THE
INDIAN LAW REPORTS

APPELLATE CIVIL

Before Tek Chand and P. C. Pandit, JJ.

THE LAKSHMI INSURANCE Co., LTD.,—*Appellant*

versus

PADMA WATI,—*Respondent.*

Regular First Appeal No. 29 of 1954

Insurance—Contract of—Nature and special features of—Uberrimae fidei *contracts—Essentials of—When can be avoided—Principle of* caveat emptor—*Whether applicable to contracts of insurance—Contract of insurance—Principles for interpretation of—Suit on policy of life insurance—Burden of proof of various matters—On whom lies—Warrantly and condition—Meaning of, in insurance policies—Insurance Act (IV of 1938)—S. 45—Scope of—Sickness, ailment or injury—Meaning of—Diseases required to be mentioned in proposal or application for revival of policy—Interest on the amount of insurance policy—Whether can be granted.*

1960

Sept., 20th

Held, that insurance, apart from its special features, is a contract between the person seeking to be insured and the insurer. Broadly speaking, it is said, that "a contract of insurance is in its nature aleatory, voluntary, executory, synallagmatic, conditional, and personal, and, except as to life and accident, that it is one of indemnity". The contract is aleatory, in so far as it depends upon a contigency, against the occurrence of which, it is intended to provide, though in certain events such a contigency may never occur, e.g., in the case of an accident. It is voluntary, as the parties acting in good faith, incorporate certain provisions and conditions as they choose, provided, of course, they are not

prohibited by law. It is executory in the sense that it is not executed until payment of a sum after an anticipated loss. Life insurance contracts are, however, executory in a limited sense, in so far as, on payment of the premium such a contract is deemed as executed so far as the insured is concerned though it is executory as to the insurer. It is synallagmatic in the sense that it imposes reciprocal obligations. Insurance contracts are bilateral being in the nature of mutual agreements imposing obligations of a reciprocal nature upon the insurer and the insured. It is conditional as it depends upon compliance of certain conditions such as payment of premium, avoidance of misrepresentations, being conditional on communication of material facts; and lastly, it is personal, as the obligation to pay does not run with the property, whether it be a real estate or a personal estate, unless, of course, there is an express stipulation to the contrary. Life insurance has originated from benevolent motives, the object being to secure to the family of the person a support on the death of the insured. The addition of many new features to insurance has not materially affected the main principle on which it rests.

Insurance contracts, whether relating to marine insurance or to any other class of insurance, are *uberrimae fidei*, founded upon the utmost good faith, and if either-party fails to observe the utmost good faith, the contract may be avoided by the other. Absence of good faith avoids the contract. This is a principle of universal application to all types of insurance contracts. The obligation to deal fairly and honestly rests to an equal degree upon both parties to a policy. The applicant for life insurance has to exercise towards the insurer, to whom he applies, the same degree of good faith which he himself rightly expects from him. In contracts *uberrimae fidei*, contracting parties are placed under a special duty towards each other, not merely to refrain from active misrepresentation, but to make full disclosure of all material facts within knowledge. In insurance contracts the principle of *caveat emptor* has no place. In these cases, ordinarily, the risk undertaken by the insurer, can only be learnt from the representations made by the intending insured, and non-disclosure of a material factor is regarded as fatal to the validity of the transaction. Upon these principles, there is a legal obligation cast upon the party proposing the insurance, to communicate, not only every material fact of

which he had actual knowledge, but he is also deemed to know, every material fact of which he ought, in the ordinary course of business, to have knowledge.

Held, that in interpreting the terms of a contract of insurance, they should receive fair, reasonable and sensible construction in consonance with the purpose of the contract as intended by the parties. Emphasis in such cases is laid, more upon a practical and reasonable, rather than, on a literal and strained construction. In interpreting the contract of insurance neither the coverage under a policy should be unnecessarily broadened, nor should the policy be rendered ineffective in consequence of unnatural or unreasonable construction. An attempt should be to construe a contract in liberal manner so as to accomplish the purpose or the object for which it is made. In the absence of ambiguity, neither party can be favoured, but where the construction is doubtful, the Courts lean strongly against the party, who prepared the contract. Where in insurance contract, there is a susceptibility of two interpretations, the one favourable to the insured is to bepreferred. The reason for this rule is, that usually, the insured has no voice in the selection or arrangement of the words employed, and the language of the contract is already written out, and is selected with great care and deliberation by expert legal advisers acting exclusively in the interest of the insurance company. This is specially so with regard to the provisions of a life insurance policy, which exempt the insurer from liability under certain conditions. These provisions are construed strictly against the insurer but, where the meaning of the language used is plain, no violence can be done to the terms of a contract by refining them away, if they convey the plain meaning of the purpose, with sufficient clarity. Any arbitrary, irrational, unnatural or technical construction has to be avoided in preference to fair, natural, reasonable and practical interpretation. Construction which is liberal rather than literal, has to be favoured, always understanding the words and pharases in the contract in their ordinary and popular sense. The rule of construction against the insurer and favourable to the insured, stems from what otherwise is called, the rule of *contra proferentem* which is based on the maxim, *Verba chartarum fortius accipiuntur contra proferentem.* It means, that the words of deeds are to be taken most strongly against the party employing them. What is meant is, that

if the words of an instrument or of a grant are of doubtful import, then, that construction shall be placed upon them which is most favourable to the holder of the instrument or the grantee. Since the language of the insurance contract is that of the insurer, it is both reasonable and just that his own words should be construed most strongly against him. In their anxiety not to subvert the very object and purposes of insurance, which is to give fullest protection to the policy-holder or his nominee, the Courts indulge in making every presumption favourable to good faith and reasonableness in preference to equivocation or verbal jugglery.

Held, that in a suit on a life insurance policy, the plaintiff has to prove facts necessary for establishing his cause of action, but the burden of proving affirmative defences is on the insurer. In cases where the policy has lapsed, the plaintiff has to prove the truth of statements in declarations made by him when applying for revival or reinstatement of his policy, but the insurer, who alleges fraud and miscrepresenation in procuring revival or reinstatement has to establish his defences. In other words it is for the insurer to show, that the insured knew or should have known of the falsity of statements made in the application for revival. The insurance company has also to discharge the onus, that the representation alleged to be fraudulent were material and made with the insured's knowledge and wrongful intent regarding the condition of his health, family history, age, habits, occupation, etc. The insurer must show that the statements made by the insured were such which he knew or should have known that they were untrue and were made wilfully in bad faith and with intent to conceal or deceive. Such defences, in so far as they result in forfeitures, have to be proved affirmatively by a pre-ponderance of the evidence.

Held, that in policies of insurance, the term 'warranty has been used interchangeably with 'condition' in the sense of a statement, forming basis of the contract, on the literal truth or the falsity of which, the validity of the entire contract depends, regardless of materiality of the statement. In this sense, a warranty has to be exactly

complied with. The term 'representation' is now employed, where, in a life insurance contract, there is a clause, which, though, refers to the subject-matter of a contract, is treated, not as essential, but only as collateral to the main purpose of the contract. The strict construction of the term 'warranty', for the breach of which the entire contract is avoided, regardless of the materiality of the statement, has resulted in grave injustice. It has almost been the universal practice of insurance companies, to treat every statement of the application as a basis of contract, and the incorrectness of any information is treated, as a ground, not only for avoiding the policy, but also for forfeiting the premiums paid to the company. But in India the rigour of the Common Law rule as to warranty has been substantially palliated by section 45 of the Insurance Act, 1938.

Held, that the policies which have been excepted from the operation of the provisions of section 45 of the Insurance Act, 1938, may be called in question by an insurer, on such grounds of inaccuracy or falsehood as are recognised by the English Common Law. In the case of all other policies of life insurance, they can now be avoided by an insurer on the ground, that a statement, made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, and further, that (a) such a statement was material; (b) *or* was on suppressed facts, which it was material to disclose *and* (c) that it was fraudulently made by the policy-holder; *and* (d) that the policy-holder knew at the time of making it that the statement was false; *or* (e) that it suppressed facts which it was material to diclose. The nice distinction created by the doctrine of warranty has thus been eliminated. The insurer, cannot avoid the consequences of the insurance contract, by simply showing inaccuracy or falsity of the statement made in the proposal for insurance, or in any report of the medical officer, or in any other document leading to the issue of the policy. Burden is cast on the insurer to show, that the statement on the basis of which, the policy is sought to be avoided by him was on a material matter, or, facts have been suppressed, which it was material for him to disclose. It has further to be proved, that the statement was fraudulently made by the policy-holder, with the knowledge of the falsity of the statement, at the time when

it was made, or that the suppression was of material facts which had not been disclosed. Statutory law as embodied in section 45 of the Insurance Act, now insists not only on proof, that the statement had been made on material matter, or that material facts had not been disclosed, but also lays stress on substantiation of fraud on the part of policy-holder and on proof of his knowledge of it, at the time of the making of the false statement. Therefore, in the case of policies of life insurance which are not excepted by the two years' rule, proof of deliberate fraud, and not merely of constructive fraud or of mis-statements has to be shown, in order to avoid the policy. A charge of fraud, naturally, requires a high degree of probability. It is well known that fraud is odious and cannot be presumed : *fraus est odiosa et non est praesumenda.* The Courts will not be satisfied with proof, which falls short of showing that intentional misrepresentation was made with the knowledge of perpetrating fraud. The *onus probandi* in all such cases rests heavily on the party alleging fraud. Fraud must be established beyond all reasonable doubt and cannot be based on suspicion and conjecture.

Held, that it is not easy to define the terms 'sickness, ailment or injury'. The contract of life insurance being one of utmost good faith and the probable expectancy or duration of the life of policy-holder being an important element in it, the controlling factor in the construction of these terms must necessarily be the intent of the parties, without attaching to any one of these terms any technical or theoretical meaning. Whatever the terms 'ailment', or 'sickness' may mean in the medical sense, or in accordance with their dictionary meaning, they cannot embrace transitory and temporary illenss in its accepted sense, as they are not material to the risk insured. These terms refer to disorders of substantially serious nature affecting general health and do not include passing indispositions which do not affect the applicant's general health. No embargo, therefore, can be placed on the insured, in not declaring occasional physical disturbances of a trivial character. These terms are, therefore, to be restricted to such illnesses which impair the constitution of the insured or interrupt the performance of vital functions. However, non-disclosure of a disease like the tuberculosis and in particular of the pulmonary type would normally avoid the acceptance or revival of a policy of a consumptive.

Held, that no interest on overdue amount of a policy of insurance can be awarded where no demand has been made and where there is no agreement between the insured and the insurer entitling the former to any interest. Nor can any question of market usage to pay interest or overdue amount of policy possibly arise.

Regular First Appeal from the decree of Shri William Augustine, Senior Sub-Judge, Amritsar, dated the 29th day of January, 1954, granting the plaintiff a decree for Rs. 46,000 with costs against the defendant.

K. L. KAPUR AND V. C. MAHAJAN, ADVOCATES, for the Appellant.

H. L. SARIN AND K. C. SUD, ADVOCATES, for the Respondent.

JUDGMENT

Tek Chand, J.

TEK CHAND, J.—This is a defendant's appeal from the judgment and decree of Senior Subordinate Judge, Amritsar, decreeing the plaintiff's suit for recevorey of Rs. 40,000; Rs. 34,000 being the principal amount and Rs. 6,000 being the interest. The plaintiff in this case is the widow of late Diwan Balkishan of Amritsar, who died on 8th of April, 1949. The deceased had taken two life insurance policies of the Laxmi Insurance Company Ltd.,which is now represented in appeal by the Life Insurance Corporation of India. Policy No. 126837 (Exhibit D. 10) was taken by the deceased on his life with effect from 8th of September, 1944, for a sum of Rs. 14,000. The proposal was sent by the deceased to the defendant Insurance Company on 25th of August, 1944, and the sum assured for this policy was Rs. 14,000. The sum was payable on 8th of September, 1959, which was the date of maturity, or, on his death, if that event took place earlier. Exhibit D. 6/7 is the medical report signed by the deceased and

The Lakshmi Insurance Co. Ltd.
v.
Padma Wati

Tek Chand, J.

also by the medical examiner of the Company, dated 26th of August, 1944.

The insured had made another proposal on 25th of September, 1944, to the Company; and policy No. 128605 for a sum of Rs. 20,000 on his life was issued with effect from 12th of November, 1944. The date of maturity of this policy was 12th of November, 1963, when the deceased would have attained the age of 65 years, and in the event of his death earlier, the sum was to be paid to his nominee Shrimati Padma Wati, his wife, who is the plaintiff in this case. The deceased continued to pay the premiums on these policies for some time and had paid a sum of Rs. 5,307-14-0 on account of the first policy No. 126837 and he had paid a sum of Rs. 6,131-4-0 on account of the second policy No. 128605. Both the policies lapsed because of non-payment of the premiums some time in 1947. On 9th of November, 1948, Dewan Balkishan wrote to the Company that his policies should be renewed and he sent a cheque for Rs. 1,047-7-0 in full payment of the amounts due to the Company,—*vide* Exhibit D. 3. He also sent an application (Exhibit D. 5) for the revival of his lapsed policies on the same date. On the death of Dewan Balkishan on 8th of April, 1949, the plaintiff sent information to the defendant-Company and sent to the Company the two original policies after filling in certain forms claiming the amounts for which her deceased husband's life had been assured.

The plaintiff has brought this suit for the recovery of the amounts due under the two policies and she has also claimed interest at the rate of Rs. 6 per cent per annum on Rs. 34,000. The total amount thus due to her came to Rs. 40,120 but

The Lakshmi Insurance Co. Ltd. *v.* Padma Wati

Tek Chand, J.

she has sued for recovery of Rs. 40,000 giving up Rs. 120. In the alternative, the plaintiff claimed Rs. 14,007-14-0 on account of the premiums actually paid by the insured and interest thereon. She also claimed future interest. The plaintiff instituted this suit on 8th April, 1952, as the nominee of the deceased policy-holder.

The defendant-Company pleaded that the plaintiff herself knew that her husband had been suffering from a dangerous and malignant disease viz., tuberculosis at the time when the original proposals had been made in August and September, 1944, and also when applications for the revival of the lapsed policies had been made in November, 1948. It was also averred that the policies had been obtained in 1944 and also got revived in 1948 by the deceased, by making a false and fraudulent representation, as to the state of his health, and true facts had been deliberately concealed by him, when the original proposals had been sent, and also, when he applied for the revival of the policies after they had lapsed. It was alleged that on account of false and fraudulent representations and acts of deliberate concealment the plaintiff's claim under the two policies was void. It was also pleaded that she was not entitled to claim any interest. The parties pleadings gave rise to the following issues :—

(1) Was any fraud or mis-representation committed by the deceased Diwan Balkishan with respect to the state of his health when he got himself insured through two policies in dispute and at the time of the revival if any? If so, what fraud or misrepresentation was committed by him and what was its effect ?

The Lakshmi Insurance Co. Ltd.
v.
Padma Wati

Tek Chand, J.

(2) Was the suit within time ?

(3) Had not the plaintiff the *locus standi* to maintain the suit, if so, on what grounds ?

(4) Was the plaintiff entitled to any interest, if so, to what extent ?

(5) Relief.

(6) Whether the plaintiff is entitled to Rs. 14,007-14-0 on account of premium paid by Shri Balkishan deceased to the defendant ?

(7) Whether the plaintiff is entitled to any interest on the amount of premia, if so, at what rate ?

The trial Court decided the first issue against the defendant-Company. It also found that the suit had been instituted within the period of limitation and that as nominee of the deceased, the plaintiff had *locus standi* to maintain the suit. It was also found that she was entitled to interest at the rate of Rs. 6 per cent. No finding was given on issues Nos. 6 and 7 as in view of the finding on issue No. 1 these had become redundant. A decree for Rs. 40,000 with costs was consequently passed in favour of the plaintiff against the defendant-Company.

Arguments have been confined by the learned counsel for the appellant to the first and fourth issues. In support of the appellant's contention that fraud had been committed by the deceased upon the defendant-Company with respect to the state of his health, reliance has been placed both upon documentary and oral evidence. The first document in point is the proposal form (Exhibit

D. 7), dated 25th of August, 1944, on which policy No. 126837 (Exhibit D. 10) was issued for Rs. 14,000. In this proposal from Diwan Balkishan answered the question 8(b) as to whether he was himself suffering or had ever suffered from tuberculosis and diabetes, etc., in the negative. He also signed a declaration that his statements in the proposal form were true and that he had not withheld or concealed any fact or circumstance tending to render assurance on his life unacceptable or more hazardous. He had also agreed that the statements, declarations and conditions agreed to in the proposal form and the anwers to the questions put to him by the Medical Examiner of the Company in connection with his assurance, as also the declarations made by him, would be the basis of contract between him and the Company, and that if any untrue averments be found or any information had been withheld, the assurance would be null and void, and all moneys paid on account of the said assurance would stand forfeited to the Company. Our attention has also been drawn to condition No. 4 in both the policies, which is reproduced below :—

> "4. *Indisputability.*—A policy after the expiry of two years from the date on which it is effected, becomes indisputable, except when the Company shows, that a statement made in the proposal for assurance or in any statement made before a Medical Examiner or a reference of a friend of the assured, or in any other document leading to the issue or revival of the policy, on a material matter, was fraudulently made by the policy-holder, and that the policy-holder knew at the time of making it that the statement was false."

The Lakshmi Insurance Co. Ltd.
v.
Padma Wati

Tek Chand, J.

Regarding revival of lapsed policies, the relevant conditions are, that the Directors will be prepared to consider the question of revival on being furnished with proof in the form of:—

(a) A personal declaration on the form prescribed by the Company if the period of lapse does not exceed six months.

(b) A medical examination report on the form prescribed by the Company if the period exceeds six months.

In this case, although the period of lapse had exceeded six months, the Company did not insist on medical examination report, but had revived the policies on receiving personal declaration of the assured on the prescribed form. The next piece of evidence is the medical report in respect of these policies. Exhibit D. 6/7 is the medical report relating to the first policy. Diwan Balkishan had denied that he had suffered from any one of the diseases mentioned in para 5 and they included "affection of the respiratory organs", "diabetes" or "any other disease'. In answer to question mentioned in para 8(e), he denied having been admitted to any hospital or sanitorium. He then signed a declaration to the effect that if any material information was found to have been withheld by him, the contract would become void and all moneys paid by him on account of the assurance would be forfeited. Reliance was next placed on two documents which are copies of Admission Register of Special Ward of V.J. Hospital, Amritsar. Exhibit D. W. 1/1 is dated 14th of November, 1952, and contains an entry to the effect that on 21st of February,

1945. Diwan Balkishan was admitted as an indoor patient and was discharged on 28th of February after seven days. Under the column 'Disease' the entry is, "Diabetic. T.B. Lungs". Exhibit D.W. 1/2 is also a copy from the Admission Register, and is dated 14th of April, 1945, showing admission of Diwan Balkishan on 17th of April, 1945, as an indoor patient and his discharge on 22nd of April. Under the Column "Disease" the words "T.B. Lungs" occur. Exhibit D. 8 is a copy of the medical certificate which had been obtained from the Medical Superintendent of V.J. Hospital by D.W. 5 Rup Lal, who was the Branch Manager of the defendant-Company, showing, that Diwan Balkishan was admitted on 17th of April, 1945, and discharged on 22nd of April, 1945, and the disease from which he was suffering was 'T.B. Lungs'. This medical certificate had been obtained by the Branch Manager when he made enquiry from V.J. Hospital, Amritsar, and when the amount assured had been claimed by the plaintiff after the death of Diwan Balkishan.

His Lordship then discussed the evidence and continued.

The other piece of evidence in this case consists of copies of entries, Exhibits D.W. 1/1 and D.W. 1/2, from the register of indoor patients of Special Ward and of Exhibit D. 8, which is a certificate granted by D.W. 1 Dr. Ram Singh, the Deputy Medical Superintendent, certifying the entries made in the Admission Register of Family Wards during the year, 1945 relating to Diwan Balkishan. It is contended on behalf of the respondent that these three entries are not admissible in evidence in view of section 35 of the Indian Evidence Act and further that they have no evidentiary value.

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

Under section 35, an entry in any public or other official book, register or record, stating a fact in issue of relevant fact, and made by a public servant in the discharge of his official duty, or by any other person in performance of a duty specially enjoined by the law of the country in which such book, register or record is kept, is itself a relevant fact. Assuming, that the entries in question are from public or other official book, and that they state a fact in issue or a relevant fact, it has not been proved that they were made by a public servant in the discharge of his official duty. In this case, no evidence has been led to show as to who made these entries, or whether, such a person was a public servant, whose official duty it was to make such entries. On the record of this case there is no evidence, whatsoever, as to who made these entries. It is not known whether these entries were made by a doctor, who had diagnosed......... the disease, by a clerk, or by any other person. No evidence has been led in this case to show, as to who examined the deceased, and who diagnosed the ailment, and as to how the opinion was formed as to the nature of the disease. No medical attendant has been produced, who could depose, that during the two periods, during which Diwan Balkishan was an idoor patient, he had been examined or treated for any particular disease. In my view, Exhibits D.W. 1/1, D.W. 1/2 and D. 8 are neither admissible, nor have they any evidentiary value and cannot be taken into consideration in basing any conclusion on the first issue.

The next question which may now be considered is, whether, the contract of insurance entered into by the insured Diwan Balkishan, with the defendant-Company as the insurer, was liable to be avoided, and if so, what circumstances and considerations govern its avoidance.

Insurance, apart from its special features, is a contract between the person seeking to be insured and the insurer. Broadly speaking, it is said, that "a contract of insurance is in its nature aleatory, voluntary, executory, synallagmatic, conditional, and personal, and, except as to life and accident, that it is one of indemnity". (*Vide.*—1 Couch on Insurance page 5). The contract is aleatory, in so far as it depends upon a contingency, against the occurrence of which, it is intended to provide, though in certain events such a contingency may never occur, e.g., in the case of an accident. It is voluntary, as the parties acting in good faith, incorporate certain provisions and conditions as they choose, provided, of course, they are not prohibited by law. It is executory in the sense that it is not executed until payment of a sum after an anticipated loss. Life insurance contracts are, however, executory in a limited sense, in so far as, on payment of the premium such a contract is deemed as executed so far as the insured is concerned though it is executory as to the insurer. It is synallagmatic in the sense that it imposes reciprocal obligations. Insurance contracts are bilateral being in the nature of mutual agreements imposing obligations of a reciprocal nature upon the insurer and the insured. It is conditional as it depends upon compliance of certain conditions such as payment of premium, avoidance of misrepresentations, being conditional on communication of material facts; and lastly, it is personal, as the obligation to pay does not run with the property, whether it be a real estate or a personal estate, unless, of course, there is an express stipulation to the contrary. Life insurance has originated from benevolent motives, the object being to secure to the family of the person

The Lakshmi Insurance Co., Ltd. v. Padma Wati

Tek Chand, J.

a support on the death of the insured. The addition of many new features to insurance has not materially affected the main principle on which it rests.

Insurance contracts, whether relating to marine insurance or to any other class of insurance, are *uberrimae fidei*, founded upon the utmost good faith and if either party fails to observe the utmost good faith, the contract may be avoided by the other. Absence of good faith avoids the contract. This is a principle of universal application to all types of insurance contracts. The obligation to deal fairly and honestly rests to an equal degree upon both parties to a policy. The applicant for life insurance has to exercise towards the insurer, to whom he applies, the same degree of good faith which he himself rightly expects from him. In contracts *uberrimae fidei*, contracting parties are placed under a special duty towards each other, not merely to refrain from active misrepresentation, but to make full disclosure of all material facts within knowledge. In insurance contracts the principle of *caveat emptor* has no place. In these cases, ordinarily, the risk undertaken by the insurer, can only be learnt from the representations made by the intending insured, and non-disclosure of a material factor is regarded as fatal to the validity of the transaction. Upon these principles, there is a legal obligation cast upon the party proposing the insurance, to communicate, not only every material fact of which he had actual knowledge, but he is also deemed to know, every material fact of which he ought, in the ordinary course of business, to have knowledge.

In interpretting the terms of a contract of insurance, they should receive fair, reasonable

The Lakshmi Insurance Co., Ltd. v. Padma Wati

Tek Chand, J.

and sensible construction in consonance with the purpose of the contract as intended by the parties. Emphasis in such cases is laid, more upon a practical and reasonable, rather than, on a literal and strained construction. In intrepretting the contract of insurance neither the coverage under a policy should be unnecessarily broadened, nor should the policy be rendered ineffective in consequence of unnatural or unreasonable construction. An attempt should be to construe a contract in liberal manner so as to accomplish the purpose or the object for which it is made. In the absence of ambiguity, neither party can be favoured but where the construction is doubtful, the Courts lean strongly against the party, who prepared the contract. Where in insurance contract, there is a susceptibility of two interpretations, the one favourable to the insured is to be preferred. The reason for this rule is, that usually, the insured has no voice in the selection or arrangement of the words employed, and the language of the contract is already written out, and is selected with great care and deliberation by expert legal advisers acting exclusively in the interest of the insurance company. This is specially so with regard to the provisions of a life insurance policy, which exempt the insurer from liability under certain conditions. These provisions are construed strictly against the insurer but, where the meaning of the language used is plain, no violence can be done to the terms of a contract by refining them away, if they convey the plain meaning of the purpose, with sufficient clarity. Any arbitrary, irrational, unnatural or technical construction has to be avoided in preference to fair, natural, reasonable and practical interpretation. Construction which is liberal rather than literal, has to be favoured, always understanding the words and phrases in

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

the contract in their ordinary and popular sense.

The rule of construction against the insurer and favourable to the insured, stems from what otherwise is called, the rule of *contra proferentem*, which is based on the maxim, *Verba chartarum fortius accipiuntur contra proferentem*. It means, that the words of deeds are to be taken most strongly against the party employing them. What is meant is, that if the words of an instrument or of a grant are of doubtful import, then, that construction shall be placed upon them which is most favourable to the holder of the instrument or the grantee.

Despite the criticism of this rule by Jessel, M. R. in *Taylor* v. *Corporation of St. Helens* (1), the maxim has received judicial recognition in a number of subsequent decisions in England,—vide *Rowett, Leakey and Company* v. *Scottish Provident Institution* (2), *Royal London Mutual Insurance Society, Limited* v. *Barrett* (3), *Kaufmann* v. *British Surety Insurance Company, Limited* (4). This rule has been applied to many kinds of insurance policies including life insurance policies,—*vide* Couch on Insurance, Volume I, section 188(b).

Since the language of the insurance contract is that of the insurer, it is both reasonable and just that his own words should be construed most strongly against him. In their anxiety not to subvert the very object and purposes of insurance, which is to give fullest protection to the policy-holder or his nominee, the Courts indulge in

(1) 6 Chancery Division, 264 (280).
(2) L.R. 1927, 1 Chancery Division, 55 (69)
(3) L.R. 1928, 1 Chancery Division, 411 (415).
(4) XLV T.L.R. 399 (401),

making every presumption favourable to good faith and reasonableness, in preference to equivocation or verbal jugglery.

As to the rule of burden of proof in a suit on a life insurance policy, the plaintiff has to prove facts necessary for establishing his cause of action, but the burden of proving affirmative defences is on the insurer.

In cases, where the policy has lapsed, the plaintiff has to prove the truth of statements in declarations made by him when applying for revival or reinstatement of his policy, but the insurer who alleges fraud and misrepresentation in procuring revival or reinstatement has to establish his defences. In other words, it is for the insurer to show, that the insured knew or should have known of the falsity of statements made in the application for revival. The insurance company has also to discharge the onus, that the representations alleged to be fraudulent were material and made with the insured's knowledge and wrongful intent regarding the condition of his health, family history, age, habits, occupation, etc. The insurer must show that the statements made by the insured were such which he knew or should have known that they were untrue and were made wilfully in bad faith and with intent to conceal or deceive (*vide* 46 C.J.S. section 1319, pp. 433 and 437). Such defences, in so far as they result in forfeitures, have to be proved affirmatively by a preponderance of the evidence.

Certain arguments have been addressed by the learned Counsel on behalf of the Life Insurance Corporation, based, upon the Common Law of England, which may be examined at this stage. The Common Law rule is, that insurance contract

The Lakshmi Insurance Co., Ltd. *v.* Padma Wati

Tek Chand, J.

can be successfully avoided by the insurer, the moment there is a breach of warranty even in relation to a matter which may not otherwise be material, foundational or essential. In support of the above proposition, reference has been made to three English decisions. In *Thomson* v. *Weems and others*, (1), Lord Blackburn at page 683 observed :

> "It is competent to the contracting parties. if both agree to it and sufficiently express their intention so to agree, to make the actual existence of anything a condition precedent to the inception of any contract ; and if they do so the non-existence of that thing is a good defence. And it is not of any importance, whether the existence of that thing was or was not material; the parties would not have made it a part of the contract if they had not thought it material, and they have a right to determine for themselves what they shall deem material."

Lord Watson at page 689 said :—

> "When the truth of a particular statement has been made the subject of warranty, no question can arise as to its materiality or immateriality to the risk, it being the very purpose of the warranty to exclude all controversy upon that point. As the Lord Chancellor (Cranworth) said in *Anderson* v. *Fitzgerald* (2) : "Nothing, therefore, can be more reasonable than that the parties entering into that contract should determine for

(1) L.R. (1884) 9 A.C. 671.
(2) L.R. (1884) 9 A.C. 689.

> themselves what they think to be material, and if they choose to do so, and to stipulate that unless the assured shall answer a certain question accurately, the policy or contract which they are entering into shall be void, it is perfectly open to them to do so, and his false answer will then avoid the policy."

The above observations were cited with approval in a later decision of the House of Lords in *Dawsons Ltd.,* v. *Bonnin and others,* (1). The observations made in the decisions referred to above and in several others, rest upon certain technical words which constituted 19th century terminology. As contractual obligations vary in importance, the early decisions used two terms in particular, i.e., 'conditions' and 'warranties'. 'Condition' is treated as a vital term going to the root of the contract and its entry entitles the insured to repudiate the entire contract. 'Warranty' was construed as a collateral or subsidiary promise which though part of the contract, did not go to the root of it and, therefore, its falsity did not entitle the party to repudiate the contract in entirety. It is in this sense that these terms are used in section 12 of the Indian Sale of Goods Act, 1930, which corresponds to section 62(1) of the English Sale of Goods Act, 1893. The above distinction between 'warranty' and 'condition' was brought out by Lord Blackburn in *Heyworth* v. *Hutchinson,* (2). It was observed that a clause may be a simple warranty or it may be a condition. The latter goes to the essence of the contract, but a warranty, is only collateral to the contract, and is the subject of a cross action or matter in reduction

(1) (1922) 2 A.C. 413 at p. 423.
(2) (1867) L.R. 2 Q.B. 447.

The Lakshmi Insurance Co., Ltd. *v.* Padma Wati

Tek Chand, J.

of damages. But about the same time, Williams J., expressed himself differently when he said: "if a descriptive statement is intended to be a substantive part of the contract, it is to be regarded as a *warranty*, that is to say, a *condition*, on the failure of which—the other party may, if he be so minded, repudiate the contract *in toto*".

Modern writers have deprecated this terminological confusion caused by the indiscriminate use of the word 'warranty' both in the strict and in the broad sense. 'Warranty' has been treated sometimes as indicative of an essential part of the contract, and on other occasions, as collateral to the main purpose of such contract,—*vide* Cheshire and Fifoot on Law of Contract (Fifth Edition) pages 118, 119, 124 and 125, Pollock on Contract (Thirteenth Edition) pages 432 and 433, Anson on Contract (Twentieth Edition) page 328, Chitty on Contract (Twenty-first Edition), Volume II, page 373.

But in policies of insurance, the term 'warranty' has been used interchangeably with 'condition' in the sense of a statement, forming basis of the contract, on the literal truth or the falsity of which, the validity of the entire contract depends, regardless of materiality of the statement. In this sense, a warranty has to be exactly complied with. The term 'representation' is now employed, where, in a life insurance contract, there is a clause, which, though, refers to the subject-matter of a contract, is treated, not as essential, but only as collateral to the main purpose of the contract.

The strict construction of the term 'warranty', for the breach of which the entire contract is

The Lakshmi Insurance Co., Ltd. v. Padma Wati

Tek Chand, J.

avoided, regardless of the materiality of the statement, has resulted in grave in justice. It has almost been the universal practice of insurance companies, to treat every statement of the applicant as a basis of contract, and the incorrectness of any information is treated, as a ground, not only for avoiding the policy but also for forfeiting the premiums paid to the company. The proposal form in this case, Exhibit D. 7, as also the declaration of the insured in the medical report form Exhibit D. 6/7, contains stringent conditions against the insured, which are almost in the nature of a trap for the unwary applicant, who has hardly any choice left if he desires to take a policy. In many jurisdictions, which had hitherto modelled their insurance law on the strict rules of English Common Law, the statute law has stepped in to relieve the insured, from the drastic consequences of inaccurate statements or misrepresentations, which according to terms of the policy, had to be treated as 'warranties', or, as the basis of the contract, or where conditions had been introduced which were in the nature of penalties. As a result of the legislative inroad on the stringent rule of warranty, the Common Law distinction between 'warranties' and 'representations' has been abrogated, with the result, that the liability of the insurer is not avoided by breach of warranty which did not relate to matters material to the risk insured. Such statutes which are of a remedial nature, and which have been enacted to relieve the rigours of the Common Law, have been adopted in a number of States in America. With a view to ameliorate the hardships on the policy-holder, consequent upon the strict doctrine of warranty, where an inadvertant mis-statement incurred a forfeiture of the policy, the clauses contained in the form of application, or the terms of policy, began

The Lakshmi Insurance Co., Ltd. *v.* Padma Wati

Tek Chand, J.

to be construed liberally. Though the several statutes passed by different legislatures in countries, which had borrowed their insurance law from the Common Law, had a varied phraseology, yet the dominant provision, which went to mitigate the severity of the rigid Common Law rule, was, that in the absence of deliberate fraud on the part of the insured, the insurance policy would not be forfeited, unless representations related to a matter material to the risk. The harshness of the doctrine of warranty, in life insurance policies, has been mitigated by treating warranties as representations. For the legislative assalut made upon the doctrine of warranty by the State Legislature in the United States of America, reference may be made to Richards on Insurance, Volume 2, page 1050.

The legislation in Canada has indicated a similar trend.

For instance, it is provided by section 156(5) of the Ontario Insurance Act that "all statements made by the insured, in the absence of fraud, be deemed representations and not warranties and no such statement of the insured shall avoid or be used in defence to a claim under this policy unless contained in the written application heretofore and a copy of the application is indorsed on or attached to this policy when issued". Again, sub-section 4 provides "that no contact shall be void by reason of the inaccuracy of any such statement (i.e., in an application for a policy) unless it is material to the contract". Sub-section 6 reads : "the question of materiality in any contract of insurance shall be a question of fact for the jury or for the court if there is no jury" vide *Mutual Life Insurance Company of New York* v. *Ontario Metal Products Company*, (1).

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(1) 1925 A.C. 344 at p. 350.

The Lakshmi Insurance Co., Ltd. *v.* Padma Wati

Tek Chand, J.

In our country, the mind of the legislature has been working on similar lines, and the rigour of the Common Law rule as to warranty, has been substantially palliated by section 45 of the Indian Insurance Act. This provision, as amended by the Insurance (Amendment) Act 1941, now runs as under :—

"45. No policy of life insurance effected before the commencement of this Act shall afetr the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall, after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement (was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made) by the policy-holder and that the policy-holder knew at the time of making it that the statement was false (or that it suppressed facts which it was material to disclose):

(Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

> merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.)"

The special provisions of this section exclude from their operation, policies of life insurance which were effected before the commencement of this Act and where two years from the date of the commencement of the Act have expired. Similarly, life insurances effected after the coming into force of the Insurance Act, 1938, where two years as from the date on which the policy was effected had expired, are also excluded from the purview of section 45. The policies which have been excepted from the operation of the special provisions may be called in question, by an insurer, on such grounds of inaccuracy or falsehood as are recognised by the English Common Law. In the case of all other policies of life insurance, they can now be avoided by an insurer on the ground, that a statement, made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, and further, that (a) such a statement was material; (b) *or* was on suppressed facts, which it was material to disclose, *and* (c) that it was fraudulently made by the policy-holder; *and* (d) that the policy-holder knew at the time of making it that the statement was false; *or* (e) that it suppressed facts which it was material to disclose. The nice distinction created by the doctrine of warranty has thus been eliminated. The insurer, cannot avoid the consequences of the insurance contract, by simply showing inaccuracy or falsity of the statement made in the proposal for insurance,

or in any report of the medical officer, or in any other document leading to the issue of the policy. Burden is cast on the insurer to show, that the statement on the basis of which, the policy is sought to be avoided by him was on a material matter ,or, facts have been suppressed, which it was material for him to disclose. It has further to be proved, that the statement was fraudulently made by the policy-holder, with the knowledge of the falsity of the statement, at the time when it was made, or that the suppression was of material facts which had not been disclosed. Statutory law as embodied in section 45 of the Insurance Act, now insists not only on proof, that the statement had been made on a material matter, or that material facts had not been disclosed, but also lays stress on substantiation of fraud on the part of policy-holder and on proof of his knowledge of it, at the time of the making of the false statement. Therefore, in the case of policies of life insurance which are not excepted by the two years' rule, proof of deliberate fraud, and not merely of constructive fraud or of mis-statements has to be shown, in order to avoid the policy.

In the light of the premises, the question which has to be examined is whether Diwan Balkishan, the deceased policy-holder, had made representations to the Insurance Company which really fall within the four corners of section 45 of the Insurance Act. The case of the insurance company is, that at the time when the proposal was made in 1944 by the applicant Diwan Balkishan, he had denied, that he had been suffering or had ever suffered from tuberculosis, or from certain other enumerated diseases, or from any other disease, likely to affect his life for insurance purposes. The learned Counsel or the insurer, has frankly con-

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

ceded, that he is not in a position to demonstrate the falsity of the statement when it was made. Out attention has not been drawn to any other statement either in Exhibit D. 7, the proposal form, or in Exhibit D. 6/7, the medical report form, which could be said to be untrue at the time of making it. According to the insurer's doctor, who had examined the deceased, he considered the life of the applicant good in every respect, and answered this, stating, 'Yes. First Class life'. He also recommended to the insurance company, to accept the proposal, at ordinary rates. On 9th of November, 1948, Diwan Balkishan in his application (Exhibit D. 5), for the revival of lapsed policies warranted as follows :—

"1. That since the date of my medical examination for the above-numbered policy, I have had no sickness, ailment or injury, nor any relation of mine has died or been effected with any hereditary disease except as follows :—

Sickness, injury, etc.	Date	Duration	Result.
Nil	Nil	Nil	Nil

(If your answer is in the negative please state 'No' or 'Nil' in the columns).

2. * * *

3. * * *

4. * * *

5. * * *

6. I hereby ratify and confirm all the statements made in the proposal and personal statement before the Medical Examiner on the basis of which the above-numbered policy was issued, except such as

are modified by the representations or agreements herein contained and hereby agree that the said proposal and my said statement before the Medical Examiner and the statement made in this application for revival shall form the basis of the contract of Insurance and further agree that the said policy shall not be revived until I have received the revival receipt of the Company and that if any of the statements or representations contained herein shall prove to be incomplete or untrue then this revival shall be *ipso facto* null and void.

(Signed at (station) Dalhousie this (date) 9th day of November, 1948).

Witness to Applicant's Signature.

Signature of the policy-holder.

Address :

(Sd.) (Illegible) (Sd.) BALKISHAN

C/o Amrit Talkies, Amritsar. (In English).

Note:—It is important to note that if any adverse circumstance either connected with your general health, or the health of your family, or any change, however unimportant you may consider the same, has occurred between the date of your statement before the Medical Examiner on the basis of which the above policy was issued and the signing of this health declaration, it must be clearly stated and nothing should be concealed.

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

(Ordered to be produced on the record on 18th August, 1952.)"

In para No. 1 above, the applicant denied having had 'sickness, ailment or injury'. It is not easy to define these terms. The contract of life insurance being one of utmost good faith and the probable expectancy or duration of the life of policy holder being an important element in it, the controlling factor in the construction of these terms must necessarily be the intent of the parties, without attaching to any one of these terms any technical or theoretical meaning. Whatever the terms 'ailment', or 'sickness' may mean in the medical sense, or in accordance with their dictionary meaning, they cannot embrace merely transitory and temporary illness in its accepted sense, as they are not material to the risk insured. These terms refer to disorders of substantially serious nature affecting general health and do not include passing indispositions which do not affect the applicant's general health. No embargo, therefore, can be placed on the insured, in not declaring occasional physical disturbances of a trivial character. These terms are, therefore, to be restricted to such illness which impair the constitution of the insured or interrupt the performance of vital functions. In this connection, the following lines from the Insurance Law and Practice by Appleman, Volume I, para 222, may be quoted with advantage :—

> "It has usually been held that the warranty or representation that the insured is in good health is not avoided by the fact that the insured may have, at some time, been subjected to some temporary or minor illness, from which he has

> recovered and which has made no permanent inroad upon his constitution. If the disorder were so slight, for example, as not to impair the carrying on of the vocation of the insured, it is hardly serious enough to avoid the policy.
>
> The words "illnesses", "ailments", or "disease" have likewise been construed to include only more serious disorders leaving a permanent mark upon the insured's health, and passing ailments or disorders are not considered by the court to be material to the risk. * * *"

It follows from what has been stated above, that in order to successfully avoid the policy, the insurer in this case must show that during the period in which the policy remained lapsed the applicant had been afflicted with a serious disease or ailment. On behalf of the insurer, it is argued by the learned counsel, firstly, that according to the statement of Dr. Amir-ud-Din, Diwan Balkishan was suffering from 'pulmonary T.B.'. He also deposed that the insured was admitted in the V. J. Hospital and that he had performed an operation. For the nature of the operation and its result, he stated, that reference should be made to the hospital record available at Amritsar. No such hospital record has been produced by the insurer in this case. Dr. Amir-ud-Din had also said that Diwan Balkishan had consulted him a number of times though he did not remember the exact dates. The import of the replies made by Dr. Amir-ud-Din may first be examined. It is not clear from the statement of Dr. Amir-ud-Din that, when Diwan Balkishan was admitted in the V. J. Hospital, from what disease was he then suffering. He

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

merely contented himself by saying, that the record of all admissions in the hospital is kept by the hospital authorities to which a reference might be made. He also stated, that he had performed an operation, but as to the nature of the operation, and as to its result, he said, that reference should be made to the hospital record. In answer to the cross-interrogatories, he said, that he could not say correctly, when Diwan Balkishan came under his treatment, but probably, as far as he could recollect, he had a cavity in the lung. On being asked to give the details of the operation or the nature of the disease which necessitated the operation, all he could remember was that he had performed the operation, but again stated, that for details, the operation register kept in the hospital should be seen. No such register has been produced in this case. Apart from his statement that Diwan Balkishan was suffering from pulmonary T.B., which will be presently examined, it is not possible to find out the nature of the disease for which he was admitted as an indoor patient, or for which, he had been operated upon. Even the duration of the period, during which he remained an indoor patient, is not disclosed by any admissible evidence. There are, however, several American cases in which insurance was avoided, because of a false statement, that the insured had never been the inmate of an infirmary, sanitorium or hospital and recovery has been precluded where the questions as to treatment in any dispensary or hospital have been answered in the negative, especially where the answers to questions were in the nature of warranties and were required to be full and true,—*vide* Couch on Insurance, Volume IV, section 889(f). Similarly, an answer that the insured had received surgical attention was treated as a breach of warranty so as to avoid the policy.

The Lakshmi Insurance Co., Ltd. J. Padma Wati

Tek Chand, J.

But in the case of a mis-representation as to surgical attention, if the truth, had it been disclosed, would have been material for determining the issuance of policy, then alone, the policy was held liable to be forfeited. But a surgical attention refers to serious operations as would be a determining factor for the insurer to undertake the risk,—*vide* Couch on Insurance section 889(g). In the absence of proof, as to the nature of the disease, for which, the deceased had to remain as an indoor patient in the V. J. Hospital, Amritsar, and of any details whatsoever, as to the serious or slight nature of the surgical attention given, I hesitate to rush to any conclusion, in favour of the existence of circumstances justifying avoidance of the risk undertaken by the insurer.

In para 6 of the application for the revival of the lapsed policies (Exhibit D. 5) Diwan Balkishan had confirmed all the statements made by him when the policies were issued after his proposals had been accepted, and had agreed, that if any of the statements turned out to be incomplete or untrue, then, the revival would be *ipso facto* null and void. This statement of Diwan Balkishan is to the effect that he had continued to be in the same good health at the time of seeking revival of the lapsed policies as before. According to his statement in the proposal from Exhibit D/7, he had denied having suffered from tuberculosis and in his statement, in the medical report from Exhibit D. 6/7, he answered in the negative, the question, whether he had suffered from any one of the enumerated diseases, including 'affection of the respiratory organs', or from any other disease, which had not been mentioned in question No. 5. Question No. 8(e) which was answered in the negative, related to his having been admitted to any hospital or sanitorium.

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

It admits of little doubt, that tuberculosis and in particular of the pulmonary type, is a serious disease which materially affects considerations relating to insurability of the person affected. Insurance Companies would not readily assume such a risk. Non-disclosure of such a disease would normally avoid the acceptance or revival of a policy of a consumptive. Consumption or tuberculosis of lungs, being a wasting disease, falsifies a representation of good health, and justifies avoidance of the policy on grounds of material misstatement or of non-disclosure of material facts.

If the insured learns from his physician, that he is suffering from pulmonary tuberculosis, a warranty of good health in his application for revival of policy, would be a good ground for avoidance of the insurance contract, as the disease is such, which definitely involves impairment of the health of the insured and thus renders the insured, a precarious risk.

It has already been considered that burden of proof of proving the defence was on the insurer, and the question now to be considered is, whether in the light of the evidence, the insurer has furnished adequate proof of the ingredients mentioned in section 45 of the Indian Insurance Act justifying annulment of the policy.

The contention, on behalf of the appellant insurer is, that the statements contained in Exhibit D. 5, the application for the revival of lapsed policies, paras Nos. 1 and 6 which have been repoduced earlier, were inaccurate or false, with respect to material matters, disclosed and not disclosed, and have been made by the policy-holder, fraudulently with the knowledge of their falsity

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

and materiality, at the time of making it. According to the insurer, the insured knew that some time after the two policies had been issued, and before making the application for their revival, that he had been suffering from pulmonary T.B.; that he had been an indoor patient in V. J. Hospital, Amritsar, and that he had been operated upon; and these were material facts, which he did not disclose in the application for revival, and deliberately gave a false answer, that he had, during the interval, not suffered from sickness, ailment or injury, and that he continued to remain in good health, as indicated by the confirmation by him, of all statements, made previously, in consequence of which, policy had been issued.

In this connection, the only admissible evidence on the record is the statement of Dr. Amir-ud-Din in answer to the interrogatories. The insurer has not produced the medical records, to which a reference was made in the statement of Dr. Amir-ud-Din. This surgeon had stated, that he was suffering from pulmonary T.B. and apart from this bare statement, no other corroborative evidence has been led, in order to come to this conclusion on the basis of any medical examinations of the insured, which are usually made when diagnosing the disease. Dr. Amir-ud-Din, has not given the reasons, which led him to conclude that Diwan Balkishan was suffering from pulmonary T.B. He has not stated, whether he based his opinion on external or internal examination, whether any X-ray was taken of the patient's lungs, or whether he had, in fact, resorted to any other means, usually employed by medical experts for finding out whether a person is stricken with this disease. The record of this case is completely silent on the

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

pathological, symptomatic or the therapeutical aspects of the disease afflicting the insured. It is not disclosed as to what precise steps were taken to discover the nature of the affliction, and from what symptoms was the disease discovered. We even do not know anything about the curative or healing aspects of the medical treatment given. Outside the *ipse dixit* of Dr. Amir-ud-Din, no material is placed on the record, to test the accuracy of his conclusion, either by resort to *a priori* methods or to *a posteriori* reasoning. It is not disclosed what facts were observed, or what methods were adopted, for forming that opinion. There is no other admissible evidence corroborative of the opinion given by Dr. Amir-ud-Din.

The learned Counsel for the insurer wants, that not only the opinion expressed by Dr. Amir-ud-Din should be treated as correct, without there being any further corroboration, but it should further be found, that Dr. Amir-ud-Din had actually told Diwan Balkishan, that he was suffering from pulmonary T.B. or, that he must have otherwise come to know of it. In this case, there is no material, whatsoever, to show, that Diwan Balkishan died of tuberculosis. No material has been placed on the record, that after Amir-ud-Din left for Pakistan on the partition of the country, Diwan Balkishan was under treatment of any doctor or was an inmate of any sanitorium and was receiving treatment for T.B.

Another important circumstance in favour of Diwan Balkishan is, that if he had really known, that he was suffering from consumption, he would not have, as a man of ordinary prudence, run the risk of allowing his policies to lapse. According to the contention of the insurer, he was stricken

with T.B. in 1944, 1945 and 1946. His policy No. 126837 lapsed in March, 1947 and the other policy No. 128605 lapsed in May, 1947. If the policies had not lapsed, the insurance contract could not have been avoided as a result of his having contracted tuberculosis subsequently. It does not convince the mind, that having come to know, that he was laid up with consumption since 1944, 1945 or 1946 he would have let the policies lapse and thus lose the benefit of insurance.

Another consideration, which somewhat militates against the stand of the insurance company, is, that D.W. 5 Rup Lal, who was the Branch Manager of the Insurance Company at Amritsar, and who had been residing in Amritsar for the last 15 or 16 years prior to 1953, as stated by him, did not insist on Diwan Balkishan, undergoing a medical examination, before reinstatement of the lapsed policies. According to the conditions of the policy, reproduced earlier in this judgment, the Directors would consider the question of revival, if they were satisfied as to the continued eligibility for insurance, either on a personal declaration made on a prescribed form of the company within six months of the lapse; or on a medical examination report on the prescribed form if the period exceeded six months. In this case, the application for revival was made almost 18 months after the policies had lapsed. No insistence on the part of the insurance company, on a medical examination report, suggests, that the company was satisfied as to the continued good health of the policy-holder. According to D.W. 4 Jagan Nath, who was incharge, Claims these policies were revived on a declaration given by the insured as to his health instead of medical certificate 'as a special concession'. If a special concession in this matter was given to the policy-holder, then the attention

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

of the officers concerned must have been drawn up this question, and the special concession was probably given, after they had satisfied themselves as to the condition of his health. D.W. 5 Shri Rup Lal, stated, that the company reinstated the policy, on the basis of health declaration, instead of medical certificate, 'as a matter of routine'. Shri Rup Lal, who has been living for very many years in the same town in which the policy-holder resided, would not have been a party to the revival of the lapsed policies, if he had not felt satisfied as to the continued good health of Diwan Balkishan. The insured has not even been shown to have died of tuberculosis.

According to the death certificate (Exhibit P. 1), the cause of death of Diwan Balkishan is stated to be 'heart failure'. The plaintiff in the death report made by her on 3rd of May, 1949, to the company stated that her husband had died suddenly of heart failure at Amritsar on 8th of April, 1949. This report of the plaintiff bears the signatures of P.W. 1, Shri G. R. Sethi. P.W. 7 is Shri Lal Chand who is a Homeopath and who treated the deceased during his last illness. He has deposed that Diwan Balkishan suddenly collapsed from heart failure, and that he treated him for vomiting and gastric ailments, and, that he was not suffering from heart trouble. In his cross-examination, nothing useful to the insurer has been brought out.

Diwan Balkishan, who died on 8th of April, 1949, lived for several years after he had been found by Dr. Amir-ud-Din to have been suffering from pulmonary tuberculosis. This circumstance also suggests, that the opinion of a solitary surgeon in this case, could be fallible. In this case, no doctor

The Lakshmi Insurance Co., Ltd. *v.* Padma Wati

Tek Chand, J.

has been summoned, under whose treatment Diwan Balkishan had been after the partition of Punjab. If Diwan Balkishan had, in fact, been suffering from T.B., he would certainly have consulted a number of physicians under whose treatment he would have placed himself.

Another difficulty that arises so far as placing implicit reliance on the testimony of Dr. Amir-ud-Din is, that having gone to Pakistan, he could be examined only through interrogatories, and his statement in examination-in-chief could not be subjected to a proper and thorough cross-examination, which was possible only if he had appeared as a witness in Court. Obviously, an examination through interrogatories cannot be as thorough and as satisfactory as a *viva voce* examination.

Commenting adversely on the practice of insurance companies' avoiding policies which have been revived on the basis of a declaration of continued good health from the policy-holder, the observations of Varadachariar, J., made in *Indian Equitable Insurance Co., Ltd.* v. *Onkarappa* (1), may be quoted with advantage :—

> "The form (declaration by the policy-holder seeking revival) is a printed slip supplied by the company and it is not by any means very clear that persons who are called upon to sign that statement are really put upon sufficient notice as to what it is that the company expects them to state. The distinction between this kind of form and the elaborate queries which are put to any person when he makes a proposal for the first time to the company is very marked,

(1) A.I.R. 1934 Madras 674 (675).

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

> and it is scarcely fair, that Insurance Companies should, without putting the assured on sufficient notice, as to the degree of care, that they are expected to exercise in making a statement like Exhibit 5, or the kind of information that they are expected to give, be permitted to take advantage of any ailment that he might have had once upon a time between the date of the original policy and the date of the declaration for the purpose of revival."

It is not sufficient, that Dr. Amir-ud-Din had diagnosed the disease to be pulmonary tuberculosis, it is necessary to determine further whether this fact had been communicated to the patient, or, was otherwise known to him. If this has not been done, it cannot be said that the policy-holder deliberately concealed his knowledge of this disease from the insurer. As observed in Halsbury's Laws of England, Third Edition, Volume 22, page 191, para 365 "statements by a proposer as to his health are asked for and given on the basis of his belief, because the ordinary man cannot be expected to know what is happening to his internal organs or what specific symptoms may indicate, * * *". In this case it cannot be said with any definiteness, that what was within the knowledge of Dr. Amir-ud-Din had also become known to Diwan Bal-kishan. It is well known that persons suffer from latent diseases which up to a certain stage do not make their effect felt on the human system, in a manner, perceptible to the person afflicted. Bad faith can be imputed to the insured only when he fails to disclose a disorder, of which he was aware. He might have had a suspicion of a disorder and might have simply believed that it was a transitory

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

trouble which would soon pass off. The reasonable rule of law which has been adopted in most jurisdictions is that "If the insured has reason to know of a disease he must disclose it, but if he has no suspicion of the existence thereof, he breaches no duty in failing to disclose it", *vide* Appleman on Insurance, Volume I, section 216 at page 216.

There can be no concealment of a fact, which is not known to the policy-holder, and it cannot be said on the record of this case, that convincing evidence, direct or circumstantial, is forthcoming to satisfy the mind, that Diwan Balkishan knew, that he was stricken with a serious malady, and that that fact, he had deliberately suppressed from the insurance company. To avoid a policy on the ground of fraudulent concealment, it must be convincingly shown, that the matter in question was knowingly concealed. From a failure to disclose facts of which, the applicant for insurance is ignorant, he cannot be deprived of the protection under the policy of insurance. Therefore, on the assumption, that even though Diwan Balkishan was suffering from pulmonary tuberculosis some time in 1944, 1945 or 1946, and further, from the fact, that such an ailment, if known to the insurer would have caused rejection of the risk, failure to give information of it when applying for revival of the lapsed policies in 1947, could not be an act of fraud on his part if he was not aware of it. Want of good faith, in the absence of knowledge, cannot be imputed to the policy-holder. The insurer has to show, that the insured knew that his representations were false or, there were circumstances of such a persuasive character, as to make him chargeable with knowledge of their falsity. It was next argued by the appellant's learned counsel, that Diwan Balkishan, must have known, that he was

The Lakshmi Insurance Co. Ltd. v. Padma Wati

Tek Chand, J.

kept as an indoor patient in the hospital, and that some surgical operation was performed on him, and both these informations were withheld by him from the insurance company. In the absence of proof as to the serious or slight nature of the trouble, the mere fact that the insured might have received some hospital treatment or care, cannot by itself, relieve the insurer of liability. Same is true when a patient is said to have received surgical attention, the details of which are not forthcoming. There are a large variety of surgical operations of a comparatively minor character which do not affect insurability. The omission to disclose, that for some time Diwan Balkishan had been an indoor patient in a hospital or had been operated upon cannot, in the circumstances of this case, tantamount to an intentional commission of fraud within the terms of section 45.

In order to entitle the insurer to avoid life insurance policy he has to prove that it has been procured by means of fraudulent misrepresentation as to matters material to the risk. In view of my finding, that there has been no such misrepresentation, on the part of the insured, as would fall within the mischief of section 45, the question of materiality recedes into the background. All that need be said in this connection is, that if in my view Diwan Balkishan had knowingly made the false statement that he did not suffer from pulmonary tuberculosis, the insurer could have avoided the policy, as such a misrepresentation or non-disclosure, would have been of a fact, which would influence a prudent insurer in determining, whether to accept the risk, and if so, at what rate or premium.

According to the provisions of section 45, the insurance contract can be avoided on fraud, and

The Lakshmi Insurance Co., Ltd. v. Padma Wati

Tek Chand, J.

a charge of fraud, naturally, requires a high degree of probability. It is well known that fraud is odious and cannot be presumed; *fraus est odiosa et non est praesumenda.* The Courts will not be satisfied with proof, which falls short of showing that intentional misrepresentation was made with the knowledge of perpetrating fraud. The *onus probandi* in all such cases rests heavily on the party alleging fraud. The Privy Council in *Narayanan* v. *Official Assignee, Rangoon,* (1), held, that fraud must be established beyond all reasonable doubt and could not be based on suspicion and conjecture. Applying the test of preponderance of evidence I am not satisfied that the defendant-appellant has discharged the heavy burden of proof.

A number of authorities have been cited at the bar not all of which are to the point, being in the nature of conclusions from the particular facts arising in those cases. In *Benarsi Debi* v. *New India Assurance Co., Ltd.* (2), which was a case under section 45 of the Insurance Act, it was held, that where an objection to a claim under a life policy on the ground of inaccuracy or falsehood in the statements in the proposal, had been admittedly taken after the expiry of two years, from the date on which the policy was effected, there is a heavy onus laid on the insurance company to establish three things: (1) that the false statements were on a material matter, (2) that the policy-holder knew at the time of making them that the statements were false, and (3) that they were fraudulently made.

The learned counsel for the appellant has placed reliance on *Manufacturers Life Insurance Co., Ltd.,* v. *Smt. Haridasi Debi and another* (3). The facts of that case are not in *pari materia* with

(1) A.I.R. 1941 P.C. 93.
(2) A.I.R. 1959 Pat. 540.
(3) A.I.R. 1939 Cal. 8.

The Lakshmi Insurance Co. Ltd.
v.
Padma Wati

Tek Chand, J.

those of this case. There, the insured gave a negative answer to the question "Whether the insured's family had ever suffered from consumption or insanity and whether the insured had lived in the same house or been associated in any way with a case of tuberculosis ?" On the evidence in that case, it was found, that the insured knew that the medical practitioners had diagnosed the disease from which his aunt was suffering as tuberculosis and he had arranged for her treatment on the basis of that diagnosis. It was found that his answer was fraudulent, being an active concealment of a fact within his knowledge or belief. But on the facts of this case, I am not satisfied that the deceased had committed any fraud or misrepresentation. In my view, the first issue was rightly decided by the trial Court in the negative.

The next point which has been canvassed before us concerns the awarding of interest to the plaintiff. The fourth issue on the question whether the plaintiff was entitled to any interest and if so, to what extent, was disposed of by the trial Court simply on the ground that the money was wrongly held by the defendant-company. The plaintiff was entitled to interest at 6 per cent and reference was made to *Adu Ram Sidhu Ram through Uttam Chand and others* v. *Tola Mal* (1).

The plaintiff's case in her plaint is that after the death of her husband, she, as the nominee of the policy-holder, claimed the sum of Rs. 34,000 from the insurance company which had become payable on the two policies. As the insurance company had repudiated its liability, she claimed a sum of Rs. 6,120 as interest, on the principal amount of Rs. 34,000, from 9th of April, 1949 to 8th

(1) A.I.R. 1925 Lahore 651 (1).

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

of April, 1952, the date of the suit,—*vide* para 7. In the prayer clause of her plaint, she claimed a decree for Rs. 40,000, on the sums assured under the two policies, and interest, along with future interest. The decree of the trial Court is silent as to future interest. The plaintiff's suit has been decreed for Rs. 40,000, and for Rs. 3,198-6-0, as costs of this suit. The learned counsel for the plaintiff-respondent relied upon a decision of a Single Judge in *Adu Ram Sidhu Ram through Uttam Chand and others* v. *Tola Mal* (1). In that case, interest was allowed to lender of money, from the borrower, though the alleged agreement to pay interest had not been proved. The ground on which the interest was allowed was, that the Interest Act was not exhaustive of all claims as to interest, and that it was open to the Courts in India, to award interest in cases not coming within the purview of the Interest Act (32 of 1839) and on principles of equity, justice and good conscience. The next decision relied upon by the plaintiff-respondent's counsel was *Messrs. Trojan and Co.* v. *RM N. N. Nagappa Chettiar* (2). The Supreme Court held, that it is well settled, that interest is allowed by a Court of Equity, in the case of money obtained or retained by fraud. It was said, that the agent must also pay interest in all cases of fraud, and on all bribes and secret profits, received by him during his agency. Reliance was placed on a decision of the Privy Council in *Johnson* v. *Rex* (3). In that case, it was laid down that money obtained by fraud, and retained by fraud, could be recovered with interest in a Court which had jurisdiction both equitable and legal, though in a case where question of fraud had been intentionally

(1) A.I.R. 1925 Lahore 651(1).
(2) A.I.R. 1953 Sup, Court 235.
(3) 1904 A.C. 817.

The Lakshmi Insurance Co., Ltd.
v.
Padma Wati

Tek Chand, J.

put aside by the plaintiff, interest was not recoverable on the ground of money having been paid by mistake.

In *Maine and New Brunswick Electrical Power Co. Ltd.* v. *Alice M. Hart* (1), which was an appeal from the Supreme Court of New Brunswick, the Privy Council observed :—

"It remains to consider whether any rule of equity entitles the plaintiff to interest.

In order to invoke a rule of equity, it is necessary in the first instance to establish the existence of a state of circumstances which attracts the equitable jurisdiction, as for example, the non-performance of a contract of which equity can give specific performance.

It must, however, be borne in mind that when once such a contract has been executed, then, apart from cases where rescission on the ground of fraud is sought, there remains nothing to attract the equitable jurisdiction and the parties are left to their remedies at law."

This question was again examined by the Privy Council in *Bengal Nagpur Railway Co. Ltd.* v. *Ruttanji Ramji and others* (2), and the earlier decision of the Privy Council in the aforementioned case was relied upon.

There is no provision of law analogous to section 3 of Law Reforms (Miscellaneous Provisions) Act, 1934, which empowers a Court of Record in England to award interest on debt or damages at such rate as it thinks fit.

(1) A.I.R. 1929 P.C. 185.
(2) A.I.R. 1938 P.C. 67.

In a recent decision of the Supreme Court of India in *Thawardas Pherumal and another* v. *Union of India* (1), this matter was examined in some detail, and it was held, that the following, among other conditions, must be fulfilled before interest can be awarded under the Act :

(1) there must be a debt or a sum certain;

(2) it must be payable at a certain time or otherwise;

(3) these debts or sums must be payable by virtue of some written contract at a certain time;

(4) there must have been a demand in writing stating that interest will be demanded from the date of the demand.

In this case, the plaintiff did not make any such demand from the insurer. Moreover, there is no agreement between the insured and the insurer entitling the former to any interest. No question of market usage, whereby insurers become liable to pay interest on overdue amounts of policy has been pleaded or could possibly arise. Prior to the coming in force of the Law Reforms (Miscellaneous Provisions) Act, 1934 (section 3), the interest upon the money payable upon a policy of insurance upon the life of the insured could not be recovered from the insurer, even though the payment had been wrongfully delayed or where such promise was to be implied from the usage of trade or other obligations. Reference has also been made in the course of the arguments to section 34 of the Code of Civil Procedure, which relates to the discretion of the Court in allowing interest after

(1) A.I.R. 1955 S.C. 468.

The Lakshmi Insurance Co., Ltd. *v.* Padma Wati

Tek Chand, J.

the due date of the suit. In this case, no interest after the suit has been allowed by the trial Court and the plaintiff is not aggrieved on this account as no appeal or cross-objections have been filed in this Court. For reasons stated above, interest must be denied to the plaintiff, and issue No. 4 is decided against her. No other issue has been pressed, and no other point has been taken by the parties.

In the result, the appeal is partly allowed, and the decree passed by the trial Court is amended to the extent, that the defendant-appellant, and now the Life Insurance Corporation of India, is ordered to pay to the plaintiff the sum of Rs. 34,000 and also the proportionate costs of the suit and the appeal.

B.R.T.

P. C. PANDIT, J.—I agree.

CIVIL MISCELLANEOUS.

Before Bishan Narain and Inder Dev Dua, JJ.

RAM PHAL,—*Appellant.*

versus

BRAHAM PARKASH AND OTHERS,—*Respondents.*

F. A. O. 47-D of 1959

Representation of Peoples Act (XLIII of 1951)—Sections 99 and 123(7)—Notice to persons sought to be named—When to be issued—Right to cross-examine witnesses already examined—Whether accrues to the petitioner after the issue of such notice—Trial of election petitions—Matters to be kept in the forefront—Duty of the Tribunal stated—Doctrine of election agency—Whether different from Civil or Criminal Law of agency—Points of difference stated—Section 123(7)—Government Servant canvassing for votes—Whether constitutes corrupt practice on the part of the candidate—Promise by Home Minister with respect to a relief demanded by the tax-payers—Whether amounts to "undue influence."