SUPREME COURT OF INDIA

Amravati Dist. Central Co-op Bank Ltd.

Vs.

United India Fire&Genl. Insurance Co.Ltd

C.A.No_____of 2010

(R V Raveendran and K.S.Radhakrishnan JJ.)

15.04.2010

JUDGEMENT

R. V. RAVEENDRAN, J.

1. Leave granted. Heard the learned counsel.

2. In pursuance of a Banker's Indemnity Insurance Proposal dated 1.7.1976 from the appellant (`Bank'), the respondent (`Insurer') issued a Renewal Insurance Policy covering the period 1.7.1976 to 1.7.1977. The policy indemnified and insured the Bank against losses caused by acts or omission of the Bank's employees to a limit of Rs.6 lacs (Basic cover) plus Rs. 9 lacs (cash in safe). The Bank furnished to the Insurer a list of its branches to be covered by the insurance which included Dhamangaon Branch and the names of the employees working in those branches. The operative portion of the policy is extracted below:-

"THE COMPANY HEREBY AGREES subject to the terms and conditions contained herein or endorsed or otherwise expressed herein that if the Insured shall discover any direct LOSS of Money and/or Securities sustained by the Insured by CONTIGENCIES as provided hereinafter at any time during the period of insurance stated herein or any subsequent period in respect of which the Insured shall have paid or agreed to pay and the company shall have accepted or agreed to accept the premium required for the renewal thereof, the company will indemnify the Insured in respect of all such direct losses but not exceeding, (a) the total sum insured hereby in respect of any loss or losses caused by acts or omissions of any one person whether Officer, Clerk or Employee of the Insured or acts or omissions in which such person is concerned or implicated or in respect of any one casualty or event irrespective of the total amount of such loss.

(b) in any one period of insurance twice the total sum insured hereby in respect of all such losses."

In lieu of Cover Note No: RENEWAL Policy No:264/52/1/00402 Schedule INSURED NAME: THE AMRAVATI DISTT. Date of Proposal & CENTRL COOP. BANK LTD., HEAD Declaration OFFICE, 1.7.76 ADDRESS: AMRAVATI TOTAL SUM Rs.6,00,000/- (Basic cover) PREMIUM INSURED And Rs.9,00,000/- (Cash in Rs. 34,443/- Safe) H.O. Amravati

EXCESS 25% on each and every claim or RETRO-ACTIVE

Rs.11,500/- Rs.11,500/-whichever is higher on DATE (PROVISO 3) D.A.R. - 2 YEARS st st PERIOD OF From 1 July, 1976 to 1 July, 1977 INSURANCE SPECIAL Contingency No.5 of the policy stand deleted.

CONDITIONS xxxxxx CONTINGENCIES INSURED

1. By reason of any Money and/or Securities for which the Insured are responsible or the custody of which they have undertaken and which now are or are by them supposed or believed to be or at any time during the period of insurance may be in or upon their own premises or upon the premises of their Bankers in any recognised place of safe deposit in India or lodged or deposited in the ordinary course of business for exchange, conversion or registration with the issuers thereof, or with any agents of such issuers or with any person employed to procure or manage the exchange, conversion or registration thereof, being (while so in or upon such premises or so placed, lodged or deposited as aforesaid) lost, destroyed or otherwise made away with by Fire, Burglary, or House breaking, Theft, Robbery or Hold-up, whether with or without violence and whether from within or without and whether by the Officers, Clerks or Employees of the Insured or any other person or persons whomsoever.

2. By reason of any Money and/or Securities being lost, stolen, mislaid, misappropriated or made away with, whether due to the negligence or fraud of the officers, Clerks or Employees of the Insured or otherwise, whilst in transit in the hands of such Officers, Clerks or Employees within India, such risk of transit to commence from the moment when the person into whose hands the same may be delivered on behalf of the Insured shall leave the premises at which he receives the same and to continue until delivery thereof at destination.

3. By reason of the payment made whether received over the Counter or through the Clearing House or by Mail in respect of forged or raised Cheques and/or Drafts or (genuine) Cheques and/or Drafts bearing forged endorsements or the establishment of any credit to any customer on the faith of such documents.

4. By reason of the dishonest or criminal act of any Officer, Clerk or Employee of the Insured with respect to the loss of Money and/or Securities wherever committed and whether committed directly or in connivance with others.

5. [Deleted] xxxxxx PROVISOS "1. EXCESS - The Insured shall bear the amount of excess stipulated in the Schedule in respect of each and every loss if the loss is under Contingencies 1, 2 or 3 insured by the Policy. In respect of losses under contingencies 4 or 5, the Insured shall bear 25% of the amount of the loss or the amount of excess stipulated in the Schedule whichever is the higher."

xxxxxx (emphasis supplied)

3. An employee of the Bank by name Lodaya working in its Dhamangaon Branch committed a series of embezzlements. On receiving a report dated 28.2.1977 from its Special Auditor about the same, the Bank reported the matter to the police and also to the Insurer. The employee concerned was suspended on 16.3.1977 and eventually dismissed from service on 19.3.1978.

4. The Bank claimed indemnity from the Insurer in terms of the policy in respect of Rs.3,58,000/- embezzled by the said employee. After prolonged correspondence, the Insurer informed the Bank that its assessors had assessed the reimbursable loss as Rs.29,000/- and offered the said sum in full settlement of the claim subject to payment of premium of Rs.538/-. The Bank was not agreeable and that gave rise to a dispute. The Bank sought arbitration and appointed its arbitrator. The Insurer however did not appoint its Arbitrator. Therefore, the Arbitrator appointed by the Bank entered upon the reference as sole arbitrator. In spite of due notice, the Insurer did not participate in the

arbitration proceedings.

5. The arbitrator proceeded ex parte and made an award dated 17.8.1983. The Arbitrator found that there were a series of embezzlements by Lodaya, which were connected together by a common modus operandi. The Arbitrator held that in all a sum of Rs.3,44,449/86 was embezzled from the various accounts of Bank's constituents with the Bank, by resorting to forgery. The Arbitrator found that the following amounts were embezzled from the following accounts of account holders/constituents of the Bank :

S.No. Name of the Account-holders Amount embezzled

1. Purohit 44,615.84

2. Bhutada 60,751.80

3. Mohata 38,483.84

4. Kothari 46,293.24

5. Roy 8,423.01

6. Bhat 57,506.92

7. Jasraj Mundhada 1,916.35

8. Radhabai Mundhada 1,911.00

9. M.Darda 1,105.15

10. Kamlabai Darda 2,216.25

11. G.H. Darda 3,210.15

12. M.S. Coop. Bank 39,781.26 The Arbitrator held that these losses were covered under contingency (4) of the policy. He noted that proviso (1) of the policy used the words "each and every loss" when referring to losses under contingencies 1, 2 or 3 but did not use the said words when referring to losses under contingency (4). Therefore, the Arbitrator held that the insurer could not apply the Excess clause to each and every loss separately; that having regard to the terms of the policy, the amounts embezzled had to be aggregated; and that out of the total loss, the Bank had to bear 25% and the insurer was liable to pay the balance. The Arbitrator therefore deducted 25% from Rs.3,44,449/86 and made an award directing the insurer to pay Rs.2,58,337/40 to the Bank.

6. The Bank made an application under Sections 14 and 17 of the Arbitration Act, 1940 (`Act' for short) in January, 1984. The Insurer filed a petition under Section 30 of the said Act for setting aside the ex parte award. Both petitions were heard together and the Civil Court by Judgement dated 27.6.1990 upheld the award and dismissed the petition under Section 30 of the Act for setting aside the award and directed that the award be made a rule of the court.

7. Feeling aggrieved, the Insurer filed an appeal in the High Court of Bombay. By Judgment dated 18.2.2008 the appeal was allowed, the judgment of the Civil Court and the award of the Arbitrator were set aside and the matter was remitted to the Arbitrator for deciding the claim afresh, after granting due opportunity to both the parties to lead further evidence and submit their statements before the Arbitrator, if they so desired. The High Court following the decision of a learned Single Judge of that Court in Central Bank v. New India Assurance Co.Ltd. - AIR 1981 Bombay 397, held that the Arbitrator ought to have considered each item of embezzlement separately and could not aggregate the amounts embezzled by Lodaya at Dhamangaon Branch, for the purpose of arriving at the claim and fixing liability of the insurer. The High Court held that the Excess Clause in the policy did not envisage consolidation or aggregation of several losses sustained by the acts of embezzlement by the employee and deduction 25% thereof to arrive at the liability of the insurer, but envisaged the deduction from every claim, that is every single amount embezzled, 25% of the amount embezzled or Rs.11,500/- whichever was higher, to arrive at the liability of the insurer.

8. The said judgment is challenged in this appeal by special leave.

The appellant submitted that the proviso relating to Excess in the Insurance Policy consists of two

parts; that the first part requires the Insurer to bear the amount of excess stipulated in the Schedule in respect of each and every loss, if the loss was under Contingencies 1,2 and 3; that if the loss was under Contingency 4, the Insured was required to bear 25% of the amount of the loss or the amount of excess stipulated in the Schedule whichever was higher. It was contended that the use of the words "each and every loss" in the first part of proviso (1) while referring the Contingencies 1, 2 and 3, and the omission to use the said words in the second part thereof when referring to losses under Contingency 4, when considered with the use of the words "insured shall bear 25% of the amount of the loss or the amount of excess stipulated in the Schedule whichever is higher", in regard to losses under contingency (4), would clearly indicate that the 25% of the aggregate of the losses had to be borne by the Bank and the balance had to be paid by the Insurer. As Lodaya had embezzled several amounts and the aggregate of such embezzlements during the period of the insurance, was Rs.3,44,449/86, having regard to Proviso (1) of the Insurance Policy, the Bank contended that 25% thereof will have to be deducted therefrom and the Insurer should be made liable to pay the balance of Rs.2,58,337/40. It was therefore submitted that the High Court ought not to have set aside the well-reasoned award of the Arbitrator nor remitted the matter for fresh consideration, after nearly a quarter century.

9. What therefore falls for consideration is the interpretation of Proviso (1) of the Insurance Policy. In General Assurance Society Ltd. v. Chandumull Jain (AIR 1966 SC 1644) a Constitution Bench of this Court laid down the principle relating to interpretation of Insurance Contracts.

This Court held:

"In interpreting documents relating to a contract of Insurance, the duty of the court is to interpret the words in which the contact 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."

In Oriental Insurance Co. Ltd vs. Sony Cheriyan - 1999 (6) SCC 451, this Court held :

"The insurance policy between the insurer and the insured represents a contract between the parties. Since the insurer undertakes to compensate the loss suffered by the insured on account of risks covered by the insurance policy, the terms of the agreement have to be strictly construed to determine the extent of liability of the insurer. The insured cannot claim anything more than what is covered by the insurance policy. That being so, the insured has also to act strictly in accordance with the statutory limitations or terms of the policy expressly set out therein."

10. "Excess" clauses are commonly used in Insurance contracts. In insurance parlance, the term "EXCESS" in the Excess clause in the policy refers to "that part of the amount of loss, under each

claim, which is not covered by the policy" or the "amount that the policy holder has, by agreement, to bear or contribute to each insurance claim". In other words it limits the liability of the insurer in regard to each claim, only to the amount of loss, in excess of the sum specified in the Excess clause, which the insured has agreed to bear (either himself or by securing other insurance coverage).

11. Excess clauses in insurance policies have been interpreted in several English decisions. We may refer to one of them. In Philadelphia National Bank v. Price reported in (1938) 2 All ER 199, the Court of Appeal was concerned with a case where a policy of insurance indemnified the bank against loss sustained by reason of making advances against forged or invalid documents subject to an excess of $25,000 "by each and every loss and occurrence". Credit facilities were granted by the Bank to a trader on the security of invoices assigned to the bank. Each day, the trader assigned a bundle of invoices and the Bank advanced a sum corresponding to the total of the invoices. The invoices turned out to be false and the bank was unable to recover advances of over $400,000 in the aggregate, although no single daily loss amounted to more than $25,000. The Court of Appeal held that a separate loss had occurred in respect of each day's advance and the loss cannot be treated as one loss, as each production of documents led to a fresh loss and must be treated as number of losses occasioned by a number of advances. The claim of the Bank was therefore dismissed as loss in each case was below the excess limit of $25000/-.

12. A learned Single Judge of Bombay High Court in Central Bank of India Ltd. v. New India Assurance Co.Ltd. (AIR 1981 Bombay 397) interpreted the word `claim' in the Excess clause therein, which provided that the Bank shall be considered co-insurer to the extent of 25% subject to the minimum excess of Rs.25000/- for each and every claim. Negating the contention of the Bank that in view of the said clause, its liability as co-insurer was not in respect of each and every loss, but in regard to each claim (that is, the aggregate of several losses which constituted a `claim'), the learned Judge held :

"The word is of common occurrence in the field of insurance and may mean either the right to make a claim or an assertion of a right. The plain object of the clause, as stated earlier, is to exempt the insurance company from the liability to pay small claims which the Bank has to bear itself.

The word, "claim" in this clause means the occurrence of a state of facts which justifies a claim on insurer and does not mean the assertion of a claim on company. In other words, in my judgment, the operation of the Excess Clause is determined by the facts which give rise to the claim and not by the form in which the claim is asserted.

The employer committed several acts of fraud and defalcation and each such separate act caused loss and gave distinct and separate cause of action to the Bank. It is true that all these acts of defalcation were discovered only on October 18, 1972 but the fact of discovery on one day would not enable the Bank to claim that several acts of defalcation constitute one single or composite

loss..... The mere fact that several acts of defalcation were discovered on one day would not lead to the conclusion that several losses under different acts could be treated as one composite loss.

In accordance with the objects and interpretation of the terms and conditions of the policy, in my judgment, the Bank is liable to be considered as co-insurer to the extent of 25% subject to minimum excess of Rs.25,000/- in respect of each loss sustained by each set of defalcation by its employee, and it is not permissible to aggregate the total loss for working out of Excess Clause."

13. It is no doubt true that the first part of Proviso (1) uses the words "each and every loss" while referring to the losses covered by contingencies 1,2 and 3, and does not specifically repeat the said words in the second part of Proviso (1) relating to Contingency 4. But a careful reading of the shows that the non-repetition of the words was not because the intention was to apply those words only to losses under contingencies 1, 2, and 3, but because the structure of the sentence did not require repetition of the words and the context showed that the words were applicable even to losses under contingency 4. This is also evident from the Schedule to the policy that `Excess" is specified as Rs.11500/- with a further stated "25% of each and every claim or Rs.11,500/- whichever is higher on DAR". Proviso (1) also reiterates the position, both in regard to contingencies 1, 2 and 3 as also in regard to Contingencies 4 and 5. The difference between the two parts of proviso (1), however, is this: In respect of each and every loss under Contingencies 1,2 and 3, the Insurer had to bear the amount of excess stipulated in the Schedule, that is at the flat rate of Rs.11,500/-. But in regard to each and every loss under Contingency 4, the Insured had to bear 25% of the amount of the loss or the amount of excess (Rs.11,500/-) stipulated in the Schedule, whichever was higher. Proviso (1) was divided into two parts, that is the first part with reference to Contingencies 1,2 and 3, and the second part in regard to Contingencies 4 (and 5 where it was applicable), only to differentiate between the quantum that had to be borne by the Insured in respect of each and every claim which was a fixed Rs.11,500/- for each and every loss under Contingencies 1, 2 and 3, whereas it was 25% of the amount of the loss or Rs.11,500/- whichever was higher in regard to each and every claim under Contingency 4 (and 5).

14. Having regard to the wording of Proviso (1), in regard to losses referable to Contingencies 1, 2 and 3, the Insured had to bear a fixed amount i.e. Rs.11,500/- in regard to each and every loss. Therefore the words "25% on each and every claim or Rs. 11,500/- whichever is higher on DAR" were not applicable in regard to the claims under Contingencies 1,2 and 3 as what was to be borne in such cases was a fixed flat sum of Rs.11,500/- per every loss. The said words "25% on each and every claim or Rs.11,500/- whichever is higher on DAR" applied only in regard to losses referable to Contingencies 4 and 5; and in regard to losses thereunder, what was to be borne by the Insured was 25% of the amount of the loss or the amount of excess stipulated whichever was higher.

Therefore, the words "each and every claim" were used in the Schedule with reference to losses under Contingency 4 by describing the Excess as "25% on each and every claim or Rs.11,500/- whichever is higher on D.A.R." This also clearly shows that the stipulated exemption from

indemnity is in regard to each and every loss. We may illustrate the effect of this proviso by the following examples:

Amount of loss Amount of loss to be borne in Amount of loss to be borne in of insured (each case of Contingencies 1,2 and 3 case of Contingency 4 claim) (Excess is Rs.11,500) (Excess is 25% of the amount of loss or Rs.11500 whichever is higher) To be borne by To be paid by To be borne To be paid Insured Insurer by Insured by Insurer Rs.10,000 10,000 - 10,000 - Rs.11,500 11,500 - 11,500 Rs.15,000 11,500 3500 11,500 3500 Rs.30,000 11,500 18,500 11,500 18,500 Rs.40,000 11,500 28,500 11,500 28,500 Rs.46,000 11,500 34,500 11,500 34,500 Rs.50,000 11,500 38,500 12,500 37,500 Rs.80,000 11,500 68,500 20,000 60,000 Rs.1,00,000 11,500 88,500 25,000 75,000 [Note : for any loss upto Rs.46,000/-, the amount of liability will be the same, whether the loss is under Contingency 1 to 3 or under Contingency 4. But where the loss is more than Rs.46,000/-, the liability of the insured will remain constant in regard to Contingencies 1, 2 and 3, whereas it will be 25% of the loss in regard to each claim in regard to Contingency No.4.]

15. It is therefore necessary to identify each act of embezzlement by Lodaya in regard to each account, as the loss on account of each embezzlement forms a separate claim. The Bank has to bear 25% of the amount embezzled (or 11500/- whichever is higher) in regard to each and every embezzlement, and not by aggregation of the embezzlements. The Arbitrator has stated the total of the amount of embezzlements in regard to each account. He has not given the details of every embezzlement. For example with reference to the account of Purohit, the amount embezzled is shown as Rs.44,615/84. But this does not constitute a single embezzlement. The Arbitrator has stated thus in regard to this account :

"The account of Shri Purohit:

On 22.6.76 Rs.4700/- were debited to the above T.D. ledger and credited to an account opened in the name of Shri Purohit. The credit slip was prepared by Shri Lodaya, who himself, signed in place of the Agent. Then he withdraw and made away with same of this money. Similar misdeed was repeated on 3.6.76 (Rs.4000/-) and 7.8.76 (Rs.1110-30)."

It is thus clear that the amount of embezzlement shown as Rs.44,615/84 with reference to the account of Purohit is not a single act, but a series of embezzlements. If in regard to each act, the amount embezzled is less than Rs.11,500/- the Bank had to bear the entire amount and no part had to be borne by the Insurer. Only where a single act of embezzlement was in excess of Rs.11,500/-, the Insurer's liability would arise. As noticed above, as the matter falls under Contingency (4), the Insurer will have to bear 25% of the each and every claim or Rs.11,500/- whichever is higher on DAR.

16. The award of the arbitrator is liable to be set aside as there is a clear error apparent on the face of the award. The award is a speaking award. It extracts the relevant clauses of the insurance policy including the excess clause. It then proceeds to put an interpretation thereon which is contrary to the express words of the contract and opposed to the well recognised insurance practices and principles. Hence the award was rightly set aside by the High Court.

17. If the amount of each and every embezzlement had been separately recorded in the award of the Arbitrator, the court could have calculated the amount that was due, instead of remitting the matter to the Arbitrator for fresh decision. But that is not possible, as the particulars are not available.

18. In view of the above, we uphold the decision of the High Court and dismiss the appeal. If however the appellant is not interested in proceeding afresh before the arbitrator after all these years, and is willing 16 to accept the sum of Rs.29,000/-, offered by the insurer, it may inform the insurer accordingly in which event, the insurer shall pay the same to the appellant -Bank, if it had not already been paid.