

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

Date of Institution: 05.04.2024

Date of Hearing: 16.12.2025

Date of Decision: 30.04.2026

FIRST APPEAL NO.- 240/2024

IN THE MATTER OF

BAJAJ ALLIANZ GENERAL INSURANCE CO. LTD

12th FLOOR, GOPALDAS BHAWAN

28 BARAKHAMBA ROAD, CONNAUGHT PLACE

NEW DELHI-110001

(Through: Mr. Amit Kumar Maihan, Advocate)

...Appellant

VERSUS

MR. ASHOK

WZ-17A, BALMIKI VIHAR,

PALAM VILLAGE, SOUTH WEST

DELHI-110045

(Through: Mr. Shripal, Advocate)

...Respondent

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

Present: Ms. Binny Sethi, Counsel for the Appellant

Mr. Shripal, Counsel for the respondent.

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

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

"2. Briefly stated the facts of the case are that complainant had taken a on line health insurance policy bearing no. OG-22-1101-8441-00001818 from opposite party. The said policy was valid from 30/12/2021 to 29/12/2022 for the sum insured of Rs.3,00,000/- (Three Lacs Only).

3. That the complainant got admitted in the Prasad Health Care Multispeciality Hospital & Fertility Centre for treatment on 08/11/2022 and remained hospitalized till 12/11/2022. The said hospital generated the final bills Rs.36,847/- (Rupees Thirty Six Thousand Eight Hundred Forty Seven) which was paid by complainant.

4. Complainant claimed the aforesaid bill amount from OP, but the same was rejected with reason stated as under:-

"Verification of claim documents reveal aforesaid claimant was hospitalized for investigation and treatment of Acute Viral Hepatitis (Jaundice) with Enteric Fever and is claiming for expenses incurred of INR.36,847/- (Rupees Thirty Six Thousand Eight Hundred Forty Seven) we have faced non-cooperation from insured for verification of claim. Hence, we regret to inform that your claim stands repudiated in view of misrepresentation of facts.2.Condition Precedent to Admission of Liability. The terms and condition of the policy

must be fulfilled by the Insured Person for the Company to make any payment for claim (s) arising under the policy”

5. It is alleged that the complaint has been filled within the period of limitation. The cause of action arose when the claim of the complainant was rejected by OP on dated 17/05/2023.

6. It is prayed that OP be directed to pay a sum of Rs.36,847/- (Rupees Thirty Six Thousand Eight Hundred Forty Seven) to the complainant on account of medical expenses with pendentlite interest @18% per annum from 17/05/2023 till the actual realization. Opposite party be also directed pay a sum of Rs.2,00,000/- (Rupees Two Lakh) as damages/compensation for the loss, pain and injury suffered by the complainant on account of mental agony, harassment and inconvenience suffered by the complainant due to deficiency in service and litigation to expenses of Rs.1,00,000/- (Rupees One Lakh).

7. Notice of the complaint was issued to OP, OP was duly served on 03.06.2023. However as written statement was not filed within the statutory period, the defence of OP was struck off vide order dated 07.08.2023.

8. Complainant filed his evidence by affidavit reiterating therein the averments made in the complaint. Complainant relied upon policy, the treatment record, the bills issued by Prasad Health Care Multispecialty Hospital and Fertility Centre, The repudiation letter.

9. We have heard the AR of complainant and counsel for OP and perused the record”

2. The District Commission after taking into consideration the material available on record passed the order dated **05.01.2024**, whereby it held as under:

“10. In view of the un rebutted testimony of complainant and the documents relied upon by complainant, we are of the view that complainant has succeeded in proving that OP was guilty of deficiency of services in repudiating the claim of complainant. It is to be noted complainant was hospitalized during the tenure of the coverage of policy in the Panel hospital of OP. We accordingly hold OP/Bajaj Allianz General Insurance Company Limited guilty of deficiency of services and direct OP to pay Rs.36,847/- (Rupees Thirty Six Thousand Eight Hundred Forty Seven) to the complainant with interest @ 9% per annum from date of filing of claim within four weeks of date of receipt of order, failing which OP will be liable to pay interest @ 12% per annum till realization. We also direct OP to pay compensation of Rs.25,000/ (Rupees Twenty Five Thousand only) for mental agony and harassment.

A copy of this order be sent to all the parties free of cost. The order be uploaded on the website of this Commission.

File be consigned to record room along with a copy of the order.”

2. Aggrieved by the aforesaid order of the District Commission, the Appellant has preferred the present Appeal contending that the District Commission failed to appreciate the terms and conditions of the policy and allowed the complaint against the terms and conditions. **Secondly**, it is submitted that the District Commission failed to appreciate that the Investigator had made an observation to the effect that the hospital is a nexus hospital and the concerned staff misbehaved with the Investigator. It is further submitted that the District Commission failed to appreciate the report of the Investigator wherein it was noted that the patient statement could not be done since the investigator's phone was retained by the nexus persons. Furthermore, the District Commission failed to appreciate that the entire ICP was written in a stereotyped handwriting and as such the claim was rightly repudiated by the Appellant as per the terms and conditions of the policy. **Fourthly**, it is submitted that the order passed by the District Commission is a non-speaking order in so much that it does not discuss the

evidence placed on record by the Appellant, which is violation of Section 38 of the Consumer Protection Act and no complaint can be decided in isolation, merely on the plain allegations of one party. Furthermore, it is submitted that the District Commission failed to adjudicate the matters collectively and overlooked the repeated claims and nexus between the hospitals, the Respondent and the AR. Pressing the aforesaid submissions, the Appellant has prayed that the Impugned Order be set aside.

3. The Respondent has filed the Reply to the Appeal and has stated therein that the claim was rightly decided by the District Commission. Secondly, it is submitted that the present appeal is absolutely frivolous and concocted and is filed with the sole motive to waste the precious judicial time of this Commission. Lastly, it is submitted that the District Commission duly considered the material available on record and passed the Impugned Order in all fairness, thus the Impugned Order warrants no interference. Pressing the aforesaid submissions, the Respondent has submitted that the present appeal be dismissed with heavy costs.
4. Parties have filed their brief Written Arguments and the same have been given due consideration.
5. We have perused the material available on record.
6. The *only question* that falls for our consideration is *whether the District Commission erred in holding the Appellant liable for deficiency in service.*
7. The facts of the case reflect that the Respondent had taken an online health insurance policy bearing no. OG-22-1101-8441-00001818 dated 30.12.2021 from the Appellant which was valid from 30.12.2021 to 29.12.2022 for the sum insured of Rs.3,00,000/-. The Respondent got admitted to Prasad Healthcare Centre for treatment of Acute Viral Hepatitis (Jaundice) with Enteric Fever on 08.11.2022 and remained hospitalized till 12.11.2022. The said hospital generated the final bills of Rs.36,847/- which was paid by the Respondent. The Respondent claimed the aforesaid bill

amount from the Appellant but the same was rejected by the Appellant vide repudiation letter dated 17.05.2023 with the reasons stated as under:-

“Verification of claim documents reveal aforesaid claimant was hospitalized for investigation and treatment of Acute Viral Hepatitis (Jaundice) with Enteric Fever and is claiming for expenses incurred of INR.36,847/- (Rupees Thirty Six Thousand Eight Hundred Forty Seven) we have faced non-cooperation from insured for verification of claim. Hence, we regret to inform that your claim stands repudiated in view of misrepresentation of facts.2.Condition Precedent to Admission of Liability. The terms and condition of the policy must be fulfilled by the Insured Person for the Company to make any payment for claim (s) arising under the policy.”

8. On the other hand, it is the primary contention of the Appellant that multiple discrepancies were found in the hospital records and the Appellant faced non-cooperation for verification of claim from the Respondent-patient, which is in contravention of Condition-8 (Condition Precedent) of the standard terms and conditions of the Policy, thus the claim was rightly repudiated by the Appellant.
9. In order to resolve the aforesaid controversy, we deem it appropriate to refer Condition-8 of the standard terms and conditions of the Policy, reproduced hereunder as:

“Condition precedent to Admission of liability: The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payments for claims arising under the policy”

- 10.A perusal of the aforesaid clause makes it clear that the Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional. The Insurer shall not be liable to make any payments against the claim arising under the policy if the Insured fails to fulfil the terms and conditions of the policy availed.

11. Here, we further deem it appropriate to refer to the report of the Investigator-M/S Clear Vision (*annexed at pg-134 alongwith the Appeal*), reproduced hereunder as:

“Patient Ashok 38y/m admitted in Prasad Health Care on date 08/11/22 and discharged on date 12/11/22 with the diagnosis of viral hepatitis and enteric fever.

Hospital Verification:

Investigator visited to the hospital and collected verified ICP, and duplicate final bills, Receipts, IPD register Registration certificate of the treating doctor attached.

Indoor and outdoor hospital pic collected.

Treating doctor statement attached.

Tariff list attached

Insured Verification:

Pending

Finding:

Nexus hospital and misbehaved with FO, No AVR available because FO phone submitted by nexus person. so patient statement not done.

Stereotype ICP.

Conclusion:

Kindly reject the claim under non cooperation of the insured.

Ask the insured to visit your office for statement and verification.”

12. A perusal of the aforesaid investigation report makes it clear that when the Investigator visited the Hospital for verification, it was found that the hospital is a nexus hospital and the concerned staff misbehaved with the investigator, and the patient statement could not be done since the investigator's phone was retained by the nexus persons. Furthermore, the investigator noted that the entire ICP was written in a stereotyped handwriting. Thus, it is clear beyond doubt that both the Respondent and

the hospital acted in contravention to Condition Precedent clause and did not cooperate with the Investigator for the verification of the claim. However, it is surprising to note here that the District Commission failed to take note of the aforesaid findings of the Investigator, which in our view, is contrary to the established position of law that Survey Report must be given consideration.

13. At this juncture, it is pertinent to remark that the Hon'ble Supreme Court and the Hon'ble National Commission have time and again held that it is an established position of law that the surveyor report is an important piece of evidence. The Hon'ble National Commission in *First Appeal No. 1275 of 2014* titled *M/S. Bhupinder Tyres Works vs New India Assurance Company Ltd.* has held that it is a well-established legal position that survey reports should be given due consideration unless they exhibit non-consideration of material evidence or misrepresentation of facts, relevant extract reproduced hereunder as:

“It is an established legal position that survey reports need due consideration, unless the report reveals non-consideration of material evidence or misrepresentation of facts, which is not the case.”

14. Here, we deem it appropriate to refer to the case of *National Insurance Co. Ltd. vs. Noli Ram and Sons, 2017 (4) CPR 388 (NC)*, the Hon'ble National Commission has held that surveyor report cannot be disbelieved and cannot be rejected without any forceful evidence on the part of the complainant.
15. Similarly, in the case of *Ashish Kumar Jaiswal vs. ICICI Lombard General Insurance Company Ltd. and Ors., 2017 (3) CPR 71 (NC)*, the Hon'ble National Commission has held that the surveyor's report is only reliable document which is to be considered for settling the insurance claim, the petitioner has failed to put forward any cogent reasons to dispute surveyor's report and there is no reason to reject it.

16. Furthermore, in the case of *Pradeep Sharma vs. Bajaj Allianz General Insurance Co. and Anr., 2017 (1) CPR 259 (NC)*, the Hon'ble National Commission has held that the assessment made by surveyor must be given due weightage. Similarly, in the case of *Devender Malhotra vs. United India Insurance Co. Ltd. & Anr., 2016 (3) CPR 461 (NC)*, the Hon'ble National Commission has held that the report made by the surveyor cannot be disbelieved unless there are cogent and convincing reasons to do so; report of the surveyor has to be given effect to unless there are contrary reasons to disregard the same.
17. The principle as laid down in the above-mentioned cases are fully applicable to the case in hand. As per the settled law discussed above, the surveyor report is an important piece of document and it cannot be brushed aside unless and until there is some cogent and believable evidence against it. Here, it is pertinent to note that the Respondent has merely submitted that the entire Appeal is an abuse of the process of law and is filed on false and frivolous grounds. However, the Respondent has not submitted any cogent and reliable evidence that on what basis, the surveyor report was not properly assessed. Thus, we are of the definite opinion that the assessment made by the surveyor is genuine and the survey report cannot be brushed aside unless and until there is some cogent and believable evidence against it.
18. In fact, the entire Reply of the Respondent is merely a repetition of the same set of words, bereft of any material particulars or cogent explanation/evidence placed on record to rebut the contentions raised by the Appellant.
19. In light of the above discussion, it is clear that the District Commission ought to have appreciated that Investigator had categorically remarked that the claim of the Respondent be repudiated on the ground of non-cooperation and discrepancies found in the hospital record. Accordingly, we opine that the claim was repudiated by the Appellant as per the terms and conditions of the policy, after getting the necessary Investigation done and no deficiency of service can be carved out on the part of the Appellant.

20. *Consequently, the present Appeal is allowed and the order dated 05.01.2024 passed by the District Consumer Disputes Redressal Commission-VI, M-Block, Vikas Bhawan, I.P.Estate, New Delhi-110002 is set aside.*
21. Application(s) pending, if any, stand disposed of in terms of the aforesaid judgment
22. FDR, if any, be released in favour of the Appellant.
23. The judgment be uploaded forthwith on the website of the commission for the perusal of the parties.
24. File be consigned to record room along with a copy of this Judgment.

**(JUSTICE SANGITA DHINGRA SEHGAL)
PRESIDENT**

**(BIMLA KUMARI)
MEMBER (FEMALE)**

**Pronounced On:
30.04.2026**

L.R.-G.P.K

