

**IN THE DELHI STATE CONSUMER DISPUTES REDRESSAL
COMMISSION**

Date of Institution: 24.05.2023

Date of hearing: 02.02.2026

Date of Decision: 24.04.2026

FIRST APPEAL NO.-237/2023

IN THE MATTER OF

**MS. SUNITA KAIN,
W/O LT. SH. BRAHM SINGH KAIN,
R/O 4/1787, GALI NO. 5,
MAHAVIR BLOCK, BHOLONATH NAGAR,
SHAHDARA, DELHI-110032**

(Through: Ms. Saloni Dwary, Advocate)

...APPELLANT

VERSUS

**INDIA FIRST LIFE INSURANCE COMPANY LTD.,
PLOT NO. 24/25/26, FUN CINEMA, N.D.M-1 MALL,
NETAJI SUBHASH PALACE COMPLEX,
PITAMPURA, NEW DELHI-110034**

**ALSO AT:
301, B, WING THE QUBE, INFINITY PARK,
DINDOSHI-FILM CITY ROAD,
MALAD (EAST), MUMBAI: 400097**

(Through: Mr. Aakash Vashishtha, Advocate)

...RESPONDENT

CORAM:**HON'BLE JUSTICE SANGITA DHINGRA SEHGAL (PRESIDENT)****HON'BLE MS. BIMLA KUMARI, MEMBER (FEMALE)**

Present : Ms. Saloni Dwary and Ms. Neetu Bansal, Counsel for the appellant (Enrl. No. D/1880/2019, Mobile: 9582076753, Email: info@aualegal.com)

Mr. Aakash Vashishtha, Counsel for the Respondent appeared through VC

**PER :HON'BLE JUSTICE SANGITA DHINGRA SEHGAL,
PRESIDENT**

JUDGMENT

1. The facts of the case as per the District Commission record are as under:

“The case of the Complainant as revealed from the record is that the husband of the Complainant was purchased a Life Insurance policy from the Opposite Party vide policy no. G0000091 and account no. 21290600023506. Mode of premium was one time and Complainant's husband was paid the premium a sum of Rs. 56,011.46/-. The commencement date of policy was 20.06.2012 and sum assured was Rs. 20,00,000/-. Unfortunately, husband of the Complainant expired and the Complainant gave the intimation to the Opposite Party. The Complainant was complete all formalities regarding the death claim which was necessary by the Opposite Party. The Complainant which she was supposed to settle the claim in advance but in spite of the fact that all required papers were submitted to the Opposite Party on the very first date and Complainant have been reminding to the Opposite Party over the phone and by personal visit to settle the claim but nothing was done. Death claim was not given by the Opposite Party when the Complainant has spent the entire amount from her pocket and was under acute financial constraint and rejecting the claim thereafter on flimsy grounds under the shelter of terms and conditions of the policy which were

never a part of the contract issued to the deponent and were never supplied to the Complainant. The act of the Opposite Party are nothing but fleecing general public under the grab of covering them under the life insurance policies which were created for the benefits of the public at large. The exclusions clauses referred by the Opposite Party are never brought to the knowledge of the general public nor are the beneficiaries made aware of these exclusions which are put in a fine print and are kept only with the insurance companies to defraud the general public of their legitimate claims. Non settlement of the genuine claim amounts to clear deficiency of service on the part of the Opposite Party. Complainant has prayed to direct the Opposite Party to pay Rs. 20,00,000/- i.e. settlement of the claim.

2. The Opposite Party contested the case and filed its written statement. It is the case of the Opposite Party is that Mr. Brahm Singh Kain had approached Opposite Party Company for issuance of insurance policy under the "India First Group Credit Life Plan" to cover the risk of the loan amount of Rs. 20,00,000/- which was taken by the Deceased Life Assured from the Bank of Baroda. The Deceased Life Assured had duly submitted the signed Member Form for the same on 18.06.2012. On based upon the information provided in the Member form, more specifically in relation to the health declaration of the life assured, the Opposite Party accepted the proposal and granted the policy bearing master policy no. G0000091 on 20.06.2012, wherein the risk commencement date was also 20.06.2012. Under the said policy the Opposite Party company had undertook to cover the risk of the unpaid loan amount on behalf of the Deceased Life Assured (DLA), subjected to the condition that the Life Assured had disclosed all the health related information to the Opposite Party Company and the information disclosed is complete and true. It is further submitted that under the said policy the Deceased Life Assured declared and agreed that the answers and statements made on the health declaration are full, complete

and true and will form the basis of the contract. It was further declared by the Deceased Life Assured under the said policy that failure to make any disclosure by the Life Assured would render the insurance contract voidable under section 45 of the Insurance Act, 1938. It is further submitted that in April, 2014 the Opposite Party had received death claim intimation from the Complainant, stating that the life assured had died on 24.02.2014 due to stomach pain. On receipt of the death claim intimation from the Complainant and the death being within 1 year & 8 months from the issuance of the policy, the claim was investigated to verify its authenticity. During the investigation it was found that the deceased life assured had been diagnosed with Diabetes (Type 2) and was on insulin injection. The deceased life assured was also diagnosed with Chronic Kidney Disease and was on continuous cycling peritoneal dialysis since March 2012 i.e. before signing the proposal form. It is pertinent to mention here that the deceased life assured had consulted AIIMS Hospital for the same on 20.03.2012 under registration no. 68767/12. As per the underwriting opinion if DLA had disclosed his past medical illness at the time of issuance of the policy, the Opposite Party would not have issued the policy to the deceased life assured. It is further submitted that at the time of seeking the insurance policies, deceased Life Assured had answered negatively to the questions sought with regard to Past Medical History under clause 2 of the "Member Forms- IndiaFirst Group Credit Life Plan" and deceased Life Assured had not entered into the contract of insurance in good faith which is one of the primary requisites of an insurance contract and had failed to disclose the true and correct information specifically for the Questions 1 to 3 pertaining to past medical history. Had the said true and correct past medical history been disclosed to the Opposite Party the said policy would not have been issued to the deceased Life Assured. Thus, the deceased Life Assured with a mala fide intention withheld this pertinent information

from the Opposite Party thereby debarring the Opposite Party a chance of fair underwriting of the policy. Thereafter, on the basis of the investigation report the Opposite Party repudiated the claim of the Complainant on the genuine ground that the deceased life assured had not disclosed his past medical history to the Opposite Party during or after signing the member form and further provided wrong information in the Member form regarding the health declaration, whereby the deceased life assured was under the mandatory obligation to disclose accurate and correct information regarding his health and past medical history. The Opposite Party duly intimated the same vide letter dated 10.11.2014. Thereafter, the Complainant sent a legal notice dated 04.12.2014, demanding the settle of the claim. The Opposite Party duly replied to the said legal notice on 11.12.2014 and duly informed the reasons/grounds of the repudiation of the claim of the Complainant in detail. It is further submitted that the deceased life assured had concealed/suppressed material facts from the Opposite Party regarding his health and obtained the policy fraudulently and therefore the claim of the Complainant was rightly repudiated by the Opposite Party.

- 3. The Complainant filed rejoinder to the written statement of Opposite Party wherein the Complainant has denied the pleas raised by the Opposite Party and has reiterated the assertion made in the complaint.*
- 4. The Complainant in support of his case filed his affidavit wherein he has supported the assertions made in the complaint.*
- 5. To support its case Opposite Party has filed affidavit of Shri K.R. Viswanarayan Head-Governance & Company Secretary, India First Life Insurance Co. Ltd. He has supported the case of the Opposite Party as mentioned in the written statement.”*

2. The District Commission after taking into consideration the material available on record passed the order dated **13.04.2023**, whereby it held as under:

6. *“We have heard the Counsel for the Complainant and Opposite Party. We have also perused the file and written arguments filed by the Complainant. The case of the complainant is that her husband took a policy from the Opposite Party under the India First Group Credit Life Plan issued to Bank of Baroda which is Master Policy holder. As per certificate of the insurance issued by the Opposite Party loan amount of Rs. 20,00,000/- was assured on the death of the Brahm Singh Kain i.e. husband of the Complainant and Complainant gave intimation to the Opposite Party regarding the death of the husband of the complainant to settle the amount by completing all formalities regarding death claim. Opposite Party repudiated the claim on account of non-disclosure of preexisting disease prior to his proposal for insurance. As per the Complainant the exclusion clauses referred by the Opposite Party are never brought to the knowledge of the general public or nor beneficiaries. Hence, non-settlement of claim amount is clear deficiency of service on the part of Opposite Party.*
7. *It is admitted by the Opposite Party that husband of the Complainant has approached the Opposite Party for issuance of insurance policy under the India First Group Credit Life Plan to cover the risk of the loan amount of Rs. 20,00,000/- which was taken by the Deceased Life Assured from the Bank of Baroda. The deceased life assured had duly submitted the signed Member form for the same. On the bases upon the information provided in the Member form, more specifically in relation to the health declaration of the life assured, the Opposite Party accepted the proposal and granted the policy. Under the said policy the Opposite Party had undertook to cover the risk of the unpaid loan amount on behalf of the deceased life assured, subjected to the condition that the Life assured had disclosed all the health related information to the Opposite Party and the information disclosed is complete and true. It is the case of Opposite Party that under the said policy the Deceased Life Assured declared and agreed that the answers and statements made*

on the health declaration are full, complete and true and will form the basis of the contract. It was further declared by the Deceased Life Assured under the said policy that failure to make any disclosure by the Life Assured would render the insurance contract voidable under the Insurance Act. On receipt death claim intimation from the Complainant, the claim was investigated to verify its authenticity. During the investigation it was found that the deceased life assured had been diagnosed with Diabetes and was on insulin injection. The deceased life assured was also diagnosed with Chronic Kidney Disease and was on continuous cycling peritoneal dialysis before signing the proposal form. If husband of the Complainant had disclosed his past medical history at the time of insurance policy, Opposite Party would not have issued the policy to the husband of the Complainant. The deceased Life Assured had not entered into the contract of insurance in good faith which is one of the primary requisites of an insurance contract and had failed to disclose the true and correct information pertaining to past medical history. Therefore, on the basis of the investigation report, Opposite Party repudiated the claim of the Complainant on the genuine ground that the deceased life assured had not disclosed his past medical history to the Opposite Party during or after signing the Member form and further provided wrong information in the Member form regarding the health declaration.

8. *It was held by the Hon'ble Supreme Court of India in, **Satwant Kaur Sandhu Vs. New India Assurance Company Ltd.(2009), 8 SCC 316:***

“25. The upshot of the entire discussion is that in a contract of insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not to accept the risk is a “material fact”. If the proposer has knowledge of such fact, he is obliged to disclose it particularly while answering questions in the proposal form. Needless to emphasise that any inaccurate answer will entitle the insurer to repudiate his liability because there is clear presumption that any information sought for in the proposal form is material for the purpose of entering into a contract of insurance”.

- 10. In this present case, medical report which have been obtained during the course of the investigation clearly indicate that the deceased was suffering from a serious pre-existing medical condition which was not disclosed to the insurer and Complainant is nowhere denied that her husband was not suffering from pre-existing medical condition prior to obtaining the policy and has failed to produce any evidence in rebuttal.*
- 11. In view of the above facts and case law, the Complainant failed to prove any deficiency of service on part of the Opposite Party, hence, the complaint is dismissed.*
- 12. Order announced on 13.04.23.”*
3. Aggrieved by the aforesaid order of the District Commission, the Appellant has preferred the present Appeal contending that the District Commission failed to appreciate that the investigation report on the basis of which the Respondent Company repudiated the claim is flawed and contradictory in nature. The investigation report relied heavily on hearsay evidence. Secondly, it is submitted that the Respondent-insurance company failed to provide any concrete medical evidence or documentation to substantiate the claim that the deceased had pre-existing medical conditions. Thirdly, it is submitted that the respondent company took 213 days to repudiate the claim, which is a clear violation of the guidelines issued by the Insurance Regulatory and Development Authority (IRDA). Fourthly, it is submitted that the insured person/Appellant was not adequately informed about the terms and conditions of the insurance policy, including any exclusions and was not given the copy of terms and conditions along at the time of issuance of the policy certificate rendering the deceased and the Appellant unaware about the exclusions under the policy. Pressing the aforesaid submissions, the Appellant has prayed that the Impugned Order be set aside.

4. The Respondent has filed the Reply to the Appeal and has stated therein that the Appellant has approached this Commission with mala fide and dishonest intention and has concealed the material facts. It is submitted that the present Appeal is not maintainable as no cause of action whatsoever has arose for the Appellant to sue the Respondent Company for negligence as alleged by the Appellant in his Appeal. It is further submitted that the Appellant did not disclose the facts correctly and truthfully further did not comply with the terms and conditions of the policy and has been unable to demonstrate the accrual of the cause of action. Therefore, in light of the aforesaid the instant Appeal deserves to be dismissed in limine qua the Respondent Company. Secondly, it is submitted that the Appellant has deliberately concealed the material facts from this Commission which clearly smacks of malafide intention on the part of the Appellant. Secondly, it is submitted that insurance is a contract between the Insurer and Insured and both parties are bound by the terms of the policy which is in the nature of a contract and its interpretation has to be made in accordance with the strict construction of the contract. Thus, the words in an insurance contract must be given paramount importance and interpreted as expressed without any addition, deletion or substitution. Lastly, it is submitted that the Appeal has been filed merely to harass and gain undue advantage and unjustified monies from the Respondent Company and hence the Appeal deserves to be set aside at the outset. It is submitted that the Appeal has been filed with ulterior motives and mala fide intention to cause harassment and prejudice to the Respondent which is a Company of long standing and high reputation.
5. Parties the brief written arguments and the same have been given due consideration.
6. We have perused the material available on record.

7. The *short question* that falls for our consideration is *whether the Respondent wrongly repudiated the claim and whether such conduct amounts to deficiency in service.*
8. On the concept, meaning and import of word disease, pre-existing disease in reference to medical insurance this commission has drawn following ten conclusions in a highly extensive, dissecting manner in their decision *Pradeep Kumar Garg v. National Insurance Co. Ltd., FA-482/2005 decided on 01.08.2008.* These are as:

- “a. Disease means a serious derangement of health or chronic deep-seated disease frequently one that is ultimately an insured must have been hospitalized or operated upon in the near proximity of obtaining the mediclaim.*
- b. Such a disease should not only be existing at the time of taking the policy but also should have existed in the insured had been hospitalized or operated upon for the said disease in the near past, say, six months or to disclose the said fact to rule out the failure of his claim on the ground of concealment of information as to.*
- c. Malaise of hypertension, diabetes, occasional pain, cold, headache, arthritis and the like in the body are normal modern day life which is full of tension at the place of work, in or out of the house and are controllable on standard medication and cannot be used as concealment of pre-existing disease for repudiation of the insurance insured in the near proximity of taking of the policy is hospitalized or operated upon for the treatment of these other disease.*
- d. If insured had been even otherwise living normal and healthy life and attending to his duties and daily chores person and is not declared as a diseased person as referred above he cannot be held guilty for concealment medical terminology of which is even not known to an educated person unless he is hospitalized and operated particular disease in the near proximity of date of insurance policy say few days or months.*

- e. *Disease that can be easily detected by subjecting the insured to basic tests like blood tests, ECG etc. the insured to disclose such disease because of otherwise leading a normal and healthy life and cannot be branded as diseased.*
- f. *Insurance company cannot take advantage of its act of omission and commission as it is under obligation to issuing mediclaim policy whether a person is fit to be insured or not. It appears that insurance companies obligation as half of the population is suffering from such malaises and they would be left with no or very little.*

Thus, any attempt on the part of the insurer to repudiate the claim for such non-disclosure is not permissible, exclusion clause invokable.

- a. *Claim of any insured should not be cannot be repudiated by taking a clue or remote reference to any so-called discharge summary of the insured had concealed his hospitalisation or operation for the said disease undertaken reasonable near proximity as referred above.*
- b. *Day to day history or history of several years of some or the other physical problem one may face occasionally landed for hospitalisation or operation for the disease cannot be used for repudiating the claim. For instance suffered from a particular disease for which he was hospitalised or operated upon 5, 10 to 20 years ago and living healthy and normal life cannot be accused of concealment of pre-existing disease while taking mediclaim being cured of the disease, he does not suffer from any disease much less the pre-existing disease while taking as after being cured of the disease, he does not suffer from any disease much less the pre-existing disease.*
- c. *For instance to pay that insured has concealed the fact that he was having pain in the chest off and on for years diagnosed or operated upon for heart disease but suddenly lands up in the hospital for the said purpose and disentitled for claim bares dubious design of the insurer to defeat the rightful claim of the insured on flimsy are not rare where people suffer a massive attack without having even been hospitalised or operated upon years or so.*

d. Non-instance of hospitalisation/or operation for disease that too in the reasonable proximity of the date of the only ground on which insured claim can be repudiated and on no other ground.”

9. From the above dicta it is clear that unless and until a person is hospitalised or undergoes operation of a particular disease in the near proximity of obtaining insurance policy or any disease for which he has never undergone operation is not a pre-existing disease.
10. The issue of pre-existing disease has been dealt with by the Hon'ble NCDRC in the matter of ***Tarlok Chand India Insurance Co. Ltd. RP-686/2007 decided on 16.08.2001*** holding as under:

“Infact, the onus to prove that she had a pre-existing disease was on the respondent who failed to file or credible evidence in support of its case. Further, the deceased had been taking he mediclaim insurance the respondent right from 1996 and she had also as per the practice, been examined by the doctor respondent/insurance company who has nowhere recorded that she had any medical problem relating.”

11. The Hon'ble NCDRC is yet another judgment in ***National Insurance co. Ltd. vs. Rai Narain-2008 NCT 559 NCDRC*** held as under:

“Most of the people are totally unaware of the symptoms of the disease that they suffer and hence they liable to suffer because the Insurance Company relies on their clause 4.1 of the policy in a mala-fide repudiate all the claims. No claim is payable under the medi-claim policy as every human being is diseases are perhaps pre-existing in the system totally unknown to him which he is genuinely unaware Hindsight everyone relies much later that he should have known from some symptom. If this is so every

person should do medical studies and further not take any insurance policy”.

12. The Hon'ble NCDRC in the matter of ***Praveen Damani v. Oriental Insurance Company Ltd. as reported 189 (NC)*** has held as under:

"...If this interpretation is upheld, the Insurance Company is not liable to pay any claim, whatsoever, person suffers from symptoms of any disease without the knowledge of the same. This policy is not just a contract entered only for the purpose of accepting the premium without the bona fide intention benefit to the insured under the garb of pre-existing disease. Most of the people are totally unaware the disease that they suffer and hence they cannot be made liable to suffer because the Insurance Company their clause 4.1 of the policy in a mala fide manner to repudiate all the claims. No claim is payable policy as every human being is born to die and diseases are perhaps pre- existing in the system totally which he is genuinely unaware of them. Hindsight everyone relies much alter than he would have known symptom. If this is so every person should do medical studies and further not take any insurance policy facts on record, there is no material to show that the petitioner had any symptoms like chest pain etc. 11.08.2000."

13. The fact that the onus to prove that insured was suffering from pre-existing disease is on the Insurance Company the orders of the Hon'ble NCDRC in the matter of ***LIC of India v. Priya Sharma and Ors.*** as reported in (NC). Secondly, if the policy was issued by the insurance company without proper verification, they cannot the claim at the later stage, as per the view held by the Hon'ble NCDRC in the *Revision*

Petition no. 1676 of 2015, Oriental Insurance Co Ltd. v Dipender Kaur decided on 07.10.2015.

14. We further deem it appropriate to refer to *Revision Petition No. 3557 of 2013* titled as “*Sunil Kumar Sharma vs. TATA AIG Life Insurance Company and Ors*” decided on *01.03.2021*, wherein the Hon’ble National Commission has dealt the issue of pre existing disease and held as follows:

“14. Moreover the claim had been repudiated only on the ground that the insured was suffering from diabetes for a long time. So far as life style diseases like diabetes and high blood pressure are concerned, Hon'ble High Court of Delhi in Hari Om Agarwal Vs. Oriental Insurance Co. Ltd., W.P.(C) No. 656 of 2007, decided on 17.09.2007 held as under:

*"Insurance-Mediclaim-Reimbursement-Present
Petition filed for appropriate directions to respondent to reimburse expenses incurred by him for his medical treatment, in accordance with policy of insurance-Held, there is no dispute that diabetes was a condition at time of submission of proposal, so was hyper tension-Petitioner was advised to undergo ECG, which he did-Insurer accepted proposal and issued cover note-It is universally known that hypertension and diabetes can lead to a host of ailments, such as stroke, cardiac disease, renal failure, liver complications depending upon varied factors-That implies that there is probability of such ailments, equally they can arise in non- diabetics or those without hypertension-It would be apparent that giving a textual effect to Clause 4.1 of policy would in most such cases render mediclaim cover meaningless-Policy would be reduced to a contract with no content, in event of happening of contingency-Therefore Clause 4.1 of policy cannot be allowed to override insurer's primary liability-Main purpose rule would have to be pressed into service-Insurer renewed policy after petitioner underwent CABG procedure-Therefore refusal by insurer to process and reimburse petitioner's claim is arbitrary and unreasonable-As a state agency, it has to set standards of model behaviour; its attitude here has displayed a contrary*

tendency-Therefore direction issued to respondent to process petitioner's claim, and ensure that he is reimbursed for procedure undergone by him according to claim lodged with it, within six weeks and petition allowed."

15. *In RP No. 4461 of 2012, Neelam Chopra Vs. Life Insurance Corporation of India & Ors., decided on 08.10.2018, (NC), it was held that:*

"11. From the above, it is clear that the insurance claim cannot be denied on the ground of these life style diseases that are so common. However, it does not give any right to the person insured to suppress information in respect of such diseases. The person insured may suffer consequences in terms of the reduced claims.

14. Moreover, the non-disclosure of information in respect of this life style disease of diabetes, will not totally disentitle the complainant for indemnification of the claim in the light of the judgment of Hon'ble High Court of Delhi in Hari Om Agarwal Vs. Oriental Insurance Co. Ltd., (supra)."

16. Based on the above discussion, I am of the opinion that the Insurance Company had not been able to prove beyond doubt that the Complainant was suffering from diabetes before filing of the proposal form. It is also to be noted that the Insurance Company had given Insurance to a person of 66 years of age without any preliminary medical examination which could have definitely revealed whether the proposer was suffering from diabetes or not. It is commonly known that a person of 66 years of age has a high probability of suffering from common lifestyle diseases like diabetes and hypertension. If the company is ready to take the risk at this age of the proposer, without any preliminary medical examination, then the company should be ready to honour the claim also because the chances of death of such persons are more during the currency of the Policy."

15. From the aforesaid settled law, it is clear that the common lifestyle disease like diabetes and hypertension, cannot be treated as pre- existing diseases, therefore, cannot be a ground of repudiation of the claim by Insurance companies. Adverting to the facts of the instant case, the

Respondents have repudiated the claim of the Appellant on the basis of the common lifestyle disease i.e. *Diabetes mellitus*.

16. Further, it is a well-settled principle that before issuing an insurance policy, the insurance company should conduct medical tests to determine whether the person has any pre-existing diseases. However, in the present case, the Respondents failed to show any evidence that any medical tests or examination were conducted before issuing the policy in question. Moreover, it is evident that the Deceased Life Assured was nearly 50 years old when he applied for the policy, and it is commonly known that at such an age, one could have common lifestyle diseases. Yet, the Respondents issued the policy without any medical examination. Therefore, in our thoughtful opinion, the Respondent cannot be allowed to take benefit of its own wrong at this belated stage and cannot repudiate the Appellant's claim on the grounds that she had a pre-existing illness at the time of obtaining the policy.
17. *Another plea has been raised by the Appellant that the terms and conditions of the policy were never supplied by the Respondent.*
18. A perusal of the record reflects that the Respondent has not placed on record any documentary proof to show that the Appellant was supplied the terms and conditions of the policy. Therefore, it is clear that the Appellant was not apprised or explained the terms and conditions of the policy. In this regard, the Hon'ble Supreme Court in *Bharat Watch Company Vs. National Insurance Company (Civil Appeal No. 3912 of 2019 arising out of S.L.P (C) No. 25468 of 2016)*, the Hon'ble Supreme Court has made it crystal clear that in the event that the terms of exclusion of a policy are not communicated to the insured, the insurer cannot rely upon the same in order to reject the claim.
19. Furthermore, a bare perusal of the investigation report makes it clear that the report suffers from inherent contradictions and major flaws. It is

surprising to note that the Respondent has arrived at bizarre findings, on the basis of hearsay evidence, the said conundrum is discussed hereinbelow: *“During Investigation, people verbally confirmed that LA was Suffering from Kidney problem from last two years and was taking his treatment in AIIMS and he was expired due to this illness.*

b) *That the Investigator enquired three doctors who confirmed that they never treated the LA (deceased insured).*

c) *That the Investigator further enquired three different chemist shops who confirmed they never dispensed any medicine to the LA (deceased insured).*

20. It is further abysmally surprising to note here that the Respondent has taken self-contradictory stance in the investigation report. On one hand, the report reflects *"As per the investigation, LA was suffering from Kidney problem and was expired due to his illness."* Albeit, in the next paragraph, the observation reflects *"No medical history was found on the name of the LA and he was not habitual of smoking and drinking."*
21. A perusal of the aforesaid observations makes it clear that the Respondent has miserably failed to place on record any solid documentary proof to show that the life assured was suffering from kidney disease or to even name as to what disease the life assured was suffering from, yet on the basis of hearsay evidence, arrived at a made-up and imaginary conclusion.
22. Furthermore, the Hon'ble National Commission in a landmark case titled ***Neelam Chopra Vs Life Insurance Corporation*** has held hereunder as:

“13. From the above observations of the Hon'ble Supreme Court, it is clear that suppression of any information relating to pre-existing disease if it has not resulted in death or has no direct relationship to cause of death, would not completely disentitle the claimant for the claim.”

23. A perusal of the aforesaid decision of the Hon'ble National Commission makes it clear that for the repudiation of the claim, the pre-existing disease must have a direct nexus to the cause of death, which is not the factum in the present case. The Respondent has vehemently submitted that the Deceased Life Assured had concealed material information as regards to the existence of diabetes and kidney disease and expired on account of the said ailments. However, we opine that the Respondent has merely made bald averments devoid of any cogent proof to substantiate the said contention. There is not even a slightest whisper in the entire record about diabetes or kidney disease being a causative/ complimentary factor to cause the death of the Appellant. The Respondent has failed to file the Past History or the Death Summary of the patient. In our considered view, had the life assured expired owing to the said ailments, the said factum would have been clearly recorded in Death Summary/Past history or other treatment record. In the absence of any such finding, we are not inclined to accept the contention of the Respondent that the pre-existing disease was the direct cause of death of the Life Assured. So be it, there is no avenue left for the Respondent to deny the Appellant's claim solely based on a common lifestyle disease.
24. Even otherwise, it is worthwhile to mention here that the Respondent company took 213 days to repudiate the claim, which is a clear violation of the guidelines issued by the Insurance Regulatory and Development Authority (IRDA). According to IRDA guidelines, claims should be settled within 30 days of receiving the final survey report, and in any case not later than 90 days and this delay indicates a clear deficiency in service on the part of the Respondent-insurer.
25. In view of aforesaid discussion and the legal position as settled, we opine that the Respondent wrongly rejected the claim in the guise of non-disclosure of pre-existing disease.

26. Consequently, the present appeal stands allowed and the Respondent is directed to pay a sum of Rs. 20,00,000/- i.e. the Sum Assured under the policy to the Appellant along with interest @ 6% p.a. calculated from 10.11.2014 (being the date on which the said claim of the Appellant was repudiated) till 24.04.2026 (being the date of the present judgment).
27. In addition to the aforesaid and taking into consideration the facts of the present case, the Respondents are directed to:
- A. Rs. 1,00,000/- as cost for mental agony and harassment to the Appellant/Complainant; and*
- B. The litigation cost to the extent of Rs. 50,000/-.*
28. The directions mentioned in para 27 above shall be complied by the Respondent within two months from the date of present judgment. In case of failure to comply with the same within two months, the entire amount would entail a penalty of 9% p.a. till the actual realization of amount.
29. Applications pending, if any, stand disposed of in terms of the aforesaid judgment.
30. The judgment be uploaded forthwith on the website of the Commission for the perusal of the parties.
31. File be consigned to record room along with a copy of this Judgment.

(JUSTICE SANGITA DHINGRA SEHGAL)
PRESIDENT

(BIMLA KUMARI)
MEMBER (FEMALE)

Pronounced On:
24.04.2026

L.R.-G.P.K