

NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION

NEW DELHI

REVISION PETITION NO. 1197 OF 2018

(Against the Order dated 22/12/2017 in Appeal No. 147/2016 of the
State Commission Rajasthan)

1. NATIONAL INSURANCE CO. LTD. &
ANR.

THROUGH REGIONAL MANAGER,
RESIDENCY ROAD,

JODHPUR

RAJASTHAN

2. NATIONAL INSURANCE CO. LTD.

NATIONAL LEGAL VETICAL DELHI
REGIONAL OFFICE I, NATIONAL
INSURANCE CO. LTD. 2E/9,
JHANDEWALAN EXTN.

NEW DELHI-110055

.....Petitioner(s)

Versus

1. REENA SHARDA & ANR.

W/O. SHRI SAURABH SHARMA, R/O.
A6/17, BEST RAJDOOT CHAMBERS
BEST COLONY, GHOTKOPAR (E)

MUMBAI

MAHARASHTRA

2. VISABH RAMCHANDER SHARDA

S/O. SHRI RAM CHANDER SHARDA, R/C
283, VYAPARIO KA MASJID,

JODHPUR

RAJASTHAN

.....Respondent(s)

BEFORE

:

HON'BLE DR. INDER JIT SINGH, PRESIDING MEMBER

FOR THE PETITIONER

:

MS. HETU ARORA SETHI,
ADVOCATE

MR. ARJUN BASRA,
ADVOCATE

FOR THE
RESPONDENT :

MS. PADMAPRIYA, ADVOCATE

MR. RISHABH SANCHETI,
ADVOCATE

MS. SHREYA BHATNAGAR,
ADVOCATE

Dated : 02 July 2024

ORDER

1. The present Revision Petition (RP) has been filed by the Petitioner against Respondents as detailed above, under section 21(b) of Consumer Protection Act, 1986, against the order dated 22.12.2017 of the State Consumer Disputes Redressal Commission, Rajasthan (hereinafter referred to as the 'State Commission'), in First Appeal (FA) No. 147/2016 in which order dated 08.07.2016 of District Consumer Disputes Redressal Forum, Jodhpur (hereinafter referred to as District Forum) in Consumer Complaint (CC) No. 512/2015 was challenged, inter alia praying for setting aside the order passed by the State Commission and restoring the order passed by the District Forum.

2. While the Revision Petitioners (hereinafter also referred to as OP/Insurance Company) were Respondents before the State Commission and Opposite Parties before the District Forum and the Respondents (hereinafter also referred to as Complainants) were Appellants before the State Commission in FA/147/2016 and Complainants before the District Forum in Complaint No. 512/2015.

3. Notice was issued to the Respondents on 22.06.2018. Parties filed Written Arguments on 26.06.2020 (Petitioner) and 10.02.2020 and 10.10.2023 (Respondents) respectively.

4. Brief facts of the case, as emerged from the RP, Order of the State Commission, Order of the District Forum and other case records are that

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Respondent No.1 (daughter-in-law of Respondent-2) had purchased a medi-claim insurance Policy for the period dated 09.04.2014 to 08.04.2015 for a sum of Rs.1.00 lakh by paying a premium of Rs.7647/- in which insurance coverage of Rs.2.00 Lakhs was given separately for critical diseases. On 05.06.2014, Respondent-2 complained of sweating and discomfort and was referred to Dr. Pawan Sharda of ADM Hospital, who advised ECG be conducted. Subsequently, Respondent-2 was admitted to the Hospital on 06.06.2014, where angiography was conducted and due to blockage, he was advised angioplasty surgery. On 13.06.2014, Respondent-2 was discharged from the Hospital. Respondent-1 filed claim of Rs.5,650/- and a second claim was placed when the angioplasty failed and a demand was made to bring ROTA machine so that there may be ease in fixing a stent. The Respondent-2 was again admitted in the Hospital on 23.06.2014 and was discharged on 02.07.2014. During this period, angioplasty was again performed and stent was placed. Respondent-1 placed a total claim of Rs.3,26,014/- with the Petitioners. After due consideration of the claim, the Petitioner company passed the claim to an amount of Rs.45,508/-. The remaining claim of the Respondent was denied on the ground of non-coverage in terms of the policy. Insurance Policy was subsequently renewed on 08.04.2015 by the Respondents by paying a premium of Rs.6952/- for further period from 09.04.2015 to 08.04.2016. Hence, the complainant filed complaint before the District Forum.

5. Vide Order dated 08.07.2016, in Complaint No. 512/2015, the District Forum

dismissed the complaint. Aggrieved by the said Order dated 08.07.2016 District Forum, complainants/Respondents herein appealed in State Commission and the State Commission vide order dated 22.12.2017 in

No.147/2016 allowed the appeal and set aside the order passed by the District Forum.

6. Petitioners have challenged the said Order dated 22.12.2017 of the State Commission mainly on following grounds:

- i. The State Commission while passing the impugned order failed to exercise the jurisdiction vested in it by law and in exercise of the same acted illegally and with material irregularity. The medical expenses, which were reimbursable as per the policy coverage, were paid to the Respondents. As angioplasty expenses were not covered under the critical illness section, the same were not paid.
- i. The terms and conditions of an insurance policy are sacrosanct as it governs the rights and obligations of the parties to the contract of insurance. The Hon'ble Apex Court in **Deokar Exports (P) Ltd. v. New India Assurance Co. Ltd.** (2008) 14 SCC 598 has categorically observed that no exception or relaxation can be made on the ground of equity in an insurance policy. In the present case angioplasty and/or other intra-arterial procedures are squarely excluded from coverage.
- i. The Hon'ble Apex Court in **United India Insurance Co. Ltd. v. Manubhai Dharmasinhbhai Gajera & Ors.**, (2008) 10 SCC 404 has categorically held that when an exclusion clause is resorted to in a medi-claim policy, the same must be given effect to. Where the coverage of the Medi-claim Policy by way of Clause 1.1.6 squarely

excludes angioplasty and/or any other intra-arterial procedures, the fact that the Respondent No. 2 underwent such a corrective surgery cannot be excluded from the list of exclusions in the terms and conditions of the policy. Clause 3.7 of the Policy further provides that the amount payable for Open Chest Coronary Artery Bypass Graft (CABG) shall be limited to 20% of the sum insured and thus, the State Commission committed error in allowing the claim of the Respondents.

7. Heard counsels of both sides. Contentions/pleas of the parties, on various issues raised in the RP, Written Arguments, and Oral Arguments advanced during the hearing, are summed up below.

7.1 In addition to the averments made under grounds (para 7) the petitioners contended that Respondent No.1 purchased a Varistha Medi-claim policy for Respondent No.2 from the Petitioner-Insurance Company on 09.04.2014 covering two sections-Hospitalization and critical illness for sum insured of Rs.1,00,000/- and Rs.2,00,000/- respectively. Respondent-2 underwent Angioplasty procedure on 23.06.2014 and was discharged on 02.07.2014. Respondent-1 claimed Rs.3,26,014/-. The Petitioner company cleared claim amounting to Rs.45,508/-. The Petitioner contended that under the Claim-Section 1 Hospitalization, the Petitioner's liability is limited to 90% of the admissible claims. The excess claim of the Respondent was denied on the ground that the same was not covered within the terms and conditions of the policy. The definition of critical ailment in the policy does not cover the procedure of placing stents and the only surgery covered by the terms of the policy is bypass surgery. Section II of

the policy deals with Critical Illness Cover. Angioplasty and/or any other intra-arterial procedures and any key hole; or laser surgery are not covered. Accordingly, the District Forum found merit in this contention and accordingly dismissed the claim of the Respondent. It is further contended that the claims and expenses were duly settled and reimbursed to the Respondent which were covered under the Policy. The State Commission committed an error in reading into and interpreting terms and conditions of the Medi Clai Policy, especially when the terms were clear and no ambiguity existed to warrant such an interpretation in favour of allowing the claim of the Respondent.

7.2 On the other hand, it is contended by the Respondents that the Petitioner is not entitled to take the defence of exclusion stated under insurance policy. The petitioner has not mentioned the reason for rejection of claim. In support of their contention Respondents have relied upon the judgment of Hon'ble Supreme Court in the case of **M/s Galada Power and Telecommunication Ltd. V. United India Insurance Co. Ltd. & Anr. Etc.** (2016) 14 SC 161. The Petitioner Insurance Company has stated that the claim is rejected on the ground that the limit is exhausted and has therefore waived any other defence/exclusion available to them under the Insurance Policy as per the above mentioned judgment and the Petitioner Insurance Company is not entitled to take any other defence. It is further contended by the Respondent that the claim of the Respondent falls under the cover for "Critical Illness Cover". Section II of the Insurance Policy defines Critical Illness Cover as *"The Company shall pay to the insured person, the compensation as set against Insured Person's name in schedule should an Insured person as diagnose during the period of insurance set in the schedule, as suffering from a critical illness,*

symptoms (and/or the treatment) which were not present in such insured person at any time prior to inception of this policy."

In continuance, Coronary Artery Surgery has been defined, where it is stated that angioplasty is excluded from the definition, meaning thereby that 'angioplasty' is excluded from the definition only if Coronary Artery Surgery is performed. This clause is to be read in continuation with the clause pertaining to "Compensation for Coronary Artery Surgery" which mentions that compensation payable for coronary artery surgery will be limited to 20% of the sum insured. A holistic reading of the terms would therefore imply that if a by-pass surgery is done on the insured person, then the liability of the Petitioner insurance company shall be limited to 20% against the total sum insured. Further, there was no exclusion in the entire original policy for angioplasty. However, along with the reply, a forged and false document was filed before the District Forum, on the basis of which the claim was rejected. However, in appeal, the State Commission, rightly looked at the correct policy and arrived at the correct conclusion. It is also contended that the order passed by the State Commission is according to the terms of policy. The State Commission, in its order, has rightly stated that Respondent No. 2 complained of discomfort and problem was found in his heart. On examination, it was found that his arteries were blocked, because of which angioplasty was performed. Stent is placed in heart disease and to avoid by-pass surgery. Heart issues are critical diseases by themselves. With the advancement in medical technology, most of the heart operations are performed by angioplasty, because they are safer and are minimal invasive. Petitioner Insurance Company cannot decide whether a disease is critical or not on the basis of method of treatment. It is also contended that the Petitioner has agreed before this Commission that the policy placed by it before the District Forum below as also before this Commission was indeed not the

correct policy, thus admitting that the State Commission passed the impugned judgement by examining the terms of the correct policy and thus arrived at findings that are correct, justified and legally sound.

8. We have carefully gone through the orders of the State Commission, District Forum, other relevant records and rival contentions of the parties. The main contentions of the Petitioner Insurance Company are that :

(a) Angioplasty and/or other intra-arterial procedures are excluded from the coverage.

(b) Under the policy, amount payable for Open Chest Coronary Artery Bypass Graft (CABG) shall be limited to 20% of the sum insured.

(c) Under the claim Section-1 Hospitalization, the Insurance Company's liability is limited to 90% of the admissible claims, the Insurance Company cleared claim amounting to Rs.45,508/-, the excess claim was denied on the ground that the same was not covered within the terms and conditions of the policy.

(d) Definition of critical ailment in the policy does not cover the procedure of placing stents and the only surgery covered by the policy is bypass surgery.

On the other hand, the main contentions of the Respondents are that:

(a) Petitioner/Insurance Company is not entitled to take the defense of exclusion under the policy as they have not mentioned it as reason for rejection of claim, Insurance Company has rejected the claim on the ground that the limit is exhausted, and has therefore, waived any other defense/exclusion available to them.

(b) The claim of Respondents fall under 'Critical Illness Cover' as defined in Section II.

(c) Policy defines Coronary Artery Surgery, wherein it is stated that angioplasty is excluded from the definition, meaning therefor that 'angioplasty' is excluded from the definition only if Coronary Artery Surgery is performed.

(d) There was no exclusion in the entire original policy for angioplasty, however, along with the reply, a forged and false document was filed by the Insurance Company before the

District Forum on the basis of which claim was rejected. However, in the Appeal, the State Commission rightly looked at the correct policy and arrived at the correct conclusion. Petitioner/Insurance Company has agreed before this Commission that the policy placed by it before the Forum below also before this Commission was indeed not the correct policy.

9. In this case, both sides had produced a document which they claimed to be the policy document of the Respondent and both sides disputed the document produced by the other side. Accordingly, vide order dated 25.07.2023, both sides were directed to submit an authentic copy of the policy document issued to the Respondents in the case. In compliance of this order, Respondents filed the certified copy of the Insurance Policy dated 09.04.2014 bearing No. 246009501410000007 issued in favour of Respondent No.2, along with requisite affidavit on 11.08.2023. However, Petitioner/Insurance Company did not file the requisite policy document and affidavit from their side as per order dated 25.07.2023 and stated on 11.08.2023 that they will go by and rely on the copy supplied by the Respondent and will not be separately filing any copy from their side. On this date, both sides were given the liberty to file revised written submissions, and the same were filed by Respondent, but the Petitioner/Insurance Company stated that they do not want to file any additional documents. Accordingly, the case was finally heard on 07.03.2024 and judgment was reserved.

10. We have carefully perused the policy document, which was placed on record by Petitioner/Insurance Company as part of Revision Petition (Annexure- RP-2) and the one which has been placed on record by Respondent vide Affidavit filed on 11.08.2023, which has now been admitted by Petitioner/Insurance Company as the correct policy

document. Both these documents are totally different, which goes to show that the Petitioner/Insurance Company placed a wrong document before the District Forum and this Commission. Such an action is not expected from a public sector Insurance Company like the Petitioner herein. Hence, we direct the Managing Director of Petitioner/Insurance Company (National Insurance Co. Ltd.) to enquire as to under what circumstances a wrong document was filed before the Consumer Commissions at various levels and how two different versions of document for the same scheme are in circulation and take appropriate action against the officials responsible for the same. Registrar, NCDRC will send a copy of this order to the Managing Director of the National Insurance Company at their Head Office address.

11. In view of the foregoing, the contentions of parties are now examined on merits in the light of policy documents placed on record by the Respondent, which has been accepted to be the correct version by Petitioner/Insurance Company by opting not to file such document from their side in pursuance to orders dated 25.07.2023 and stating that they will go by and rely on the copy supplied by the Respondent and will not separately filing any copy from their side.

12. Respondents have made a claim of Rs.5650/- on 13.06.2014, a second claim of Rs.29,500/- on 15.06.2014 and third one for Rs.2,90,864/- on 02.07.2014, in total the Respondents made a claim of Rs.3,26,014/-. The Insurance Company passed the claim for a total of Rs.45,508/- only. Respondents contend that as per policy, they are entitled to 90% of the amount as 10% is to be borne by the insured. Hence, a claim of Rs.2,80,506/- was filed before the District Forum. The Respondents contend that Petitioners in their reply before the District Forum have stated at one place that an amount of Rs.44,922/- has been

paid, while at another place they stated that an amount of Rs.90,427/- has been paid to the complainant.

13. After a careful consideration of entire facts and circumstances of the case, we are of the considered view that State Commission has passed well-reasoned order and we find no reason to interfere with its findings. We are in agreement with the contentions of Respondents herein, as summarized in the preceding paras, and hold that the claim is covered under the policy. There is no illegality or material irregularity or jurisdictional error in the order of the State Commission, hence the same is upheld. Accordingly, Revision Petition is dismissed with cost of Rs.5,000/- to be paid by Petitioner/Insurance Company to the Respondents herein. Petitioner/Insurance Company shall implement the order of the State Commission within 30 days from the date of this order.

14. The pending IAs in the case, if any, also stand disposed off.

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DR. INDER JIT SINGH

PRESIDING MEMBER

