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REPORTABLE

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 6778 OF 2013

JACOB PUNNEN & ANR. ...APPELLANT(S)

VERSUS

UNITED INDIA INSURANCE CO. LTD. ...RESPONDENT(S)

J U D G M E N T

S. RAVINDRA BHAT, J.

1. The appellants challenge the order of the National Consumer Disputes Redressal Commission ("the NCDRC")[1] which upheld the concurrent rejection of their application seeking relief.

2. The undisputed facts are that the appellants contracted with the respondent (hereinafter referred to as "the insurer"), and secured a medical insurance policy (hereinafter referred to as "Mediclaim"), for the first time in 1982. The policy was annual and was renewed successively, each year by the appellants by paying the appropriate premium - the last renewal policy forming the subject matter of the present appeal. The policy renewed by the appellants on 28.03.2007 was in force for a year i.e., till 27.03.2008. Before the date of expiry of the Mediclaim (on 27.03.2008), the insurer sent a reminder to the

1 Order dated 11.07.2012 in Revision Petition No.2743 of 2011.

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appellants to renew their policy, if they so wished, annually. The reminder also intimated the appellants that the premium was ₹17,705/- and had to be paid by 27.03.2008. The appellants paid the requisite amount by cheque (issued on 26.03.2008) and in this regard the receipt was received from the insurer on 30.03.2008. This receipt indicated that the insurance policy period would be operative from 28.03.2008 to 27.03.2009. The monetary coverage of the policy was ₹ 8,00,000/- (₹ 4,25,000/- for the first appellant and ₹ 3,75,000/- for the second appellant). The second appellant had to undergo angioplasty in June (09.06.2008 to 12.06.2008) at Chennai. The appellants submitted a claim for ₹ 3,82,705.27/- to the insurer, as amounts due under the contract of insurance policy, towards the expenses incurred by them. The insurer, however, accepted the claim and paid the partial amount by releasing ₹ 2,00,000/- to them.

3. Feeling aggrieved, the appellants represented to the insurer, repeatedly and unavailingly to the insurer to make good the balance amount. Exhausted, the appellants filed a complaint before the District Consumer Disputes Redressal Forum (hereafter "the District Forum"), Kottayam for a direction that the insurer ought to pay them ₹ 2,07,705/- along with costs and interests on the compensation.

4. The insurer's position before the District Forum was that the terms and conditions of Mediclaim policy changed periodically. The policy for the relevant year indicated that in respect of procedures (such as angioplasty), 70% of the policy limit could be claimed subject to an overall limit of ₹ 2,00,000/- for any

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one surgery or procedure. The insurer also argued that having been issued with the policy document which was accepted by the appellants, the latter could not then complain that they were any amounts over and above the terms agreed upon.

5. The District Forum allowed the appellants' complaint holding firstly that an insurance contract evidences a commercial transaction, and is to be construed like any other agreement, on its own terms subject to fulfillment of the conditions of *uberrima fides* i.e., utmost good faith by the parties and secondly that the insurer was under a duty to intimate to be insured with respect to change in terms before the renewal of the policy. On the basis of these findings, the District Forum directed the insurer to pay the appellants,₹ 1,75,000/- as the balance amount and also awarded ₹ 5,000/- as compensation. Aggrieved, the insurer approached the State Consumer Redressal Commission which by its order upset the findings of the Consumer Forum, holding that the terms of the policy were known to the appellants who were bound by it. In these circumstances, the appellants approached the NCDRC with a revision petition. The NCDRC upheld the insurer's contention that the insurance policy renewed by the appellants on 28.03.2008 was a fresh contract entered into between the parties which reflected changes compared with the previous terms. These conditions – the NCDRC held – were known to the appellants or were presumed to be known since they had claimed under that policy and that it was not open to

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them to claim ignorance of the terms under the fresh policy which had placed percentage and monetary cap on certain types of surgical procedures.

6. It is argued by the counsel for the appellants Ms. Arundhati Katju that the State Forum and the NCDRC fell into error in holding that the appellants were aware and were deemed to have been aware of the terms of the policy. It was emphasized that the appellants had not applied and obtained a fresh policy but had rather renewed an existing policy – as they did earlier from time to time annually. Placing reliance on *Biman Krishna Bose v. United India Insurance Co. Ltd.*[2], and *United India Insurance Co. Ltd. v. Manubhai Dharmasinhbhai Gajera*[3], it was argued that the renewal of an insurance policy would imply that the existing terms would bind the parties. As a consequence, the insurer being a party cannot impose unilateral changes, either at the point of time when the policy is renewed or during its currency.

7. Learned counsel compared the terms of the previous policy (which had covered the period March 2007-March 2008) with the policy in question (for the period March 2008 to March 2009) and submitted that the overall limit of coverage was changed by the appellants as compared to the previous year. It was also stated that the previous policy covered health risks of three individuals i.e., the appellants and their son whereas the policy in question covered only the appellants. Counsel submitted furthermore that the insurer had undeniably issued a notice pursuant to which a policy was renewed on 26.03.2008. In the

2(2001) 6 SCC 477.
3(2008) 10 SCC 404.

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circumstances, it was duty of the insurer to inform the insured of the likely change in coverage to enable them to explore an alternative i.e., to opt for a policy that would cover all risks more comprehensively, even if it were to cost them more. Counsel urged that in these circumstances, the insurer was clearly guilty of deficiency of service in as much as the insurer was in the dark about the nature of the limited coverage.

8. Learned counsel on behalf of the insurer Mr. Amit Kumar urged this court to uphold the finding of the NCDRC submitting that there was no deficiency in service by the respondents. It was submitted that the appellants never disputed that in fact the policy was dispatched pursuant to the renewal. A careful reading of the policy for the year 2008-2009 would have indicated that it differed radically from the policy from the previous year because of a term indicating a monetary limit on the reimbursable expenditure, by the insurer. In these circumstances, the appellants could not place any blame upon the insurer.

9. It was submitted that the insurer was under no obligation to indicate or to intimidate to the appellants about the likely changes under its policies. In other words, there was no duty in law which obliged the insurer to intimate the policy holder – at the point of time of renewal that the terms of the new policy would be different from those of the earlier, lapsed/expired policy. It was submitted that the term “renewal” has no special significance given that the contract of insurance i.e., policy in this case is the first annual one. Therefore, the policy for 2008-09 is a different contract of insurance from the one which preceded it.

Learned counsel submitted that the very circumstance that a higher coverage limit was indicated in respect of two individuals only as compared to three insured under the previous policy showed that the insurer had complied with the offer of the insured, who desired such coverage.

10. Learned counsel for the insurer brought to the notice of this Court that the obligation of intimating the insured, has been spelt out in the Standardized General Terms and Clauses in Health Insurance Policy Contracts by the Insurance Regulatory and Development Authority of India (IRDA), in 2020. He submitted that the obligation to intimate stems out of Clause 14 which deals with the possibility of revision of terms of a policy including the premium rates. This clearly indicates that only the existing policy holder has to be notified. However, in renewal of same policy does not place any such obligation upon the insurer to intimate insured person at the point of renewal of the policy.

11. It was urged furthermore that the monetary cap of ₹2,00,000/- in the present case was not conjured by the insurer, which merely complied the IRDA’s directions. In this regard, the learned counsel submitted that insurer acted upon the IRDA’s direction, which were communicated to its offices and branches by way of internal guidelines. Learned counsel also submitted that at the point of time of renewal, no implied obligation on the part of the insurer can be inferred given that each transaction signifies a fresh contract of Insurance. In other words, it is up to the insured to inquire, if the terms of the renewed policy would be in any way would be different from the previous one.

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Analysis and Conclusions

12. The previous policy[4] indicated a limit of ₹3 lakhs each for the appellants, and ₹ 1 lakh cover to Ajay Punnen Jacob (their son). The policy in question, i.e., for 2008-09 covered an overall limit of ₹8 lakhs (₹ 4,25,000/- for the first appellant and ₹ 3,75,000/- for the second appellant, his wife). A copy of the policy which has been produced indicates that the premium (including service tax) paid was ₹17,705/. The period of insurance was from 00.00 hrs of 28.03.2008 to midnight of 27.03.2009. Clause 1.2 of the policy in question for 2008-09 indisputably introduced the following restrictive condition:

> *"1.2 In the event of any claim(s) becoming admissible under this scheme, the company will pay through TPA to the Hospital/Nursing Home or the insured person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate mentioned in the schedule hereto.*
>
> *A) Room, Boarding Expenses as provided by the Hospital/ nursing home*
> *B) Nursing Expenses*
> *C) Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees*
> *D) Anaesthetist, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of organs and similar expenses*
> *Expenses in respect of the following specified illnesses will be restricted as detailed below:*

Hospitalisation benefits	*LIMITS RESTRICTED TO*
1. Cataract	*a.10% of SI or Max Rs.25,000/-*
2. Hernia	*b.15% of SI or Max Rs.35,000/-*
3. Hysterectomy	*c.20% of SI or Max Rs.50,000/-*
4. Major Surgery-Angioplasty	*d.70% of SI or Max Rs. 2 lacs*
5. Pre & post hospitalization	*e.Maximum 10% of the sum insured*

> *(N.B: Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person as mentioned in the schedule)"*

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4 Effective for 2006-2007

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13. In the previous policy[5] the stipulation, limiting for medical expenditure under various heads, were as follows:

> *"1 In the event of any claim/s becoming admissible under this scheme, the company will pay through TPA to the Hospital/Nursing Home or the insured person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate mentioned in the schedule herein.*
> *A) Room, Boarding Expenses as provided by the Hospital/ nursing home*
> *B) Nursing Expenses*
> *C) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees*
> *D) Anesthesia, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray*
> *E) Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of organs and similar expenses.*
> *(N.B: Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person as mentioned in the schedule)"*

14. What is apparent from the record is that upon receipt of the renewed notice, sometime in March 2008, the appellants issued a cheque dated 26.03.2008 which was duly received. That the cheque was encashed and a policy document issued by the insurer is not in dispute. Both parties, i.e., the first appellant and the Divisional Manager of the insurer have filed affidavits in evidence. However, the pleadings as well as these affidavits are unclear as to when the policy document was actually despatched and received by the insurer and on which date it was received by the appellants. Clearly, the policy containing the fresh terms was issued after receipt of the premium for the year 2008-09. In this regard, interestingly, the affidavit evidence of the insurer states as follows:

5 For 2006-2007

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"3. That it is stated that the petitioners renewed their policy No.100505/48/07/00002034 for the period 28.03.2008 to 27.03.2009 and received the terms of the policy which has been renamed as "United India Health Insurance Policy (Gold)". The total coverage of the policy was Rs.8,00,000/- being Rs.4,25,000/- for petitioner No.1 and Rs.3,75,000/- for the petitioner No.2. The petitioner received no claim discount of Rs.3184.7 when renewing the same.

XXXXXXXX XXXXXXXX XXXXXXX

5. That it is stated that the petitioners made representation vide letter dated 10.10.2008, to the respondent claiming the entire amount of treatment from the respondent and in reply dated 04.11.2008, it was stated that the insurance company in terms of the United India health insurance policy Gold was liable to pay to the insured 70% of the sum insured or Rs.2,00,000/- whichever was less in case of angioplasty."

15. The insurer's counsel had, during the course of the hearing, relied upon a document titled *'Guidelines on Standardization of General Terms and Clauses in Health Insurance Policy Contracts'* dated 11.06.2020 highlighting clauses 10 and 14 of the document. They are extracted below:

"10 Renewal of Policy
The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of ...... days ***(Note to insurers: Insurer to specify grace period as per product design)*** *to maintain continuity of benefits without break in policy.*
Coverage is not available during the grace period.
V. No loading shall apply on renewals based on individual claims experience"

XXXXXXX XXXXXXX XXXXXXX

14. ***Possibility of Revision of Terms of the Policy including the Premium Rates***
The company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected."

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The insurer had also relied upon a copy of the United India Insurance Company administrative guidelines for the new insurance products effective 28.01.2007, especially para 14 which reads as follows:

> ***"14 RENEWALS OF EXISTING POLICIES***
>
> *Existing Policyholders who are below the age of 35 years as on the date of introduction of this Product will be allowed to renew the Policy as Platinum. All other Policyholders will be brought under the Gold Policy.*
> *An entrant into the Platinum Policy will be allowed to continue under the Policy even after he crosses 35 years. As on date the table is available upto the age of 45 years. This will be expanded based on the claims experience of the next two years.*
> *In respect of Senior Citizens who are our existing policyholders, they will be allowed to renew the policy on existing terms and conditions but at revised rates of premium under Gold Policy. They should not be compelled to migrate to the new Scheme. If they so desire to enter the new Scheme, the same may be allowed on collection of fresh proposal.*
> *Persons above the age of 60 years and taking a Health Policy for the first time can be granted the Senior Citizens Policy only."*

Analysis:-

The first point: on renewal

16. In the facts of the present appeal, the insurer insisted that the 2008-09 'Gold' policy was in fact a 'new' one, and not a renewal, which was available with the appellants, before the second appellant's surgery took place. There is some dispute on this aspect; the appellants contended that the amended terms of the 2008-09 Gold policy were received only after three months of the payment of the renewal premium, and thus there was no scope for them to have read and given consent to the cap on angioplasty coverage in the new Gold policy.

17. The insurer had placed reliance on the administrative guidelines (supra) to highlight the clause on renewal, in order to demonstrate that the 2008-09

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Gold policy was a new insurance product, and not a renewal of the previous Mediclaim policy. However, the same clause stated that, "*In respect of senior citizens who are our existing policy holders, they will be allowed to renew the policy on existing terms and conditions but at revised rates of premium under Gold policy*". The clause further stated that, "*They should not be compelled to migrate to the new* (Gold) *scheme. If they so desire to enter the new scheme, the same may be allowed on collection of fresh proposal*".

18. In such a situation, there can be said to be no *consensus ad idem* on the introduction of the cap on the coverage by the insurer, as the appellants were not informed that they had paid premium for a new policy, but were led to believe that they had in fact renewed a pre-existing policy on the same terms, with only difference being the removal of their son as a beneficiary and a higher coverage (from Rupees 6 lakhs to Rupees 8 lakhs in total) for the appellants, which was accepted by the insurer. The general rule of acceptance of an insurance proposal by the assured involves unconditional acceptance of all the terms.[6] Thus the cap on the coverage placed by the insurer without prior intimation to the assured and without providing an opportunity to the assured to seek alternate insurance policies that were more favourable to their needs was restrictive, and thus not enforceable.

19. In these circumstances, this Court is of the opinion that the eventuality contemplated in *Biman Krishna Bose* (supra), i.e., inapplicability of old terms,

6 *LIC v. Raja Vasireddy Komalavalli Kamba*, (1984) 2 SCC 719 (para 15).

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in the cases of renewal, when the contracts provide "or otherwise", has to be applied contextually. If the renewed contract is agreed, in all respects, by both parties, undoubtedly the fresh terms (with restrictions) would be binding. However, that would not be the case when a new term is introduced unilaterally about which the policy holder is in the dark. Further, the allusion to continuation of the terms of the Gold policy in respect of senior citizens (who were not to be compelled to migrate to another policy) but were to be subject to the same terms, upon payment of a different *rate* of premia, reinforces the conclusion that there was in fact, a renewal of the existing terms.

20. *Arguendo*, assuming the appellants had received the policy documents on time, i.e., requisite disclosure had been made, and then the appellants had in fact misunderstood the terms and mistaken the new Gold policy for the previous policy, the question is, post payment of premium, were they in a position to protest, or do anything about it. Irrespective of the answer to the question of whether the renewal of an insurance contract results in a new contract or otherwise, the issue which arises is whether the appellants, as beneficiaries of the policy, could complain about mistake in its terms, and the possible consequences of such mistake.

21. There cannot be any gainsaying to the fact that if parties are not agreed on the terms, one of the likely results would be its avoidance. "Mistake" is not defined, under the Contract Act, 1872; however, Section 22 of the Act[7] enacts

7 Extracted below:

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that a unilateral mistake of fact, does not result in its nullity. The general law on avoidance of a contract was explained by this court in *Canara Bank v. United India Insurance Co. Ltd.*[8] in the following terms:

> *"[T]o make a contract void, the non-disclosure should be of some very material fact. No doubt, it would have been better if the Bank and the insured had given at least one tripartite agreement to the Insurance Company but, in our view, in the peculiar facts of this case, not disclosing the tripartite agreement or the names of the owners cannot be said to be such a material fact as to make the policy void or voidable. We are clearly of the view that there is no fraudulent claim made. There is no false declaration made and neither is the loss and damage occasioned by any wilful act or connivance of the insured".* [Para. 45, emphasis supplied]

What is a "material fact" was explained in *Satwant Kaur Sandhu v. New India Assurance Co. Ltd.*[9], as follows:

> *"The term "material fact" is not defined in the Act and, therefore, it has been understood and explained by the courts in general terms to mean as any fact which would influence the judgment of a prudent insurer in fixing the premium or determining whether he would like to accept the risk. Any fact which goes to the root of the contract of insurance and has a bearing on the risk involved would be "material".* [Para 22].

22. In *Tarsem Singh v. Sukhminder Singh*[10], this court clarified that a unilateral mistake would not render a contract void under Indian contract law:

> *"20. Section 20 of the Act lays down as under:*
>
> > *"20. Agreement void where both parties are under mistake as to matter of fact.—Where both the parties to an agreement are under a mistake as to a matter of fact essential to the agreement, the agreement is void.*
> > *Explanation. —An erroneous opinion as to the value of the thing which forms the subject-matter of the agreement, is not to be deemed a mistake as to a matter of fact."*
>
> *21. This section provides that an agreement would be void if both the parties to the agreement were under a mistake as to a matter of fact essential to the agreement. The mistake has to be mutual and in order that the agreement be*

"Section 22. Contract caused by mistake of one party as to matter of fact.—A contract is not voidable merely because it was caused by one of the parties to it being under a mistake as to a matter of fact. —A contract is not voidable merely because it was caused by one of the parties to it being under a mistake as to a matter of fact."

8(2020) 3 SCC 455

9(2009) 8 SCC 316

10(1998) 3 SCC 471

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> *treated as void, both the parties must be shown to be suffering from mistake of fact. Unilateral mistake is outside the scope of this section."*
> [emphasis supplied]

Therefore, the law in India is that unless the unilateral mistake about the terms of a contract is so serious as to adversely undermine the entire bargain, it does not result in automatic avoidance of a contract. Applied to the facts of this case, it is evident that the appellants could insist on the old insurance policy, on the premise that it *renewed* the pre-existing policy. The other conclusion would be cold comfort to the party seeking insurance cover, as the choice would be to avoid it altogether- too drastic as to constitute a choice. The first point is answered accordingly, in favour of the appellants.

The second point: duty of insurers

23. This court next proceeds to address itself to the second question, namely what are the duties of an insurer, when a policy holder seeks renewal of an existing policy. The insurer here contends that the consumer was under an obligation to inquire about the terms of the policy, and any changes that might have been introduced, in the standard terms. It was urged that the appellants, in the facts of this case, should have inquired from the concerned agent; since they omitted to do so, they were bound by the terms of the policy.

24. A striking feature of insurance law, is the principle of *uberrima fide* (duty of utmost good faith) which applies to both the insured as well as one who seeks indemnity and cover. In *United India Insurance Co. Ltd. v. M.K.J. Corpn.*[11] this

11 1996 (6) SCC 428

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court underlined the importance of this principle, and its application to the insurer, in the following terms:

> *"It is a fundamental principle of Insurance law that utmost good faith must be observed by the contracting parties. Good faith forbids either party from concealing (non-disclosure) what he privately knows, to draw the other into a bargain, from his ignorance of that fact and his believing the contrary. Just as the insured has a duty to disclose, similarly, it is the duty of the insurers and their agents to disclose all material facts within their knowledge, since obligation of good faith applies to them equally with the assured. The duty of good faith is of a continuing nature. After the completion of the contract, no material alteration can be made in its terms except by mutual consent. The materiality of a fact is judged by the circumstances existing at the time when the contract is concluded."*

Other decisions too have expressed the same view.[12] In *Modern Insulators Ltd. v Oriental Insurance Co. Ltd*[13] this court observed that:

> *"It is the fundamental principle of insurance law that utmost good faith must be observed by the contracting parties and good faith forbids either party from non-disclosure of the facts which the parties know. The insured has a duty to disclose and similarly it is the duty of the insurance company and its agents to disclose all material facts in their knowledge since the obligation of good faith applies to both equally."*

25. The universal applicability of the principle of *uberrima fides* to both parties to a contract of insurance- and in the context of omission of one of them (the insurer) to notify the other, about a material change in the terms, at the stage of pre-contract, was highlighted in *Sherdley v Nordea Life and Pension*[14]. The insured invested in two individual unit-linked life insurance contracts with Nordea Life and Pensions SA ("Nordea"). The contracts were designed to enhance the tax efficient growth of a capital assurance plan. At the relevant time, the insured were living in both Wales and Spain and were British

12 *Reliance Life Insurance Co. Ltd. vs Rekhaben Nareshbhai Rathod* 2019 (6) SCC 175; *Life Insurance Corporation of India vs Asha Goel* 2001 (2) SCC 160*; P.C. Chacko vs Chairman, Life Insurance Corporation of India* 2008 (1) SCC 321 *and Satwant Kaur Sandhu vs New India Assurance Company Limited* 2009 (8) SCC 316

13 2000 (2) SCC 734

14 [2012] 2 All ER (Comm) 725; SA [2012] EWCA Civ 88

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nationals. At the time of contract, they were habitually resident in the jurisdiction of England and Wales; when they commenced proceedings, they had become habitually resident in Spain. Their investments went "disastrously wrong"; when they sued Nordea in England, the company argued that there was no jurisdiction in England under the "Judgments Regulation" (EC No 44/2001) and claimed that proper jurisdiction were courts in Spain, or Luxembourg. The contractual documents referred to than three law and jurisdiction agreements: for England, for Luxembourg, and for Spain. The plaintiff-insured, however, argued that there was an initial agreement in favour of jurisdiction in England, as the country of their habitual residence at the time of contract, and that that agreement was never displaced. The Court of Appeal rejected the insurer's objection, and held as follows:

> *"Against the background of these principles, which in the absence of relevant submission from the parties I am content to adopt, then, the argument was to be conducted purely in terms of the judge's own analysis, I would regard his decision, that there was an albeit inchoate consensus in favour of English law and jurisdiction at a time prior to the submission and acceptance of Nordea's proposal, as a critical finding, raising the question whether that consensus had ever been displaced. It is true that the application forms are at a stage pre-contract: however, in my judgment they constitute, on the judge's finding, an agreement that if a contract is ultimately made it will be on the terms agreed in the application forms. It seems to me that on that basis there would be a strong argument that that finding never had been displaced. That would be because, although the Sherdleys had signed the proposal acceptance forms, Nordea had not brought to the Sherdleys' attention that, on page 6 of the proposal, an applicable law and jurisdiction clause was now proposed in a form which departed from the earlier consensus. An insurance contract is a contract of the utmost good faith, and I do not think it is consistent with that required good faith that an insurer should present to an insured an alteration in the previously agreed law and jurisdiction provisions of their proposed contract without making that clear to the insured. That is consistent with the Directive's requirements that the applicable law of the parties' insurance contract should be communicated to the insured before the conclusion of the contract "in a clear and accurate manner, in writing, in an official language*

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> *of the Member State of the commitment". If, however, there had been no prior agreement on English law and jurisdiction, then I think that a straightforward proposal, in writing, which the insured was asked to read carefully, as the Sherdleys were asked to read Nordea's proposal, before indicating their consent on a proposal acceptance form, would satisfy the requirements of article 23."*

26. In view of the state of law, which is, that the insurer was under a duty to disclose any alteration in the terms of the contract of insurance, at the formation stage (or as in this case, at the stage of renewal), the respondent cannot be heard to now say that the insured were under an obligation to satisfy themselves, if a new term had been introduced. If one considers the facts of this case, it is evident that the insurer had caused a renewal reminder, which was acted upon and the renewal cheque, issued by the appellant. At that stage, or just before the renewal premium was furnished the insurer, or its agent was under a duty to alert the appellants that the change in terms, was likely to impact their decision, and if so required, offer a better or fuller coverage. One cannot be oblivious to two circumstances here. The first, is that medical or health insurance cover becomes crucial with advancing age; the policy holder is more likely to need cover; therefore, if there are freshly introduced limitations of liability, the insured may, if advised properly, and in a position to afford it, seek greater coverage, or seek a different kind of policy. The second, is that most policies – health and medical insurance policies being no exception, are in standard form. It would be worthwhile to notice at this stage that one who seeks coverage of a life policy/a personal risk, such as accident or health policy has little choice but

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to accept the offer of certain standard term contracts – which are termed as contracts d' adhesion, a French legal term. This has been defined as [15]

> *"A standard-form contract prepared by one party, to be signed by the party in a weaker position, usually a consumer, who has little choice about the terms. Also termed Contract of adhesion; adhesory contract; adhesionary contract; take it or leave it contract; leonire contract.*
> *Some sets of trade and professional forms are extremely one-sided, grossly favouring one interest group against others, and are commonly referred to as contracts of adhesion. From weakness in bargaining position, ignorance or indifference, unfavoured parties are willing to enter transactions controlled by these lopsided legal documents"*

27. The Law Commission[16] has addressed this issue in the report titled *'Unfair (Procedural & Substantive) Terms in Contract'*. The commission recommended enactment of a law to counter such unfair terms in contracts. The draft legislation suggested by the report, defined an unfair contract as follows:

> *"A contract or a term thereof is substantively unfair if such contract or the term thereof is in itself harsh, oppressive or unconscionable to one of the parties."*

28. The courts' remedial power, to refuse enforcement of such contracts, or contractual terms, finds support in a few decisions of this Court.[17] Recently, while deciding a consumer dispute, this Court applied the principle that unfair terms in a contract, cannot be enforced, if there is absence of free choice, on the part of a consumer, in *Pioneer Urban Land & Infrastructure Ltd v Govindan*

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15 Black's Law Dictionary, 9th edn., p. 368
16 The Law Commission of India in its 199th Report
17 *Central Inland Water v Brojo Nath Ganguly&Anr* 1986 (3) SCC 156; *Life Insurance Corporation of India v Consumer Education and Research Centre &Ors* 1995 (5) SCC 482, where it was observed that:

> *"The appellants or any person or authority in the field of insurance owe a public duty to evolve their policies subject to such reasonable, just and fair terms and conditions accessible to all the segments of the society for insuring the lives of eligible persons. The eligibility conditions must be conformable to the Preamble, fundamental rights and the directive principles of the Constitution. The term policy under Table 58 is declared to be accessible and beneficial to the large segments of the Indian society. The rates of premium must also be reasonable and accessible."*

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Raghavan[18]. It was held that a term introduced in a standard form contract can be unfair, as to constitute an unfair trade practice[19] under the Consumer Protection Act, 1986, and observed as follows:

> *"A term of a contract will not be final and binding if it is shown that the flat purchasers had no option but to sign on the dotted line, on a contract framed by the builder. The contractual terms of the Agreement dated 08.05.2012 are ex-facie one-sided, unfair, and unreasonable. The incorporation of such one-sided clauses in an agreement constitutes an unfair trade practice as per Section 2 (r) of the Consumer Protection Act, 1986 since it adopts unfair methods or practices for the purpose of selling the flats by the Builder."*

29. Contracts of adhesion (as contracts d' adhesion are also called), as discussed previously, leave little or no choice to the customer; in this case, the policy holders were left with no room to bargain and negotiate. In the present case, the standard form contract, renewed year after year, left the appellants only with the choice of raising the insurance cover. The last renewal, of course, resulted in the deletion of their son as a beneficiary. However, even with this little choice, the result of their being kept in the dark about the new terms which placed limits on individual surgical procedures meant that had any other information with respect to the increased coverage which could have resulted in the higher individual limits (for surgical procedures) from they might have

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18 2019 (5) SCC 525

19 Defined by Section 2 (r) of the Act as follows:

> *(r) "unfair trade practice" means a trade practice which, for the purpose of promoting the sale, use or supply of any goods or for the provision of any service, adopts any unfair method or unfair or deceptive practice including any of the following practices, namely-*
>
> --------------------- ---------------------
>
> *(vi) makes a false or misleading representation concerning the need for, or the usefulness of, any goods or services;*
>
> *(vii) gives to the public any warranty or guarantee of the performance, efficacy or length of life of a product or of any goods that is not based on an adequate or proper test thereof:…"*

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benefitted was denied to them. For that reason, the "informational blackout", so to say, on the part of the insurer, was a crucial omission.

30. During the hearings, it was urged on behalf of the insurer that the agent would have ordinarily informed the policy holder as she or he was in touch with them. The insurer did not lead evidence in this regard. Its agent was not asked to affirm any affidavit. In these circumstances, the inference to be drawn is that the agent did not inform – at the time of renewal of the policy, in 2008, about the limits in regard to coverage of individual procedures but also omitted them any information that there could have been possibility of higher coverage by payment of higher premium which might have resulted in a higher limit for the various surgeries or procedures covered by the policy.

31. There is no doubt that insurance business is run through brokers and agents. The role of an agent in this regard is to be examined. This Court has spelt out, in the context of insurance business the role of insurance agents and the liability or responsibility of insurance companies in the event of failure to discharge the duties cast upon agents, and the likely vicarious responsibility or liability of the insurer.

32. In *Delhi Electric Supply Undertaking* v. *Basanti Devi*[20] the insurer, Life Insurance Corporation, had floated a 'Salary Savings Scheme' in which the employer deducted premium from its employees' salaries and paid them to LIC on the employees' behalf. The premium for a period of time was not deducted

20 (1999) 8 SCC 229

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from an employee's salary. On the death of the employee, his legal representatives claimed the insured amount. LIC rejected the claim on the grounds of lapse of the policy due to non-payment of premium, and that the actions of the employer did not bind LIC given that it was not an 'agent' of LIC. This Court turned down the argument, and held that

> *"11. In the present case we are not concerned with the insurance agent. It is not the case of LIC that DESU could be permitted as an insurance agent within the meaning of the Insurance Act and the regulations. DESU is not procuring or soliciting any business for LIC. DESU is certainly not an insurance agent within the meaning of the aforesaid Insurance Act and the regulations but DESU is certainly an agent as defined in Section 182 of the Contract Act. The mode of collection of premium has been indicated in the Scheme itself and the employer has been assigned the role of collecting premium and remitting the same to LIC. As far as the employee as such is concerned, the employer will be an agent of LIC. It is a matter of common knowledge that insurance companies employ agents. When there is no insurance agent as defined in the regulations and the Insurance Act, the general principles of the law of agency as contained in the Contract Act are to be applied.*
>
> ***12.** Agent in Section 182 means a person employed to do any act for another, or to represent another 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. The 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 an agent of LIC to collect premium on its behalf."*

33. This reasoning was applied in *Life Insurance Corporation of India v Rajiv Kumar Bhaskar*[21]. It would be useful, in the present context to extract the

21 2005 (6) SCC 188

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relevant terms of the notification, [22][especially Clauses 3 (2) and 4 (1)] issued by the IRDA:

> *"3(2) An insurer or its agents or other intermediatory 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."*
>
> ************** *************** **************
>
> *4(1) 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 evident by a written document. It is the duty of an insure to furnish to the insured free of charge, within 30 days of the acceptance of a proposal, a copy of the proposal form."*

In the present case, even if, for arguments' sake, one was to accept the submissions of the insurer which is that their agent should have informed the appellant policy holders, the absence of any evidence that he did or any evidence adduced by the insurer that despite information the appellants chose to accept the policy in the terms which they eventually were furnished, the only consequence would be that as principal the insurer is liable.

34. Such a failure assumes importance even from the perspective of consumer protection law. The Consumer Protection Act, 1986 states the definition of 'deficiency' in service under Section 2(g) as "*[A]ny 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*". In order to demonstrate deficiency, it is not necessary that the same emanates only from a law or a contract. The term "*or otherwise*" clearly provides for circumstances

22 Dated 16 October 2002

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where a certain level of service *is expected* from a provider. As stated above in the judgment, the principle of *uberrima fides* involves prior intimation of change in terms in insurance contracts. The deficiency of service assumes even more significance in the present case, as it pertains to senior citizens.

35. The special status of senior citizens in general was taken cognizance of by the insurer as well, when it relied on guidelines (applicable for new insurance products, with effect from 28.1.2017) which *inter alia,* stated that

> *"In respect of Senior Citizens who are our existing policyholders, they will be allowed to renew the policy on existing terms and conditions but at revised rates of premium under Gold Policy. They should not be compelled to migrate to the new Scheme. If they so desire to enter the new Scheme, the same may be allowed on collection of fresh proposal."*

The insurer's argument here was that no existing senior citizen policy holder could be compelled to migrate to a new Scheme. However, in the present case, the Mediclaim holders were kept in the dark, and asked to renew a policy, the terms of which had undergone a significant change in that its cover was radically different, and imposed limitations on the insurer's liability. The argument of the insurer has no merit and is not acceptable.

36. Worldwide, nations are seeking viable answers to the question of how to offer health care to their citizens. The World Health Organization (WHO) defines health as a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.[23] Healthy

23 The Constitution of the WHO in its preamble says as much:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

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living conditions and good quality health is not only a necessary requirement it is also recognized as a fundamental right. Article 25 of the Universal Declaration of Human Rights 1948[24] lays down that everyone has the right to a standard of living, adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care. The International Covenant on Economic, Social and Cultural Rights, 1976, too recognizes the right to health, of citizens of every nation.[25]

In *Calcutta Electric Supply Corporation Ltd.* v. *Subhash Chandra Bose*, (1992) 1 SCC 441 this court, quoting from various international covenants, observed that,

> *"the term 'health' implies more than an absence of sickness. Medical care and health facilities not only project against sickness but also ensure stable man power for economic development. Facilities of health and medical care generate devotion and dedication to give the workers' best, physically as well as mentally in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful, economic, social and cultural life. The medical facilities, are therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. health is thus a state of complete physical, menial and social well-being and nut merely the absence of disease or infirmity".*

24 Article 25 reads as follows:

> *(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*
>
> *(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or t of wedlock, shall enjoy the same social protection.*

25***Article 12*(of the Covenant, of 1976, reads as follows:**

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

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37. Part IV of the Indian Constitution which contain the Directive Principles of State Policy imposes duties on the state. Some of its provisions directly or indirectly are associated with public health. These principles direct the state to take measures to improve the condition of health care of the people. Articles 38 imposes duty on state that state secure a social order for the promotion of welfare of the people. Without an overall viable framework of public health, the state cannot achieve this obligation, in a meaningful manner. Article 39(e) relates to workers and enjoins the state to protect their health. Article 41 imposes the duty on the state to public assistance essentially for those who are sick and disabled. Article 42 casts primary responsibility upon the state to protect the health of infants and mother through maternity benefit. Article 47 spells out the duty of the state to raise the level of nutrition and standard of living of its people. Other provisions relating to health fall in this Part of the Constitution. The state is asked in particular, to direct its policies towards securing health of workers.

38. For a long time, state policy in this country was to involve only public sector entities in the insurance sector. All this changed, with the opening up of the economy and entry of private sector insurers. To regulate entities in the insurance business, the Insurance Regulatory and Development Authority Act, 1999 ("the IRDA Act") was enacted. Its provisions, together with that of the Insurance Act, 1938, and regulations framed under both enactments, regulate all

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insurance related activities (except marine and certain kinds of insurance) in India. Section 2 (6C) of the Insurance Act defines "health insurance business" and defines it as follows:

> *"(6C) "health insurance business" means the effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient travel cover and personal accident cover;]*

The IRDA (Health Insurance) Regulations, 2016, (which replaced the previously applicable regulations of 2013- which were preceded by guidelines regulating health insurance products contains regulations which are relevant for the purpose of this case. Chapter III of these regulations contains general provisions relating to Health Insurance. The relevant part of Regulation 11 reads as follows:

> ***"11. Designing of Health Insurance Policies***
> *a. Subject to Regulation 3 as applicable, Health insurance product may be designed to offer various covers;*
> *i. For specific age or gender groups*
> *ii. For different age groups*
> *iii. For treatment in all hospitals throughout the country, provided the hospitals comply with the definition specified*
> *iv. For treatment in specific hospitals only, provided the morbidity rates used are representative*
> *v. For treatment in specific geographies only, provided the morbidity rates used are representative*
> *Provided, such specifications are disclosed clearly upfront in the product prospectus, documents and during sale process. And provided that no insurer shall offer any benefit or service without any insurance element.*
> ********** ********** **********
> *c. Insurer shall not compel the insured to migrate to other health insurance products. In case of migration from a withdrawn product, the insurer shall offer the policyholder an alternative available product subject to portability conditions.*
> *d. Insurers shall ensure adequate dissemination of product information on all their health insurance products on their websites. This information shall include a description of the product, copies of the prospectus as approved under the Product Filing Guidelines, proposal form, policy document wordings and premium rates inclusive and exclusive of Service Tax as applicable…."*

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Regulation 13 is relevant for the purposes of this appeal; it deals with renewal of policies, and reads as follows:

> ***"13. Renewal of Health Policies issued by General Insurers and Health Insurers (not applicable for travel and personal accident policies)***
> *i. A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the insured, provided the policy is not withdrawn.*
> *ii. An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy.*
> *iii. The insurer shall provide for a mechanism to condone a delay in renewal up to 30 days from the due date of renewal without deeming such condonation as a break in policy. However, coverage need not be available for such period. 8 [Provided the renewal premium shall not be accepted more than 90 days in advance of the due date of the premium payment.]*
> *iv. The promotion material and the policy document shall explicitly state the conditions under which a policy terminates, such as on the payment of the benefit in case of critical illness benefits policies."*

39. These regulations only underline expressly what was implicit, i.e., the insurer's obligation to inform every policy holder, about any important changes that would affect her or his choice of product. These have been given statutory shape. Yet, the obligation of the insurer to provide information to existing and policy holders, for them to exercise choice, meaningfully, and choose products suited to their needs, existed. In this case, that obligation was breached.

40. In view of the above discussion, this Court is of the opinion that the findings of the State Commission and the NCDRC cannot be sustained. The insurer was clearly under a duty to inform the appellant policy holders about the limitations which it was imposing in the policy renewed for 2008-2009. Its failure to inform the policy holders resulted in deficiency of service. The impugned order of the NCDRC as well as the order of the State Commission are

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hereby set aside. The order of the District Forum is accordingly restored. Consequently, the appeal is allowed; in the circumstances of this case, the respondent shall bear additional costs, quantified at ₹ 50,000/-.

..J
[S. RAVINDRA BHAT]

New Delhi,
December 9, 2021

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REPORTABLE

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO(S). 6778 OF 2013

JACOB PUNNEN & ANR. ... APPELLANT(S)

VERSUS

UNITED INDIA INSURANCE CO. LTD. ... RESPONDENT(S)

J U D G M E N T

K.M. JOSEPH, J.

1. **I have gone through the draft Judgment authored by my learned Brother Justice S. Ravindra Bhat.**

2. **While I would agree with the relief proposed, I feel it is necessary to articulate my reasons by a separate opinion.**

3. **The facts have been set out by my learned brother. I would avoid elaborate repetition. Suffice it to say that the appellants are husband and wife and along with their son obtained an insurance_policy in the year 2006 with certain conditions attached.**

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In fact, they have a case that they had a policy of insurance for several years with the respondent insurer. They obtained the policy in question for the year 2008, however, wherein the son was not included and there was also change in the amount of the insurance. The period of insurance was operative from 28.03.2008 to 27.03.2009. It is while this policy was in force that the second appellant went for angioplasty in June 2008 and a claim for Rs.3,82,705.27 was submitted. The insurer paid a sum of Rupees Two Lakhs only. The reduction in the claim was based on the express provisions which was in force in the policy in issue. Under the earlier policy for previous year such a clause was conspicuous by its absence. It is also true that a notice was issued by the respondent Insurer for renewal and the appellants issued a cheque towards renewal on 26.3.2008. It is thereafter that the policy in question for the period in question (28.3.2008 to 27.3.2009) came to be issued.

4. **In *Biman Krishna Bose v. United India Insurance Co.Ltd.*[26] this Court *inter alia* held as follows:**

26 (2001) 6 SCC 477

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"5. A renewal of an insurance policy means repetition of the original policy. <u>When renewed, the policy is extended and the renewed policy in identical terms from a different date of its expiration comes into force. In common parlance, by renewal, the old policy is revived and it is sort of a substitution of obligations under the old policy unless such policy provides otherwise.</u> It may be that on renewal, a new contract comes into being, but the said contract is on the same terms and conditions as that of the original policy. Where an insurance company which has exclusive privilege to carry on insurance business has refused to renew the mediclaim policy of an insured on extraneous and irrelevant considerations, any disease which an insured had contacted during the period when the policy was not renewed, such disease cannot be covered under a fresh insurance policy in view of the exclusion clause. The exclusion clause provides that the pre-existing diseases would not be covered under the fresh insurance policy. If we take the view that the mediclaim policy cannot be renewed with retrospective effect, it would give handle to the Insurance Company to refuse the renewal of the policy on extraneous consideration thereby deprive the claim of the insured for treatment of diseases which have appeared during the relevant time and further deprive the insured for all time to come to cover those diseases under an insurance policy by virtue of the exclusion clause. This being the disastrous effect of wrongful refusal of renewal of the insurance policy, the mischief and harm done to the insured

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> **must be remedied. We are, therefore, of the view that once it is found that the act of an insurance company was arbitrary in refusing to renew the policy, the policy is required to be renewed with effect from the date when it fell due for its renewal."**
>
> **(Emphasis supplied)**

5. **Proceeding on the basis of the principles enunciated thereunder, a renewal of the contract would ordinarily, undoubtedly involve the expectation of replication of the terms of the original contract and what is more, the actual continuation of the terms. However, as noted, the actual contract may provide otherwise. The terms of the renewed contract of insurance may be located in the actual contract of insurance. A renewed contract of insurance may provide terms which are different from the terms of the original contract of insurance.**

6. **However, I am in agreement with my learned brother that the claim under the Consumer Protection Act must allowed on the ground that there has been a deficiency on the part of the Insurer. The Insurer brought about a change in the policy. This change introduced a cumbersome limitation. It kept the Insured in the dark about the limitation at the time**

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when the renewal notice was issued, and what is more, the premium was accepted. The Insurer had a duty to inform the appellants that a change regarding the limitation on its liability was being introduced. This duty to take the insured into confidence was breached. This was the deficiency in service. Even proceeding on the basis that the policy incorporates the terms of the contract, insofar as the respondent insurer unilaterally purported to incorporate a clearly cumbersome limitation involving a breach of the duty to take the appellants into confidence, the court would not be powerless to undo the wrong. Be it that the policy purported to incorporate the substantive limitation, the appellant can be relieved of the result of the deficiency in service by the insured. This can be done by restoring the position, the appellants would occupy if there was no breach. I would, therefore, agree with my learned Brother that the appeal be allowed on the basis that there was unjustifiable non-disclosure by the Insurer about the introduction of clause of limitation and, in this case, it constituted a deficiency in service and

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resultantly the appellants are entitled to relief.

I, therefore, agree that the appeal be allowed.

……………………………………………J.
[K.M. JOSEPH]

NEW DELHI;
DATED: December 09, 2021.

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