RESEARCH QUESTION

> *"What can a policyholder in India do when a health insurance claim is rejected or partially settled, what do IRDAI regulations say about claim settlement and pre-existing conditions, and what have courts and the insurance ombudsman held about wrongful repudiation?"*

Remedies for Health Insurance Claim Repudiation, IRDAI Framework, and Judicial Standards on Pre-Existing Conditions

TL;DR

The Supreme Court in *United India Insurance Company Ltd. v. Manubhai Dharmasinhabhai Gajera* (2008) established that public sector insurers must act fairly and reasonably, and cannot arbitrarily exclude newly developed diseases or refuse policy renewal to reject claims. When health insurance claims are rejected or partially settled, policyholders can seek cost-efficient, fair, and equitable relief through the Insurance Ombudsman, or approach Consumer Disputes Redressal Commissions and Permanent Lok Adalats. Under settled jurisprudence, the insurer bears the strict burden of proving deliberate suppression of material pre-existing conditions, and general symptoms or conditions cannot be used for automatic repudiation unless a direct clinical nexus with the hospitalized illness is proven.

VERIFIED CASES	STATUTES	LATEST RULING
13	2	2025
12 *High Courts* · 1 *SC*		*High Court of Punjab and Haryana*

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I. Detailed Analysis

KEY PRINCIPLES ESTABLISHED

01 Insurers bear the strict burden of proof for pre-existing disease allegations

The onus to prove that the insured was suffering from a pre-existing disease and intentionally suppressed material facts at the time of proposal lies entirely upon the insurance company (*Pnb Metlife India Insurance Company Limited v. Mandeep Devi* (2025)).

02 Pre-policy medical examination waives subsequent non-disclosure pleas

Once an insurer subjects the proposer to medical check-ups and is satisfied with the results prior to policy issuance, it is bound by the contract and cannot subsequently escape liability by asserting the non-disclosure of pre-existing ailments (*Bajaj Allianz Life Insurance Company Ltd. v. Smt. Punamlata* (2024)).

03 Insurers must verify unanswered questions in proposal forms

If an insurance proposer leaves a material query regarding pre-existing illness blank in the data sheet or proposal form, the insurer must verify the same before issuing the policy, and cannot later allege active or fraudulent concealment (*National Insurance Company Ltd. v. Virendra Madhusudan Joshi* (2020)).

04 Duty of disclosure is restricted to facts actually known to the insured

A proposer is only under a duty to disclose material facts within their actual knowledge and cannot be penalized for failing to disclose latent medical conditions they could not reasonably have been expected to know (*Bajaj Allianz General Insurance Company Limited v. Kashmir Singh Gill* (2025)).

05 Common ailments do not automatically constitute pre-existing diseases

Metabolic and cardiovascular conditions like general diabetes and hypertension do not automatically qualify as pre-existing exclusions for unrelated cardiac events unless their clinical severity, type, and direct connection are proven (*National Insurance Company Ltd. v. Sanjib Kumar Das* (2019)).

HOW THE COURTS HAVE APPLIED THIS

FORUM FOR REDRESSAL AND JURISDICTION	Policyholders whose claims are wrongfully repudiated or delayed can file a complaint with the Insurance Ombudsman under the Insurance Ombudsman Rules, which covers partial or total repudiation, delay, and non-observance of IRDAI policyholder protection regulations (*Star Health and Allied Insurance Company Limited v. Insurance Ombudsman* (2024)).
ALTERNATIVE FORUMS	Insured beneficiaries are legally classified as "consumers" entitled to file complaints before the Consumer Disputes Redressal Commissions under the Consumer Protection Act, 2019 (*ICICI Lombard General Insurance Company Ltd. v. Noorunissa* (2024)), or approach Permanent Lok Adalats, which hold statutory authority to settle insurance claims up to a pecuniary limit of one crore rupees (*Life Insurance Corporation of India v. The Permanent Lok Adalat* (2023)).
HIGH COURT VARIATIONS	High Courts will not invoke discretionary writ jurisdiction under Article 226 of the Constitution of India to interfere with a fair and equitable award of the Insurance Ombudsman, whose main objective is cost-efficient, impartial, and non-technical claim resolution (*Life Insurance Corporation of India v. Office of the Insurance Ombudsman* (2019)).
REQUIREMENT OF ACTUAL EVIDENCE	Insurers cannot sustain a claim rejection based on posterior medical records or speculative hospital summaries unless they produce tangible, examinee-supported evidence proving a prior diagnosed medical procedure or condition (*Abirami v. State Bank of India* (2025)).
UNRELATED DISEASE AND CAUSE OF DEATH	Claim repudiation on the ground of non-disclosure is improper and arbitrary if the undisclosed condition has no logical, clinical, or fatal nexus with the actual cause of death or hospitalization (*Dr. Ruhul Amin Khan v. The Zonal Manager, L.I.C. of India* (2020)).

UNSETTLED AREAS OR CAVEATS

Utmost good faith is not an absolute shield for insurers

While insurance contracts are governed by *uberrimae fidei* (utmost good faith), the duty of disclosure is bounded by actual knowledge, and insurers cannot use speculative panel doctor opinions guessing that a condition must have pre-existed to avoid their liability under the contract (*Santosh Kumar Banka v. The New India Assurance Co. Ltd.* (2010)).

II. Statutory Provisions 2 PROVISIONS

SECTION 14, INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY ACT, 1999 — DUTIES, POWERS AND FUNCTIONS OF AUTHORITY

Empowers the Authority to protect policyholders' interests regarding claim settlements, terms of contracts, and to regulate the insurance business.

> "Section 14. Duties, powers and functions of Authority
>
> (1) Subject to the provisions of this Act and any other law for the time being in force, the Authority shall have the duty to regulate, promote and ensure orderly growth of the insurance business and re-insurance business.
>
> (2) Without prejudice to the generality of the provisions contained in sub-section (1), the powers and functions of the Authority shall include,-- ... (b) protection of the interests of the policy-holders in matters concerning assigning of policy, nomination by policy-holders, insurable interest, settlement of insurance claim, surrender value of policy and other terms and conditions of contracts of insurance;" *Cited in*: (Not cited in the retrieved case snippets)

SECTION 14B, INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY ACT, 1999 — POWER TO CALL FOR RETURNS CONTAINING POLICY INFORMATION

Enables the Authority to direct insurers to submit statements and details relating to policies and policyholder information.

> "Section 14B. Power to call for returns containing policy information.---(1) For the purpose of enabling the Authority to discharge its functions under this Act and the Insurance Act, 1938, it may at any time direct any insurer or other regulated entities to submit statements relating to policies and policyholder related information in such form and within such time as may be specified by the regulations." *Cited in*: (Not cited in the retrieved case snippets)

III. Cases Discussed

13 CASES · SUMMARY TABLE

#	CASE TITLE	COURT	YEAR	KEY HOLDING
01	*Star Health and Allied Insurance Company Limited v. Insurance Ombudsman* ODHC010342662023	ORISSA HIGH COURT	2024	Ombudsman has jurisdiction to decide complaints regarding total or partial repudiation of claims.
02	*ICICI Lombard General Insurance Company Ltd. v. Noorunissa* HCMA011754312024	MADRAS HIGH COURT	2024	Insurance policy beneficiaries are consumers entitled to seek redress from consumer commissions.
03	*Bajaj Allianz Life Insurance Company Ltd. v. Smt. Punamlata* UPHC020698602024	ALLAHABAD HIGH COURT	2024	Insurers conducting pre-policy medical exams cannot later escape liability alleging pre-existing conditions.
04	*Pnb Metlife India Insurance Company Limited v. Mandeep Devi* PHHC011347342025	HIGH COURT OF PUNJAB AND HARYANA	2025	Burden of proving suppression of pre-existing condition rests entirely upon the insurer.
05	*Life Insurance Corporation of India v. The Permanent Lok Adalat* UPHC011706592016	ALLAHABAD HIGH COURT	2023	Permanent Lok Adalats have valid jurisdiction to resolve claims up to one crore.
06	*Bajaj Allianz General Insurance Company Limited v. Kashmir Singh Gill* PHHC011774402024	HIGH COURT OF PUNJAB AND HARYANA	2025	Proposer is not liable for failing to disclose symptoms not diagnosed as diseases.
07	*National Insurance Company Ltd. v. Sanjib Kumar Das* ODHC010598552018	ORISSA HIGH COURT	2019	General diabetes and hypertension do not automatically qualify as pre-existing cardiac diseases.
08	*Life Insurance Corporation of India v. Office of the Insurance Ombudsman* HCBM020058892017	BOMBAY HIGH COURT	2019	Ombudsman resolves claims in a fair, cost-efficient, and equitable manner without strict technicalities.
09	*Abirami v. State Bank of India* HCMA011279022020	MADRAS HIGH COURT	2025	Arbitrary repudiation is invalid if insurer's own pre-policy medical checks showed normal health.
10	*National Insurance Company Ltd. v. Virendra Madhusudan Joshi* HCBM010417192015	BOMBAY HIGH COURT	2020	Insurers must verify unanswered proposal queries prior to policy issuance to assert suppression.
11	*Santosh Kumar Banka v. The New India Assurance Co. Ltd.* BRHC010284452008	PATNA HIGH COURT	2010	Utmost good faith obligation is limited strictly to facts within actual knowledge.

#	CASE TITLE	COURT	YEAR	KEY HOLDING
12	*Dr. Ruhul Amin Khan v. The Zonal Manager, L.I.C. of India* UPHC010362472009	ALLAHABAD HIGH COURT	2020	Repudiation is improper if undisclosed pre-existing symptom is completely unrelated to death cause.
13	*United India Insurance Company Ltd. v. Manubhai Dharmasinhabhai Gajera* ESCR010014902008	SUPREME COURT OF INDIA	2008	State insurers must renew policies fairly without arbitrary exclusions for newly developed illnesses.

IV. Case Details 13 CASE FILES

01 Star Health and Allied Insurance Company Limited v. Insurance Ombudsman

ORISSA HIGH COURT · 2024-11-21 · WP(C)/14213/2023

The petitioner, an insurance company, challenged an award passed by the Insurance Ombudsman that directed the payment of a health insurance claim. The insurer argued that the claimant had obtained the policy through fraud by concealing a pre-existing medical condition, specifically a brain tumour, for which she had received prior medical advice. The insurer further alleged that the treating physician had provided a false certificate claiming no prior history of the illness. The court examined the evidence of non-disclosure and misrepresentation of material facts by the insured when applying for the policy. Ultimately, the court reviewed the validity of the repudiation based on these findings of suppression of health history.

HELD The Insurance Ombudsman holds valid statutory powers to receive and resolve disputes alleging deficiencies in insurance performance, including partial or total claim repudiations, delays, and non-observance of IRDAI policyholder protection regulations. The Ombudsman must act as an equitable mediator and pass awards that are fair under the circumstances.

> “Duties and functions of Insurance Ombudsman.— (1) The Ombudsman shall re ceive and consider complaints alleging deficiency in performance required of an insurer (including its agents and intermediaries) or an insurance broker, on any of the following grounds:— (a) delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999; (b) any partial or total repudiation of claims by th e life insurer, General insurer or the health insurer; ... (i) any other matter arising from non -observance of or non -adherence to the provisions of any regulations made by the Authority with regard to protection of policyholders‘ interests or otherwise, or of any circular, guideline or instruction issued by the Authority”

ORISSA HIGH COURT · 2024 SOURCE ODHC010342662023

02 ICICI Lombard General Insurance Company Ltd. v. Noorunissa

MADRAS HIGH COURT · 2024-12-02 · CRP/4445/2024

The petitioner, an insurance company, challenged an order passed by the District Consumer Disputes Redressal Commission, arguing that the complainant was not a 'consumer' and therefore the Commission lacked jurisdiction to decide the matter regarding the delay in remitting TDS amounts. The High Court, relying on Supreme Court precedent, observed that the definition of a consumer under the Consumer Protection Act is broad enough to include beneficiaries of insurance services, thus affirming the jurisdiction of the District Commission. Without addressing the merits of the deficiency of service claim, the court dismissed the revision petition, noting that the petitioner has an alternative statutory remedy by filing an appeal before the State Commission. The court granted the petitioner liberty to approach the State Commission, directing that the time spent during the pendency of the revision be excluded from the limitation period.

HELD A beneficiary of an insurance contract who avails of or hires services for consideration is classified as a "consumer" under Section 2(7)(ii) of the Consumer Protection Act, 2019. Consequently, Consumer Commissions possess full jurisdiction to entertain and adjudicate disputes regarding deficiencies in insurance services.

> "The respondent is the beneficiary of the insurance . Therefore, she certainly will come within the ambit of the consumer. ... (ii) hires or avails of any service for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such service other than the person who hires or avails of the services for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person"

MADRAS HIGH COURT · 2024 SOURCE HCMA011754312024

03 Bajaj Allianz Life Insurance Company Ltd. v. Smt. Punamlata

ALLAHABAD HIGH COURT · 2024-10-03 · /8642/2024

The petitioner challenged an order by the Permanent Lok Adalat which directed them to pay an insurance claim following the death of the policyholder. The insurance company had initially repudiated the claim, alleging the deceased failed to disclose a pre-existing chronic liver disease. The court upheld the Lok Adalat's decision, noting that the insurance company had conducted a medical examination of the insured prior to issuing the policy and was satisfied with his health at that time. Consequently, the court ruled that the company could not rely on non-disclosure of a pre-existing ailment to escape liability after they had independently verified the insured's medical condition and accepted the premium.

HELD Where an insurer carries out its own pre-policy medical screening and independently satisfies itself of the proposer's health condition, it cannot subsequently escape liability or repudiate claims under the guise of *uberrima fides* based on posterior investigations of pre-existing diseases.

> "Once the policy has been issued after due satisfaction by the insurance company and they have received premium then the contract is binding on both the parties and merely because it suits the insurance company that subsequently during the investigation came to know about pre-existing disease could not be a reason in itself to escape from their liability under the insurance policy. Had the petitioner not medically examined the deceased and satisfied itself with regard to his medical condition, it was certainly open for them to have taken advantage of the pre-existing disease but after they have satisfied themselves about the medical condition of the deceased it was not open for them to repudiate the claim on the basis of uberrima fides."

ALLAHABAD HIGH COURT · 2024 SOURCE UPHC020698602024

04 Pnb Metlife India Insurance Company Limited v. Mandeep Devi

HIGH COURT OF PUNJAB AND HARYANA · 2025-08-27 · CWP/24937/2025

The dispute arose after the petitioners repudiated a life insurance death claim, alleging that the insured individual had failed to disclose a pre-existing cancer diagnosis when applying for the policy. The nominee of the deceased filed a consumer complaint, arguing that the insurer failed to provide any medical evidence supporting their claim of non-disclosure. The District Consumer Forum, upheld by the State Consumer Commission and the National Consumer Disputes Redressal Commission, ruled in favor of the nominee, finding that the insurer failed to provide cogent, tangible evidence to substantiate the allegation of a pre-existing condition. The court affirmed that the burden of proving suppression of material facts rests entirely on the insurer.

HELD The entire burden of proving that the insured actively suppressed material facts concerning a pre-existing disease rests upon the insurer. The insurer must provide concrete, tangible medical evidence of prior treatment and hospitalization, and cannot rely on wild guesswork or uncorroborated investigator reports.

> “From the repudiation letter it is clear that the repudiation has been made on the ground of non-disclosure of material facts regarding pre-existing disease as the OPs alleged that the DLA was suffering from cancer prior to the issuance of the policy, therefore, the onus to prove that the DLA was suffering from Cancer prior to the issuance of the policy was upon the OPs. ... since the respondents had come out with the case that the deceased did not disclose correct facts relating to his illness, it was for them to produce cogent evidence to prove the allegation. However, as found by the District Forum and the State Commission, the respondents did not produce any tangible evidence to prove that the deceased had withheld Information about his hospitalization and treatment.”

HIGH COURT OF PUNJAB AND HARYANA · 2025 SOURCE PHHC011347342025

05 Life Insurance Corporation of India v. The Permanent Lok Adalat

ALLAHABAD HIGH COURT · 2023-04-06 · WRIC/20577/2016

The Life Insurance Corporation of India challenged an award by the Permanent Lok Adalat directing them to pay a death claim of 14 lakh rupees. The Corporation argued that the claim was invalid due to the insured's failure to disclose pre-existing health conditions in the proposal form, thereby breaching the principle of utmost good faith. They also challenged the jurisdiction of the Lok Adalat regarding the claim amount and alleged a failure to follow mandatory conciliation procedures. The Court noted that the pecuniary jurisdiction limit for the Permanent Lok Adalat had been increased to one crore rupees by a 2015 government notification, rendering the jurisdictional challenge meritless. As the litigation proceeded on merits and the petitioner failed to raise procedural objections at the appropriate time, the Court upheld the award.

HELD Permanent Lok Adalats hold valid jurisdiction to decide claims and award binding compensations in insurance matters up to a limit of one crore rupees. Claims cannot be repudiated on the ground of pre-existing health conditions if the insurer's medical examiner conducted a confidential pre-policy examination and found everything fine.

> “The pecuniary jurisdiction limit for the Permanent Lok Adalat had been increased to one crore rupees by a 2015 government notification … before accepting the policy, the insured was medically examined by the Medical Examiner of L.I.C. and the confidential report of the Medical Examiner of L.I.C. … in which, there was nothing adverse to the insured, therefore, the order of repudiating the claim cannot be sustained.”

ALLAHABAD HIGH COURT · 2023 SOURCE UPHC011706592016

06 Bajaj Allianz General Insurance Company Limited v. Kashmir Singh Gill

HIGH COURT OF PUNJAB AND HARYANA · 2025-03-03 · CWP/34766/2024

The petitioner-insurance company challenged a National Consumer Disputes Redressal Commission order directing it to reimburse medical expenses incurred by the respondent for 'haematuria' treatment while traveling in the USA. The insurer argued the condition was pre-existing and undisclosed. The Court found that the insurer had conducted a medical examination, including a urine test, prior to issuing the policy and declared the respondent fit. Furthermore, the Court observed that 'haematuria' is a symptom rather than a disease, and no evidence showed the respondent sought prior treatment for it. Relying on the principle that an insurer cannot repudiate a claim for a condition it failed to detect during its own medical screening, the court dismissed the petition.

HELD The duty of good faith requires a proposer to disclose only those material facts that are within their actual knowledge. An insurer cannot reject a claim based on an undisclosed symptom (such as blood in urine) which was never clinically diagnosed or treated as a specific disease, particularly where the insurer's pre-policy screening declared the respondent fit.

> “However, the assured is not under a duty to disclose facts which he did not know and which he could not reasonably be expected to know at the material time. … A bare reading of the above, would reveal that it would be difficult to consider ‘haematuria,’ by itself, as an ailment or disease. It simply refers to presence of blood in the urine, which, by itself, is not a disease, though it could be a symptom of several conditions … In the instant case, there is nothing to indicate that the respondent No.1 had followed up the symptoms, sought diagnosis and treatment.”

HIGH COURT OF PUNJAB AND HARYANA · 2025 SOURCE PHHC011774402024

07 National Insurance Company Ltd. v. Sanjib Kumar Das

ORISSA HIGH COURT · 2019-07-23 · WP(C)/20490/2018

The National Insurance Company challenged an award by the Permanent Lok Adalat that ordered the payment of a medical insurance claim. The insurance company had originally repudiated the claim on the grounds that the policyholder suppressed a pre-existing condition, specifically diabetes and hypertension, which contributed to a subsequent cardiac event. The court affirmed the findings of the Lok Adalat, holding that general conditions like diabetes and hypertension do not automatically qualify as pre-existing diseases for unrelated heart ailments in the absence of evidence regarding their severity or clinical connection. The court upheld the claim amount but

modified the order by reducing the compensation and litigation costs while maintaining interest requirements upon default.

HELD General conditions such as diabetes or hypertension do not automatically constitute "pre-existing diseases" to deny coverage for cardiac events. Insurers cannot reject claims on such grounds unless they show the specific severity or direct clinical contribution of these conditions to the diagnosed cardiac illness.

> “The Medical Discharge Papers perused by me, as submitted by learned counsel for the Petitioner, show that Opposite Party No.1 was admitted in the Hospital for some cardiac problem and he was a diabetic and had hyper-tension. There is nothing on record to show regarding the degree of diabetis or type of diabetis of the Opposite Party No.1 or the status of his hyper-tension. Long diabetis and hyper-tension may contribute to heart ailment, but such disease of diabetis and hyper-tension cannot be said to be a “pre-existing disease” so far as heart ailment is concerned.”

ORISSA HIGH COURT · 2019 SOURCE ODHC010598552018

08 Life Insurance Corporation of India v. Office of the Insurance Ombudsman

BOMBAY HIGH COURT · 2019-04-03 · WP/2359/2017

The petitioner, Life Insurance Corporation of India, challenged an Insurance Ombudsman's award directing the refund of premiums with interest to an insured policyholder. The dispute arose when the insurer claimed a typographical error in the policy document regarding the Maturity Sum Assured (MSA), which was only disclosed to the insured after the 11-year policy term concluded. The insurer argued the Ombudsman exceeded its jurisdiction by disregarding contractual terms. The High Court upheld the Ombudsman's decision, finding that the insurer could not unilaterally alter material contract terms after 11 years. The court held that the Ombudsman's role is to resolve grievances in a fair and equitable manner, and deemed the award reasonable given the insured could not have known of the error.

HELD The Insurance Ombudsman possesses wide equitable jurisdiction to resolve disputes relating to the settlement of claims in a cost-efficient, impartial, and fair manner. High Courts will not invoke writ jurisdiction under Article 226 of the Constitution to interfere with fair and equitable awards passed by the Ombudsman.

> “The Ombudsman shall act as counsellor and mediator in matters which are within his terms of reference... the Ombudsman shall pass an award which he thinks fair in the facts and circumstances of a claim. ... the object of the Rules is to resolve all complaints relating to settlement of claim on the part of insurance companies in cost efficient and impartial manner.”

BOMBAY HIGH COURT · 2019 SOURCE HCBM020058892017

09 Abirami v. State Bank of India

MADRAS HIGH COURT · 2025-09-01 · WP/20044/2020

The petitioner challenged an insurance ombudsman's decision that upheld the denial of a life insurance claim. The insurer had rejected the claim upon the death of the petitioner's father, alleging non-disclosure of pre-existing heart conditions and a prior medical procedure. However, the court found that the insurance policy was issued only after the insurer's own panel doctor conducted medical tests, including a treadmill test, which showed no cardiac abnormalities at the time of the proposal. The court concluded that the insurer failed to provide sufficient evidence to prove the alleged pre-existing illness or the occurrence of a prior medical procedure, rendering the rejection of the claim arbitrary and unjustified.

HELD Repudiation of an insurance claim is arbitrary when the policy was issued following normal/negative pre-policy cardiovascular screening tests (such as a Treadmill Test) conducted by the insurer's panel doctor. Insurers cannot rely on posterior documents or medical summaries without examining their authors or establishing prior diagnosed diseases.

> "Treadmill Test, wherein, the opinion with regard to the condition of the heart has been recorded as 'TMT Negative for Inducible Ischemia', meaning thereby that at the time when the test was performed, no abnormal condition was found with regard to the functioning of the heart. ... Medical check up of the life assured was undertaken on 28.5.2017, wherein as well there was no abnormal opinion recorded by the doctor, who was the panel doctor of the insurer. ... The whole case has been looked into by the 4th respondent by placing reliance on a document, which had come posterior in point of time to the taking of the policy."

MADRAS HIGH COURT · 2025 SOURCE HCMA011279022020

10 National Insurance Company Ltd. v. Virendra Madhusudan Joshi

BOMBAY HIGH COURT · 2020-02-21 · WP/7767/2016

The petitioner challenged an order dated 20th March 2015 passed by the learned Insurance Ombudsman, Pune directing the payment of an amount of Rs.10,39,000/- by way of ex-gratia payment to the respondent. The petitioner argued that there was suppression of pre-existing diseases (hypertension) as the question was left blank in the datasheet, and that the Ombudsman was unreasoned and exceeded jurisdiction. The High Court rejected these contentions, holding that the insurer should have verified any unanswered questions on the data sheet before issuing the policy, and that the pre-existing condition (hypertension) was unrelated to the acute ischemic heart disease episode.

HELD If a material query regarding health is left completely unanswered in a proposal form or data sheet, the insurer bears the responsibility to verify it before issuing the policy. Having failed to do so, the insurer cannot later disown liability by claiming active suppression, particularly when the pre-existing ailment has no clinical connection with the acute medical episode.

> "It does not appear that the question about pre-existing illness or medicine was answered either in the affirmative or in the negative so as to demonstrate that there was an active or intentional concealment on behalf of the petitioner. It is necessary to note that if at all a particular question which was material before the petitioner could have issued the medical policy was not answered either in the affirmative or in the negative, it was for the petitioner to have verified the same. ... the Ombudsman has rightly found that the pre-existing ailment has nothing to do with the episode of acute IHD"

BOMBAY HIGH COURT · 2020 SOURCE HCBM010417192015

11 Santosh Kumar Banka v. The New India Assurance Co. Ltd.

PATNA HIGH COURT · 2010-05-10 · CWJC/7509/2008

The petitioner sought reimbursement for medical expenses under a Mediclaim policy after undergoing treatment for a heart condition. The insurer repudiated the claim, citing the policy's exclusion clause for pre-existing conditions, alleging the ailment existed before the policy's inception. The court observed that the insurer failed to produce evidence of deliberate suppression of material facts or prior knowledge by the insured at the time of proposal. Following the principle that disclosure obligations depend on the applicant's actual knowledge, the court quashed the repudiation letters and directed the insurer to settle the claim.

HELD Under *uberrimae fidei*, an insurance contract demands utmost good faith, but the proposer's obligation to make full disclosure is limited strictly to facts within their actual knowledge. Insurers cannot reject claims based on speculative panel doctor opinions guessing that a disease must have existed prior to policy inception.

> "Thus, it needs little emphasis that when an information on a specific aspect is asked for in the proposal from, an assured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. ... Of course, the obligation to disclose extends only to facts which are known to the applicant and not to what he ought to have known. The obligation to disclose necessarily depends upon the knowledge one possesses. ... the Company has not done any wrong in repudiating the claim in view of the opinion of the so called panel of doctors that the problem of the petitioner for which he under went treatment must have pre-existed."

PATNA HIGH COURT · 2010 SOURCE BRHC010284452008

12 Dr. Ruhul Amin Khan v. The Zonal Manager, L.I.C. of India

ALLAHABAD HIGH COURT · 2020-01-27 · WRIC/69563/2009

The petitioner challenged the repudiation of a life insurance claim following his wife's death. The insurance company claimed the insured had failed to disclose prior medical history, specifically body pains, in the proposal form. The court noted the insured died from dengue fever, an unrelated ailment, and that the insurer failed to provide substantial evidence that any undisclosed condition was material or fatal. Distinguishing this from cases where critical health history was intentionally concealed, the court held that the repudiation was unjustified. The court set aside the rejection orders and directed the insurance company to process the claim.

HELD Claim repudiation on the ground of non-disclosure is illegal and unjustified if the allegedly concealed health condition or symptom (such as general palpitations or lumbar spondylitis) is completely unrelated to the actual fatal cause of death or hospitalization (such as dengue fever or myocardial infarction).

> "The death of the insured due to ischaemic heart disease and myocardial infarction had nothing to do with this lumbar spondylitis with PID with sciatica. In our considered opinion, since the alleged concealment was not of such a nature as would disentitle the deceased from getting his life insured, the repudiation of the claim was incorrect and not justified."

ALLAHABAD HIGH COURT · 2020 SOURCE UPHC010362472009

13 United India Insurance Company Ltd. v. Manubhai Dharmasinhabhai Gajera

SUPREME COURT OF INDIA · 2008-05-16 · 2008 INSC 730

This case concerned whether public sector insurance companies could arbitrarily refuse the renewal of medical insurance policies for their policyholders. The Supreme Court held that while renewal of a mediclaim policy is not strictly automatic, it should ordinarily be granted subject to just exceptions. Because public sector insurance companies function as 'State' entities under the Constitution, they are bound to act fairly, reasonably, and without discrimination. The Court determined that companies cannot refuse to renew policies simply because the insured made claims in previous years or developed a new disease after the initial policy was issued. Consequently, such companies must adhere to statutory guidelines and ensure their actions do not violate public policy or fair practice principles.

HELD Public sector insurance companies are bound by public law obligations to act fairly and reasonably under Article 226. When an exclusion clause is resorted to, its terms must be strictly given effect, and an insurer cannot deny policy renewal or claim settlement merely because a disease developed after the inception of the initial cover.

> "When an insurance policy is cancelled, the conditions precedent therefor must be fulfilled. Some reasons therefor must be assigned. When an exclusion clause is resorted to, the terms thereof must be given effect to. What was necessary was a pre-existing disease when the cover was inspected for the first time. Only because the insured had started suffering from a disease, the same would not mean that the said disease shall be excluded."

SUPREME COURT OF INDIA · 2008 SOURCE ESCR010014902008