JUDGMENT SHEET

ISLAMABAD HIGH COURT, ISLAMABAD
JUDICIAL DEPARTMENT

1. Writ Petition No. 294 of 2024
United Insurance Company of Pakistan Limited
Versus
President of Pakistan and others

Date of Hearing 24.06.2025

2. Writ Petition No. 2015 of 2023
United Insurance Company of Pakistan Limited
Versus
President of Pakistan and others

Date of Hearing 24.06.2025

3. Writ Petition No. 605 of 2024
United Insurance Company of Pakistan Limited
Versus
President of Pakistan and others

Date of Hearing 03.07.2025

Petitioner by:	M/s Ali Ibrahim and Barrister Faiza Asad, Advocates.
Respondents No. 1 & 3 by:	Mr. Muhammad Saeed Raja, DAG.
Respondents No. 2 by:	M/s Anees Jillani and Abid Hassan, Advocates (in W.P No.294/2024). Rana Abdul Hafeez, Advocate (in W.P No.2015/2023). Respondent No.2 in person in W.P No.605/2024.
Assisted by:	Muhammad Yahya Khan Niazi and Muhammad Fahad, Advocates.

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INAAM AMEEN MINHAS, J:- This judgment shall decide the aforementioned writ petitions, as they involve similar questions of law and facts.

2. In all the petitions, the petitioner United Insurance Company of Pakistan Limited **("Insurance Company")** has assailed the orders passed by respondent No.1 i.e. the President of Pakistan and respondent No.3 i.e. Federal Insurance Ombudsman **("FIO")**.

3. The facts, in brief, leading to the filing of the W.P. No. 294/2024 are that the Insurance Company issued a travel insurance policy titled "UIC Travel & Health Guard Policy" **("Subject Policy")** to respondent No. 2 (Zarina Jillani) on 06.09.2022, effective from 10.09.2022 to 10.12.2022 for a period of 92 days, providing coverage for medical expenses and hospitalization up to US$50,000. During the currency of the Subject Policy, respondent No. 2, while in Maryland, United States, experienced pain on 24.09.2022, following which she was admitted to Suburban Hospital, Maryland, where various procedures were conducted and she was diagnosed with Acute Cholecystitis, necessitating a cholecystectomy. The surgery was performed on 26.09.2022, resulting in the removal of gallstones and the gallbladder. Subsequently, respondent No.2 contacted Mapfre Asistencia **("Mapfre")** Insurance Company's partner, as per the Subject Policy, to inform them of her hospitalization and treatment. Mapfre assessed and processed the claim, engaged in correspondence with respondent No.2 and her children, requesting travel details, tickets and medical information, which were provided. Throughout this period, respondent No.2 persistently sought approval of her claim but the Insurance Company decided that as gallstones typically develop gradually over 10 to 20 years, the condition was a pre-existing one under the policy terms and thus the claim was rejected. Following the rejection, respondent No.2 filed a complaint before the FIO alleging maladministration and sought reasonable compensation for the operation and related hospital expenses incurred. The FIO vide impugned order dated 12.07.2023 directed the Insurance Company to pay respondent No.2 USD 7,879/- as reasonable compensation for the amount paid out from her own pocket. Aggrieved by the impugned order of the FIO, the Insurance

Uncertified

Company filed a representation under Section 14 of the Federal Ombudsman Institutional Reforms Act, 2013 **("FOIRA, 2013")** before the President, which was rejected vide impugned order dated 08.11.2023 directing the Insurance Company to reimburse the claimed amount of USD 7879/-.

4. The facts, in brief, leading to the filing of W.P. No. 2015 of 2023 are that the Insurance Company issued the Subject Policy, in favour of respondent No. 2 for his father (the insured individual), covering the period from 30.12.2019 to 30.03.2020 with a sum insured of USD 50,000/- for "Medical Expenses & Hospitalization Abroad". Father of respondent No. 2, while visiting Australia in December 2019 contracted pneumonia and was admitted at Northwest Hospital from 11.01.2020 to 18.01.2020, thereafter he was discharged but was subsequently again admitted at Blacktown Hospital from 04.02.2020 to 17.02.2020. Respondent No. 2's sister initiated correspondence with the Insurance Company's partner, Mapfre, seeking indemnification of the medical expenses incurred, whereupon the first claim amounting to AUD 10,117/- was accepted, whereas the second claim of AUD 57,712/- was repudiated on the ground of being attributable to pre-existing medical conditions excluded under the Subject Policy. However, respondent No. 2 persisted in contending that the second admission was a continuation of the first but upon review of the complete record, the Insurance Company maintained its stance that the second claim was not admissible. Thereafter, respondent No. 2 filed a complaint before the FIO, which was decided vide impugned order dated 15.11.2022 directing the Insurance Company to pay the full claimed amount of AUD 57,712/-, where after, being aggrieved, the Insurance Company filed a representation under section 14 of the FOIRA, 2013 before the President, which was dismissed vide impugned order dated 17.04.2023.

5. The facts, stated tersely, leading to the filing of W.P. No. 605 of 2024 are that the Insurance Company issued the Subject Policy, to respondent No. 2, on 23.06.2018 with the coverage period spanning 180 days from 01.07.2018 to 27.12.2018 and a sum insured of US$50,000. Respondent No. 2 traveled to Sudan on 08.09.2018, where he on 15.10.2018 suffered a sudden Transient Ischemic Attack/Stroke while showering in his apartment

Uncertified

in Kassala, Sudan. Emergency medical treatment was administered to respondent No.2 at Rama Hospital, Kassala, followed by an urgent medical evacuation via Air Ambulance to Royal Care International Hospital, Khartoum, where he remained hospitalized until 29.10.2018. Subsequently, on the evening of 29.10.2018 respondent No. 2 was evacuated from Khartoum and entered Peshawar, Pakistan on 30.10.2018 via Emirates Airlines. On 02.04.2019, respondent No. 2 visited the Insurance Company's office in Peshawar, where he submitted insurance documents, premium receipts, a statement regarding the incident, and other claim-related documents. However, vide letter dated 03.05.2019, the Insurance Company informed respondent No. 2 that his claim is time-barred and thus not covered under the Subject Policy. Thereafter respondent No. 2 filed a complaint with the FIO on 31.10.2019. The FIO vide impugned order dated 07.08.2023 directed the Insurance Company to pay respondent No. 2 an amount of US$7,920 and 8,850 Sudanese Pounds. Feeling aggrieved, the Insurance Company filed a representation under section 14 of the FOIRA, 2013 before the President, which was rejected vide impugned order dated 26.12.2023.

6. The learned counsel for the Insurance Company contended that FIO is not vested with the jurisdiction in the present matters, as under section 127 of the Insurance Ordinance, 2000 **("Ordinance, 2000")** the disputes between the Insurance Company and respondent. No.2 **("private respondents")** arose purely from the terms of the Subject Policy and not from any act of maladministration by the Insurance Company. He argued that there exists a fundamental distinction between section 122 and section 127 of the Ordinance, 2000, as these sections provide separate and distinct forums for the redress of insurance related grievances, section 122 of the Ordinance, 2000 empowers the Insurance Tribunal **("Tribunal")** to adjudicate claims filed by a policyholder against an insurance company in respect of or arising out of a policy of insurance, whereas section 127 vests jurisdiction in the FIO to decide complaints by any aggrieved person on allegations of maladministration by an insurance company, the Tribunal. He also argued that these matters involve factual controversy, which require recording of evidence, an exercise that cannot be undertaken by FIO or the President of Pakistan. He further added that the impugned orders passed by

Uncertified

the President were not signed by a person qualified under section 14(3) of the FOIRA, 2013 rather by the Director (Legal-I). Lastly, the learned counsel submitted that all the Impugned Orders, are without jurisdiction, non-speaking, arbitrary, rushed and have been passed without affording the Insurance Company a fair opportunity of hearing, in violation of the principles of natural justice and Article 10-A of the Constitution of the Islamic Republic of Pakistan, 1973.

7. Conversely, the learned counsel for the Private Respondents raised a preliminary objection that the Law Officer of the Insurance Company was not duly authorized by the Board of Directors to file these petitions, therefore the same are not maintainable. On merits he submitted that respondent No.2/Zarina Jillani did not suffer from a pre-existing condition as she was never aware of gallstones prior to September 2022 and never experienced symptoms, diagnosis, or treatment for such a condition and that Acute cholecystitis is a sudden, emergency condition. He further submitted that the analogy drawn by the Insurance Company regarding the gradual development of gallstones applies to many acute illnesses and does not justify denial of the claim under the pretext of pre-existing conditions, when none existed or were known, is arbitrary, unreasonable and amounts to maladministration. The learned counsel further submitted that the Insurance Company's arguments regarding the jurisdiction of the FIO are afterthoughts, as no such objection was raised during the proceedings before the FIO and that there is no factual controversy requiring further evidence or expert testimony, as the medical record from a reputable U.S. hospital is clear and undisputed. He also argued that the Insurance Company's reliance on the Code of Civil Procedure, 1908 **("CPC")** and Qanun-e-Shahadat Order, 1984 is misplaced, as the FIO's proceedings are designed to provide expeditious relief to aggrieved policyholders. Lastly, he contended that the impugned orders of the FIO and the President are well-reasoned, address all relevant issues and were passed after affording the Insurance Company ample opportunity to present its case.

8. I have given anxious consideration to the arguments of the learned counsel for the parties and perused the record with their able assistance.

Uncertified

9. The question of law involved in all three petitions is the same, i.e., whether the Private Respondents should have made (as they in fact did) complaints for the redress of their grievances to the FIO appointed under section 127 of the Ordinance, 2000 or they should have approached the Tribunal set up under section 121 of the Ordinance, 2000. While considering the background of the petitions and the grounds raised by the parties, the following question of law needs adjudication by this Court:-

> *Whether the Insurance Ombudsman under section 127 of the Insurance Ordinance, 2000 had jurisdiction to entertain and decide the complaints filed by the Private Respondents?*

10. In order to adjudicate the above question, it is essential to examine the legal framework governing the subject matter i.e. the Insurance Ordinance, 2000. Therefore, this Court will first examine, the scope of jurisdiction of the FIO and the Tribunal provided under sections 127 and 122 of the Ordinance, 2000. The relevant portion of these sections are reproduced as under:-

> *"**127. Jurisdiction, functions and powers of Insurance Ombudsman**.—(1) The Insurance Ombudsman may on a complaint by any aggrieved person undertake any investigation into any allegation of mal-administration on the part of any insurance company:*
>
> *Provided that the Insurance Ombudsman shall not have any jurisdiction to investigate or inquire into any matters which.*
>
> *(a) are within the jurisdiction of the Office of the Wafaqi Mohtasib under the Establishment of the Office of Wafaqi Mohtasib (Ombudsman) Order, 1983, (P.O.1 of 1983); or*
>
> *(b) are sub-judice before a court of competent jurisdiction or tribunal or board in Pakistan on the date of the receipt of a complaint, reference or motion by him.*
>
> *(2) For the purposes of this section "mal-administration" includes—*
>
> *(a) a decision, process, recommendation, act of omission or commission which:-*

Uncertified

(i) is contrary to law, rules or regulations or is a departure from established practice or procedure, unless it is bona fide and for valid reasons; or

(ii) is perverse, arbitrary or unreasonable, unjust, biased, oppressive, or discriminatory; or

(iii) is based on irrelevant grounds; or

(iv) involves the exercise of powers, or the failure or refusal to do so, for corrupt or improper motives, such as, bribery, jobbery, favoritism, nepotism and administrative excesses; and

(b) corruption, nepotism, neglect, inattention, inordinate delay, incompetence, inefficiency and ineptitude in the administration or discharge of duties and responsibilities.

(3) Notwithstanding anything contained in sub-section (1), the Insurance Ombudsman shall not accept for investigation any complaint which is brought by or on behalf of an insurance company and which relates to a contract of reinsurance.

(4) Notwithstanding anything contained in sub-section (1), the Insurance Ombudsman shall not accept for investigation any complaint by or on behalf of an employee of an insurance company concerning any matters relating to the insurance company in respect of any personal grievance relating to his service therein.

(5) For carrying out the objectives of this Ordinance and, in particular for ascertaining the root causes of corrupt practices and injustice, the Insurance Ombudsman may arrange for studies to be made or research to be conducted and may recommend appropriate steps for their eradication."

*"**122. Powers of Tribunal**.—(1) A Tribunal shall:*

(a) in the exercise of its civil jurisdiction, have in respect of a claim filed by a policy holder against an insurance company in respect of, or arising out of a policy of insurance, all the powers vested in a civil Court under the Code of Civil Procedure, 1908, (Act V of 1908);

(b) in the exercise of its criminal jurisdiction, try the offenses punishable under this Ordinance and shall, for this

Uncertified

> *purpose, have the same powers as are vested in the Court of Sessions under the Code of Criminal Procedure, 1898 (Act V of 1898);*
>
> *(c) exercise and perform such other powers and functions as are, or may be, conferred upon, or assigned to it, by or under this Ordinance; and*
>
> *(d) in all matters with respect to which procedure has not been provided for in this Ordinance, follow the procedure laid down in the Code of Civil Procedure, 1908 (Act V of 1898) or the Code of Criminal Procedure, 1898 (Act V of 1898) as the case may be.*
>
> *(2) The jurisdiction of a Tribunal shall not extend to appeals to which section 33 and section 34 of the SECP Act apply.*
>
> *(3) No Court other than a Tribunal shall have or exercise any jurisdiction with respect to any matter to which the jurisdiction of a Tribunal extends under this Ordinance, including a decision as to the territorial limits and the execution of a decree, order or judgment passed by a Tribunal:*
>
> *Provided that for the purposes of this section a Small Claims Settlement Committee established under section 117 shall not be deemed to be a Court."*

11. A plain reading of the aforementioned sections reveals that the legislature has established two distinct forums with separate yet complementary functions. Section 127 of the Ordinance, 2000 establishes the FIO as an accessible and informal dispute resolution mechanism, primarily focused on addressing complaints of maladministration by insurance companies. Its powers are investigatory and recommendatory in nature, aimed at ensuring administrative fairness through facilitation of mediation and issuance of corrective recommendations. In contrast, section 122 creates the Tribunal as a formal judicial forum vested with exclusive jurisdiction over substantive insurance claims and offences. The Tribunal is empowered with comprehensive adjudicatory powers equivalent to those of civil and criminal Courts under CPC including summoning witnesses, enforcing decrees and trying offences, thereby operating as a binding authority with full Court-like powers.

Uncertified

12. Specifically, under section 122 of the Ordinance, 2000 the Tribunal is empowered to adjudicate claims by policyholders against insurance companies in respect of or arising out of insurance contracts. Conversely, section 127 confers jurisdiction on the FIO to entertain complaints from any aggrieved person alleging maladministration by an insurance company. The term "maladministration," as elaborated in subsection (2) of section 127, encompasses decisions, processes, recommendations, acts, omissions, or commissions that are contrary to law, rules, or regulations; depart from established practice or procedure; or are perverse, arbitrary, unreasonable, unjust, biased, oppressive, or discriminatory. While access to the Tribunal under section 122 requires the complainant to be a policyholder asserting a claim against the insurer, the FIO's jurisdiction under section 127 is broader, allowing any aggrieved person to lodge a complaint alleging maladministration within the defined parameters. Thus, the Ordinance, 2000 delineates a clear demarcation: the Tribunal functions as a judicial body for substantive insurance claims, whereas the FIO acts as an administrative authority addressing complaints of insurer's misconduct or unfair administrative practices. This distinction ensures that aggrieved person has access to both judicial remedies for contractual disputes and administrative recourse for grievances related to insurer conduct.

13. The upshot of the above discussion is that the jurisdiction of the FIO is contingent upon the existence of maladministration as defined in section 127(2), which includes decisions, processes, or acts that are contrary to law, rules, or regulations, or that are arbitrary, perverse, unjust, or discriminatory. Therefore, it has to be seen whether the dispute between the parties pertains to an insurance claim, or whether the decision of repudiation of the claim under the Subject Policy amounts to maladministration. It is apparent from the record that admittedly in all three petitions the declaration part of the Subject Policy contains the stipulation *"All pre-existing conditions are not covered",* however, it does not define the term "pre-existing conditions". The terms and conditions of the Subject Policy, which are in fine print contain another exclusion clause i.e. *"Any Condition or set of circumstances known to an Insured Person at the time the red Trip was booked (pre-existing conditions)",* on the basis of which the claims of the Private

Uncertified

Respondents were repudiated. Thus, what needs to be seen is whether the Insurance Company's decision of relying on "pre-existing conditions" to reject the claims amounts to maladministration.

14. Since the facts of W.P. No. 294 of 2024 and W.P. No. 2015 of 2023 are substantially similar, this Court shall treat W.P. No. 294 of 2024 as the leading case for the purpose of applying the law to the facts and resolving the common question of law arising in both petitions and address the contention of Complaint being time barred in W.P. No. 605 of 2024 at later stage. In W.P. No. 294 of 2024 the Private Respondent was diagnosed with Acute Cholecystitis (Acute cholecystitis is inflammation of the gallbladder and generally happens when a gallstone blocks the cystic duct) while in the United States, necessitating a cholecystectomy. She received surgery, resulting in the removal of the gallstones and gallbladder. The Insurance Company rejected the claim vide its decision dated 15.12.2022. The relevant portion is reproduced below:-

> *"Kindly note that after reviewing the medical records, we found that Ms. Zarina has a Gallbladder stone and upon reaching the hospital and the necessary procedures that have been done, the treating doctor diagnosed the case with acute calculus Cholecystitis which lead to Ms. Zarina underwent cholecystectomy. The gallstones grow very gradually. It may take 10 to 20 years for gallstones to grow large enough to cause an obstruction. So based on the policy wording and the final diagnosis the case is complications of pre-existed condition (gallbladder) which is not covered under the policy:*
>
> *Quote*
> *"Pre-existing disease: the disease that the insured suffered prior to the date of taking out this policy, even if it wasn't diagnosed."*

15. The above referred decision of the Insurance Company reflects twofold elements of maladministration. Firstly, the terms and conditions of the Subject Policy, which are in fine print contain the exclusion clause i.e. *"Any Condition or set of circumstances known to an Insured Person at the time the red Trip was booked (pre-existing conditions)"*, whereas the Insurance Company's rejection of the claim cited a different exclusion clause which included "*the diseases that the insured suffered prior to the currency of the Subject Policy, even if it was not diagnosed*". This deliberate

Uncertified

use of inconsistent definition and misuse of the vague exclusion clause to deny valid claims is a dishonest act on behalf of the Insurance Company and borders on fraudulent conduct of insurance business, particularly when applied in a blanket manner without regard to individual circumstances. It falls squarely within the statutory ambit of maladministration since the decision is perverse, unjust, unreasonable and oppressive.

16. Secondly, the conclusion drawn by the Insurance Company, regarding the presence of gallstones as a "pre-existing condition" is not only incorrect but also inconsistent with the express language and intent of the Subject Policy. The record reflects that the private respondents' gallstone condition was asymptomatic and remained undiagnosed, and therefore cannot be retrospectively construed as a pre-existing condition within the contemplation of the exclusion clause. To permit insurers to invoke exclusions on the basis of theoretical disease progression without evidence of prior symptoms, diagnosis, or disclosure would render the concept of "pre-existing condition" so expansive and uncertain that virtually any acute illness could be retroactively excluded. Every individual to whom a travel health insurance policy is offered must, in the natural course of human life, have at some stage suffered from some form of ailment or disease. To interpret such past and undiagnosed ailments in a manner so as to invariably classify them as "pre-existing conditions" and thereby repudiate claims under the policy would render the very object of travel insurance nugatory and defeat the purpose of the policy if the insured had to bear the risk of a disease that is latent at the time of policy.

17. If every latent medical condition, irrespective of its nature, severity, or remoteness in time, were to be treated as pre-existing condition, then hardly any individual would ever qualify for coverage. It is observed that certain diseases develop gradually in a subtle manner within the human body but ultimately manifest through sudden and acute symptoms, which lead to their diagnosis. By way of illustration, a cerebral or brain aneurysm may be cited. This condition represents a bulging in a weakened segment of an artery situated in or around the brain. Its presence may remain undetected for an extended period, owing to its gradual and progressive formation caused by

Uncertified

the weakening of the vessel wall, its rupture can have catastrophic consequences. Such rupture results in hemorrhage into the surrounding brain tissue, triggering a hemorrhagic stroke, which in turn may lead to permanent brain damage or other grave complications. Conditions of this nature, which are progressive but asymptomatic until an acute episode occurs, cannot, in the absence of prior diagnosis, be construed as "pre-existing conditions" within the meaning of the Subject Policy. A contrary decision would not only be arbitrary but also unreasonable and falls within the ambit of maladministration, since such interpretation or decision would defeat the reasonable expectations of the insured.

18. Moreover, maladministration also includes those decisions and acts of omission or commission, which are contrary to law, rules or regulations or is a departure from established practice or procedure. As a general rule in the insurance industry, it is standard practice that such policies describe the nature of the risk to be covered and the circumstances affecting it. They define the precise nature and scope of the proposed insurance. Merely incorporating "pre-existing conditions are not covered" in the exclusion term of the Subject Policy would not allow the Insurance Company to repudiate the claim since it is trite law that where a stipulation is not merely unreasonable but impossible, in the sense that from the outset it never could be performed, it is a nullity, which is simply disregarded.

19. It is a fundamental principle of insurance law that the objectively reasonable expectations of the parties to an insurance contract must be fulfilled. This doctrine applies where the language of the policy is ambiguous, where a major exclusion is concealed, or where the provision in question is bizarre, oppressive, eviscerates terms explicitly agreed upon, or defeats the dominant purpose of the transaction. The doctrine is applicable in limited situations involving standardized contracts. Similarly, where concealed pitfalls in the policy language conflicts with the reasonable expectations of the insured, such language cannot be relied upon to defeat coverage, as it would amount to maladministration. Accordingly, the process of interpreting the Subject Policy should not be in a strained, forced, unnatural, or unreasonable manner nor in a way that extends or restricts the

Uncertified

policy beyond its fair meaning that could lead to an absurd result rendering the policy ineffective or nonsensical. Where two constructions are possible, the one that tends to defeat the intention of the policyholder or renders the coverage practically illusory must be rejected. Likewise, where a literal interpretation would lead to manifest absurdity, it must yield to a construction that is broad, liberal and reasonable, provided that both interpretations are legally permissible.

20. As such in W.P No.294/2024 the Insurance Company's decision that gallstones grow very gradually taking 10 to 20 years to cause obstruction and thus falls under the interpretation of pre-existing condition essentially renders the coverage illusory and the purpose of the policy will be defeated if the insured had to bear the risk of disease that is latent at the time of policy. It is trite law that the exemption of liability clauses in insurance contracts are to be construed *contra proferentem* i.e. in favour of the insured in case of ambiguity. The insurance policy and its components must be read as a whole and given a meaning, which furthers the expectations of the parties and also of the realities of the insurance business.

21. Furthermore, it is industry practice that a timeframe is given for such clauses of pre-existing conditions otherwise every disease or illness will be considered as a pre-existing disease, which will exclude the benefit of the policy to a policyholder. An element of dishonesty is evident from the record, as the terms and conditions apart from being clear and precise should have been set out in bold, express language and prominently displayed on the subject policy. It is a settled principle that fine print exclusions, which provide deceptive impressions are in themselves a deceptive measure.

22. This Court observes another element of dishonesty from the record, which is a prerequisite for maladministration. All material information required by the insurer in respect of a risk, in order to enable the insurer to decide whether to undertake the risk was not sought by the Insurance Company from any of the Private Respondents. It is evident from the record that only a computer generated proposal form/declarations were sought by the Insurance Company. It is also apparent from the record that the Subject Policy is worded in such a manner that does not suggest that the Private

Uncertified

Respondents were required to disclose that they were suffering from any ailment or were aware of any such conditions. It is pertinent to state that insurance contracts are special contracts based on the general principles of full disclosure inasmuch as a person seeking insurance is bound to disclose all material facts relating to the risk involved. This principle has received statutory recognition, under section 75 of the Ordinance, 2000. The relevant portion is reproduced hereunder:-

> "***75. Duty of utmost good faith.***—*(1) A contract of insurance is a contract based on the utmost good faith and there shall be implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.*
>
> *(2) If reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision."*

23. The upshot of the above section is that there is an inherent duty of the parties to make full and honest disclosure. The principle of utmost good faith imposes positive obligation of disclosure of material facts within the knowledge of either party, so any statement, made about such facts must be accurate and not misleading. However, this duty is not absolute or unilateral; it is activated only when the insurer, through a proposal form, questionnaire, or similar instrument, specifically requests relevant information material to the risk being insured. The only inference that can be drawn from this is that this is a deliberate act on the part of the Insurance Company to repudiate claims on the basis of "pre-existing conditions" without seeking disclosure.

24. It is common practice that a proposer is required to fill in and sign a standard proposal form or submit it electronically. The standard form typically contains particulars of the proposer necessary for risk assessment. In cases where policies are availed electronically and incorporate published leaflets or policy documents, any specific event upon the occurrence of which the insurer may escape liability must be stated in clear and unambiguous language. This principle safeguards the insured from arbitrary repudiation and ensures that insurers cannot adopt a passive stance during policy formation to deny liability. Law demands a higher standard of good faith in matters of insurance contracts, which is expressed in the legal maxim

Uncertified

uberrimae fidei. Lord Mansfield in Carter v. Boehm (1766) 3 Burr 1905 has summarized the principles necessitating disclosure in the following words:-

> *"Good faith forbids either party, by concealing what he privately knows, to draw the other into a bargain from his ignorance of the fact, and his believing the contrary."*

25. This omission to make an inquiry is a classic case of maladministration since it is an act of omission on part of the Insurance Company not to request material information and repudiate the claim on the ground of "pre-existing condition". Such conduct is arbitrary, unreasonable, and undermines the trust that forms the foundation of insurance contracts. Similar view was adopted by the Honorable Supreme Court in case of ***Jubilee Life General Insurance Company Co. LTD., Karachi vs. Ravi Steel Company, Lahore, (2020 PLD 324 SC)***, wherein it was held that:-

> *"Common law principle of "utmost good faith" (also recognized as 'Uberrimae Fidei') has received statutory recognition, under Section 75 of the Insurance Ordinance 2000; it means that every person who enters into a contract (of insurance) has a legal obligation to act with utmost good faith towards each other and parties (to insurance) contract are required to deal with each other in an honest and upright manner, disclose all material facts to each other and not to take unfair advantage over another person or to fulfill a promise to act, even when some legal technicality is not fulfilled. (see section 76 ibid also) Additionally, Insurer is obligated not to engage in a misleading or deceptive conduct that may put the insured or beneficiary of Insurance Policy into a disadvantageous position (see section 76 ibid). Even ambiguities in insurance policies are construed in favour of the insured (Section 77 ibid)."*

26. This Court finds untenable the Insurance Company's argument that travel health policies are primarily issued for visa purposes and that requiring medical checkups would raise costs, cause delays and undermine the convenience of online procurement. This Court observes that such policies are issued in good faith and on the declarations of the policy holders. The doctrine of utmost good faith places the duty of disclosure on the insured but this duty is triggered only when the insurer requests relevant information through a proposal form or questionnaire. The Insurance Company's argument that the matter requires evidence is untenable. If the insurer chooses not to seek disclosure, it is presumed to have waived its right

Unverified

to that information. Therefore, the Insurance Company cannot rely on non-disclosure as a ground requiring evidentiary support, since it failed to provide the mechanism to elicit that information. Any denial based on non-disclosure effectively amounts to maladministration and for emphasis it is reiterated that maladministration includes acts or omissions that are contrary to law or is a departure from established practice or procedure and involves the exercise of powers or the failure or refusal to do so, for corrupt or improper motives.

27. The purpose of a travel insurance policy is to indemnify against sudden and unforeseen illnesses while travelling abroad, hence, the repudiation of claims, particularly where the insured had no clear knowledge or warning of the need to disclose pre-existing conditions, amounts to maladministration. The record further shows that the complainants in all three complaints allege *mala fide* conduct, delay in claim settlement, arbitrary repudiation, misrepresentation of policy terms and repudiation contrary to law. Upon reviewing the Subject Policy and the facts, the FIO rightly found maladministration and directed payment of reasonable compensation for the medical expenses incurred by the Private Respondents. Accordingly, this Court holds that the FIO rightly assumed its jurisdiction while deciding the complaints filed by the Private Respondents/complainants as their grievances fell squarely within the Ombudsman's jurisdiction under section 127 of the Insurance Ordinance, 2000.

28. The contention that the proceedings before the Ombudsman necessitated the recording of formal evidence is misconceived and devoid of merit. The FIO upon assumption of jurisdiction, is vested with the authority to investigate and conduct a searching inquiry for the purpose of ascertaining the relevant facts. In the present matters, it stands admitted and undisputed that the Insurance Company had issued the Subject Policy in favour of the Private Respondents, which provided coverage for medical expenses and hospitalization. Subsequently, medical complications arose during the subsistence of the said policies and claims were lodged by the insured with the Insurance Company. Upon examination of the medical record and the

Uncertified

ailments, the Insurance Company, invoking the terms and conditions of the Subject Policy, treated the ailments as pre-existing conditions and repudiated the claims. Thereafter, the Private Respondents instituted complaints before the FIO. In the given context, once all the claims and supporting documents stood admitted and duly processed by the Insurance Company, the sole question before the learned FIO was whether the subsequent repudiation of such claims constituted maladministration. For this purpose, no further evidence was required, as it was the very act of repudiation that called for adjudication.

29. This Court now turns to the remaining issue. The learned counsel for the Insurance Company contended that the FIO is not a Court and is only competent to render findings and recommendations, implementation of which is not the duty of the FIO, as it would be leaning into the powers of the Courts, which are exclusively vested with them under the Constitution and placed reliance on the case of ***Saleem Ahmed Jan vs. Deputy Commissioner & others***, ***(2024 CLC 953),*** however, this judgment has been suspended by the Division Bench of this Court in I.C.A No. 85 of 2023 titled, ***"Tabbasum Qureshi vs. Deputy Commissioner, etc."*** and is distinguishable.

30. In order to address the above mentioned contention it is essential to examine the scheme of the Ordinance, 2000. The preamble of the Ordinance, affirms that object of the Ordinance is to regulate the insurance industry for safeguarding the interests of policyholders and matters connected therewith. In furtherance of this purpose, section 130 of the Ordinance expressly empowers the FIO to implement its recommendations, thereby conferring statutory authority upon it. The relevant portion is reproduced hereunder:-

> "***130. Recommendations for implementation.-- (1)*** *In the event the Insurance Ombudsman comes to the conclusion that the complaint is justified, in part or in whole, he shall try and facilitate an amicable resolution or settlement by resort to mediation and failing that communicate his findings to the concerned insurance company with the direction –*
>
> *(a) to reconsider the matter;*
> *(b) to modify or cancel the earlier decision, action or failure to take appropriate action;*

Uncertified

> *(c)to pay reasonable compensation to the complainant as fixed by the Insurance Ombudsman;*
> *(d)to take the requisite steps to improve the functioning or efficiency of the insurance company; or*
> *(e)to take such other remedial steps or actions as may be specified by the Insurance Ombudsman."*

31. When preamble of the Ordinance, 2000 is read in conjunction with section 130(1), it becomes evident that the Ordinance envisions the FIO as a unique authority vested with dual functions, both administrative and quasi-judicial. Upon concluding that a complaint is justified, whether wholly or partially, the FIO is empowered to act as a conciliatory authority facilitating amicable resolution primarily through mediation. The FIO may issue recommendations to an insurance company aimed at rectifying maladministration and safeguarding the interests of policyholders. Such recommendations encompass directions to reconsider or modify prior decisions, award reasonable compensation and implement remedial measures to enhance insurer conduct. The Ordinance confers express statutory authority upon the FIO as part of the regulatory framework for insurance dispute resolution in Pakistan. It is not the Insurance Company's case that these provisions are *ultra vires* the Constitution and as long as they remain in force, the FIO is fully empowered to exercise the jurisdiction vested in it. Consequently, what the Insurance Company characterizes as adjudication of civil rights is, in substance, the exercise of statutory powers by the FIO to rectify maladministration through appropriate compensation and corrective actions.

32. Therefore, the Insurance Company's assertion that the FIO lacks the authority to issue binding decisions or recommendations is devoid of merit. The legislative intent behind section 130(1) of the Ordinance, 2000 is to protect the rights of policyholders by ensuring that the FIO's determinations are not merely declaratory but enforceable. Power, if stripped of the means of implementation, ceases to be power in any meaningful sense and becomes illusory. Similarly, justice, if not accompanied by enforceability, is reduced to an aspirational statement devoid of practical consequence. In absence of such authority, an aggrieved/complainant would be left with nothing more

Uncertified

than a declaration of maladministration, devoid of any remedy. Even from a jurisprudential aspect the necessity of enforceability flows from the fundamental ideals of fairness, balance and the authority of law to ensure swift and effective justice. To deprive the FIO of the means to redress maladministration would defeat the very purpose of its creation and render justice illusory for the aggrieved.

33. This framework enhances accountability in the insurance sector while safeguarding policyholders' rights. The FIO's powers under section 130(1) of the Ordinance, 2000 reflect principles of administrative justice and consumer protection, enabling compensation and remedial measures that go beyond a mere advisory role. Nonetheless, these powers are confined to matters of maladministration, as in the present matters and do not extend to judicial adjudication of contractual disputes or evidentiary controversies, which fall within the Tribunal's domain under section 122 of the Ordinance. The legal effect of the FIO's recommendations operate with force unless set aside and their non-compliance may attract regulatory consequences.

34. Moreover, the contention advanced by the Insurance Company in W.P. No. 605/2024, that the claim was barred by time, is wholly untenable. It would be manifestly inequitable to insist that a person who had suffered a Transient Ischemic Attack/Stroke and was undergoing extensive medical treatment ought, in such circumstances, to have strictly adhered to the prescribed period for lodging the claim. A person, who has suffered a Transient Ischemic Attack/Stroke is left in a state of serious debilitation, often accompanied by impaired cognitive and motor functions, diminished capacity to attend to routine affairs and a prolonged need for medical care and rehabilitation. To expect such an individual, while grappling with the immediate aftereffects of a life-threatening ailment and undergoing extensive treatment, to pursue and perfect a claim within the rigid confines of contractual limitation is to impose a standard, which is neither realistic nor just. The law does not countenance such a mechanical application of limitation provisions where it results in manifest unfairness and thus the plea of the Insurance Company is without merit.

Uncertified

35. It is also settled principle of law that the question of limitation is not a pure question of law rather the same is mixed question of law and facts. In its Constitutional jurisdiction High Court cannot interfere with the findings of facts merely on the ground that the reasons, which found favour with the authority, whose order is under scrutiny were not such which would have been accepted by the High Court. It is to be pressed into service against an order, which is without jurisdiction or tainted with malice or in violation of constitutional or statutory provisions and not to correct a finding of fact. Reliance is placed upon ***1994 SCMR 859 (Export Promotion Bureau vs. Qaiser Shafiullah).*** Under Article 199, the Court will not ordinarily interfere with factual findings of an executive or quasi-judicial authority. In the case reported as ***Lt. Gen. (R) Salahuddin Tirmizi vs. Election Commission of Pakistan, (PLD 2008 SC 735),*** the Apex Court observed that the jurisdiction of High Court under Article 199 cannot be enlarged to cases relating to factual inquiry or in cases where another view of the matter was also possible and if such view would have been taken it would not be illegal or unconstitutional. High Court is not supposed to substitute its opinion on the question of fact. Similar view was expressed by the Hon'ble Supreme Court in case reported as ***Karachi Shipyard and Engineering Works Ltd, vs. Abdul Gaffar, (1993 SCMR 511).*** Applying the above principle to the present cases, the findings arrived at by the forums below cannot be interfered with as there is no apparent illegality or jurisdictional error in the impugned orders.

36. In view of the above discussion, the impugned orders passed by the FIO and the President are in accordance with law, which do not call for interference by this Court. The captioned writ petitions bear no merits, therefore, **dismissed.** No order as to cost.

(INAAM AMEEN MINHAS)
JUDGE

Announced in open Court on 16.09.2025

JUDGE

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APPROVED FOR REPORTING

M. YAHYA, J.L.C

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