NEW SYLLABUS

442

Roll No. ..... **OPEN BOOK EXAMINATION**

Time allowed : 3 hours ***Maximum marks : 100***

Total number of questions : 6 ***Total number of printed pages : 9***

NOTE : *1. Answer **ALL** Questions.*

2. Suitable assumptions, if considered necessary, may be made while answering a question. However, such assumptions must be stated clearly.

1. A was issued a Life Insurance 'Jeevan Anand' Policy No. 12345678 with sum assured of ₹ 5,00,000. B his spouse was a nominee under the said Policy. The date of commencement of the Policy was 4.12.2012. Unfortunately, on 26.9.2015, due to unknown reasons A committed suicide. B lodged a claim with the Divisional Manager of XYZ Insurance Co. Ltd., but the same was rejected, vide letter dated 24.6.2016, on the ground that the deceased concealed material facts at the time of buying the insurance policy. B filed an appeal before the Zonal Manager of XYZ Co. Ltd. against the order of the Divisional Manager of XYZ Co. Ltd. The Zonal Office upheld the repudiation decision of the Divisional Office and dismissed the Appeal, vide order dated 9.11.2016. B then filed an Appeal before the Claims Disputes Redressal Committee, XYZ Co. Ltd. of India, no decision was taken by the aforesaid Committee for quite a long time. B then filed a complaint before the National Consumer Redressal Commission, New Delhi.

The Complaint was contested by XYZ Co. Ltd. stating that after the death of the deceased life assured (for brevity 'DLA'), a claim was lodged which was immediately examined and it was found that the DLA was suffering from Bipolar Disorder (a mental illness) and had taken treatment from different places and this material information had been deliberately suppressed by him while taking the Policy. In the proposal form made on 2.2.2012, while filling the questionnaire regarding his medical condition, he answered in the negative. However, the deceased remained hospitalised at Neuro Psychiatry and Drug Deaddiction Rehabilitation Centre during 2008 to 2009 and later in 2015. Hence, the claim of the Respondent (B) was repudiated, vide letter dated 24.6.2016, pleading that there was no deficiency in service

or unfair trade practice on the part of the Insurer and prayed for dismissal of the Complaint. XYZ Co. Ltd. further stated that the Consumer Courts at District and State levels erred in interpreting section 45 of the Insurance Act, 1938. According to section 45 of the Act, which has been amended w.e.f. 26.12.2014, Policy is not to be questioned on ground of misstatement after three years. It was further stated that the State Commission and District Forum failed to appreciate the law laid down by this Commission in other cases. In one of the case, the Policy was questioned after two years and the Hon'ble Commission had observed that as the insured made untrue declaration, as such the orders of the Fora below were set aside and the Consumer Complaint was dismissed. The Insurance company submitted that the insured was under solemn obligation to make true and full disclosure of information which was within his knowledge, in the proposal form and withholding of such information or making misstatement was a fraudulent act and breach of principle of utmost good faith and the insurer was justified in repudiating the claim under the provisions of section 45 of the Insurance Act, 1938. It was further submitted that both the consumers forums at District as well as State Level erred in appreciating that life insurance agents do not act as an agent of XYZ Co. Ltd. The agents work on commission basis, and there was no relationship of employer-employee or master-agent between the XYZ Ltd. and the agents. It also submitted that in various cases Hon'ble Supreme Court has held, ''It is settled law that terms of the policy shall govern the contract between the parties, they have to abide by the definition given therein and all those expressions appearing in the policy should be interpreted with reference to the terms of policy and not with reference to the definition given in other laws. It is a matter of contract and in terms of the contract the relation of the parties shall abide and it is presumed that when the parties have entered into a contract of insurance with their eyes wide open, they cannot rely on definition given in other enactment. XYZ Co. Ltd. also mentioned that in the said judgement, Hon'ble Supreme Court also observed that, ''In interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves."

The District Forum directed the Petitioner to pay ₹ 5,00,000 being death claim of the deceased to the Complainant and ₹ 25,000 as Compensation for deficiency in service, unfair trade practice and mental agony suffered by the Respondent along with ₹ 10,000 towards cost of litigation. The above order was to be complied within 30 days of its receipt by the Petitioner (Insurance Company). Thereafter, they shall be liable for an interest @ 12% p.a. from the date of institution of this Complaint, till it is paid, apart from cost of litigation. Being aggrieved by the order of the District Forum, the Petitioner filed an Appeal before the State Commission. The State Commission, vide order dated 28.11.2017, dismissed the Appeal and upheld the order passed by the District Forum. It stated that the A took the life insurance policy on 4.12.2012, whereas he died on 26.9.2015 i.e. after a period of more than two and a half years from the date of commencement of the policy. Being aggrieved by the order passed by the State Commission, the Petitioner Insurance company filed the Revision Petition before this Commission (National Commission).

According to B, the deceased was asked to simply put his signature on the proposal form and rest of the columns and answers were filled by the insurance agent. The entire proposal form was filled in the handwriting of the insurance agent. The deceased cannot be made responsible for concealing information, filed by the insurance agents.

The National Commission heard the Learned Counsel for the Insurer Petitioner as well as B the Respondent.

The Respondent's contention was that the insured was simply asked to append his signature and all other answers were filled in by the agent, in his own handwriting. The deceased cannot be held responsible for concealing any facts. This aspect is well covered by judgment in LIC *Vs.* Bina Joshi where the entries filled by agents, the policy holders were not blamed for concealing information.

It is very clear that as per Section 45 of the Act in force when the proposal was made and Policy taken, no Insurance Policy can be repudiated after two years on the grounds of concealment/suppression of facts. The amendment to Section 45 providing a period of three years came later in 2014. The present case is covered by this section before its amendment and the deceased died after more than two years nine months after taking the Policy.

In view of the above, National Consumer Commission confirmed the orders of the State Commission and the District Forum and dismissed the Revision Petition filed by XYZ Co. Ltd.

From the information given above, answer the following questions :

(*a*) What types of Consumer Courts are available for insurance complaints ? Explain powers of the lowest consumer court.

(*b*) Was the National Consumer Commission justified in its decision ? Give reasons for your answers citing relevant case laws if any.

(*c*) Explain the provisions of Section 45 of Insurance Act, 1938 and how do these provisions affect the assured after the amendment of 26.12.2014 ?

(*d*) Would the decisions of the Consumer Forums have been different if the assured had committed suicide before 03.12.2014 ?

(*e*) Explain the procedure of claims in case of different types of life insurance policies.

(*8 marks each*)

2. ABC Insurance Limited received a proposal on 1st April, 2019 from M/s MC Pvt. Co. Ltd., a proprietary firm to take a fire and allied insurance policy. The proposer was a chemical manufacturer and their plant was commissioned in November, 2017. The proposal required coverage for :

Building :	₹ 80 lakhs
Plant and Machinery :	₹ 95 lakhs
Stocks :	₹ 1.6 crores

The insurance company issued fire and allied perils policy without carrying out any inspection. M/s. MC Co. Ltd. sent a communication on 24th September, 2019 intimating about a major fire accident in the factory in the early morning hours of 24th September. This intimation though email received by the insurance company on 24th September was followed by a detailed letter and claim form claiming full loss of the stocks of ₹ 1.4 crores in stock on that day and also damage to the Plant and Machinery estimated at ₹ 20 lakhs. The stocks were all hazardous chemicals. The claim form stated that the Fire originated in the control room and spread to the machinery and stocks. The fire brigade report also stated the probable cause of the fire also as accidental.

ABC Insurance Limited deputed XYZ Surveyors to survey and assess the loss. The surveyors submitted the report assessing the losses as under :

Particular	Assessed loss
Plant and Machinery	₹ 22 lakhs
Stocks	₹ 1.3 crores

The insurance company immediately on receipt of the first intimation from the insured deputed its claim officer R an engineer to the factory at about 11 am of 24th September, 2019. R could meet S son of the proprietor of the firm G who was out of the factory during that time. R observed that the fire had been extinguished by that time. He also observed that the electrical wiring on the wall was at a safe distance from the machinery and stock. The insurance company while processing the claim asked for various documents from the insured which included copies of invoices, bank statements, books of accounts, electricity bills and other relevant papers from the date of inception to the date of fire. On the scrutiny of the documents submitted it was found that the purchases of the raw materials and sales of finished goods were quite high but the bank transactions were too small not justifying the volume of sales and purchases and stocks. The electricity bills were also too small as compared to the level of operations claimed by sales and purchases. Even one of the electricity bills had a remark ‘premises closed’. These facts aroused suspicion in the minds of officials of the insurance company. The insurance company deputed N, a Chartered Accountant to investigate the claim.

N submitted the investigation report on 5th December, 2019. The main observations from her report were :

(*i*) Most of the purchases invoices were from non-existent parties.

(*ii*) The GST registration numbers mentioned on the invoices were fake.

(*iii*) The GST authorities confirmed that the numbers were fake.

(*iv*) One of the customers mentioned in the sales invoices confirmed that he never purchased any goods from M/s MC Co. Pvt. Ltd. and he showed a letter from M/s MC Co. Ltd. that their plant was closed and not in operation, so no supplies could be made due to non-production for long. Copy of the letter was submitted with the report.

ABC Insurance Limited sent a letter to M/s MC Pvt. Co. Ltd. on 8th December, 2019 repudiating the claim. The insurance company also complained to IRDAI for alleged misconduct on the part of the surveyors.

However it did not lodge any police complaint against M/s MC Co. Ltd. for the alleged or attempted fraud. It however, confidentially circulated brief particulars of the claim among members of the general insurers' association.

As an insurance expert you are required to comment on the following with reasons :

(*i*) The Insurance Company had deputed a Chartered Accountant for investigating the claim in detail. What are the reasons that led to investigation ? Is the Insurance company justified in repudiating the claim ? How will the insurer justify in the Consumer Court ?

(*6 marks*)

(*ii*) Comment on the role of surveyor in this case. Did he discharge his duty ? What in your opinion should be the Regulation action for such surveyors ?

(*6 marks*)

3. (*a*) A company RST Limited has the following policies of fire from the insurers for its stocks at its manufacturing unit :

Standard Policy A = ₹ 50,00,000

Standard Policy B = ₹ 30,00,000

Declaration Policy C = ₹ 1,00,00,000

A fire took place on 15th July, 2020. The value of stocks at the time of fire was ₹ 1,50,00,000. The loss of stocks due to fire was assessed at ₹ 15,00,000. Calculate the claim amount under each of the three policies. State the principle of Insurance, governing the above claim settlement process.

(*6 marks*)

(*b*) Distinguish between ''Agent'' and ''Broker''. What actions does the Regulator take when there is a breach in their code of conduct ?

(*6 marks*)

4. (*a*) What is Nomination ? Explain the difference between Nomination and Assignment citing relevant sections and provisions of the Act. Which of these clause can be used for Estate Planning by an individual ?

(*b*) Differentiate between surrender value and paid up value. Which is a better option for a policyholder to exercise, if he wants to discontinue the policy ?

(*6 marks each*)

5. (*a*) What are the features of Sovereign Gold Bonds ? And how does the scheme help in the economic welfare of the country.

(*b*) What is a Reinsurance Contract ? How is it helpful as a Risk Management ? Examine for an Insurance Company.

(*6 marks each*)

6. S from Indore, purchased a Jeep Compass from its Authorised Dealer in Mumbai 24th April, 2019 for a sum of ₹ 21,24,000. The vehicle bearing registration No. MP-09-UA-1413 was insured comprehensively from 24th April, 2019 to 23rd April, 2020 with ABC Insurance Company. S went to RNT Marg for some official work on 23rd May, 2019 where he parked and locked the car in a parking area. He returned to the parking area at about 5 PM. To his surprise, he found the vehicle missing. He searched for the car frantically and on not finding it, lodged an FIR with the M. G. Road police station for the missing car. Next day, he also informed the insurance company in writing about the said theft of the vehicle. Despite vigorous efforts of the police, the vehicle could not be traced. Hence, after 90 days, the police gave a non-traceable certificate/report to S. S, thereafter, again pursued the matter of settlement of claim with the insurance company and submitted a copy of the purchase invoice of the vehicle along with copies of the relevant documents. The insurance company did not respond positively and kept delaying the matter on one pretext or the other.

S was aggrieved by this inaction on the part of the insurer, filed a complaint with the District Forum. During the pendency of the complaint, the insurance company repudiated the claim on the ground that the vehicle was being used as a Taxi. The District Forum, after hearing both sides, directed the insurance company to pay S, the insured declared value of the vehicle, i.e., ₹ 21,24,000 along with interest @ 6% p.a. from four months after the date of lodging of claim till realisation. The District Forum also awarded ₹ 15,000 as costs. The insurance company filed an appeal before the State Commission. The plea highlighted the fact that the insurer was not liable to reimburse the loss of stolen vehicle as the same was being used as a taxi. This plea was rejected by the State Commission by observing that theft of the vehicle had nothing to do with the use of the vehicle. The appeal, therefore, was dismissed and the awarded amount was ordered to be released by the insurer.

The insurance company further filed a revision petition before the National Forum. During arguments, both sides vehemently advocated their views. Finally, it was pointed out by the counsel of the insured that in the decided case of 'National Insurance Company Ltd. *Vs.*

Nitin Khandelwal', the Supreme Court had held that, ''in a case where the vehicle had been snatched or stolen, the breach of condition is not germane and the insurance company is liable to indemnify the owner of the vehicle where the insured owner has obtained a comprehensive policy for the vehicle in question." In view of the aforesaid judgment of the apex court in the earlier order of the State Commission in the 'Nitin Khandelwal case of 2008', the counsel for the insurance company did not press the point that insurer was not liable to reimburse for the stolen vehicle because it was being used as a taxi. Hence, the claim was finalised at 75% on 'non-standard basis' as upheld earlier by the Supreme Court in 2008 plus cost.

In light of the above, answer the following :

Question

(*i*) Was the stand taken by the Insurance company to settle the claim on ''Non-standard basis" justified ? Give reason. Explain the concept of standard claim and non-standard claim.

(*12 marks*)

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