstitutional. No case has been made out for interference with the impugn judgment. [Para 20 and 26] [360-H; 361-A-B; 363-D]

Insurance Act, 1938:
s 45-Life Insurance policy-Non-disclosure and mis-statement in proposal for Repudiation of policy within two years-Legality of-HELD: A deliberate wrong answ which has a great bearing on contract of insurance, if discovered, may lead to the poli being vitiated in law-On facts, it has not been shown that repudiation of contract insurance was not done by insurer with extreme care and caution or was otherwise inval in law.

One `C' took an insurance policy on 21.2.1987. He died on 6.7.1987. The claim of h nominees, the appellants, was not acceded to by the respondent-Corporation for no disclosure and mis-statement in the proposal form. The insured had undergone operation for Adenoma Thyroid. But in the proposal form in answer to the question as whether he ever had any operation he replied `No'. Therefore, the insurer repudiated t policy on 10.2.1989. However, the suit filed by the appellants for recovery of the insur amount was decreed by the trial court and the single Judge of the High Court declined interfere. But the Division Bench of the High Court allowed the appeal of the insu holding that the non- disclosure related to a material fact which was required to answered correctly. Aggrieved, the plaintiffs filed the instant appeal.

ASSIGNMENT:

IN THE HIGH COURT OF JUDICATURE AT BOMBAY

CASE NO.: WRIT PETITION NO.2159 OF 2004

PETITIONER: I.P.P Services India (P) Ltd

RESPONDENT: LIC of India &Anr.

Equivalent Citation: 2007(3)ALLMR462, 2007(3)BomCR98, (2007)109BOMLR559, [2007]79SCL583(Bom)

Hon'ble Judges: F.I. Rebello and Anoop V. Mohta, JJ.

Subject: Insurance

Acts/Rules/Orders:
Companies Act; Life Insurance Corporation Act, 1956 - Sections 3, 6, 9, 26, 28, 30, 43 and 43(1); Insurance Regulatory and Development Authority Act, 1999 - Section 3; Insurance Act, 1938 - Sections 6, 24, 26, 30A, 37, 38, 38(1), 38(2), 38(4), 38(5), 38(7), 39, 39(4), 113 and 378;Indian Contract Act, 1872 - Sections 23 and 30; Public Debts Act; Transfer of Property Act, 1882 - Section 3; Insurance Regulatory Act - Section 43; Income Tax Act, 1971 - Section 10(1) and 10(1OD); Gaming Act, 1892; Income Tax Act, 1961 - Section 80DDA; Civil Procedure Code (CPC), 1908 - Section 60; Constitution of India - Articles 12, 14 and 19(1)

Case Note:

Insurance — Life Insurance — Assignment — Validity of — Section 38 of the Life Insurance Corporation Act — Petitioner-Company engaged in business of assignment of life insurance policies issued by Respondent No. 1 — Petitioner involved for several years in business of acquiring policies from policy holders and assignment to third parties for consideration — Assignment of policies recorded by Respondent No. 1 during the initial few years — Subsequently, Respondent No. 1 refused to accept notices of assignments lodged by Petitioner and issued circular refusing the same — Hence, the present petition — Whether life insurance policies issued by the Respondent tradable and assignable under the provisions of the Act — Held, Respondent No. 1 authority to view assignment in light of the terms of the policy — Clearly provided under the terms of policy and Section 38 of the Insurance Act that the said policies can be transferred and assigned in the favour of any person — Further, Insurance Company issues policies with terms and conditions and in full knowledge of the provisions of Section 38 — When Respondent No. 1 itself accepted assignment of policies earlier, it is bound to accept such assignment now in the absence of specific provision barring such assignment — Petition allowed

Insurance — Policies — Assignment — Insurable interest — Section 38 of the Life

Insurance Corporation Act — Whether life insurance policies issued by the Responde not assignable to Petitioners in the absence of their having any insurable interest in t life insured under the policies — Whether the policy taken without insurable intere mere wager and against public policy — Insurable interest may be defined as a reasonable expectation of pecuniary benefit to one person from the continued life another — Insurable interest required to exist when the initial contract entered into, b for subsequent assignments no requirement of insurable interest exists — Therefo assignment of life insurance policy not to amounts to wager in the absence of insurab interest — The said assignment not against public policy — Petition allow

Insurance — Policies — Life Insurance Corporation Act, 1956 — Whether the polici issued under the Act a measure of social welfare — Held, domestic law of the count may be interpreted on the basis of similar law as recognised internationally — Insuran policy in India, U.S. and other countries following the common law understood as one the best recognised forms of investment and self compelled saving — Transfer assignment not viewed by Legislature as a security for protection of widows dependents of the life assured — Hence, Life Insurance Corporation Act treated commercial more than welfare legislation — Desirable to give life insurance policies t ordinary characters of property

RatioDecidendi:

"As long as there is no provision in the contract, barring such assignment and such a te is otherwise not void, the parties would be bound by the provisions of Section 38 of t InsuranceAct."

"Insurable interest is required to exist when the initial contract is entered into, but subsequent assignments no requirement of insurable interest exists."

DATING BACK

2005 AIR 3349, 2005(2)Suppl.SCR342 , 2005(6)SCC274 ,

CASE NO.: Appeal (civil) 4806 of 2005

PETITIONER: LIFE INSURANCE CORPORATION OF INDIA

RESPONDENT: MANI RAM

DATE OF JUDGMENT: 05/08/2005

BENCH: CJI R.C. Lahoti,C.K. Thakker & P.K. Balasubramanyan

JUDGMENT @ SPECIAL LEAVE PETITION (CIVIL) No.2795 of 2003)

Allowing the appeal, the Court

HELD: 1.1. From condition no. 2 of terms and conditions of the policy, it is abundantly clear that payment of premium due had to be made within a grace period of one month. If such payment was made within the said period, the policy would be treated as valid and the assured would be paid the amount to which he was entitled after deducting the premium amount. But it was also made clear that if the premium was not paid before the expiry of the days of grace, the policy would lapse.

2. The material date was not the date of deposit/payment of premium amount which was August 21, 1995, but the date of policy which was April 28, 1995. Since it was yearly, the payment was due on April 28, 1996, but the assured was entitled to grace period of one month up to May 28, 1996. Neither the premium was paid on April 28, 1996 nor on May 28, 1996. As per condition No. 2, policy lapsed on May 28, 1996. In the eyes of law, there was no subsisting policy, on August 2, 1996. Insurance Company was therefore wholly justified in rejecting the claim of the complainant and no exception can be taken against such a decision.

All the terms and conditions of the policy have to be kept in mind and given effect to Court of law cannot construe a document in manner that any term would make redundant, otioise and inoperative; and a court of law cannot construe a document in the manner. The fora below hence, committed an error in allowing the complaint of the respondent; its orders are liable to be set aside.

Life insurance Corporation of India and Another v. Dharam Vir Anand, [1998] 7 SCC 348, distinguished.

PRESUMPTION OF DEATH

2005 AIR SCW 2017, 2005 AIR SC 2070 ,

PETITIONER: LIFE INSURANCE CORPORATION OF INDIA

RESPONDENT: ANURADHA

DATE OF JUDGMENT: 05/08/2005

BENCH R. C. LAHOTI AND Dr. A. R. LAKSHMANAN, JJ

(A) Evidence Act (1 of 1872), S.108, S.107 - PRECEDENT - EVIDENCE **Presumption as to date/time of death of a person - Cannot be drawn in respect c person not heard of for seven years - But, can be inferred on basis of evidenc factual or circumstantial - Onus of proving that person was alive/dead on particula date/time - Lies on person who asserts it - S. 108 is exception to rule enacted in S 107 relating to presumption of human life for thirty years.**

Precedents - Presumptions of fact or law - Recognised by successive judici pronouncements over years - To be valued as precedents

Constitution of India, Art.141.

The law as to presumption of death remains the same whether in Common Law c England or in the statutory provisions contained in Ss. 107 and 108 of the India Evidence Act, 1872. In the scheme of Evidence Act, though Ss. 107 and 108 are drafte as two Sections, in effect, S. 108 is an exception to the rule enacted in S. 107. The huma life shown to be in existence, at a given point of time which according to S. 107 ought be a point within 30 years calculated backwards from the date when the question arises, presumed to continue to be living. The rule is subject to a proviso or exception contained in S. 108. If the persons, who would have naturally and in the ordinary cours of human affairs heard of the person in question, have not so heard of him for seve years, the presumption raised under S.107 ceases to operate. Section 107 has the effect shifting the burden of proving that the person is dead on him who affirms the fac Section 108, subject to its applicability being attracted, has the effect of shifting th burden of proof back on the one who asserts the fact of that person being alive. Th presumption raised under S. 108 is a limited presumption confined only to presuming th factum of death of the person whose life or death is in issue. Though it will be presume that the person is dead but there is no presumption as to the date or time of death. There no presumption as to the facts and circumstances under which the person may have die The presumption as to death by reference to S. 108 would arise only on lapse of seve years and would not by applying any logic or reasoning be permitted to be raised c expiry of 6 years and 364 days or at any time short of it. An occasion for raising th presumption would arise only when the question is raised in a Court, Tribunal or befo

NOMINATION

1984 AIR 346, 1984(1)SCR 992, 1984(1)SCC 424, 1983(2)SCALE869 ,

PETITIONER: SMT. SARABATI DEVI & ANR.

Vs.

RESPONDENT SMT. USHA DEVI

DATE OF JUDGMENT06/12/1983

BENCH: VENKATARAMIAH, E.S. (J) MISRA, R.B. (J)

ACT:

Insurance Act, 1938 (Act IV of 1938), Section 39-Assured of a life insurance policy dies intestate leaving behind him his mother, his widow, and a son, but for the purpose of Section 39 has nominated his widow alone-Whether the nominee of a life insurance policy, on the assured dying intestate would become entitled to the beneficial interest in the amount received under the policy to the exclusion of the heirs of the assured.

HEADNOTE:

The appellants being mother and son of one Jagmohan Swarup who was governed by the Hindu Succession Act, 1956 and who died intestate on June 15, 1967 filed Civil Suit No. 122 of 1970 on the file of the first Additional Civil Judge, Dehradun for a declaration to the effect that they were together entitled to 2/3rd share of the amount due and payable under the insurance policies though the deceased assured has nominated the respondent his widow as the person to whom the amounts were payable. The respondent contested the suit claiming that she has the absolute right to the amounts to the exclusion of her son and her mother-in-law. The suit was dismissed. The First Appeal before the Dt. Judge, Dehradun and the Second Appeal before the High Court were dismissed.

an authority who is called upon to decide as to whether a person is alive or dead. So long as the dispute is not raised before any Forum and in any legal proceedings the occasion for raising the presumption does not arise. If an issue may arise as to the date or time of death the same shall have to be determined on evidence - direct or circumstantial and not by assumption or presumption. The burden of proof would lay on the person who makes assertion of death having taken place at a given date or time in order to succeed in his claim. Rarely it may be permissible to proceed on premise that the death had occurred on any given date before which the period of seven years' absence was shown to have elapsed.(Paras 14, 15)

A presumption of fact or law which has gained recognition in statute or by successive judicial pronouncements spread over the years cannot be stretched beyond the limits permitted by the statute or beyond the contemplation spelled out from the logic, reason and sense prevailing with the Judges, having written opinions valued as precedents, so as to draw such other inferences as are not contemplated. (Para 13)

(B) Evidence Act (1 of 1872), S.108 - Consumer Protection Act (68 of 1986), S.21 - CONSUMER PROTECTION - INSURANCE - Consumer claim for benefit under Insurance policy - Premiums regularly paid up to time of disappearance of insured person - Person not heard of for a period of seven years - Life insured cannot be presumed to be dead - Nor can it be assumed that presumed death had synchronized with date when he was reported to be missing - Or that, date and time of death could be correlated to the point of time coinciding with the commencement of calculation of seven years backwards from the date of initiation of legal proceedings - Policy lapses because of non-payment of premium until claim is made - Claimant only entitled to paid up value of policy.
1999 (1) Rec Civ R 489 (JandK), Reversed.

Insurance Act (4 of 1938), Pre. (Para 16)

(C) Life Insurance Corporation Act (31 of 1956), S.30 - LIFE INSURANCE CORPORATION - Life insurance service - In regions or States which are insurgency afflicted - Life Insurance Corporation suggested to devise and propagate insurance policies with terms and conditions suited to requirements of people inhabiting insurgency or military affected areas. (Para 18)

LIC – Nomination – Will: AIR 2010 ORISSA 73 "Chakraram Samal v. Radha Palaka"

ORISSA HIGH COURT

Coram : 1 M. M. DAS, J. (Single Bench)

Chakraram Samal and Anr. v. Radhamani Palaka and Ors.

R.F.A. No. 194 of 2005, D/- 15 -10 -2009.

Insurance Act (4 of 1938), S.39 - INSURANCE - WILL - Nomination by policy ho Insurance claim - Petitioner is successor of deceased by virtue of Will - W respondent being wife of said deceased, is nominee - Divorce between spouses p filing of suit - Nominee wife cannot be held to be successor having interest over available under L.I.C. policy of deceased husband - Mere nomination does not effect of conferring any beneficial interest in amount payable under L.I.C. Poli exclusion of heirs of assured.

AIR 1984 SC 346, Relied on. (Paras 3, 4)

Cases Referred : Chronological Paras

AIR 1984 SC 346 : 1984 All LJ 194 (Relied on) 3

ATTACHMENT OF INSURANCE POLICY MONEY

AIR 2002 MADRAS 348

CASE NO.: Civil Revision Petition 3694 of 2000

PETITIONER: Regional Manager,LIC of India, Thanjavur.

RESPONDENT: John Bosco &Anr.

Civil P.C. (5 of 1908), S.60(1), Proviso (kb) -EXECUTION - Execution of decree - Amount payable under policy of life insurance scheme to father of judgment-debtor - Cannot be attached.

Proviso (kb) to S. 60(1) CPC no doubt, exempts all money payable under the policy of insurance under the life of the judgment debtor, but the policy amount under life insurance scheme only confers a right not on the policy holder but on his legal representatives. Therefore, moneys payable under the insurance policy of a judgment debtor are entirely exempted from the attachment and sale, irrespective of the circumstances as to whether the insurance policy matures during the life time of the assured or the moneys become payable after the death of the judgment debtor.

The legislative object behind the above exemption protected under proviso (kb) to S. 60(1) CPC is that the money payable under the policy of insurance of life of a policy holder is intended to give some security to his heirs and legal representatives. Such legislative object, cannot, in any way be diluted, merely because the policy amount sought to be attached is that of the judgment debtor or otherwise; as otherwise, the intention of the Legislature to provide security to the legal representatives of the policy holder would be defeated. Therefore the amount payable under the policy to father of judgment debtor also cannot be attached.

FORFEITURE:

IN THE HIGH COURT OF KARNATAKA AT BANGALORE

CASE NO.: WRIT PETITION 22682/2004

PETITIONER: HUTCHAPPA AND ANOTHER.

RESPONDENT: Union of India & Another.

Hon'ble Judges: H.V.G. Ramesh, J.

Subject: Insurance

Acts/Rules/Orders:
Life Insurance Corporation Act, 1956 - Section 6; Contract Act, 1872 - Section 23; Constitution of India - Articles 14, 21, 38 and 39

Cases Referred:
Reserved Bank of India v. Peerless General Finance and Investment Co. Ltd. AIR 1987 SC 1023

Disposition: Petition allowed

CaseNote:
Insurance — Forfeiture of Policy Amount — Right to life — Articles 14 and 21of the Constitution of India — Petitioners were policy holders with Life Insurance Corporation (LIC) — Due to non-payment of the premium amount, their policy lapsed — LIC deprived Petitioners from the benefits of policy and forfeited their policy amount as per Clause 4 of Insurance Policy — Petitioners were later allowed to renew the policy after paying the premium amount, interest and undergoing medical test again — Petitioners objected to undergo medical test again — Hence, present writ — Held, forfeiture of amount of poor persons by LIC was arbitrary and the forfeiture clause was in violation of Articles 14 and 21 — Although in the beginning the Petitioners had undergone medical test before issuing the policy, further insisting them to undergo medical test once again could not be faulted with — Further such contingency to undergo medical test arise only when there was a lapse i.e., in not paying the premium regularly — Same may be considered as reasonable condition as long as it would not come in the way of the Petitioners' right to continue their policy — Petition partly allowed

Ratio Decidendi:
"Forfeiture of amount of poor persons by the Life Insurance Corporation is arbitrary and the forfeiture clause in the insurance policy is in violation of Articles 14 and 21 of the Constitution of India".

"Contingency to undergo medical test arises only when there was a lapse i.e., in not paying the premium regularly. The same may be considered as reasonable condition as long as it will not come in the way of the Petitioners' right to continue their policy".

Marine Insurance – Contract on F.O.B :
AIR 2010 SUPREME COURT 1704 "Contship Container Lines Ltd. v. D. K. L

Coram : 2 MARKANDEY KATJU AND T. S. THAKUR, JJ.
Civil Appeal No. 3245 of 2005* with C.A. Nos. 6232 of 2004 and 8276 of 2003, D/
3 -2010, Contship Container Lines Ltd. v. D. K. Lall and Ors.

(A) Sale of Goods Act (3 of 1930), S.23(2) - SALE OF GOODS - CONTRA
INSURANCE - Misdelivery of goods - Liability of Seller - Contract on F.O.B. b
Seller placing goods safely on board at his cost - Liability of seller ceases and he
have no insurable interest in goods - Insurance Company absolved of liabili
reimburse loss.
Marine Insurance Act (11 of 1963), S.67.
In the case of FOB contracts the goods are delivered free on board the ship. Onc
seller has placed the goods safely on board at his cost and thereby handed ove
possession of goods to the ship in terms of the Bill of Lading or other document
responsibility of the seller ceases and the delivery of the goods to the buyer is com
The goods are from that stage onwards at the risk of the buyer. (Para 21)
Therefore, where the seller had placed the goods safely on board, he would hav
insurable interest in the goods thereby absolving the Insurance Company of the lia
to reimburse the loss, if any, arising from the mis-delivery of such goods. (Paras 21

(B) Marine Insurance Act (11 of 1963), S.19 - Sale of Goods Act (3 of 1930), S.2
INSURANCE - SALE OF GOODS - Misdelivery of goods - Liability of Insu
Company - Insurance cover obtained by exporter, envisaged goods being despatch
CIF basis whereas goods were, in fact, sent on FOB basis - It was material dep
which breached duty of utmost good faith cast upon exporter towards Insu
Company - Duty to make complete disclosure not thus, observed by exporter - Insu
Company would stand absolved of its liability under contract - Petition for compens
- Liable to be dismissed qua Insurance Company. (Para 27)

(C) Consumer Protection Act (68 of 1986), S.21 - CONSUMER PROTECTI
NATIONAL COMMISSION - CARRIAGE OF GOODS - Jurisdiction of Na
Commission - Compensation - Determination - Misdelivery of goods - Na
Commission instead of going by number of packages entered in Bill of Lading, goi
packages mentioned in packing list - Order of compensation - Liable to be set aside.
Carriage of Goods by Sea Act (26 of 1925), S.4 and Sch., Art.4, R.5.
Bill of Lading was only document on basis of which compensation could be deter
against carrier in terms of provisions of Carriage of Goods by Sea Act, 192
Schedule thereto. Therefore, where the National Commission passed orde
compensation for misdelivery of goods on basis of number of packages mention

packing list, instead of going by number of packages entered in bill of lading the order of compensation was liable to be set aside. Packing list might have mentioned several packages consolidated in one bigger package, delivery whereof was acknowledged in Bill of Lading. Commission ought to have taken number of packages to be only one as mentioned in Bill of Lading. (Paras 29, 30)

(D) Carriage of Goods by Sea Act (26 of 1925), Sch., Art.4, R.5 (as amended by Act 28 of 1993) - CARRIAGE OF GOODS - AMENDMENT - CONSUMER PROTECTION - Compensation - Determination - Misdelivery of goods - Weight of Package meant for delivery was 200 Kgs. - Amount of compensation payable by reference to weight of package would come to 400 Special Drawing Rights - Amount of compensation, actually payable would, however, be 666.67 Special Drawing Rights being higher of two amounts as provided by amended R.5 - Order determining compensation at U.S. $100 per package as provided under unamended R.5 - Liable to be set aside.
Consumer Protection Act (68 of 1986), S.21.
After the amendment to the Schedule in the year 1992 by Act 28 of 1993 the amount of compensation was to be paid in terms of Special Drawing Rights. The shipper would be entitled to the compensation of 666.67 Special Drawing Rights per package or two Special Drawing Rights per kilogram according to the gross weight of the goods lost or damaged whichever is higher. (Para 31)
Thus, where the weight of package meant for delivery was 200 kgs. amount of compensation payable by reference to weight of package would come to 400 Special Drawing Rights. However, amount of compensation, actually payable would, however, be 666.67 Special Drawing Rights being higher of two amounts. (Para 31)
Moreover, the Bill of Lading did not mention either the nature or the value of the goods. That being so, compensation of rupee equivalent of 666.67 Special Drawing Rights was the only amount that could be awarded by the Commission to the shipper. (Para 32)

Cases Referred : Chronological Paras
AIR 2000 SC 1014 : 2000 AIR SCW 680 : 2000 CLC 834 (Ref.) 26
AIR 1997 SC 408 : 1996 AIR SCW 3787 (Ref.) 25
AIR 1961 SC 311 (Ref.) 22
(1806) 2 Bos and PNR 269 (Ref.) 15
(1766) 3 Burr 1905 (Ref.) 23
Kailash Vasdev, Sr. Advocate, N. Ganpathy, Chitranshul Sinha, Sanjeev Sachdeva, Ms. Meenakshi Midha, B.K. Satija, for the appearing parties.
* From judgment and order of National Consumer Disputes Redressal Commission in M.P. No. 214 of 2003, D/-29-10-2003.

Judgement

Fire Insurance – Definition of Terrorism: AIR 2010 JAMMU AND KASHM
"Naqash Royal Arts, M/s. v. United India Insurance Co."

JAMMU & KASHMIR HIGH COURT

Coram : 2 J. P. SINGH AND SUNIL HALI, JJ. (Division Bench)

M/s. Naqash Royal Arts v. United India Insurance Co.

CIMA No. 102 of 2004, D/- 11 -3 -2009.

J. and K. Consumer Protection Act (16 of 1987), S.24 - Insurance Act (4 of 1938), CONSUMER PROTECTION - INSURANCE - PREAMBLE - WORDS PHRASES - DOCTRINES - Insurance claim - Stocks of appellant insured unde Policy robbed by some unidentified intruders - Policy covering risk of damage caus an act of 'terrorism' - Definition of expression 'terrorism' means an act having back an organization - Expression is defined in light of doctrine flowing from latin n 'ejusdem generis' - Expression "any use of violence for purpose of putting public section of public in fear" cannot be read in isolation – Appellant having suffered l his insured goods in robbery cannot be construed to be an act of terrorism - Appella entitled to any damage. (Paras 9, 10, 11, 12)

Refusal of Renewal of Medi-claim Insurance policy - AIR 2010 ANDHRA PRADESH 86 "T. Suresh v. Oriental Insurance Co. Ltd."

ANDHRA PRADESH HIGH COURT

Coram : 1 L. NARASIMHA REDDY, J. (Single Bench)

Dr. T. Suresh v. Oriental Insurance Co. Ltd. and Ors.

W. P. No. 21513 of 2008, D/- 4 -12 -2009.

Insurance Act (4 of 1938), S.64VA - INSURANCE - Renewal of Medi-claim Insurance policy - Refusal - Ground that ailment for which petitioner-insured was undergoing treatment was excluded from coverage - Once policy was taken and it was being renewed from time to time it becomes continuous phenomenon - Any change as to coverage that takes place in between would not apply to policy holder - Also exclusion of any disease from list does not effect rights of petitioner to claim reimbursement - Insured would be entitled for renewal of policy as long as premium of renewal was paid within stipulated time. (Paras 8, 12)

Cases Referred : Chronological Paras

AIR 2009 SC 446 : 2008 AIR SCW 7532 3, 10

P. Vinod Kumar, for Petitioner; N. Mohana Krishna, for Respondents.

Electricity if hazardous substance – PLIA - AIR 2010 ALLAHABAD 117 "Pradesh Power Corporation Ltd. v. Kaleemullah"

ALLAHABAD HIGH COURT
(LUCKNOW BENCH)
Coram : 1 DEVI PRASAD SINGH, J. (Single Bench)
Uttar Pradesh Power Corporation Ltd. and Anr. v. Kaleemullah and Ors.
Writ Petition No. 542 of 2006, D/- 18 -3 -2010.

(A) Public Liability Insurance Act (6 of 1991), S.2(d) - INSURANCE - WORDS PHRASES - "Hazardous substance" - Electricity is hazardous substance covere definition under Act.
Electricity is the flow of free electrons in a particular direction at the particular mo The flow can be any wire or even an atmosphere like lightening or in body or in body. The electron is very small and it has been discovered by the scientist th electron is a pins about an excess and it has got organic field. The electron is t material article and electricity is the flow of all these small material particulars particular direction. The flow consequently is the flow of a matter having ph chemical properties like when passed through water, it separates the hydrogen fro Oxygen atoms (electrolysis). Thus, the electricity is a substance having physico che process and also hazardous. Accordingly it is a hazardous substance covere definition under the Act.
AIR 1998 All 1 : 1998 All LJ 1, Rel. on (Paras 8, 9)

(B) Public Liability Insurance Act (6 of 1991), S.3(1), S.6 - INSURANCE - No liability - Payment of compensation - Filing of application by victim/claiman necessary - Compensation has to be paid by Collector after due investigation even application is moved by victim who suffered injury or is dependent of deceased - B purpose of compensation u/S.6 it shall be necessary for claimant to move appro application before Collector - Quantum of compensation may be higher than w claimant is entitled in view of S.3(1) of Act under no fault liability. (Paras 16

Cases Referred : Chronological Paras
AIR 2009 SC (Supp) 383 : 2008 AIR SCW 4165 21
AIR 2007 SC 1956 : 2007 AIR SCW 3540 17
AIR 2007 SC 1984 : 2007 AIR SCW 3752 17
AIR 2007 SC 2582 : 2007 AIR SCW 4590 23
AIR 2007 SC 2625 : 2007 AIR SCW 4714 17
2004 (1) ACJ 35 (Bom) 23
AIR 2001 SC 485 : 2001 AIR SCW 85 : 2001 All LJ 166 23
AIR 1998 All 1 : 1998 All LJ 1 : 1998 AIHC 665 (Rel. on) 8
AIR 1987 SC 1086 18, 19, 20
AIR 1981 SC 487 18
AIR 1979 SC 1628 18
(1868) 19 L.T. 220 : 37 LJ Ex 161 20
Abdul Rashid, Himanshu Kumar Srivastava, for Petitioners; C.S.C., for Respondents