

Mercantile Law – Insurance

Case Digest



**UNIVERSITY OF SANTO TOMAS
FACULTY OF CIVIL LAW**

**LIST OF CASES
Insurance**

I. Insurance Laws

a. Concept of Insurance

- Philippine Health Care Providers, Inc., vs. Commissioner of Internal Revenue, G.R. No. 167330, September 18, 2009

a.1 Interpretation of insurance contract

- Philamcare Health System vs. Court of Appeals (379 SCRA 356 [2002])
- Lalican vs. Insular Life Assurance Company, Ltd. (597 SCRA 159 [2009])
- Alpha Insurance and Surety Co. vs. Castor, GR No. 198174, September 2, 2013

b. Elements of an Insurance Contract

- Philamcare Health System vs. Court of Appeals (379 SCRA 432 [1997])
- Fortune Medicare Inc. vs Amorin, G.R. No. 195872, March 12, 2014
- JAIME T. GAISANO v. DEVELOPMENT INSURANCE and SURETY CORPORATION, G.R. No. 190702, February 27, 2017

c. Characteristics/Nature of Insurance Contracts

- Heirs of Loreto C. Maramag vs. Eva Verna De Guzman Maramag, et al., G.R. No. 181132, June 5, 2009
- Tibay vs. Court of Appeals (257 SCRA 126 [1996])

d. Classes

i. Marine

- Isabela Roque, doing business under the name and style of Isabela Roque Timber Enterprises, *et al.*, vs. The Intermediate Appellate Court, *et al.*, G.R. No. L-66935, November 11, 1985
- Cathay Insurance Co., vs. Court of Appeals, *et al.*, G.R. No. L-76145, June 30, 1987
- Filipino Merchants Insurance Co., Inc., vs. Court of Appeals, et al., G.R. No. 85141, November 28, 1989
- Choa Tiek Seng, doing business under the name and style of Seng's Commercial Enterprises vs. Court of Appeals, et al., G.R. No. 84507, March 15, 1990
- Keppel Cebu Shipyard, Inc. vs. Pioneer Insurance and Surety Corporation, 601 SCRA 96
- Mayer Steel Pipe Corp. vs. Court of Appeals and South Sea Surety (274 SCRA 432 [1997])

ii. Fire

- Development Insurance Corporation vs. Intermediate Appellate Court, et al., G.R. No. L-71360, July 16, 198
- Pacific Banking Corp. vs. Court of Appeals and Oriental Assurance Corporation (168 SCRA 1 [1988])
- Philippine Home Assurance Corporation vs. Court of Appeals, G.R. No. 106999, June 20, 1996
- MALAYAN INSURANCE CO., INC. v. LIN. G.R. No. 207277, January 16, 2017

iii. Casualty

- Fortune Insurance and Surety Co., Inc. vs. Court of Appeals and Producers Bank of the Philippines, G.R. No. 115278, May 23, 1995
- Coquia vs. Fieldmen's Insurance Company, Inc., 26 SCRA 178
- Far Eastern Surety & Trust Company, Inc. vs. Misa, 25 SCRA 662
- Finman General Assurance Corporation vs. Court of Appeals, 213 SCRA 493

iv. Suretyship

- First Lepanto-Taisho Insurance Corporation vs. Chevron Philippines, Inc., G.R. No. 177839, January 18, 2012
- National Power Corporation vs. Court of Appeals, et al., G.R. No. L-43706, November 14, 1986
- Finman General Assurance Corporation vs. William Inocencio, et al., G.R. No. 90273-75, November 15, 1989
- Country Bankers Insurance Corporation vs. Antonio Lagman, G.R. No. 165487, July 13, 2011

v. Life

- Re: Claims for Benefits of the Heirs of the Late Mario vs. Chanliongco, Adm. Matter No. 190-RET., October 18, 1977
- The Insular Life Assurance Company, Ltd., vs. Carponia T. Ebrado and Pascuala Vda. De Ebrado, G.R. No. l-44059, October 28, 1977
- Great Pacific Life Assurance Company vs. Court of Appeals, 89 SCRA 543 (1979)
- Tan vs. Court of Appeals, 174 SCRA 403 (1989)
- Sun Insurance Office, Ltd. vs. Court of Appeals, G.R. No. 92383, July 17, 1992
- Heirs of Loreto C. Maramag vs. Maramag, GR No. 181132, June 5, 2009

vi. Compulsory Motor Vehicle Liability Insurance

- Vda. De Maglana vs. Hon. Consolacion (212 SCRA 268 [1992])
- The Heirs of George Y. Poe vs. Malayan Insurance Company, Inc., G.R. No. 156302, April 7, 2009
- Jewel Villacorta vs. Insurance Commission, et al., G.R. No. 54171. October 28, 1980

- James Stokes, as Attorney-in-Fact of Daniel Stephen Adolfson vs. Malayan Insurance Co., Inc., G.R. No. L-34768. February 24, 1984
- Andrew Palermo vs. Pyramid Insurance Co., Inc., G.R. No. L-36480. May 31, 1988
- Agapito Gutierrez vs. Capital Insurance & Surety Co., Inc., G.R. No. L-26827, June 29, 1984
- Lao vs. Standard Insurance Company, Inc., 409 SCRA 43
- Perla Compania De Seguros, Inc., vs. Hon. Constante A. Ancheta, Presiding Judge of the Court of First Instance of Camarines Norte, Branch III, et al., G.R. No. L-49699, August 8, 1988

e. Insurable Interest

i. In Life/Health

- Philamcare Health System vs. Court of Appeals (379 SCRA 356 [2002])
- Lalicán vs. Insular Life Assurance Company Ltd (597 SCRA 159 [2009])
- El Oriente Fabrica de Tabacos vs. Posada (56 Phil 147 [1931])

ii. In Property

- Spouses Nilo Cha and Stella Uy Cha vs. Court of Appeals, G.R. No. 124520, August 18, 1997
- Malayan Insurance Company vs. PAP Co. (PHIL. BRANCH), G.R. No. 200784, August 07, 2013

3. Double Insurance and Over Insurance

- Armando Geagonia vs. Court of Appeals, et al., G.R. No. 114427, February 6, 1995
- Malayan Insurance Co., Inc., vs. Philippine First Insurance Co., Inc. and Reputable Forwarder Services, Inc., G.R. No. 184300, July 11, 2012

4. Multiple or Several Interests on Same Property

- Armando Geagonia vs. Court of Appeals, et al., G.R. No. 114427, February 6, 1995
- Great Pacific Life vs. Court of Appeals (316 SCRA 677 [1999])

f. Perfection of the Contract of Insurance

1. Offer and Acceptance/Consensual

- People of the Philippines vs. Yip Wai Ming, G.R. No. 120959, November 14, 1996
- Great Pacific Life Assurance Company vs. Hon. Court of Appeals, G.R. No. L-31845. April 30, 1979

- a. Delay in Acceptance**
- b. Delivery of Policy**
- c. Cancellation of policy**

- Malayan Insurance Co., Inc. vs. Gregoria Cruz Arnaldo, in her capacity as the Insurance Commissioner, et al., G.R. No. L-67835, October 12, 1987

2. Premium Payment

- Capital Insurance & Surety Co., Inc., vs. Plastic Era Co., Inc., et al., G.R. No. L-22375, July 18, 1975
- Philippine Phoenix Surety & Insurance Company vs. Woodwork, Inc., G.R. No. L-25317, August 6, 1979
- Pacific Timber Export Corporation vs. Court of Appeals, et al., G.R. No. L-38613, February 25, 1982
- Arturo Valenzuela, et al. vs. Court Of Appeals, et al., G.R. No. 83122, October 19, 1990
- Philippine Pryce Assurance Corporation vs. Court of Appeals, et al., G.R. No. 107062, February 21, 1994
- American Home Assurance vs. Antonio Chua, G.R. 130421, June 28, 1999
- UCPB General Insurance Co. Inc., vs. Masagana Telemart, Inc., G.R. No. 137172, April 4, 2001
- Makati Tuscany Condominium Corp. vs. Court of Appeals (215 SCRA 463 [1992])
- Jose Marques and Maxilite Technologies, Inc., vs. Far East Bank And Trust Company, et al., G.R. No. 171379, January 10, 2011
- PHILAM INSURANCE CO., INC., NOW CHARTIS PHILIPPINES INSURANCE, INC., v. PARC CHATEAU CONDOMINIUM UNIT OWNERS ASSOCIATION, INC., AND/OR EDUARDO B. COLET, G.R. No. 201116, SECOND DIVISION, March 4, 2019, REYES, JR., J.

3. Non-Default Options in Life Insurance

4. Reinstatement of a Lapsed Policy of Life Insurance

- James McGuire v. The Manufacturers Life Insurance Co., G.R. No. L-3581, September 21, 1950
- Andres vs. Crown Life Ins. Co., G.R. No. L-10875, January 28, 1958

5. Refund of Premiums

- Great Pacific Life Insurance Corporation vs. Court of Appeals, et al., G.R. No. L-57308, April 23, 1990

g. Rescission of Insurance Contracts

1. Concealment

- Great Pacific Life Assurance Company vs. Court of Appeals, G.R. No. L-31845. April 30, 1979
- Ng Gan Zee vs. Asian Crusader Life Assurance Corporation, G.R. No. L-30685, May 30, 1983

- New Life Enterprises and Julian Sy vs. Court of Appeals, et al., G.R. No. 94071, March 31, 1992
- Sunlife Assurance Company of Canada vs. Court of Appeals, et al., G.R. No. 105135, June 22, 1995
- Saturnino v. Phil-Am Life (7 SCRA 316 [1963])
- Thelma Vda. De Canilang vs. Court of Appeals and Grepalife (223 SCRA 443 [1993])
- The Insular Life Assurance Co., Ltd. v. Heirs of Alvarez, G.R. Nos. 207526 & 210156, October 3, 2018, Third Division, J. Leonen

2. Misrepresentation/Omissions

- Ma. Lourdes s. Florendo vs. Philam Plans, Inc., et al., G.R. No. 186983, February 22, 2012
- Emilio Tan vs. Court of Appeals, G.R. No. 48049, June 29, 1989
- Manila Bankers Life Insurance Corporation vs. Cresencia P. Aban, G.R. No. 175666, July 29, 2013
- Florendo vs. Philam Plans, G.R. No. 186983, February 22, 2012
- The Insular Life Assurance Co., Ltd. v. Heirs of Alvarez, G.R. Nos. 207526 & 210156, [October 3, 2018]

3. Breach of Warranties

- Qua Chee Gan v. Law Union (98 Phil 85 [1955])
- Malayan Insurance Company, Inc. vs. Pap Co., Ltd., G.R. No. 200784, August 7, 2013
- New Life Enterprises vs. Court of Appeals, 207 SCRA 669
- Young vs. Midland Textile Insurance Company, 30 Phil. 617
- Bachrach vs. British American Assurance Company, 17 Phil. 555
- Young vs. Midland Textile Insurance Company, 30 Phil. 617

h. Claims Settlement and Subrogation

- Perla Compania De Seguros, Inc. vs. Court of Appeals, G.R. No. 78860, May 28, 1990
- Malayan Insurance Co vs. Alberto, G.R. No. 194320, February 1, 2012

i. Notice and Proof of Loss

- FGU Insurance Corporation vs. Court of Appeals, 454 SCRA 351
- United Merchants Corporation vs. Country Bankers Insurance Corporation, G.R. No. 198588, July 11, 2012
- Finman Gen. Assurance vs. Court of Appeals (361 SCRA 214 [2001])
- Tan It vs. Sun Insurance 51 Phil 212
- Industrial Personnel and Management Services, Inc. v. Country Bankers Insurance Corp., G.R. No. 194126, [October 17, 2018]

ii. Guidelines on Claims Settlement

a. Unfair Claims Settlement; Sanctions

b. Prescription of Action

- Summit Guaranty and Insurance Company, Inc. vs. Hon. Jose C. De Guzman, in his capacity as Presiding Judge of Branch III, CFI of Tarlac, et al., G.R. No. L-50997, June 30, 1987
- Sun Life Office, Ltd. vs. Court of Appeals, GR. No. 89741, Mar. 13, 1991
- Country Bankers Insurance Corp., vs. Travellers Insurance and Surety Corp., et al., G.R. No. 82509, August 16, 1989
- H.H. Hollero Construction vs GSIS, GR no. 152334, September 24, 2014

c. Subrogation

- Pan Malayan Insurance Corporation vs. Court of Appeals, et al., G.R. No. 81026, April 3, 1990
- Aboitiz Shipping Corporation v. Insurance Company Of North America, G.R. No. 168402, August 6, 2008
- Malayan Insurance Co., Inc., vs. Rodelio Alberto, et al., G.R. No. 194320, February 1, 2012
- The Philippine American General Insurance Company, Inc., vs. Court of Appeals, et al., G.R. No. 116940, June 11, 1997
- Fireman's Fund Insurance Company vs. Jamila & Company, Inc., G.R. No. L-27427, April 7, 1976
- St. Paul Fire & Marine Insurance Co. vs. Macondray & Co., Inc., et al., G.R. No. L-27796, March 25, 1976
- Manila Mahogany Manufacturing Corporation vs. Court of Appeals, G.R. No. L-52756, October 12, 1987
- Delsan Transport Lines, Inc. vs. Court of Appeals, et al., G.R. No. 127897, November 15, 2001
- Eastern Shipping Lines, Inc. vs. Prudential Guarantee and Assurance, Inc., G.R. No. 174116, September 11, 2009
- Asian Terminals vs First Lepanto-Taisho Insurance, GR no. 185964, June 16, 2014
- Loadstar Shipping Company vs Malayan Insurance Company, GR no. 185565, November 26, 2014
- LOADSTAR SHIPPING COMPANY, INCORPORATED and LOADSTAR INTERNATIONAL SHIPPING COMPANY, INCORPORATED v. MALAYAN INSURANCE COMPANY, INCORPORATED, G.R. No. 185565 (Resolution), April 26, 2017
- EQUITABLE INSURANCE CORPORATION v. TRANSMODAL INTERNATIONAL, INC., G.R. No. 223592, August 7, 2017
- KEIHIN-EVERETT FORWARDING CO., INC., v. TOKIO MARINE MALAYAN INSURANCE CO., INC. and SUNFREIGHT FORWARDERS & CUSTOMS BROKERAGE, INC., G.R. No. 212107, SECOND DIVISION, October 28, 2019, REYES, J. JR., J.

I. Miscellaneous Topics

1. Liability of Insurer

- Pacific Timer Export Corporation vs. Court of Appeals, 112 SCRA 199 (1982)
- Zenith Insurance Corporation vs. Court of Appeals, 119 SCRA 485 (1982)
- Noda vs. Cruz-Arnaldo, 151 SCRA 227 (1987)
- Vda, De Maglana vs. Consolacion, 212 SCRA 268 (1992)
- GSIS vs. CA, 308 SCRA 559 (1999)
- Tiu vs. Arriesgado, 437 SCRA 426 (2004)

2. Insurance Agent

- Aisporna vs. Court of Appeals, 113 SCRA 459 (1982)
- Great Pacific Life Assurance Corporation vs. Judico, 180 SCRA 445 (1989)
- Great Pacific Life Assurance Corporation vs. National Labor Relations Commission, 187 SCRA 694 (1990)
- Pineda vs. Court of Appeals, 226 SCRA 754 (1993)
- Philippine American Life Insurance Company vs. Ansaldo, 234 SCRA 509 (1994)
- South Sea Surety and Insurance Co., Inc. vs. Court of Appeals, 244 SCRA 744 (1995)
- Smith, Bell & Co., Inc. vs. Court of Appeals, 267 SCRA 530 (1997)

3. Reinsurance

- Gibson vs. Revilla, 92 SCRA 219 (1979)
- Avon Insurance PLC vs. Court of Appeals, 278 SCRA 312 (1997)
- COMMUNICATION and INFORMATION SYSTEM v. MARK SENSING AUSTRALIA, et al G.R. No. 192159, January 25, 2017

4. Documentary Stamp Tax on Insurance Policy

- Philippine Home Assurance Corp. vs. Court of Appeals, 301 SCRA 443 (1999)
- Commissioner of Internal Revenue vs. Lincoln Philippine Life Insurance Co., Inc., 379 SCRA 423 (2002)

I. Insurance Laws

i. Concept of Insurance

- Philippine Health Care Providers, Inc., vs. Commissioner of Internal Revenue, G.R. No. 167330, September 18, 2009

**PHILIPPINE HEALTH CARE PROVIDERS, INC., Petitioner, vs.
COMMISSIONER OF INTERNAL REVENUE, Respondent.
G.R. No. 167330, September 18, 2009, SPECIAL FIRST DIVISION CORONA, J.:**

HMOs are not insurance business. One test that they have applied is whether the assumption of risk and indemnification of loss (which are elements of an insurance business) are the principal object and purpose of the organization or whether they are merely incidental to its business. If these are the principal objectives, the business is that of insurance. But if they are merely incidental and service is the principal purpose, then the business is not insurance.

Philippine Health Care Providers appears to provide insurance-type benefits to its members (with respect to its curative medical services), but these are incidental to the principal activity of providing them medical care. The "insurance-like" aspect of Philippine Health Care Providers' business is miniscule compared to its noninsurance activities. Therefore, since it substantially provides health care services rather than insurance services, it cannot be considered as being in the insurance business.

FACTS

Philippine Health Care Providers, Inc. is a domestic corporation whose primary purpose is "[t]o establish, maintain, conduct and operate a prepaid group practice health care delivery system or a health maintenance organization to take care of the sick and disabled persons enrolled in the health care plan and to provide for the administrative, legal, and financial responsibilities of the organization." Individuals enrolled in its health care programs pay an annual membership fee and are entitled to various preventive, diagnostic and curative medical services provided by its duly licensed physicians, specialists and other professional technical staff participating in the group practice health delivery system at a hospital or clinic owned, operated or accredited by it.

January 27, 2000: Commissioner of Internal Revenue (CIR) sent petitioner a formal demand letter and the corresponding assessment notices demanding the payment of deficiency taxes, including surcharges and interest, for the taxable years 1996 and 1997 in the total amount of P224,702,641.18. Petitioner protested the assessment in a letter dated February 23, 2000.

CIR did not act on the protest, petitioner filed a petition for review in the Court of Tax Appeals (CTA) seeking the cancellation of the deficiency VAT and DST assessments.

CTA: PARTIALLY GRANTED to pay VAT

DST assessment CANCELLED AND SET ASIDE

CIR: health care agreement was a contract of insurance subject to DST under Section 185 of the 1997 Tax Code

CA: health care agreement was in the nature of a non-life insurance contract subject to DST
Court Affirmed CA

ISSUE

Whether or not the Philippine Health Care Providers, Inc (HMO) was engaged in the business of insurance during the pertinent taxable years - NO

Whether or Not the Philippine Health Care Providers, Inc enters into an insurance contract - NO

RULING

Motion for reconsideration is GRANTED

1.NO. P.D. 612 Insurance Code Sec. 2 (2)

(2) The term "doing an insurance business" or "transacting an insurance business", within the meaning of this Code, shall include:

- (a) making or proposing to make, as insurer, any insurance contract;
- (b) making or proposing to make, as surety, any contract of suretyship as a vocation and not as merely incidental to any other legitimate business or activity of the surety;
- (c) doing any kind of business, including a reinsurance business, specifically recognized as constituting the doing of an insurance business within the meaning of this Code;
- (d) doing or proposing to do any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this Code.

In the application of the provisions of this Code the fact that no profit is derived from the making of insurance contracts, agreements or transactions or that no separate or direct consideration is received therefor, shall not be deemed conclusive to show that the making thereof does not constitute the doing or transacting of an insurance business.

No profit is derived from the making of insurance contracts, agreements or transactions or that no separate or direct consideration is received therefore, shall not be deemed conclusive to show that the making thereof does not constitute the doing or transacting of an insurance business

2. NO. The basic distinction between medical service corporations and ordinary health and accident insurers is that the former undertake to provide prepaid medical services through participating physicians, thus relieving subscribers of any further financial burden, while the latter only undertake to indemnify an insured for medical expenses up to, but not beyond, the schedule of rates contained in the policy

A participating provider of health care services is one who agrees in writing to render health care services to or for persons covered by a contract issued by health service corporation in return for which the health service corporation agrees to make payment directly to the participating provider

any indemnification resulting from the payment for services rendered in case of emergency by non-participating health providers would still be incidental to petitioner's purpose of providing and arranging for health care services and does not transform it into an insurer.

As an HMO, it is its obligation to maintain the good health of its members its undertaking under its agreements is not to indemnify its members against any loss or damage arising from a medical condition but, on the contrary, to provide the health and medical services needed to prevent such loss or damage

Overall, petitioner appears to provide insurance-type benefits to its members (with respect to its curative medical services), but these are incidental to the principal activity of providing them medical care. The "insurance-like" aspect of petitioner's business is miniscule compared to its noninsurance activities. Therefore, since it substantially provides health care services rather than insurance services, it cannot be considered as being in the insurance business.

Principal purpose test

Purpose of determining what "doing an insurance business" means, we have to scrutinize the operations of the business as a whole and not its mere components

The letter dated September 3, 2000, the Insurance Commissioner confirmed that petitioner is not engaged in the insurance business. This determination of the commissioner must be accorded great weight

Section 2 (1) of the Insurance Code defines a contract of insurance as an agreement whereby one undertakes for a consideration to indemnify another against loss, damage or liability arising from an unknown or contingent event. An insurance contract exists where the following elements concur: - NOT present

1. The insured has an insurable interest;
2. The insured is subject to a risk of loss by the happening of the designed peril;
3. The insurer assumes the risk;
4. Such assumption of risk is part of a general scheme to distribute actual losses among a large group of persons bearing a similar risk and
5. In consideration of the insurer's promise, the insured pays a premium.

Assumption of the expense by petitioner is not confined to the happening of a contingency but includes incidents even in the absence of illness or injury

Since indemnity of the insured was not the focal point of the agreement but the extension of medical services to the member at an affordable cost, it did not partake of the nature of a contract of insurance HMO, undertakes a business risk when it offers to provide health services. But it is not the risk of the type peculiar only to insurance companies. Insurance risk, also known as actuarial risk, is the risk that the cost of insurance claims might be higher than the premiums paid. The amount of premium is calculated on the basis of assumptions made relative to the insured.

In our jurisdiction, a commentator of our insurance laws has pointed out that, even if a contract contains all the elements of an insurance contract, if its primary purpose is the rendering of service, it is not a contract of insurance. The primary purpose of the parties in making the contract may negate the existence of an insurance contract.

Health care agreements are clearly not within the ambit of Section 185 of the NIRC and there was never any legislative intent to impose the same on HMOs

a.1 Interpretation of insurance contract

- Philamcare Health System vs. Court of Appeals (379 SCRA 356 [2002])

PHILAMCARE HEALTH SYSTEMS, INC., vs. COURT OF APPEALS and JULITA TRINOS G.R. No. 125678 March 18, 2002 YNARES-SANTIAGO, J.:

The health coverage agreement entered upon by Ernani with Philamcare is a non-life insurance contract and is covered by the Insurance Law. It is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract. There is no concealment on the part of Ernani. He answered the question with good faith. He was not a medical doctor hence his statement in answering the question asked of him when he was applying is an opinion rather than a fact. Answers made in good faith will not void the policy.

Further, Philamcare, in believing there was concealment, should have taken the necessary steps to void the health coverage agreement prior to the filing of the suit by Julita. Philamcare never gave notice to Julita of the fact that they are voiding the agreement.

FACTS

Ernani Trinos, deceased husband of Julita Trinos, applied for a health care coverage with Philamcare Health Systems, Inc. In the standard application form, he answered “NO” to the following question:

Have you or any of your family members ever consulted or been treated for high blood pressure, heart trouble, diabetes, cancer, liver disease, asthma or peptic ulcer? (If Yes, give details).

Coverage of the health care agreement (HCA):

- approved for a period of one year, Renewed 3 times yearly: March 1, 1988 - March 1, 1990; March 1, 1990 – June 1, 1990. The amount of coverage was increased to a maximum sum of P75,000.00 per disability.

Ernani's entitlement under HCA:

- hospitalization benefits, whether ordinary or emergency, listed therein
- out-patient benefits" such as annual physical examinations, preventive health care and other out-patient services.

Ernani was subsequently confined. HISTORY (everything happened within the period of coverage):

1. Ernani suffered a heart attack and was confined at the Manila Medical Center (MMC) for one month beginning March 9, 1990.
2. Julita tried to claim the benefits under the health care agreement.
3. Philamdenied her claim saying that the Health Care Agreement was void. there was a concealment regarding Ernani's medical history. Doctors at the MMC allegedly discovered at the

time of Ernani's confinement that he was hypertensive, diabetic and asthmatic, contrary to his answer in the application form.

4. Julita paid the hospitalization expenses herself, amounting to about P76,000.00
5. Ernani was discharged at MMC
6. He was attended by a physical therapist at home.
7. Again he was admitted at the Chinese General Hospital.
8. Julita brought her husband home again due to financial difficulties.
9. In the morning of April 13, 1990, Ernani had fever and was feeling very weak.
10. Julita was constrained to bring him back to the Chinese General Hospital where he died on the same day.

On July 24, 1990, respondent instituted with the Regional Trial Court of Manila, Branch 44, an action for damages against Philam and its president, Dr. Benito Reverente, She asked for reimbursement of her expenses plus moral damages and attorney's fees. After trial, the lower court ruled against Philam, ordered:

1. Defendants to pay and reimburse the medical and hospital coverage of the late Ernani Trinos in the amount of P76,000.00 plus interest, until the amount is fully paid to plaintiff who paid the same;
2. Defendants to pay the reduced amount of moral damages of P10,000.00 to plaintiff;
3. Defendants to pay the reduced amount of P10,000.00 as exemplary damages to plaintiff;
4. Defendants to pay attorney's fees of P20,000.00, plus costs of suit.

CA: affirmed the decision of the trial court but deleted all awards for damages and absolved petitioner Reverente. Denied MR.

ISSUES

1. Whether health care agreements are considered insurance contracts.
2. Whether there was concealment of material facts on the part of Ernani that rendered the HCA void by virtue of the "Invalidation of agreement" contained in the contract.
3. Suppose there was concealment, what are the steps Philam should have done?

RULING

1. YES, it is an insurance contract.

Section 2 (1) of the Insurance Code defines a contract of insurance as an agreement whereby one undertakes for a consideration to indemnify another against loss, damage or liability arising from an unknown or contingent event. An insurance contract exists where the following elements concur:

- (1) The insured has an insurable interest;
- (2) The insured is subject to a risk of loss by the happening of the designated peril;
- (3) The insurer assumes the risk;
- (4) Such assumption of risk is part of a general scheme to distribute actual losses among a large group of persons bearing a similar risk; and
- (5) In consideration of the insurer's promise, the insured pays a premium.

Section 3 of the Insurance Code states that any contingent or unknown event, whether past or future, which may damnify a person having an insurable interest against him, may be insured against. Every person has an insurable interest in the life and health of himself. Section 10 provides:

Every person has an insurable interest in the life and health:

- (1) of himself, of his spouse and of his children;
- (2) of any person on whom he depends wholly or in part for education or support, or in whom he has a pecuniary interest;
- (3) of any person under a legal obligation to him for the payment of money, respecting property or service, of which death or illness might delay or prevent the performance; and
- (4) of any person upon whose life any estate or interest vested in him depends.

In the case at bar, the insurable interest of respondent's husband in obtaining the health care agreement was his own health. The health care agreement was in the nature of non-life insurance, which is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract.

2. NONE, there was no concealment of material facts.

Petitioner cannot rely on the stipulation regarding "Invalidation of agreement" which reads:

Failure to disclose or misrepresentation of any material information by the member in the application or medical examination, whether intentional or unintentional, shall automatically invalidate the Agreement from the very beginning and liability of Philamcare shall be limited to return of all Membership Fees paid. An undisclosed or misrepresented information is deemed material if its revelation would have resulted in the declination of the applicant by Philamcare or the assessment of a higher Membership Fee for the benefit or benefits applied for.

The answer assailed by petitioner was in response to the question relating to the medical history of the applicant. This largely depends on opinion rather than fact, especially coming from respondent's husband who was not a medical doctor. Where matters of opinion or judgment are called for, answers made in good faith and without intent to deceive will not avoid a policy even though they are untrue. Thus,

(A)lthough false, a representation of the expectation, intention, belief, opinion, or judgment of the insured will not avoid the policy if there is no actual fraud in inducing the acceptance of the risk, or its acceptance at a lower rate of premium, and this is likewise the rule although the statement is material to the risk, if the statement is obviously of the foregoing character, since in such case the insurer is not justified in relying upon such statement, but is obligated to make further inquiry. There is a clear distinction between such a case and one in which the insured is fraudulently and intentionally states to be true, as a matter of expectation or belief, that which he then knows, to be actually untrue, or the impossibility of which is shown by the facts within his knowledge, since in such case the intent to deceive the insurer is obvious and amounts to actual fraud. (Underscoring ours)

The fraudulent intent on the part of the insured must be established to warrant rescission of the insurance contract. Concealment as a defense for the health care provider or insurer to avoid liability is an affirmative defense and the duty to establish such defense by satisfactory and convincing evidence rests upon the provider or insurer. In any case, with or without the authority to investigate, petitioner is liable for claims made under the contract. Having assumed a responsibility under the agreement, petitioner is bound to answer the same to the extent agreed upon. In the end, the liability

of the health care provider attaches once the member is hospitalized for the disease or injury covered by the agreement or whenever he avails of the covered benefits which he has prepaid.

3. Philam should have followed Section 27 of the Insurance Code:

"a concealment entitles the injured party to rescind a contract of insurance." The right to rescind should be exercised previous to the commencement of an action on the contract. In this case, no rescission was made. Besides, the cancellation of health care agreements as in insurance policies require the concurrence of the following conditions:

- a. Prior notice of cancellation to insured;
- b. Notice must be based on the occurrence after effective date of the policy of one or more of the grounds mentioned;
- c. Must be in writing, mailed or delivered to the insured at the address shown in the policy;
- d. Must state the grounds relied upon provided in Section 64 of the Insurance Code and upon request of insured, to furnish facts on which cancellation is based.

None of the above pre-conditions was fulfilled in this case.

Anent the incontestability of the membership of respondent's husband, we quote with approval the following findings of the trial court:

(U)nder the title Claim procedures of expenses, the defendant Philamcare Health Systems Inc. had twelve months from the date of issuance of the Agreement within which to contest the membership of the patient if he had previous ailment of asthma, and six months from the issuance of the agreement if the patient was sick of diabetes or hypertension. The periods having expired, the defense of concealment or misrepresentation no longer lie.

- Lalican vs. Insular Life Assurance Company, Ltd. (597 SCRA 159 [2009])

VIOLETA R. LALICAN, Petitioner, vs. **THE INSULAR LIFE ASSURANCE COMPANY LIMITED, AS REPRESENTED BY THE PRESIDENT VICENTE R. AVILON**, Respondent.
G.R. No. 183526, 25 August 2009 THIRD DIVISION **CHICO-NAZARIO, J**

A stipulation for reinstatement of an insurance policy does not give an absolute right of reinstatement to the insured by mere filing of an application. Insurer still has the right to deny said application if unsatisfied. "After the death of the insured the insurance Company cannot be compelled to entertain an application for reinstatement of the policy because the conditions precedent to reinstatement can no longer be determined and satisfied.

FACTS

Through his lifetime, Eulogio Lalican applied for life insurance with Insular Life Insurance Co., Ltd. (Insular Life). Through Josephine Malaluan (agent in Gapan City), Policy No. 9011992 was issued containing a 20-year endowment variable income package flexi plan (worth in total P1,500,000) to be paid on quarterly basis. Violeta Lalican (Eulogio's wife) was the primary beneficiary. Eulogio paid the first two premiums (24 July and 24 October 1997) but failed to pay subsequent one (24 January, even within the 31-day grace period). Policy thus, in accordance with their agreement, lapsed and became void. Eulogio's first try to reinstate said plan was not successful. On 17 September 1998, however, he went to Malaluan's house and filed his second application for reinstatement. Due to her absence, Malaluan's husband accepted said application and issued a receipt for payment of P17,500

(for Jan 24, plus interest, and for April 24 and July 24). On said day, Eulogio died of cardio-respiratory arrest secondary to electrocution. Not knowing of said death, Malaluan forwarded the application to Insular Life, but the same did not act upon said application upon knowledge of Eulogio's death. Upon demand, Insular Life only refunded P25,417 (payments made by Eulogio). For failure to re-evaluate said plan, Violeta filed before RTC Gapan City a complaint for death claim. RTC dismissed said complaint on ground that reinstatement "upon lifetime and good health" of insured was not met, and subsequently ordered the finality thereof and denied Violeta's notice of appeal. Hence, this appeal by certiorari.

ISSUE

Whether Eulogio successfully reinstated the lapsed insurance policy on his life before his death.

RULING

NO. To reinstate a policy means to restore the same to premium-paying status after it has been permitted to lapse. Both the Policy Contract and the Application for Reinstatement provide for specific conditions for the reinstatement of a lapsed policy:

"You may reinstate this policy at any time within three years after it lapsed if the following conditions are met: (1) the policy has not been surrendered for its cash value or the period of extension as a term insurance has not expired; (2) evidence of insurability satisfactory to [Insular Life] is furnished; (3) overdue premiums are paid with compound interest at a rate not exceeding that which would have been applicable to said premium and indebtedness in the policy years prior to reinstatement; and (4) indebtedness which existed at the time of lapsation is paid or renewed;" and,

"I/We agree that said Policy shall not be considered reinstated until this application is approved by the Company during my/our lifetime and good health and until all other Company requirements for the reinstatement of said Policy are fully satisfied.... [and] any payment made or to be made in connection with this application shall be considered as deposit only and shall not bind the Company until this application is finally approved by the Company during my/our lifetime and good health."

In the instant case, Eulogio's death rendered impossible full compliance with the conditions for reinstatement of his policy. True, Eulogio, before his death, managed to file his Application for Reinstatement and deposit the amount for payment of his overdue premiums and interests thereon with Malaluan; but Policy No. 9011992 could only be considered reinstated after the Application for Reinstatement had been processed and approved by Insular Life during Eulogio's lifetime and good health. (Payment to Malaluan, who has only limited authority, was not deemed equivalent to Insular Life's approval.)

In *Andres v. The Crown Life Insurance Company*, citing *McGuire v. The Manufacturer's Life Insurance Co.*, SC held that a stipulation for reinstatement of an insurance policy does not give an absolute right of reinstatement to the insured by mere filing of an application. Insurer still has the right to deny said application if unsatisfied. "After the death of the insured the insurance Company cannot be compelled to entertain an application for reinstatement of the policy because the conditions precedent to reinstatement can no longer be determined and satisfied." Petition is DENIED.

- Alpha Insurance and Surety Co. vs. Castor, GR No. 198174, September 2, 2013

ALPHA INSURANCE AND SURETY CO. vs. ARSENIA SONIA CASTOR
G.R. No. 198174, September 02, 2013, J. Peralta

Contracts of insurance, like other contracts, are to be construed according to the sense and meaning of the terms which the parties themselves have used. If such terms are clear and unambiguous, they must be taken and understood in their plain, ordinary and popular sense. Accordingly, in interpreting the exclusions in an insurance contract, the terms used specifying the excluded classes therein are to be given their meaning as understood in common speech.

A contract of insurance is a contract of adhesion. So, when the terms of the insurance contract contain limitations on liability, courts should construe them in such a way as to preclude the insurer from non-compliance with his obligation.

FACTS

On February 21, 2007, respondent entered into a contract of insurance, Motor Car Policy No. MAND/CV-00186, with petitioner, involving her motor vehicle, a Toyota Revo DLX DSL. The contract of insurance obligates the petitioner to pay the respondent the amount of Six Hundred Thirty Thousand Pesos (P630,000.00) in case of loss or damage to said vehicle during the period covered, which is from February 26, 2007 to February 26, 2008.

On April 16, 2007, respondent's car was stolen by his driver but petitioner denied the insurance claim on the ground that the insurance policy provides that: The Company shall not be liable for any malicious damage caused by the Insured, any member of his family or by "A PERSON IN THE INSURED'S SERVICE.

Respondent filed a Complaint for Sum of Money where RTC rendered a decision in favor of respondent and directed petitioner to pay respondent the amount of the car plus interest. The Court of Appeals affirmed the ruling of the RTC. Hence, this petition.

ISSUE

Whether the theft perpetrated by the driver of the insured is an exception to the coverage from the insurance policy of respondent.

RULING

The petition is denied.

Ruling in favor of respondent, the RTC of Quezon City scrupulously elaborated that theft perpetrated by the driver of the insured is not an exception to the coverage from the insurance policy, since Section III thereof did not qualify as to who would commit the theft. Thus:

Theft perpetrated by a driver of the insured is not an exception to the coverage from the insurance policy subject of this case. This is evident from the very provision of Section III – "Loss or Damage." The insurance company, subject to the limits of liability, is obligated to indemnify the insured against theft. Said provision does not qualify as to who would commit the theft. Thus, even if the same is committed by the driver of the insured, there being no categorical declaration of exception, the same must be covered. As correctly pointed out by the plaintiff, "(A)n insurance contract should be

interpreted as to carry out the purpose for which the parties entered into the contract which is to insure against risks of loss or damage to the goods. Such interpretation should result from the natural and reasonable meaning of language in the policy.

Where restrictive provisions are open to two interpretations, that which is most favorable to the insured is adopted.” The defendant would argue that if the person employed by the insured would commit the theft and the insurer would be held liable, then this would result to an absurd situation where the insurer would also be held liable if the insured would commit the theft. This argument is certainly flawed. Of course, if the theft would be committed by the insured himself, the same would be an exception to the coverage since in that case there would be fraud on the part of the insured or breach of material warranty under Section 69 of the Insurance Code.

Moreover, contracts of insurance, like other contracts, are to be construed according to the sense and meaning of the terms which the parties themselves have used. If such terms are clear and unambiguous, they must be taken and understood in their plain, ordinary and popular sense. Accordingly, in interpreting the exclusions in an insurance contract, the terms used specifying the excluded classes therein are to be given their meaning as understood in common speech.

Adverse to petitioner’s claim, the words “loss” and “damage” mean different things in common ordinary usage. The word “loss” refers to the act or fact of losing, or failure to keep possession, while the word “damage” means deterioration or injury to property. Therefore, petitioner cannot exclude the loss of respondent’s vehicle under the insurance policy under paragraph 4 of “Exceptions to Section III,” since the same refers only to “malicious damage,” or more specifically, “injury” to the motor vehicle caused by a person under the insured’s service. Paragraph 4 clearly does not contemplate “loss of property,” as what happened in the instant case.

Lastly, a contract of insurance is a contract of adhesion. So, when the terms of the insurance contract contain limitations on liability, courts should construe them in such a way as to preclude the insurer from non-compliance with his obligation.

j. Elements of an Insurance Contract

- Philamcare Health System vs. Court of Appeals [379 SCRA 432 [1997]]

**PHILAMCARE HEALTH SYSTEMS, INC., vs. COURT OF APPEALS and JULITA TRINOS
G.R. No. 125678 March 18, 2002 YNARES-SANTIAGO, J.:**

The health coverage agreement entered upon by Ernani with Philamcare is a non-life insurance contract and is covered by the Insurance Law. It is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract. There is no concealment on the part of Ernani. He answered the question with good faith. He was not a medical doctor hence his statement in answering the question asked of him when he was applying is an opinion rather than a fact. Answers made in good faith will not void the policy.

Further, Philamcare, in believing there was concealment, should have taken the necessary steps to void the health coverage agreement prior to the filing of the suit by Julita. Philamcare never gave notice to Julita of the fact that they are voiding the agreement.

FACTS

Ernani Trinos, deceased husband of Julita Trinos, applied for a health care coverage with Philamcare Health Systems, Inc. In the standard application form, he answered "NO" to the following question:

Have you or any of your family members ever consulted or been treated for high blood pressure, heart trouble, diabetes, cancer, liver disease, asthma or peptic ulcer? (If Yes, give details).

Coverage of the health care agreement (HCA):

- approved for a period of one year, Renewed 3 times yearly: March 1, 1988 - March 1, 1990; March 1, 1990 – June 1, 1990. The amount of coverage was increased to a maximum sum of P75,000.00 per disability.

Ernani's entitlement under HCA:

- hospitalization benefits, whether ordinary or emergency, listed therein
- out-patient benefits" such as annual physical examinations, preventive health care and other out-patient services.

Ernani was subsequently confined. HISTORY (everything happened within the period of coverage):

11. Ernani suffered a heart attack and was confined at the Manila Medical Center (MMC) for one month beginning March 9, 1990.
12. Julita tried to claim the benefits under the health care agreement.
13. Philam denied her claim saying that the Health Care Agreement was void. there was a concealment regarding Ernani's medical history. Doctors at the MMC allegedly discovered at the time of Ernani's confinement that he was hypertensive, diabetic and asthmatic, contrary to his answer in the application form.
14. Julita paid the hospitalization expenses herself, amounting to about P76,000.00
15. Ernani was discharged at MMC
16. He was attended by a physical therapist at home.
17. Again he was admitted at the Chinese General Hospital.
18. Julita brought her husband home again due to financial difficulties.
19. In the morning of April 13, 1990, Ernani had fever and was feeling very weak.
20. Julita was constrained to bring him back to the Chinese General Hospital where he died on the same day.

On July 24, 1990, respondent instituted with the Regional Trial Court of Manila, Branch 44, an action for damages against Philam and its president, Dr. Benito Reverente, She asked for reimbursement of her expenses plus moral damages and attorney's fees. After trial, the lower court ruled against Philam, ordered:

1. Defendants to pay and reimburse the medical and hospital coverage of the late Ernani Trinos in the amount of P76,000.00 plus interest, until the amount is fully paid to plaintiff who paid the same;
2. Defendants to pay the reduced amount of moral damages of P10,000.00 to plaintiff;
3. Defendants to pay the reduced amount of P10,000.00 as exemplary damages to plaintiff;
4. Defendants to pay attorney's fees of P20,000.00, plus costs of suit.

CA: affirmed the decision of the trial court but deleted all awards for damages and absolved petitioner Reverente. Denied MR.

ISSUES

4. Whether health care agreements are considered insurance contracts.
5. Whether there was concealment of material facts on the part of Ernani that rendered the HCA void by virtue of the "Invalidation of agreement" contained in the contract.
6. Suppose there was concealment, what are the steps Philam should have done?

RULING

4. YES, it is an insurance contract.

Section 2 (1) of the Insurance Code defines a contract of insurance as an agreement whereby one undertakes for a consideration to indemnify another against loss, damage or liability arising from an unknown or contingent event. An insurance contract exists where the following elements concur:

- (1) The insured has an insurable interest;
- (2) The insured is subject to a risk of loss by the happening of the designated peril;
- (3) The insurer assumes the risk;
- (4) Such assumption of risk is part of a general scheme to distribute actual losses among a large group of persons bearing a similar risk; and
- (5) In consideration of the insurer's promise, the insured pays a premium.

Section 3 of the Insurance Code states that any contingent or unknown event, whether past or future, which may damnify a person having an insurable interest against him, may be insured against. Every person has an insurable interest in the life and health of himself. Section 10 provides:

Every person has an insurable interest in the life and health:

- (1) of himself, of his spouse and of his children;
- (2) of any person on whom he depends wholly or in part for education or support, or in whom he has a pecuniary interest;
- (3) of any person under a legal obligation to him for the payment of money, respecting property or service, of which death or illness might delay or prevent the performance; and
- (4) of any person upon whose life any estate or interest vested in him depends.

In the case at bar, the insurable interest of respondent's husband in obtaining the health care agreement was his own health. The health care agreement was in the nature of non-life insurance, which is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract.

5. NONE, there was no concealment of material facts.

Petitioner cannot rely on the stipulation regarding "Invalidation of agreement" which reads:

Failure to disclose or misrepresentation of any material information by the member in the application or medical examination, whether intentional or unintentional, shall automatically invalidate the Agreement from the very beginning and liability of Philamcare shall be limited to return of all Membership Fees paid. An undisclosed or misrepresented information is deemed material if its revelation would have resulted in the declination of the applicant by Philamcare or the assessment of a higher Membership Fee for the benefit or benefits applied for.

The answer assailed by petitioner was in response to the question relating to the medical history of the applicant. This largely depends on opinion rather than fact, especially coming from respondent's husband who was not a medical doctor. Where matters of opinion or judgment are called for, answers made in good faith and without intent to deceive will not avoid a policy even though they are untrue. Thus,

(A)lthough false, a representation of the expectation, intention, belief, opinion, or judgment of the insured will not avoid the policy if there is no actual fraud in inducing the acceptance of the risk, or its acceptance at a lower rate of premium, and this is likewise the rule although the statement is material to the risk, if the statement is obviously of the foregoing character, since in such case the insurer is not justified in relying upon such statement, but is obligated to make further inquiry. There is a clear distinction between such a case and one in which the insured is fraudulently and intentionally states to be true, as a matter of expectation or belief, that which he then knows, to be actually untrue, or the impossibility of which is shown by the facts within his knowledge, since in such case the intent to deceive the insurer is obvious and amounts to actual fraud. (Underscoring ours)

The fraudulent intent on the part of the insured must be established to warrant rescission of the insurance contract. Concealment as a defense for the health care provider or insurer to avoid liability is an affirmative defense and the duty to establish such defense by satisfactory and convincing evidence rests upon the provider or insurer. In any case, with or without the authority to investigate, petitioner is liable for claims made under the contract. Having assumed a responsibility under the agreement, petitioner is bound to answer the same to the extent agreed upon. In the end, the liability of the health care provider attaches once the member is hospitalized for the disease or injury covered by the agreement or whenever he avails of the covered benefits which he has prepaid.

6. Philam should have followed Section 27 of the Insurance Code:

"a concealment entitles the injured party to rescind a contract of insurance." The right to rescind should be exercised previous to the commencement of an action on the contract. In this case, no rescission was made. Besides, the cancellation of health care agreements as in insurance policies require the concurrence of the following conditions:

- e. Prior notice of cancellation to insured;
- f. Notice must be based on the occurrence after effective date of the policy of one or more of the grounds mentioned;
- g. Must be in writing, mailed or delivered to the insured at the address shown in the policy;
- h. Must state the grounds relied upon provided in Section 64 of the Insurance Code and upon request of insured, to furnish facts on which cancellation is based.

None of the above pre-conditions was fulfilled in this case.

Anent the incontestability of the membership of respondent's husband, we quote with approval the following findings of the trial court:

(U)nder the title Claim procedures of expenses, the defendant Philamcare Health Systems Inc. had twelve months from the date of issuance of the Agreement within which to contest the membership of the patient if he had previous ailment of asthma, and six months from the issuance of the agreement if the patient was sick of diabetes or hypertension. The periods having expired, the defense of concealment or misrepresentation no longer lie.

- Fortune Medicare Inc. vs Amorin, G.R. No. 195872, March 12, 2014

***FORTUNE MEDICARE, INC. vs. DAVID ROBERT AMORIN
G.R. No195872; March 12, 2014 J. Reyes***

For purposes of determining the liability of a health care provider to its members, a health care agreement is in the nature of non-life insurance, which is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract. Limitations as to liability must be distinctly specified and clearly reflected in the extent of coverage which the company voluntarily assume, otherwise, any ambiguity arising therein shall be construed in favor of the member.

FACTS

David Robert Amorin was a cardholder/member of Fortune Medicare, Inc. (Fortune Care). While on vacation in Hawaii, Amorin underwent an emergency surgery, specifically appendectomy, at St. Francis Medical Center, causing him to incur professional and hospitalization expenses of \$7,242.35 and \$1,777.79, respectively. He attempted to recover from Fortune Care the full amount thereof upon his return to Manila, but the company merely approved a reimbursement of P12, 151, an amount that was based on the average cost of appendectomy if the procedure were performed in an accredited hospital in Metro Manila. Amorin received the said amount under protest, but asked for its adjustment to cover the total amount of professional fees which he had paid, and 80% of the approved standard charges based on “American standard” considering that the emergency procedure occurred in the US. To support his claim, Amorin cited Section 3, Art. V on Benefits and Coverages of the Health Care Contract.

Fortune Care denied the request thereby prompting Amorin to file a complaint for breach of contract with damages. For its part, Fortune Care argued that the Health Care Contract did not cover hospitalization costs and professional fees incurred in foreign countries, as the contract’s operation was confined to Philippine territory. The RTC dismissed Amorin’s complaint. Dissatisfied, Amorin appealed the RTC decision to the CA. Subsequently, the CA rendered its decision granting the appeal, thereby reversing and setting aside the trial court decision. Hence, the appeal. Fortune Care argues that the phrase “approved standard charges” did not automatically mean “Philippine Standard”

ISSUE

Whether Fortune Care is liable to the member for the amount demanded by the latter.

RULING

Petition Denied.

For purposes of determining the liability of a health care provider to its members, jurisprudence holds that a health care agreement is in the nature of non-life insurance, which is primarily a contract of indemnity. Once the member incurs hospital, medical or any other expense arising from sickness, injury or other stipulated contingent, the health care provider must pay for the same to the extent agreed upon under the contract.

In the instant case, the extent of Fortune Care's liability to Amorin under the attendant circumstances was governed by Section 3(B), Article V of the subject Health Care Contract, considering that the appendectomy which the member had to undergo qualified as an emergency care, but the treatment was performed at St. Francis Medical Center in Honolulu, Hawaii, U.S.A., a non-accredited hospital.

We restate the pertinent portions of Section 3(B):

B. EMERGENCY CARE IN NON-ACCREDITED HOSPITAL 1. Whether as an in-patient or out-patient, FortuneCare shall reimburse the total hospitalization cost including the professional fee (based on the total approved charges) to a member who receives emergency care in a non-accredited hospital. The above coverage applies only to Emergency confinement within Philippine Territory. However, if the emergency confinement occurs in foreign territory, Fortune Care will be obligated to reimburse or pay eighty (80%) percent of the approved standard charges which shall cover the hospitalization costs and professional fees.

The point of dispute now concerns the proper interpretation of the phrase "approved standard charges", which shall be the base for the allowable 80% benefit. The trial court ruled that the phrase should be interpreted in light of the provisions of Section 3(A), *i.e.*, to the extent that may be allowed for treatments performed by accredited physicians in accredited hospitals. As the appellate court however held, this must be interpreted in its literal sense, guided by the rule that any ambiguity shall be strictly construed against Fortune Care, and liberally in favor of Amorin.

As may be gleaned from the Health Care Contract, the parties thereto contemplated the possibility of emergency care in a foreign country. As the contract recognized Fortune Care's liability for emergency treatments even in foreign territories, it expressly limited its liability only insofar as the percentage of hospitalization and professional fees that must be paid or reimbursed was concerned, pegged at a mere 80% of the approved standard charges.

In the absence of any qualifying word that clearly limited Fortune Care's liability to costs that are applicable in the Philippines, the amount payable by Fortune Care should not be limited to the cost of treatment in the Philippines, as to do so would result in the clear disadvantage of its member. If, as Fortune Care argued, the premium and other charges in the Health Care Contract were merely computed on assumption and risk under Philippine cost and, that the American cost standard or any foreign country's cost was never considered, such limitations should have been distinctly specified and clearly reflected in the extent of coverage which the company voluntarily assumed.

- JAIME T. GAISANO v. DEVELOPMENT INSURANCE and SURETY CORPORATION, G.R. No. 190702, February 27, 2017

**JAIME T. GAISANO v. DEVELOPMENT INSURANCE and SURETY CORPORATION,
G.R. No. 190702, February 27, 2017, Third Division, JARDELEZA, J.:**

The notice of the availability of the check, by itself, does not produce the effect of payment of the premium.

FACTS

On September 27, 1996, respondent issued a comprehensive commercial vehicle policy to petitioner over the 1992 Mitsubishi Montero for a period of one year. Petitioner's company, Noah's Ark immediately processed the payments and issued a check dated September 27, 1996 payable to Trans-Pacific on the same day. The check represents payment for the policy, with ₱55,620.60 for the premium and other charges over the vehicle. However, nobody from Trans-Pacific picked up the check that day (September 27) because its president and general manager, Herradura, was celebrating his birthday. Trans-Pacific informed Noah's Ark that its messenger would get the check the next day, September 28.

In the evening of September 27, 1996, while under the official custody of Noah's Ark marketing manager Pacquing as a service company vehicle, the vehicle was stolen in the vicinity of SM Megamall. Oblivious of the incident, Trans-Pacific picked up the check the next day, September 28. It issued an official receipt dated September 28, 1996, acknowledging the receipt of ₱55,620.60 for the premium and other charges over the vehicle.

On October 1, 1996, Pacquing informed petitioner of the vehicle's loss. In its Answer, respondent asserted that the non-payment of the premium rendered the policy ineffective. The premium was received by the respondent only on October 2, 1996, and there was no known loss covered by the policy to which the payment could be applied.

ISSUE

Whether or not there is a binding insurance contract between petitioner and respondent.

RULING

NO. Insurance is a contract whereby one undertakes for a consideration to indemnify another against loss, damage or liability arising from an unknown or contingent event. Just like any other contract, it requires a cause or consideration. The consideration is the premium, which must be paid at the time and in the way and manner specified in the policy. If not so paid, the policy will lapse and be forfeited by its own terms.

The law, however, limits the parties' autonomy as to when payment of premium may be made for the contract to take effect. The general rule in insurance laws is that unless the premium is paid, the insurance policy is not valid and binding. Section 77 of the Insurance Code, applicable at the time of the issuance of the policy, provides:

Sec. 77. An insurer is entitled to payment of the premium as soon as the thing insured is exposed to the peril insured against. Notwithstanding any agreement to the contrary, no policy or contract of insurance issued by an insurance company is valid and binding unless and until the premium thereof has been paid, except in the case of a life or an industrial life policy whenever the grace period provision applies.

There is no dispute that the check was delivered to and was accepted by respondent's agent, Trans-Pacific, only on September 28, 1996. No payment of premium had thus been made at the time of the loss of the vehicle on September 27, 1996. While petitioner claims that Trans-Pacific was informed that the check was ready for pick-up on September 27, 1996, the notice of the availability of the check, by itself, does not produce the effect of payment of the premium. Trans-Pacific could not be

considered in delay in accepting the check because when it informed petitioner that it will only be able to pick-up the check the next day, petitioner did not protest to this, but instead allowed Trans-Pacific to do so. Thus, at the time of loss, there was no payment of premium yet to make the insurance policy effective.

Petitioner also failed to establish the fact of a grant by respondent of a credit term in his favor, or that the grant has been consistent. While there was mention of a credit agreement between Trans-Pacific and respondent, such arrangement was not proven and was internal between agent and principal. Under the principle of relativity of contracts, contracts bind the parties who entered into it. It cannot favor or prejudice a third person, even if he is aware of the contract and has acted with knowledge.

We cannot sustain petitioner's claim that the parties agreed that the insurance contract is immediately effective upon issuance despite non-payment of the premiums. Even if there is a waiver of pre-payment of premiums, that in itself does not become an exception to Section 77, unless the insured clearly gave a credit term or extension. This is the clear import of the fourth exception in the *UCPB General Insurance Co., Inc.* To rule otherwise would render nugatory the requirement in Section 77 that "notwithstanding any agreement to the contrary, no policy or contract of insurance issued by an insurance company is valid and binding unless and until the premium thereof has been paid, x x x."

Moreover, the policy states that the insured's application for the insurance is subject to the payment of the premium. There is no waiver of pre-payment, in full or in installment, of the premiums under the policy. Consequently, respondent cannot be placed in *estoppel*.

Thus, we find that petitioner is not entitled to the insurance proceeds because no insurance policy became effective for lack of premium payment. The consequence of this declaration is that petitioner is entitled to a return of the premium paid for the vehicle in the amount of ₱55,620.60 under the principle of unjust enrichment.

k. Characteristics/Nature of Insurance Contracts

- Heirs of Loreto C. Maramag vs. Eva Verna De Guzman Maramag, et al., G.R. No. 181132, June 5, 2009

HEIRS OF LORETO C. MARAMAG, represented by surviving spouse VICENTA PANGILINAN MARAMAG, Petitioners, v. EVA VERNA DE GUZMAN MARAMAG, ODESSA DE GUZMAN MARAMAG, KARL BRIAN DE GUZMAN MARAMAG, TRISHA ANGELIE MARAMAG, THE INSULAR LIFE ASSURANCE COMPANY, LTD., and GREAT PACIFIC LIFE ASSURANCE CORPORATION, Respondents.

G.R. NO. 181132, June 5, 2009 THIRD DIVISION NACHURA, J.

Any person who is forbidden from receiving any donation under Article 739 cannot be named beneficiary of a life insurance policy of the person who cannot make any donation to him. If a concubine is made the beneficiary, it is believed that the insurance contract will still remain valid, but the indemnity must go to the legal heirs and not to the concubine, for evidently, what is prohibited under Art. 2012 is the naming of the improper beneficiary.

FACTS

Petitioner Vicenta Maramag (heir of deceased) alleges that (1) petitioners were the legitimate wife and children of Loreto Maramag (Loreto), while respondents were Loreto's illegitimate family; (2) Eva de Guzman Maramag (Eva) was a concubine of Loreto and a suspect in the killing of the latter, thus, she is disqualified to receive any proceeds from his insurance policies from Insular Life Assurance Company, Ltd. (Insular) and Great Pacific Life Assurance Corporation (Grepalife); (3) the illegitimate children of Loreto—Odessa, Karl Brian, and Trisha Angelie—were entitled only to one-half of the legitime of the legitimate children, thus, the proceeds released to Odessa and those to be released to Karl Brian and Trisha Angelie were inofficious and should be reduced; and (4) petitioners could not be deprived of their legitimes, which should be satisfied first. In answer, Insular admitted that Loreto misrepresented Eva as his legitimate wife and Odessa, Karl Brian, and Trisha Angelie as his legitimate children, and that they filed their claims for the insurance proceeds of the insurance policies; that when it ascertained that Eva was not the legal wife of Loreto, it disqualified her as a beneficiary and divided the proceeds among Odessa, Karl Brian, and Trisha Angelie, as the remaining designated and further claimed that it was bound to honor the insurance policies designating the children of Loreto with Eva as beneficiaries pursuant to Section 53 of the Insurance Code.

In its own answer with compulsory counterclaim, Grepalife alleged that Eva was not designated as an insurance policy beneficiary; that the claims filed by Odessa, Karl Brian, and Trisha Angelie were denied because Loreto was ineligible for insurance due to a misrepresentation in his application form that he was born on December 10, 1936 and, thus, not more than 65 years old when he signed it in September 2001; that the case was premature, there being no claim filed by the legitimate family of Loreto; and that the law on succession does not apply where the designation of insurance beneficiaries is clear. Both Insular and Grepalife countered that the insurance proceeds belong exclusively to the designated beneficiaries in the policies, not to the estate or to the heirs of the insured. Grepalife also reiterated that it had disqualified Eva as a beneficiary when it ascertained that Loreto was legally married to Vicenta Pangilinan Maramag.

ISSUE

Whether or not Eva can claim even though prohibited under the civil code against donation

RULING

YES. Petition is DENIED.

Any person who is forbidden from receiving any donation under Article 739 cannot be named beneficiary of a life insurance policy of the person who cannot make any donation to him

If a concubine is made the beneficiary, it is believed that the insurance contract will still remain valid, but the indemnity must go to the legal heirs and not to the concubine, for evidently, what is prohibited under Art. 2012 is the naming of the improper beneficiary.

SECTION 53. The insurance proceeds shall be applied exclusively to the proper interest of the person in whose name or for whose benefit it is made unless otherwise specified in the policy.

GR: only persons entitled to claim the insurance proceeds are either the insured, if still alive; or the beneficiary, if the insured is already deceased, upon the maturation of the policy.

EX: situation where the insurance contract was intended to benefit third persons who are not parties to the same in the form of favorable stipulations or indemnity. In such a case, third parties may directly sue and claim from the insurer

It is only in cases where the insured has not designated any beneficiary, or when the designated beneficiary is disqualified by law to receive the proceeds, that the insurance policy proceeds shall redound to the benefit of the estate of the insured

- Tibay vs. Court of Appeals (257 SCRA 126 [1996])

SPS. ANTONIO A. TIBAY and VIOLETA R. TIBAY and OFELIA M. RORALDO, VICTORINA M. RORALDO, VIRGILIO M. RORALDO, MYRNA M. RORALDO and ROSABELLA M. RORALDO, petitioners, vs. COURT OF APPEALS and FORTUNE LIFE AND GENERAL INSURANCE CO., INC., respondents.
G.R. No. 119655 May 24, 1996 Bellosillo, J

Where the premium has only been partially paid and the balance paid only after the peril insured against has occurred, the insurance contract did not take effect and the insured cannot collect at all on the policy.

FACTS

On January 22, 1987, private respondent Fortune Life and General Insurance Co., Inc. (Fortune) issued fire insurance policy in favor of Violeta Tibay and/or Nicolas Roraldo on their two-storey residential building in Makati City, together with all their personal effects therein. The insurance was for P600,000.00 covering the period from January 23, 1987 to January 23, 1988. Of the total premium of P2,983.50, petitioner Violeta Tibay only paid P600.00, thus leaving a considerable balance unpaid.

On March 8, 1987, the insured building was completely destroyed by fire. Two days later, or on March 10, 1987, Violeta Tibay paid the balance of the premium. On the same day, she filed with Fortune a claim on the fire insurance policy.

In a letter dated June 11, 1987, Fortune denied the claim of Violeta for violation of “Policy Condition No. 2” and of Section 77 of the Insurance Code. Efforts to settle the case before the Insurance Commission proved futile. Thus, petitioners sued Fortune for damages in the amount of P600,000.00 representing the total coverage of the fire insurance policy plus interests and damages.

The trial court ruled for petitioners and held Fortune liable. Upon appeal, the Court of Appeals reversed the decision and declared that Fortune was not liable.

ISSUE

May a fire insurance policy be valid, binding and enforceable upon mere partial payment of premium?
NO.

RULING

Insurance is a contract whereby one undertakes for a consideration to indemnify another against loss, damage or liability arising from an unknown or contingent event. The consideration is the *premium*, which must be paid at the time and in the way and manner specified in the policy, and if not so paid, the policy will lapse and be forfeited by its own terms.

In this case, the subject Policy provides for payment of premium in full. Accordingly, where the premium has only been partially paid and the balance paid only after the peril insured against has occurred, the insurance contract did not take effect and the insured cannot collect at all on the policy. This is fully supported by Sec. 77 of the Insurance Code which provides –

Section 77. An insurer is entitled to payment of the premium as soon as the thing insured is exposed to the peril insured against. Notwithstanding any agreement to the contrary, *no policy or contract of insurance issued by an insurance company is valid and binding unless and until the premium thereof has been paid*, except in the case of a life or an industrial life policy whenever the grace period provision applies.

While it maybe true that under Section 77 of the Insurance Code, the parties may not agree to make the insurance contract valid and binding without payment of premiums, there is nothing in said section which suggests that the parties may not agree to allow payment of the premiums in installment, or to consider the contract as valid and binding upon payment of the first premium. Otherwise we would allow the insurer to renege on its liability under the contract, had a loss incurred before completion of payment of the entire premium, despite its voluntary acceptance of partial payments, a result eschewed by basic considerations of fairness and equity.

In this case, as expressly agreed upon in the contract, full payment must be made before the risk occurs for the policy to be considered effective and in force. Thus, no *vinculum juris* ever resulted from the fractional payment of premium.

Verily, it is elemental law that the payment of premium is requisite to keep the policy of insurance in force. If the premium is not paid in the manner prescribed in the policy as intended by the parties the policy is ineffective. Partial payment even when accepted as a partial payment will not keep the policy alive even for such fractional part of the year as the part payment bears to the whole payment.

The case of *South Sea Surety and Insurance Company, Inc. v. Court of Appeals*, speaks only of two (2) statutory exceptions to the requirement of payment of the entire premium as a prerequisite to the validity of the insurance contract. These exceptions are: (a) in case the insurance coverage relates to life or industrial life (health) insurance when a grace period applies, and (b) when the insurer makes a written acknowledgment of the receipt of premium, this acknowledgment being declared by law to, be then conclusive evidence of the premium payment.

I. Classes

i. Marine

- Isabela Roque, doing business under the name and style of Isabela Roque Timber Enterprises, *et al.*, vs. The Intermediate Appellate Court, *et al.*, G.R. No. L-66935, November 11, 1985

**ISABELA ROQUE, doing business under the name and style of Isabela Roque Timber Enterprises and ONG CHIONG, petitioners, vs. HON. INTERMEDIATE APPELLATE COURT and PIONEER INSURANCE AND SURETY CORPORATION, respondents.
G.R. No. L-66935 Nov. 11, 1985, FIRST DIVISION, GUTIERREZ,J**

In marine insurance (which includes cargo), the implied warranty of seaworthiness attaches to the shipper whether shipowner or not.—From the above-quoted provisions, there can be no mistaking the fact that the term "cargo" can be the subject of marine insurance and that once it is so made, the implied warranty of seaworthiness immediately attaches to whoever is insuring the cargo whether he be the shipowner or not.

Moreover, the fact that the unseaworthiness of the ship was unknown to the insured is immaterial in ordinary marine insurance and may not be used by him as a defense in order to recover on the marine insurance policy.

The cargo owner is required to look for a common carrier that keeps its vessels seaworthy. In the absence of stipulation that insurer answers for perils of the ship, insurance cannot be recovered on losses from perils of the ship.

Loss of cargo is not due to perils of the sea where there was no typhoon, but ordinary strong wind and waves and where cargo was negligently handled by ship's crew.

Barratry" defined.—Barratry as defined in American Insurance Law is "any wilful misconduct on the part of master or crew in pursuance of some unlawful or fraudulent purpose without the consent of the owners, and to the prejudice of the owner's interest," Barratry necessarily requires a willful and intentional act in its commission. No honest error of judgment or mere negligence, unless criminally gross, can be barratry.

FACTS

Isabela Roque (Roque of Isabela Roque Timber Enterprises) hired the Manila Bay Lighterage Corp. (Manila Bay) to load and carry its logs from Palawan to North Harbor, Manila. The logs were insured with Pioneer Insurance and Surety Corp. (Pioneer). The logs never reached Manila due to certain circumstances (as alleged by Roque and found by the appellate court), such as the fact that the barge was not seaworthy that it developed a leak, that one of the hatches were left open causing water to enter, and the absence of the necessary cover of tarpaulin causing more water to enter the barge.

When Roque demanded payment from Pioneer, the latter refused on the ground that its liability depended upon the "Total Loss by Total Loss of Vessel Only."

The trial court ruled in favor of Roque in the civil complaint filed by the latter against Pioneer, but the decision was reversed by the appellate court.

ISSUE

1. Whether in cases of marine insurance, there is a warranty of seaworthiness by the cargo owner.
2. Whether the loss of the cargo was due to perils of the sea, not perils of the ship.

RULING

1. Yes, there is. The liability of the insurance company is governed by law. Section 113 of the Insurance Code provides that "In every marine insurance upon a ship or freight, or freightage, or upon anything which is the subject of marine insurance, a warranty is implied that the ship is seaworthy."

Hence, there can be no mistaking the fact that the term "cargo" can be the subject of marine insurance and that once it is so made, the implied warranty of seaworthiness immediately attaches to whoever is insuring the cargo whether he be the shipowner or not.

Moreover, the fact that the unseaworthiness of the ship was unknown to the insured is immaterial in ordinary marine insurance and may not be used by him as a defense in order to recover on the marine insurance policy.

2. As to the second issue, by applying Sec. 113 of the Insurance Code, there is no doubt that the term 'perils of the sea' extends only to losses caused by sea damage, or by the violence of the elements, and does not embrace all losses happening at sea; it is said to include only such losses as are of extraordinary nature, or arise from some overwhelming power, which cannot be guarded against by the ordinary exertion of human skill and prudence.

It is also the general rule that everything which happens thru the inherent vice of the thing, or by the act of the owners, master or shipper, shall not be reputed a peril, if not otherwise borne in the policy.

It must be considered to be settled, furthermore, that a loss which, in the ordinary course of events, results from the natural and inevitable action of the sea, from the ordinary wear and tear of the ship, or from the negligent failure of the ship's owner to provide the vessel with proper equipment to convey the cargo under ordinary conditions, is not a peril of the sea.

Such a loss is rather due to what has been aptly called the "peril of the ship." The insurer undertakes to insure against perils of the sea and similar perils, not against perils of the ship. Neither barratry can be used as a ground by Roque.

Barratry as defined in American Insurance Law is "any willful misconduct on the part of master or crew in pursuance of some unlawful or fraudulent purpose without the consent of the owners, and to the prejudice of the owner's interest." Barratry necessarily requires a willful and intentional act in its commission. No honest error of judgment or mere negligence, unless criminally gross, can be barratry.

In the case at bar, there is no finding that the loss was occasioned by the willful or fraudulent acts of the vessel's crew. There was only simple negligence or lack of skill.

- Cathay Insurance Co., vs. Court of Appeals, *et al.*, G.R. No. L-76145, June 30, 1987

CATHAY INSURANCE CO., petitioner, vs. HON. COURT OF APPEALS, and REMINGTON INDUSTRIAL SALES CORPORATION, respondents.
G.R. No. 76145 June 30, 1987 SECOND DIVISION PARAS, J.:

A cardinal rule in the interpretation of contracts, namely, that any ambiguity therein should be construed against the maker/issuer/drafter thereof, namely, the insurer.

FACTS

A complaint was filed by private respondent corporation against petitioner (then defendant) company seeking collection of the sum of P868,339.15 representing private respondent's losses and damages incurred in a shipment of seamless steel pipes under an insurance contract in favor of the said private respondent as the insured, consignee or importer of aforesaid merchandise while in transit from Japan to the Philippines on board vessel SS "Eastern Mariner." The total value of the shipment was P2,894,463.83 at the prevailing rate of P7.95 to a dollar in June and July 1984, when the shipment was made. The trial court decided in favor of private respondent corporation by ordering petitioner to pay it the sum of P866,339.15 as its recoverable insured loss equivalent to 30% of the value of the seamless steel pipes; ordering petitioner to pay private respondent interest on the aforesaid amount at the rate of 34% or double the ceiling prescribed by the Monetary Board per annum from February 3, 1982 or 90 days from private respondent's submission of proof of loss to petitioner until paid as provided in the settlement of claim provision of the policy; and ordering petitioner to pay private respondent certain amounts for marine surveyor's fee, attorney's fees and costs of the suit.

ISSUE

Whether the rusting of steel pipes in the course of a voyage is a "peril of the sea" in view of the toll on the cargo of wind, water, and salt conditions.

RULING

There is no question that the rusting of steel pipes in the course of a voyage is a "peril of the sea" in view of the toll on the cargo of wind, water, and salt conditions. At any rate if the insurer cannot be held accountable therefor, We would fail to observe a cardinal rule in the interpretation of contracts, namely, that any ambiguity therein should be construed against the maker/issuer/drafter thereof, namely, the insurer. Besides the precise purpose of insuring cargo during a voyage would be rendered fruitless. Be it noted that any attack of the 15-day clause in the policy was foreclosed right in the pre-trial conference.

- Filipino Merchants Insurance Co., Inc., vs. Court of Appeals, *et al.*, G.R. No. 85141, November 28, 1989

FILIPINO MERCHANTS INSURANCE CO., INC., Petitioner, -versus- COURT OF APPEALS and CHOA TIEK SENG, Respondents.
G.R. No. 8514, November 28, 1989, Regalado, J.

Section 13 of the Insurance Code defines insurable interest in property as every interest in property, whether real or personal, or any relation thereto, or liability in respect thereof, of such nature that a contemplated peril might directly damnify the insured.

As vendee/consignee of the goods in transit, Choa has such existing interest. His interest over the goods is based on the perfected contract of sale. The perfected contract of sale between him and the shipper of the goods operates to vest in him an equitable title even before delivery or before be performed the conditions of the sale.

FACTS

Choa Tiek Seng, consignee of the shipment of fishmeal loaded, insured in "all risks policy" 600 metric tons of fishmeal in new gunny bags of 90 kilos each from Bangkok, Thailand to Manila against all risks under warehouse to warehouse terms but only 59.940 metric tons was imported.

When it was unloaded unto the arrastre contractor E. Razon, Inc. and Filipino Merchants's surveyor ascertained and certified that in such discharge 105 bags were in bad order condition which was reflected in the survey report of Bad Order cargoes. Before delivery to Choa, E. Razon's Bad Order Certificate showed that a total of 227 bags in bad order condition.

Choa brought an action against Filipino Merchants Insurance Co. who brought a third party complaint against Compagnie Maritime Des Chargeurs Reunis and/or E. Razon, Inc.

Filipino Merchants contended that Chao has no insurable interest and therefore the policy should be void and that it was fraud that it did not disclose of such fact.

ISSUE

Whether or not Choa Tiek Seng as consignee of the shipment, has insurable interest

RULING

YES. Section 13 of the Insurance Code defines insurable interest in property as every interest in property, whether real or personal, or any relation thereto, or liability in respect thereof, of such nature that a contemplated peril might directly damnify the insured.

As vendee/consignee of the goods in transit, Choa has such existing interest. His interest over the goods is based on the perfected contract of sale. The perfected contract of sale between him and the shipper of the goods operates to vest in him an equitable title even before delivery or before be performed the conditions of the sale. The contract of shipment, whether under F.O.B., C.I.F., or C. & F. as in this case, is immaterial in the determination of whether the vendee has an insurable interest or not in the goods in transit.

Article 1523 of the Civil Code provides that where, in pursuance of a contract of sale, the seller is authorized or required to send the goods to the buyer, delivery of the goods to a carrier, whether named by the buyer or not, for, the purpose of transmission to the buyer is deemed to be a delivery of the goods to the buyer, the exceptions to said rule not obtaining in the present case. The Court has

heretofore ruled that the delivery of the goods on board the carrying vessels partake of the nature of actual delivery since, from that time, the foreign buyers assumed the risks of loss of the goods and paid the insurance premium covering them

C & F contracts are shipment contracts. The term means that the price fixed includes in a lump sum the cost of the goods and freight to the named destination. It simply means that the seller must pay the costs and freight necessary to bring the goods to the named destination but the risk of loss or damage to the goods is transferred from the seller to the buyer when the goods pass the ship's rail in the port of shipment. Moreover, the issue of lack of insurable interest was not among the defenses averred in petitioners answer.

- Choa Tiek Seng, doing business under the name and style of Seng's Commercial Enterprises vs. Court of Appeals, et al., G.R. No. 84507, March 15, 1990

CHOA TIEK SENG, doing business under the name and style of SENG'S COMMERCIAL ENTERPRISES, *Petitioner*, -versus- HON. COURT OF APPEALS, FILIPINO MERCHANTS' INSURANCE COMPANY, INC., BEN LINES CONTAINER, LTD. AND E. RAZON, INC., *Respondents*.
G.R. No. 84507, March 15, 1990, Gancayco, J.

The insurance policy covers all loss or damage to the cargo except those caused by delay or inherent vice or nature of the cargo insured. It is the duty of the respondent insurance company to establish that said loss or damage falls within the exceptions provided for by law, otherwise it is liable therefor.

FACTS

Petitioner imported some lactose crystals from Holland which involved 15 metric tons packed in 600 6-ply paper bags. The goods were loaded at the port at Rotterdam in sea vans on board the vessel "MS Benalder" as the mother vessel and aboard the feeder vessel "wesser Broker V-25" of respondent Ben Lines Container. Such goods were insured by the respondent Filipino Merchants' Insurance Co. against all risks under the terms of the insurance cargo policy.

Upon arrival in the Manila port, the cargo was discharged into the custody of the arrastre operator respondent E.Razon, Inc. (broker) prior to the delivery to petitioner through his broker. Out of 600 bags delivered, 403 were in bad order which suffered spillage and loss valued at P33,117.63

Petitioner filed a claim for the loss against respondent insurance company. The Insurance company rejected such claim alleging that "*assuming that spillage took place while the goods were in transit, petitioner and his agent failed to minimize the loss by failing to recover spillage from the sea van which violates the terms of the insurance policy; assuming that spillage did not occur while the cargo was in transit, the 400 bags were loaded in bad order since the van did not carry any evidence of spillage*". The Insurance company then filed a third-party complaint against respondents Ben Lines and broker.

ISSUE

Whether or not Filipino Merchant's is liable to indemnify the petitioner for the loss he encountered due to the spillage of the goods?

RULING

YES. An "All risk" insurance policy insures against all causes of conceivable loss or damage, except when excluded in the policy due to fraud or intentional misconduct on the part of the insured. It covers all losses during voyage whether arising from a marine peril or not, including pilferage losses during the war

The "all risks" clause of the policy sued in this case upon reads as follows:

5. This insurance is against all risks of loss or damage to the subject matter insured but shall in no case be deemed to extend to cover loss, damage, or expense proximately caused by delay or inherent vice or nature of the subject matter insured. Claims recoverable hereunder shall be payable irrespective of percentage

The terms of the policy are so clear and require no interpretation. The insurance policy covers all loss or damage to the cargo except those caused by delay or inherent vice or nature of the cargo insured. It is the duty of the respondent insurance company to establish that said loss or damage falls within the exceptions provided for by law, otherwise it is liable therefor.

An "all risks" provision of a marine policy creates a special type of insurance which extends coverage to risks not usually contemplated and avoids putting upon the insured the burden of establishing that the loss was due to peril falling within the policy's coverage. The insurer can avoid coverage upon demonstrating that a specific provision expressly excludes the loss from coverage

- Keppel Cebu Shipyard, Inc. vs. Pioneer Insurance and Surety Corporation, 601 SCRA 96

KEPPEL CEBU SHIPYARD, INC., *Petitioner*, -versus- PIONEER INSURANCE AND SURETY CORPORATION, *Respondent*.

G.R. Nos. 180880-81, September 25, 2009, Nachura, J.

In marine insurance, a constructive total loss occurs under any of the conditions set forth in Section 139 of the Insurance Code, which provides—

Sec. 139. A person insured by a contract of marine insurance may abandon the thing insured, or any particular portion hereof separately valued by the policy, or otherwise separately insured, and recover for a total loss thereof, when the cause of the loss is a peril insured against:

(a) If more than three-fourths thereof in value is actually lost, or would have to be expended to recover it from the peril;

(b) If it is injured to such an extent as to reduce its value more than three-fourths; x x x.

FACTS

WG & A Jebsens Shipmgmt, owner/operator of M/V “SUPERFERRY 3” and Keppel Cebu Shipyard, Inc. (KCSI) entered into an agreement for the Drydocking and Repair of the above-named vessel as ordered by the Owner’s Authorized Representative.

In the course of its repair, M/V “Superferry 3” was gutted by fire. Claiming that the extent of the damage was pervasive, WG&A declared the vessel’s damage as a “total constructive loss” and, hence, filed an insurance claim with Pioneer.

Pioneer paid the insurance claim of WG&A, which in turn, executed a Loss and Subrogation Receipt in favor of Pioneer.

Pioneer tried to collect from KCSI, but the latter denied any responsibility for the loss of the subject vessel. As KCSI continuously refused to pay despite repeated demands, Pioneer, filed a Request for Arbitration before the Construction Industry Arbitration Commission CIAC seeking for payment of U.S.\$8,472,581.78 plus interest, among others.

ISSUE

Whether or not there was total constructive loss.

RULING

YES. In marine insurance, a constructive total loss occurs under any of the conditions set forth in Section 139 of the Insurance Code, which provides—

Sec. 139. A person insured by a contract of marine insurance may abandon the thing insured, or any particular portion hereof separately valued by the policy, or otherwise separately insured, and recover for a total loss thereof, when the cause of the loss is a peril insured against:

(a) If more than three-fourths thereof in value is actually lost, or would have to be expended to recover it from the peril;

(b) If it is injured to such an extent as to reduce its value more than three-fourths; x x x.

It cannot be denied that M/V “Superferry 3” suffered widespread damage from the fire that occurred on February 8, 2000, a covered peril under the marine insurance policies obtained by WG&A from Pioneer. The estimates given by the three disinterested and qualified shipyards show that the damage to the ship would exceed P270,000,000.00, or $\frac{3}{4}$ of the total value of the policies – P360,000,000.00. These estimates constituted credible and acceptable proof of the extent of the damage sustained by the vessel.

Considering the extent of the damage, WG&A opted to abandon the ship and claimed the value of its policies. Pioneer, finding the claim compensable, paid the claim, with WG&A issuing a Loss and Subrogation Receipt evidencing receipt of the payment of the insurance proceeds from Pioneer.

The Loss and Subrogation Receipt issued by WG&A to Pioneer is the best evidence of payment of the insurance proceeds to the former, and no controverting evidence was presented by KCSI to rebut the presumed authority of the signatory to receive such payment.

- Mayer Steel Pipe Corp. vs. Court of Appeals and South Sea Surety (274 SCRA 432 [1997])

MAYER STEEL PIPE CORPORATION and HONGKONG GOVERNMENT SUPPLIES DEPARTMENT, Petitioners, -versus- COURT OF APPEALS, SOUTH SEA SURETY AND INSURANCE CO., INC. and the CHARTER INSURANCE CORPORATION, Respondents.

G.R. No. 124050, June 19, 1997, Puno, J.

The Filipino Merchants case is different from the case at bar. In Filipino Merchants, it was the insurer which filed a claim against the carrier for reimbursement of the amount it paid to the shipper. In the case at bar, it was the shipper which filed a claim against the insurer. The basis of the shipper's claim is the "all risks" insurance policies issued by private respondents to petitioner Mayer.

FACTS

Defendant contracted with petitioner to manufacture and supply various steel pipes and fittings. Mayer shipped the pipes and fittings to Hongkong. Prior to the shipping, Mayer insured the pipes and fittings against all risks with private respondents. It was certified that the pipes and fittings were in good condition before they were loaded in the vessel.

Nonetheless, when the goods reached Hongkong, it was discovered that a substantial portion thereof was damaged. Mayer filed a claim for indemnity under the insurance contract. Private respondents refused to pay because the insurance surveyor's report allegedly showed that the damage is a factory defect.

The trial court ruled in favor of Mayer. It found that the damage to the goods is not due to manufacturing defects. It also noted that the insurance contracts executed by Mayer and private respondents are "all risks" policies which insure against all causes of conceivable loss or damage. The only exceptions are those excluded in the policy, or those sustained due to fraud or intentional misconduct on the part of the insured.

CA affirmed the ruling of the RTC (on factory defect) but set aside the complaint on the ground of prescription. It held that the action is barred under Section 3(6) of the Carriage of Goods by Sea Act since it was filed more than two years from the time the goods were unloaded from the vessel. Respondent court ruled that this provision applies not only to the carrier but also to the insurer, citing *Filipino Merchants Insurance Co., Inc. v. Alejandro*.

ISSUE

Whether or not the CA was correct in applying the case of *Filipino Merchants Insurance Co., Inc.* and in dismissing the complaint?

RULING

NO. Section 3(6) of the Carriage of Goods by Sea Act states that the carrier and the ship shall be discharged from all liability for loss or damage to the goods if no suit is filed within one year after delivery of the goods or the date when they should have been delivered. Under this provision, only the carrier's liability is extinguished if no suit is brought within one year. But the liability of the

insurer is not extinguished because the insurer's liability is based not on the contract of carriage but on the contract of insurance. A close reading of the law reveals that the Carriage of Goods by Sea Act governs the relationship between the carrier on the one hand and the shipper, the consignee and/or the insurer on the other hand. It defines the obligations of the carrier under the contract of carriage. **It does not, however, affect the relationship between the shipper and the insurer. The latter case is governed by the Insurance Code.**

The Filipino Merchants case is different from the case at bar. In Filipino Merchants, it was the insurer which filed a claim against the carrier for reimbursement of the amount it paid to the shipper. In the case at bar, it was the shipper which filed a claim against the insurer. The basis of the shipper's claim is the "all risks" insurance policies issued by private respondents to petitioner Mayer.

An insurance contract is a contract whereby one party, for a consideration known as the premium, agrees to indemnify another for loss or damage which he may suffer from a specified peril. An "all risks" insurance policy covers all kinds of loss other than those due to willful and fraudulent act of the insured. Thus, when private respondents issued the "all risks" policies to petitioner Mayer, they bound themselves to indemnify the latter in case of loss or damage to the goods insured. Such obligation prescribes in ten years, in accordance with Article 1144 of the New Civil Code.

ii. Fire

- Development Insurance Corporation vs. Intermediate Appellate Court, et al., G.R. No. L-71360, July 16, 1986

DEVELOPMENT INSURANCE CORPORATION, *Petitioner*, -versus- INTERMEDIATE APPELLATE COURT, and PHILIPPINE UNION REALTY DEVELOPMENT CORPORATION, *Respondents*.

G.R. No. 71360, July 16, 1986, Cruz, J.

The Court notes that Policy RY/F-082 is an open policy. As defined in Section 60 of the Insurance Code, "an open policy is one in which the value of the thing insured is not agreed upon but is left to be ascertained in case of loss." This means that the actual loss, as determined, will represent the total indemnity due the insured from the insurer except only that the total indemnity shall not exceed the face value of the policy.

FACTS

A fire occurred in the building of the private respondent and it sued for recovery of damages from the petitioner on the basis of an insurance contract between them. The petitioner allegedly failed to answer on time and was declared in default by the trial court. A judgment of default was subsequently rendered on the strength of the evidence submitted *ex parte* by the private respondent, which was allowed full recovery of its claimed damages. On learning of this decision, the petitioner moved to lift the order of default, invoking excusable neglect, and to vacate the judgment by default. Its motion was denied. It then went to the respondent court, which affirmed the decision of the trial court *in toto*.

On the merits of the case, the petitioner argues that the insurance covers only the building and not the elevators, and that the elevators were insured only after the fire.

ISSUE

Whether or not private respondent is liable for the amount of the building.

RULING

YES. The petitioner's claim that the insurance covered only the building and not the elevators is absurd, to say the least. This Court has little patience with puerile arguments that affront common sense, let alone basic legal principles with which even law students are familiar. The circumstance that the building insured is seven stories high and so had to be provided with elevators—a legal requirement known to the petitioner as an insurance company—makes its contention all the more ridiculous.

No less preposterous is the petitioner's claim that the elevators were insured after the occurrence of the fire, a case of shutting the barn door after the horse had escaped, so to speak. This pretense merits scant attention. Equally undeserving of serious consideration is its submission that the elevators were not damaged by the fire, against the report of the arson investigators of the INP⁵ and, indeed, its own expressed admission in its answer where it affirmed that the fire "damaged or destroyed a portion of the 7th floor of the insured building and more particularly a Hitachi elevator control panel."

The heat and moisture caused by the fire damaged, although they did not actually burn, the elevators. Neither is this Court justified in reversing their determination, also factual, of the value of the loss sustained by the private respondent in the amount of P508,867.00.

The only remaining question to be settled is the amount of the indemnity due to the private respondent under its insurance contract with the petitioner. This will require an examination of this contract, Policy No. RY/F-082, as renewed, by virtue of which the petitioner insured the private respondent's building against fire for P2,500,000.00.

The Court notes that Policy RY/F-082 is an open policy and is subject to the express condition that:

Open Policy

This is an open policy as defined in Section 57 of the Insurance Act. In the event of loss, whether total or partial, it is understood that the amount of the loss shall be subject to appraisal and the liability of the company, if established, shall be limited to the actual loss, subject to the applicable terms, conditions, warranties and clauses of this Policy, and in no case shall exceed the amount of the policy.

As defined in the aforesaid provision, which is now Section 60 of the Insurance Code, "an open policy is one in which the value of the thing insured is not agreed upon but is left to be ascertained in case of loss." This means that the actual loss, as determined, will represent the total indemnity due the insured from the insurer except only that the total indemnity shall not exceed the face value of the policy.

The actual loss has been ascertained in this case and, to repeat, this Court will respect such factual determination in the absence of proof that it was arrived at arbitrarily. There is no such showing. Hence, applying the open policy clause as expressly agreed upon by the parties in their contract, we

hold that the private respondent is entitled to the payment of indemnity under the said contract in the total amount of P508,867.00.

- Pacific Banking Corp. vs. Court of Appeals and Oriental Assurance Corporation (168 SCRA 1 [1988])

PACIFIC BANKING CORPORATION, *Petitioner*, -versus- COURT OF APPEALS and ORIENTAL ASSURANCE CORPORATION, *Respondents*.

G.R. No. L-41014, November 28, 1988, Paras, J.

It is not disputed that the insured failed to reveal before the loss 3 other insurances. As found by the CA, by reason of said unrevealed insurances, the insured had been guilty of false declaration; a clear misrepresentation and a vital one because where the insured had been asked to reveal but did not, that was deception. Had the insurer known that there were many co-insurances, it could have hesitated or plainly desisted from entering into such contract. Hence, insured was guilty of clear fraud

FACTS

Paramount Shirt Manufacturing Co. (insured) was issued a Fire Policy by which respondent insurance corporation bound itself to indemnify the former for any loss or damage caused by fire to its property. The insured was, at the time of the issuance of the policy and is up to this time, a debtor of petitioner and the goods described in the policy were held in trust by the insured for the petitioner. Said policy was duly endorsed to petitioner as mortgagee/trustor of the properties insured, with the knowledge and consent of the respondent corporation to the effect that "loss if any under this policy is payable to" the petitioner. While the aforesaid policy was in full force and effect, a fire broke out on the subject premises destroying the goods contained in its ground and second floors. It was thereafter learned that the insured did not reveal undeclared co-insurances.

ISSUE

Whether or not the policy be rescinded?

RULING

YES. It is not disputed that the insured failed to reveal before the loss 3 other insurances. As found by the CA, by reason of said unrevealed insurances, the insured had been guilty of false declaration; a clear misrepresentation and a vital one because where the insured had been asked to reveal but did not, that was deception. Had the insurer known that there were many co-insurances, it could have hesitated or plainly desisted from entering into such contract. Hence, insured was guilty of clear fraud. Representations of facts are the foundation of the contract and if the foundation does not exist, the superstructure does not arise. Undoubtedly, it is but fair and just that where the insured is primarily entitled to receive the proceeds of the policy has by its frauds and/or misrepresentation, forfeit said right, with more reason, petitioner which is merely claiming as indorsee of said insured, cannot be entitled to such proceeds.

Generally, the cause of action on the policy accrues when the loss occurs. But when the policy provides that no action shall be brought unless the claim is first presented extrajudicially in the manner provided in the policy, the cause of action will accrue from the time the insurer finally rejects the claim for payment. The evidence adduced shows that 24 days after the fire, petitioner merely

wrote letters to private respondent to serve as notice of loss.

Petitioner should have endeavored, as provided under the policy conditions, to file the formal claim and procure all the documents, papers, inventory needed by private respondent or its adjuster to ascertain the amount of loss and after compliance await the final rejection of its claim.

- Philippine Home Assurance Corporation vs. Court of Appeals, G.R. No. 106999, June 20, 1996

**PHILIPPINE HOME ASSURANCE CORPORATION, *Petitioner*, -versus COURT OF APPEALS and EASTERN SHIPPING LINES INC., *Respondents*.
G.R. No. 106999, June 20, 1996, Kapunan, J.**

In our jurisprudence, fire may not be considered a natural disaster or calamity since it almost always arises from some act of man or by human means. It cannot be an act of God unless caused by lightning or a natural disaster or casualty not attributable to human agency.

FACTS

Eastern Shipping Lines, Inc. (ESLI) loaded on board its SS Eastern Explorer in Kobe, Japan, shipments for carriage to Manila and Cebu, consigned to William Lines, Inc., Orca's Company, Pan Oriental Match Company and Ding Velayo under their respective Bills of Lading.

While the vessel was off Okinawa, Japan, a small flame was detected on the acetylene cylinder located in the accommodation area near the engine room on the main deck level. As the crew was trying to extinguish the fire, the acetylene cylinder suddenly exploded sending a flash of flame throughout the accommodation area, thus causing death and severe injuries to the crew and instantly setting fire to the whole superstructure of the vessel. The incident forced the master and the crew to abandon the ship.

The cargoes which were saved were loaded to another vessel for delivery to their original ports of destination. ESLI charged the consignees several amounts corresponding to additional freight and salvage charges. The charges were all paid by Philippine Home Assurance Corporation (PHAC) under protest for and in behalf of the consignees.

PHAC, as subrogee of the consignees, thereafter filed a complaint against ESLI to recover the sum paid under protest on the ground that the same were actually damages directly brought about by the fault, negligence, illegal act and/or breach of contract of ESLI.

ISSUE

Whether or not the fire that gutted the ship is a natural disaster.

RULING

NO. In absolving respondent carrier of any liability, the Court of Appeals sustained the trial court's finding that the fire that gutted the ship was a natural disaster or calamity. Petitioner takes exception to this conclusion and we agree.

In our jurisprudence, fire may not be considered a natural disaster or calamity since it almost always arises from some act of man or by human means. It cannot be an act of God unless caused by lightning or a natural disaster or casualty not attributable to human agency.

In the case at bar, it is not disputed that a small flame was detected on the acetylene cylinder and that by reason thereof, the same exploded despite efforts to extinguish the fire. Neither is there any doubt that the acetylene cylinder, obviously fully loaded, was stored in the accommodation area near the engine room and not in a storage area considerably far, and in a safe distance, from the engine room. Moreover, there was no showing, and none was alleged by the parties, that the fire was caused by a natural disaster or calamity not attributable to human agency. On the contrary, there is strong evidence indicating that the acetylene cylinder caught fire because of the fault and negligence of respondent ESLI, its captain and its crew.

Verily, there is no merit in the finding that the fire was not the fault or negligence of respondent but a natural disaster or calamity. The records are simply wanting in this regard. Respondent Eastern Shipping Lines, Inc. is thus ordered to return to petitioner Philippine Home Assurance Corporation the amount it paid under protest in behalf of the consignees herein.

- MALAYAN INSURANCE CO., INC. v. LIN. G.R. No. 207277, January 16, 2017

MALAYAN INSURANCE CO., INC., YVONNE S. YUCHENGCO, ATTY. EMMANUEL G. VILLANUEVA, SONNY RUBIN, ENGR. FRANCISCO MONDELO, and MICHAEL REQUIJO, *Petitioners.* vs. EMMA CONCEPCION L. LIN, *Respondent.*

G.R. No. 207277, January 16, 2017, Del Castillo, J.

Petitioner's causes of action in the Civil Case are predicated on the insurers' refusal to pay her fire insurance claims despite notice, proofs of losses and other supporting documents. Thus, petitioner prays in her complaint that the insurers be ordered to pay the full-insured value of the losses, as embodied in their respective policies.

On the other hand, the core, if not the sole bone of contention in Adm. Case No. RD-156, is the issue of whether or not there was unreasonable delay or denial of the claims of petitioner, and if in the affirmative, whether or not that would justify the suspension or revocation of the insurers' licenses.

FACTS

Lin alleged that she obtained various loans from RCBC secured by six clustered warehouses located at Plaridel, Bulacan; that the five warehouses were insured with Malayan against fire; that on February 24, 2008, the five warehouses were gutted by fire; that on April 8, 2008 the Bureau of Fire Protection (BFP) issued a Fire Clearance Certification to her after having determined that the cause of fire was accidental; that despite the foregoing, her demand for payment of her insurance claim was denied since the forensic investigators hired by Malayan claimed that the cause of the fire was arson and not accidental; that she sought assistance from the Insurance Commission (IC) which, after a meeting among the parties and a conduct of reinvestigation into the cause/s of the fire, recommended

that Malayan pay Lin's insurance claim and/or accord great weight to the BFP's findings; that in defiance thereof, Malayan still denied or refused to pay her insurance claim; and that for these reasons, Malayan's

Lin thus prayed that judgment be rendered ordering petitioners to pay her insurance claim

Later on, while the case was being filed, Lin filed an administrative case before the Insurance Commission (IC) against the Malayan. In this administrative case, Lin claimed that since it had been conclusively found that the cause of the fire was "accidental," the only issue left to be resolved is whether Malayan should be held liable for unfair claim settlement practice under Section 241 in relation to Section 247 of the Insurance Code due to its unjustified refusal to settle her claim; and that in consequence of the foregoing failings, Malayan's license to operate as a non-life insurance company should be revoked or suspended, until such time that it fully complies with the IC Resolution ordering it to accord more weight to the BFP's findings.

On August 17, 2010, Malayan filed a motion to dismiss Civil Case No. 10-122738 based on forum shopping arguing that the administrative case's purpose is to prompt IC into ordering the former to pay her claim and that the elements of forum shopping are present; specifically the identity of parties shared the same interests and were represented in both civil and administrative cases.

ISSUE

Whether or not there is willful and deliberate forum shopping.

RULING

NO. The SC held that the case at bar is to be governed by the case law rulings in the Go and Almendras cases where it was stressed that an administrative case for unfair claim settlement practice may proceed simultaneously with the civil case for collection of the insurance proceeds filed by at the same claimant since a judgment in one will not amount to res judicata to the other, and vice versa, due to the variance or differences in the issues, in the quantum of evidence, and in the procedure to be followed in prosecuting the cases.

In the present case, petitioners basically insist that Lin committed willful and deliberate forum shopping which warrants the dismissal of her civil case because it is not much different from the administrative case in terms of the parties involved, the causes of action pleaded, and the reliefs prayed for. Petitioners also posit that another ground warranting the dismissal of the civil case was Lin's failure to notify the RTC about the pendency of the administrative case within five days from the filing thereof.

These above-mentioned arguments will not avail. The proscription against forum shopping is found in Section 5, Rule 7 of the Rules of Court which cover the very essence of forum shopping itself. It is the filing of multiple suits involving the same parties for the same cause of action, either simultaneously, for the purpose of obtaining a favorable judgment. It exists where the elements of *litis pendentia* are present or where a final judgment in one case will amount to *res judicata* in another. The settled rule is that criminal and civil cases are altogether different from administrative matters as postulated in *Almendras Mining Corporation v. Office of the Insurance Commission*.

The Office of the Ombudsman further reiterated and enunciated in the decision that a civil case before the trial court involving recovery of payment of the insured's insurance claim plus damages, can proceed simultaneously with an administrative case before the I.C. As the afore cited cases are analogous in many aspects to the present case, both in respect to their factual backdrop and in their jurisprudential teachings, the case law ruling in the Almendras and in the Go cases must apply with implacable force to the present case. Consistency alone demands----because of justice cannot be inconsistent, that the final authoritative mandate in the cited cases must produce and end result not much different from the present case.

Petitioner's causes of action in the Civil Case are predicated on the insurers' refusal to pay her fire insurance claims despite notice, proofs of losses and other supporting documents. Thus, petitioner prays in her complaint that the insurers be ordered to pay the full-insured value of the losses, as embodied in their respective policies. Petitioner also sought payment of interests and damages in her favor caused by the alleged delay and refusal of the insurers to pay her claims. The principal issue then that must be resolved by the trial court is whether or not petitioner is entitled to the payment of her insurance claims and damages. The matter of whether or not there is unreasonable delay or denial of the claims is merely an incident to be resolved by the trial court, necessary to ascertain petitioner's right to claim damages, as prescribed by Section 244 of the Insurance Code.

On the other hand, the core, if not the sole bone of contention in Adm. Case No. RD-156, is the issue of whether or not there was unreasonable delay or denial of the claims of petitioner, and if in the affirmative, whether or not that would justify the suspension or revocation of the insurers' licenses.

iii. Casualty

- Fortune Insurance and Surety Co., Inc. vs. Court of Appeals and Producers Bank of the Philippines, G.R. No. 115278, May 23, 1995

**FORTUNE INSURANCE AND SURETY CO., INC., *Petitioner*, -versus- COURT OF APPEALS and PRODUCERS BANK OF THE PHILIPPINES, *Respondents*.
G.R. No. 115278, May 23, 1995, Davide, Jr. J.**

It has been aptly observed that in burglary, robbery, and theft insurance, "the opportunity to defraud the insurer - the moral hazard - is so great that insurers have found it necessary to fill up their policies with countless restrictions, many designed to reduce this hazard. Seldom does the insurer assume the risk of all losses due to the hazards insured against."

FACTS

Fortune issued a policy to Producers wherein it stipulated under the General Exceptions Clause that "[t]he company shall not be liable under this policy in respect of x x x (b) any loss caused by any dishonest, fraudulent or criminal act of the insured or any officer, employee, partner, director, trustee or authorized representative of the Insured whether acting alone or in conjunction with others. x x x" An armored car of the bank was robbed of P725,000 while transferring it to another branch. After an investigation conducted by the Pasay police authorities, the driver Magalong and guard Atiga (et. al.) were charged with violation of the Anti- Highway Robbery Law. Petitioner claims that it was not liable because the incident fell under the General Exception Clause. Private respondent says otherwise.

ISSUE

Whether or not the petitioner is liable under the Money, Security, and Payroll Robbery policy it issued to the private respondent.

RULING

NO. A contract of insurance is a contract of adhesion, thus any ambiguity therein should be resolved against the insurer, or it should be construed liberally in favor of the insured and strictly against the insurer. An insurance contract is a contract of indemnity upon the terms and conditions specified therein.

It is settled that the terms of the policy constitute the measure of the insurer's liability. In the absence of statutory prohibition to the contrary, insurance companies have the same rights as individuals to limit their liability and to impose whatever conditions they deem best upon their obligations not inconsistent with public policy.

It has been aptly observed that in burglary, robbery, and theft insurance, "the opportunity to defraud the insurer - the moral hazard - is so great that insurers have found it necessary to fill up their policies with countless restrictions, many designed to reduce this hazard. Seldom does the insurer assume the risk of all losses due to the hazards insured against." Persons frequently excluded under such provisions are those in the insured's service and employment. The purpose of the exception is to guard against liability should the theft be committed by one having unrestricted access to the property. In such cases, the terms specifying the excluded classes are to be given their meaning as understood in common speech. The terms "service" and "employment" are generally associated with the idea of selection, control, and compensation.

Magalong and Atiga were, in respect of the transfer of Producer's money from its Pasay City branch to its head office in Makati, its "authorized representatives" who served as such with its teller Maribeth Alampay. Howsoever viewed, Producers entrusted the three with the specific duty to safely transfer the money to its head office, with Alampay to be responsible for its custody in transit; Magalong to drive the armored vehicle which would carry the money; and Atiga to provide the needed security for the money, the vehicle, and his two other companions. In short, for these particular tasks, the three acted as agents of Producers. A "representative" is defined as one who represents or stands in the place of another; one who represents others or another in a special capacity, as an agent and is interchangeable with "agent."

- Coquia vs. Fieldmen's Insurance Company, Inc., 26 SCRA 178

MELECIO COQUIA, MARIA ESPANUEVA and MANILA YELLOW TAXICAB CO., INC., Plaintiffs-appellees, -versus- FIELDMEN'S INSURANCE CO., INC., Defendant-appellant.

G.R. No. L-23276, November 29, 1968, Concepcion, C.J

In the case at bar, the policy under consideration is typical of contracts pour autrui, this character being made more manifest by the fact that the deceased driver paid fifty percent (50%) of the corresponding premiums, which were deducted from his weekly commissions. Under these conditions, it is clear that the Coquias — who, admittedly, are the sole heirs of the deceased — have a direct cause

of action against the Company, and, since they could have maintained this action by themselves, without the assistance of the insured it goes without saying that they could and did properly join the latter in filing the complaint herein.

FACTS

On Dec. 1, 1961, Fieldmen's Insurance co. Issued in favor of the Manila Yellow Taxicab a common carrier insurance policy with a stipulation that the company shall indemnify the insured of the sums which the latter may be held liable for with respect to "death or bodily injury to any fare-paying passenger including the driver and conductor". The policy also stated that in "the event of the death of the driver, the Company shall indemnify his personal representatives and at the Company's option may make indemnity payable directly to the claimants or heirs of the claimants."

During the policy's lifetime, a taxicab of the insured driven by Coquia met an accident and Coquia died. When the company refused to pay the only heirs of Coquia, his parents, they instituted this complaint. The company contends that plaintiffs have no cause of action since the Coquias have no contractual relationship with the company.

ISSUE

Whether or not plaintiffs have the right to collect on the policy.

RULING

YES. Although, in general, only parties to a contract may bring an action based thereon, this rule is subject to exceptions, one of which is found in the second paragraph of Article 1311 of the Civil Code of the Philippines, reading: "*If a contract should contain some stipulation in favor of a third person, he may demand its fulfillment provided he communicated his acceptance to the obligor before its revocation. A mere incidental benefit or interest of a person is not sufficient. The contracting parties must have clearly and deliberately conferred a favor upon a third person.*" This is but the restatement of a well-known principle concerning contracts pour autrui, the enforcement of which may be demanded by a third party for whose benefit it was made, although not a party to the contract, before the stipulation in his favor has been revoked by the contracting parties.

In the case at bar, the policy under consideration is typical of contracts pour autrui, this character being made more manifest by the fact that the deceased driver paid fifty percent (50%) of the corresponding premiums, which were deducted from his weekly commissions. Under these conditions, it is clear that the Coquias — who, admittedly, are the sole heirs of the deceased — have a direct cause of action against the Company, and, since they could have maintained this action by themselves, without the assistance of the insured it goes without saying that they could and did properly join the latter in filing the complaint herein.

- Far Eastern Surety & Trust Company, Inc. vs. Misa, 25 SCRA 662

FAR EASTERN SURETY & INSURANCE COMPANY, INC., *Petitioner*, -versus- SOCORRO DANCEL VDA. DE MISA, ARACELI MARIA PINTO and LA MALLORCA, *Respondents*.

G.R. No. L-24377, October 26, 1968, Reyes, J.

While La Mallorca was found to be in estoppel, it does not apply to the insurer, FESIC. It did not appear that the insurance company authorized or consented to, or even knew of, the representation made by La Mallorca to its passengers, it follows that the source of the award of damages against the taxicab was beyond the contemplation of the parties to the contract of the Accident Insurance and that the insurer may not be held liable for such damages

FACTS

On Sept 3 1957, Socorro Dancel vda de Misa and Araceli Pinto hired a taxi operated by La Mallorca in Quezon City and while on their way to the Archbishop's Palace in Shaw Blvd, they collided with a gravel and sand truck. As a result, Misa and Pinto were injured and filed a suit for damages against La Mallorca. La Mallorca denied liability but instituted a third party complaint against Far Eastern (FESIC) to recoup damages based on its Common Carrier's Accident Insurance, however, they also denied liability.

ISSUE

Whether or not FESIC was liable as an insurer.

RULING

NO. The policy insurance limited the recovery of the insured to "all sums including claimants" "costs and expenses which the Insured shall become legally liable" in the "event of accident caused by or arising out of the use of the Motor Vehicle". The SC finds that La Mallorca had indeed insured its passengers and since such stipulation was not at all illegal, it must bind La Mallorca, enough to render it liable for the injuries to the passengers thereof, even though it had not been at fault.

While La Mallorca was found to be in estoppel, it does not apply to the insurer, FESIC. It did not appear that the insurance company authorized or consented to, or even knew of, the representation made by La Mallorca to its passengers, it follows that the source of the award of damages against the taxicab was beyond the contemplation of the parties to the contract of the Accident Insurance and that the insurer may not be held liable for such damages. Thus, decision of CA is modified.

- Finman General Assurance Corporation vs. Court of Appeals, 213 SCRA 493

FINMAN GENERAL ASSURANCE CORPORATION, *Petitioner*, -versus- THE HONORABLE COURT OF APPEALS and JULIA SURPOSA, *Respondents*.

G.R. No. 100970, September 2, 1992, Nocon, J.

Murder and assault, not having been expressly included in the enumeration of the circumstances that would negate liability in said insurance policy, cannot be considered by implication to discharge the petitioner insurance company from liability for any injury, disability or loss suffered by the insured.

The failure of the petitioner insurance company to include death resulting from murder or assault among the prohibited risks leads inevitably to the conclusion that it did not intend to limit or exempt itself from liability for such death. Article 1377 (NCC) provides that: "The interpretation of obscure words or stipulations in a contract shall not favor the party who caused the obscurity."

FACTS

Carlie Surposa was insured with petitioner Finman General Assurance Corporation. While said policy was in full force and effect, the insured died as a result of a stab wound without provocation and warning on the part of the insured as he and his cousin were waiting for a ride on their way home after attending the celebration of the "Maskarra Annual Festival." Thereafter, private respondent and the other beneficiaries of said insurance policy filed a written notice of claim with the petitioner insurance company which denied said claim contending that murder and assault are not within the scope of the coverage of the insurance policy.

ISSUE

Whether or not petitioner can invoke the principle *expresso unius exclusio alterius* and be excused from liability?

RULING

NO. Where the death or injury is not the natural or probable result of the insured's voluntary act, or if something unforeseen occurs in the doing of the act which produces the injury, the resulting death is within the protection of the policies insuring against death or injury from accident. The happening was a pure accident on the part of the victim. The insured died from an event that took place without his foresight or expectation, an event that proceeded from an unusual effect of a known cause and, therefore, not expected. Neither can it be said that there was a capricious desire on the part of the accused to expose his life to danger considering that he was just going home after attending a festival.

Murder and assault, not having been expressly included in the enumeration of the circumstances that would negate liability in said insurance policy, cannot be considered by implication to discharge the petitioner insurance company from liability for any injury, disability or loss suffered by the insured. The failure of the petitioner insurance company to include death resulting from murder or assault among the prohibited risks leads inevitably to the conclusion that it did not intend to limit or exempt itself from liability for such death. Article 1377 (NCC) provides that: "The interpretation of obscure words or stipulations in a contract shall not favor the party who caused the obscurity."

iv. Suretyship

- First Lepanto-Taisho Insurance Corporation vs. Chevron Philippines, Inc., G.R. No. 177839, January 18, 2012

FIRST LEPANTO-TAISHO INSURANCE CORPORATION (now known as FLT PRIME INSURANCE CORPORATION), *Petitioner*, -versus- CHEVRON PHILIPPINES, INC. (formerly known as CALTEX [PHILIPPINES], INC.), *Respondent*.
G.R. No. 177839, January 18, 2012, Villarama, Jr. J.

The extent of the surety's liability is determined by the language of the suretyship contract or bond itself. It cannot be extended by implications beyond the terms of the contract.

Thus, to determine whether First Lepanto is liable to Chevron under the surety bond, we need to examine the terms of the contract itself. A reading of the bond shows that it secures the payment of purchases on credit by Fumitechniks in accordance with the terms and conditions of the "agreement"

it entered into with Chevron. The word “agreement” has reference to the distributorship agreement, the principal contract and by implication included the credit agreement in the rider. But in this case, Chevron has executed written agreements only with its direct customers but not to distributors like Fumitechniks and it also never relayed the terms and conditions of its distributorship agreement to First Lepanto after the delivery of the bond

FACTS

Chevron Philippines sued First Lepanto-Taisho Insurance Corp. for payment of unpaid oil and petroleum purchases made by its distributor Fumitechniks Corp.

Fumitechniks applied for and was issued a Surety Bond by First Lepanto. As stated in the attached rider, **the bond was in compliance with the requirement for the grant of a credit line with Chevron** to guarantee payment/remittance of the cost of fuel products withdrawn within the stipulated time in accordance with the terms and conditions of the agreement.

Fumitechniks defaulted on its obligation to Chevron. As such, Chevron notified First Lepanto of Fumitechniks' unpaid purchases.

First Lepanto then demanded from Fumitechniks the delivery of documents including, among others, a copy of the agreement secured by the Surety Bond and information such as terms and conditions of any arrangement that Fumitechniks might have made or ongoing negotiations with Chevron in connection with the settlement of its obligations. Fumitechniks responded by saying that no such agreement was executed with Chevron.

First Lepanto then advised Chevron the non-existence of the principal agreement as confirmed by Fumitechniks.

Chevron formally demanded from First Lepanto the payment of its claim under the surety bond. First Lepanto reiterated its position that without the basic contract subject of the bond, it cannot act on Chevron's claim. Thus, Chevron sued.

ISSUE

Whether or not First Lepanto, as surety, is liable to Chevron, the creditor, in the absence of a written contract with the principal.

RULING

NO. Sec. 175, Insurance Code defines suretyship as a contract or agreement whereby a party, called the surety, guarantees the performance by another party, called the principal or obligor, of an obligation or undertaking in favor of a third party, called the obligee. It arises upon the solidary binding of a person – deemed the surety – with the principal debtor, for the purpose of fulfilling an obligation.

Such undertaking makes a surety agreement an ancillary contract as it presupposes the existence of a principal contract. Although the contract of a surety is in essence secondary only to a valid principal obligation, the surety becomes liable for the debt or duty of another although it possesses no direct

or personal interest over the obligations nor does it receive any benefit therefrom. And notwithstanding the fact that the surety contract is secondary to the principal obligation, the surety assumes liability as a regular party to the undertaking.

The extent of the surety's liability is determined by the language of the suretyship contract or bond itself. It cannot be extended by implications beyond the terms of the contract.

Thus, to determine whether First Lepanto is liable to Chevron under the surety bond, we need to examine the terms of the contract itself. A reading of the bond shows that it secures the payment of purchases on credit by Fumitechniks in accordance with the terms and conditions of the "agreement" it entered into with Chevron. The word "agreement" has reference to the distributorship agreement, the principal contract and by implication included the credit agreement in the rider. But in this case, Chevron has executed written agreements only with its direct customers but not to distributors like Fumitechniks and it also never relayed the terms and conditions of its distributorship agreement to First Lepanto after the delivery of the bond.

The law is clear that a surety contract should be read and interpreted together with the contract entered into between the creditor and the principal (Sec. 176). A surety contract is merely a collateral one, its basis is the principal contract or undertaking which it secures. Necessarily, the stipulations in such principal agreement must at least be communicated or made known to the surety.

The bond in this case specifically makes reference to a WRITTEN AGREEMENT. Having accepted the bond, the creditor is bound by the recital in the surety bond that the terms and conditions of its distributorship contract be reduced in writing or at the very least communicated in writing to the surety. Such non-compliance by the creditor impacts not on the validity or legality of the surety contract but on the creditor's right to demand performance.

- National Power Corporation vs. Court of Appeals, et al., G.R. No. L-43706, November 14, 1986

NATIONAL POWER CORPORATION, *Petitioner*, -versus- COURT OF APPEALS and PHILIPPINE AMERICAN GENERAL INSURANCE CO., INC., *Respondents*.

G.R. No. L-43706, November 14, 1986, Paras, J.

The surety bond must be read in its entirety and together with the contract between NPC and the contractors. The provisions must be construed together to arrive at their true meaning. Certain stipulations cannot be segregated and then made to control.

FACTS

NPC entered into a contract with the Far Eastern Electric, Inc. (FEEI) on December 26, 1962 for the erection of the transmission lines for the Angat Hydroelectric Project. FEEI agreed to complete the work within 120 days from the signing of the contract, otherwise it would pay NPC P200.00 per calendar day as liquidated damages, while NPC agreed to pay the sum of P97,829.00 as consideration.

On the other hand, Philippine American General Insurance Co., Inc. (Philamgen) issued a surety bond in the amount of P30,672 for the faithful performance of the undertaking by FEEL, as required. The condition of the bond reads:

"The liability of the PHILIPPINE AMERICAN GENERAL INSURANCE COMPANY, INC. under this bond will expire One (1) year from final Completion and Acceptance and said bond will be cancelled 30 days after its expiration unless surety is notified of any existing obligation thereunder."

The Specifications of the contract between petitioner and FEEL states that "[s]hould the Contractor fail to complete the construction of the work as herein specified and agreed upon, or if the work is abandoned, . . . the Corporation shall have the power to take over the work by giving notice in writing to that effect to the Contractor and his sureties of its intention to take over the construction work," and that "[i]t is expressly agreed that in the event the Corporation takes over the work from the Contractor, the latter and his bondsmen shall continue to be liable under this contract for any expense in the completion of the work in excess of the contract price and the bond filed by the Contractor shall be answerable for the same and for any and all damages that the Corporation may suffer as a result thereof."

The work was abandoned on June 26, 1963, leaving the construction unfinished. On July 19, 1963, in a joint letter, Philamgen and FEEL informed NPC that FEEL was giving up the construction due to financial difficulties. On the same date, NPC wrote Philamgen informing it of the withdrawal of FEEL from the work and formally holding both FEEL and Philamgen liable for the cost of the work to be completed as of July 20, 1962 plus damages.

The work was completed by NPC on September 30, 1963. On January 30, 1967 NPC notified Philamgen that FEEL had an outstanding obligation in the amount of P75,019.85, exclusive of interest and damages, and demanded the remittance of the amount of the surety bond the answer for the cost of completion of the work. In reply, Philamgen requested for a detailed statement of account, but after receipt of the same, Philamgen did not pay as demanded but contended instead that its liability under the bond has expired on September 20, 1964 and claimed that no notice of any obligation of the surety was made within 30 days after its expiration. RTC ruled in favor of NPC, which was later reversed by the CA.

ISSUE

Whether or not Philamgen is liable.

RULING

YES. As correctly assessed by the trial court, the evidence shows that as early as May 30, 1963, Philamgen was duly informed of the failure of its principal to comply with its undertaking. In fact, said notice of failure was also signed by its Assistant Vice President. On July 19, 1963, when FEEL informed NPC that it was abandoning the construction job, the latter forthwith informed Philamgen of the fact on the same date. Moreover, on August 1, 1963, the fact that Philamgen was seasonably notified, was even bolstered by its request from NPC for information of the percentage completed by the bond principal prior to the relinquishment of the job to the latter and the reason for said relinquishment. The 30-day notice adverted to in the surety bond applies to the completion of the work by the contractor. This completion by the contractor never materialized.

The surety bond must be read in its entirety and together with the contract between NPC and the contractors. The provisions must be construed together to arrive at their true meaning. Certain stipulations cannot be segregated and then made to control.

Furthermore, it is well settled that contracts of insurance are to be construed liberally in favor of the insured and strictly against the insurer. Thus ambiguity in the words of an insurance contract should be interpreted in favor of its beneficiary. In the case at bar, it cannot be denied that the breach of contract in this case, that is, the abandonment of the unfinished work of the transmission line of the petitioner by the contractor Far Eastern Electric, Inc. was within the effective date of the contract and the surety bond. Such abandonment gave rise to the continuing liability of the bond as provided for in the contract which is deemed incorporated in the surety bond executed for its completion. To rule therefore that private respondent was not properly notified would be gross error.

- *Finman General Assurance Corporation vs. William Inocencio, et al.*, G.R. No. 90273-75, November 15, 1989

FINMAN GENERAL ASSURANCE CORP., *Petitioner*, -versus- WILLIAM INOCENCIO, ET AL. AND EDWIN CARDONES, THE ADMINISTRATOR, PHILIPPINE OVERSEAS AND EMPLOYMENT ADMINISTRATION, THE SECRETARY OF LABOR AND EMPLOYMENT, *Respondents*.

G.R. No. 90273-75, November 15, 1989, Feliciano, J.

Finman General is solidarily liable. Under Section 176 of the Insurance Code, as amended, the liability of a surety in a surety bond (Finman) is joint and several with the principal obligor (Pan Pacific).

FACTS

Pan Pacific Overseas is a recruitment agency which offers jobs abroad duly registered with the POEA. **Finman General is acting as Pan Pacific's surety (as required by POEA rules and Art. 31 of the Labor Code).** Pan Pacific was sued by William Inocencio and 3 others for alleged violation of Article 32 and 34 of the Labor Code. Inocencio alleged that Pan Pacific charged and collected fees but failed to provide employment abroad.

POEA ruled in favor of Inocencio et al and had impleaded Finman (upon request of Inocencio) in the complaint as well (Pan Pacific changed business address without prior notice to POEA). The Labor Secretary affirmed POEA's ruling.

Finman General asserts that it should not be impleaded in the case because it is not a party to the contract between Pan Pacific and Inocencio et al.

ISSUE

Whether or not Finman General is solidarily liable in the case at bar

RULING

YES. Since Pan Pacific had thoughtfully refrained from notifying the POEA of its new address and from responding to the complaints, petitioner Finman may well be regarded as an indispensable party to the proceedings before the POEA. **Whether Finman was an indispensable or merely a proper party to the proceedings, the SC held that the POEA could properly implead it as party respondent either upon the request of Inocencio et al or motu proprio. Such is the situation under the Revised Rules of Court.**

Finman General is solidarily liable. Under Section 176 of the Insurance Code, as amended, the liability of a surety in a surety bond (Finman) is joint and several with the principal obligor (Pan Pacific). Further, Article 31 of the Labor Code provides:

Art. 31. Bonds. — All applicants for license or authority shall post such cash and surety bonds as determined by the Secretary of Labor to guarantee compliance with prescribed recruitment procedures, rules and regulations, and terms and conditions of employment as appropriate. xxx

The Secretary of Labor shall have the exclusive power to determine, decide, order or direct payment from, or application of, the cash and surety bond for any claim or injury covered and guaranteed by the bonds.

- Country Bankers Insurance Corporation vs. Antonio Lagman, G.R. No. 165487, July 13, 2011

COUNTRY BANKERS INSURANCE CORPORATION, *Petitioner*, -versus ANTONIO LAGMAN, *Respondent*.

G.R. No. 165487, July 13, 2011, Perez, J.

The effectivity of the bond is not wholly dependent on the payment of premium

FACTS

Nelson Santos (Santos) applied for a license with the National Food Authority (NFA) to engage in the business of storing *palay* in his warehouse at *Barangay* Malacampa, Camiling, Tarlac. Under Act No. 3893 or the General Bonded Warehouse Act, as amended, the approval for said license was conditioned upon posting of a cash bond, a bond secured by real estate, or a bond signed by a duly authorized bonding company.

Accordingly, Country Bankers Insurance Corporation (Country Bankers) issued Warehouse Bond No. 03304 for P1,749,825.00 on 5 November 1989 and Warehouse Bond No. 02355 for P749,925.00 on 13 December 1989 (1989 Bonds) through its agent, Antonio Lagman (Lagman). Santos was the bond principal, Lagman was the surety and the Republic of the Philippines, through the NFA was the obligee.

In consideration of these issuances, corresponding Indemnity Agreements were executed by Santos, as bond principal, together with Ban Lee Lim Santos (Ban Lee Lim), Rhosemelita Reguine (Reguine) and Lagman, as co-signors. **The latter bound themselves jointly and severally liable to Country Bankers for any damages, prejudice, losses, costs, payments, advances and expenses of whatever kind and nature, including attorneys fees and legal costs, which it may sustain as a**

consequence of the said bond; to reimburse Country Bankers of whatever amount it may pay or cause to be paid or become liable to pay thereunder; and to pay interest at the rate of 12% per annum computed and compounded monthly, as well as to pay attorneys fees of 20% of the amount due it.

Santos then secured a loan using his warehouse receipts as collateral. When the loan matured, Santos defaulted in his payment. The sacks of *palay* covered by the warehouse receipts were no longer found in the bonded warehouse. **By virtue of the surety bonds, Country Bankers was compelled to pay P1,166,750.37.**

Consequently, Country Bankers filed a complaint for a sum of money before the Regional Trial Court (RTC) of Manila. In his Answer, Lagman alleged that the 1989 Bonds were valid only for 1 year from the date of their issuance, as evidenced by receipts; that the bonds were never renewed and revived by payment of premiums; that on 5 November 1990, Country Bankers issued Warehouse Bond No. 03515 (1990 Bond) which was also valid for one year and that no Indemnity Agreement was executed for the purpose; and that the 1990 Bond supersedes, cancels, and renders no force and effect the 1989 Bonds.

The bond principals, Santos and Ban Lee Lim, were not served with summons because they could no longer be found. The case was eventually dismissed against them without prejudice. The other co-signor, Reguine, was declared in default for failure to file her answer.

ISSUE

Whether or not the 1989 Bonds have expired and the 1990 Bond novates the 1989 Bonds.

RULING

NO. The official receipts in question serve as proof of payment of the premium for one year on each surety bond. It does not, however, automatically mean that the surety bond is effective for only one (1) year. In fact, the effectivity of the bond is not wholly dependent on the payment of premium. Section 177 of the Insurance Code expresses:

Sec. 177. The surety is entitled to payment of the premium as soon as the contract of suretyship or bond is perfected and delivered to the obligor. No contract of suretyship or bonding shall be valid and binding unless and until the premium therefor has been paid, except where the obligee has accepted the bond, in which case the bond becomes valid and enforceable irrespective of whether or not the premium has been paid by the obligor to the surety: Provided, That if the contract of suretyship or bond is not accepted by, or filed with the obligee, the surety shall collect only reasonable amount, not exceeding fifty per centum of the premium due thereon as service fee plus the cost of stamps or other taxes imposed for the issuance of the contract or bond: Provided, however, That if the non-acceptance of the bond be due to the fault or negligence of the surety, no such service fee, stamps or taxes shall be collected.

v. Life

- Re: Claims for Benefits of the Heirs of the Late Mario vs. Chanliongco, Adm. Matter No. 190-RET., October 18, 1977

RE: CLAIMS FOR BENEFITS OF THE HEIRS OF THE LATE MARIO V. CHANLIONGCO, FIDELA B. CHANLIONGCO, MARIO B. CHANLIONGCO II, MA. ANGELINA C. BUENAVENTURA and MARIO C. CHANLIONGCO, JR., Claimants.

A.M. No. 190, October 18, 1977, Makasiar, J.

This matter refers to the claims for retirement benefits filed by the heirs of the late ATTY. MARIO V. CHANLIONGCO an attorney in this Court, under the provisions of R.A. No. 1616, as amended by R.A. No. 4986, which was approved by this Court in its resolution of August 19, 1976, effective on July 12, 1976. It appears from the records that at the time of his death on July 12, 1976, Atty. Chanliongco was more than 63 years of age, with more than 38 years of service in the government. He did not have any pending criminal administrative or not case against him, neither did he have any money or property accountability.

According to law, the benefits accruing to the deceased consist of: (1) retirement benefits; (2) money value of terminal leave; (3) life insurance and (4) refund of retirement premium.

From the records now before US, it appears that the GSIS had already released the life insurance proceeds; and the refund of rent to the claimants.

What, therefore, to be settled are the retirement benefits and the money value of leave, both of which are to be paid by this court as the deceased's last employer.

The record also shows that the late Atty. Chanliongco died ab intestate. Hence, the retirement benefits shall accrue to his estate and will be distributed among his Legal heirs, as in the case of a life if no beneficiary is named in the policy (Vda. de vs. GSIS, L-28093, Jan. 30, 1971, 37 SCRA 315, 325).

- The Insular Life Assurance Company, Ltd., vs. Carponia T. Ebrado and Pascuala Vda. De Ebrado, G.R. No. 1-44059, October 28, 1977

THE INSULAR LIFE ASSURANCE COMPANY, LTD., Plaintiff-appellee, -versus- CARPONIA T. EBRADO and PASCUALA VDA. DE EBRADO, Defendants-appellants.

G.R. No. L-44059, October 28, 1977, Martin, J.

Art. 739 (NCC) states, among others, that a donation made between persons who are guilty of adultery or concubinage at the time of the donation is void. A life insurance policy is no different from a civil donation insofar as the beneficiary is concerned. Both are founded on the same consideration: liberality. As a consequence, the proscription in Art. 739 should equally operate in life insurance contracts. In such a case, there is no need that a conviction for adultery or concubinage is exacted before the disabilities mentioned in Art. 739 may effectuate. Criminal conviction is not a condition precedent

FACTS

Buenaventura Ebrado was issued a whole-life plan by petitioner, and Carponia Ebrado was named as the revocable beneficiary in his policy. Buenaventura died as a result of an accident. As the insurance policy was in force, petitioner was liable to pay the coverage of the face value of the policy. Carponia filed a claim for the proceeds of the policy although she admits that she and the deceased were common-law spouses. Pascuala also filed a claim. The CFI rendered judgment declaring

Carponia to be disqualified to claim, and the insurance proceeds was to be paid to the estate of the deceased.

ISSUE

Whether or not a common-law spouse named as a beneficiary claim the proceeds of an insurance policy?

RULING

NO. Art. 739 (NCC) states, among others, that a donation made between persons who are guilty of adultery or concubinage at the time of the donation is void. A life insurance policy is no different from a civil donation insofar as the beneficiary is concerned. Both are founded on the same consideration: liberality. As a consequence, the proscription in Art. 739 should equally operate in life insurance contracts. In such a case, there is no need that a conviction for adultery or concubinage is exacted before the disabilities mentioned in Art. 739 may effectuate. Criminal conviction is not a condition precedent (as regards the first paragraph of the same article).

So long as marriage remains, the threshold of family laws, reason and morality dictate that the impediments imposed upon a married couple should likewise be imposed upon extra-marital relationship. If legitimate relationship is circumscribed by these legal disabilities, with more reason should an illicit relationship be restricted by these disabilities.

- Great Pacific Life Assurance Company vs. Court of Appeals, 89 SCRA 543 (1979)

GREAT PACIFIC LIFE ASSURANCE COMPANY, *Petitioner*, -versus- HONORABLE COURT OF APPEALS, *Respondents*.

G.R. No. L-31845, April 30, 1979, De Castro, J.

The receipt is merely an acknowledgment that the latter's branch office had received from the applicant the insurance premium and had accepted the application subject for processing by the insurance company. There was still approval or rejection the same on the basis of whether or not the applicant is "insurable on standard rates." Since Pacific Life disapproved the insurance application of respondent Ngo Hing, the binding deposit receipt in question had never become in force at any time.

FACTS

Ngo Hing filed an application with the Great Pacific for a twenty-year endowment policy in the amount of P50,000.00 on the life of his one-year old daughter Helen. He supplied the essential data which petitioner Mondragon, the Branch Manager, wrote on the form. The latter paid the annual premium the sum of P1,077.75 going over to the Company, but he retained the amount of P1,317.00 as his commission for being a duly authorized agent of Pacific Life.

Upon the payment of the insurance premium, the binding deposit receipt was issued Ngo Hing. Likewise, petitioner Mondragon handwrote at the bottom of the back page of the application form his strong recommendation for the approval of the insurance application. Then Mondragon received a letter from Pacific Life disapproving the insurance application. The letter stated that the said life insurance application for 20-year endowment plan is not available for minors below seven years old,

but Pacific Life can consider the same under the Juvenile Triple Action Plan, and advised that if the offer is acceptable, the Juvenile Non-Medical Declaration be sent to the company.

The non-acceptance of the insurance plan by Pacific Life was allegedly not communicated by petitioner Mondragon to private respondent Ngo Hing. Instead, on May 6, 1957, Mondragon wrote back Pacific Life again strongly recommending the approval of the 20-year endowment insurance plan to children, pointing out that since the customers were asking for such coverage.

Helen Go died of influenza. Ngo Hing sought the payment of the proceeds of the insurance, but having failed in his effort, he filed the action for the recovery before the Court of First Instance of Cebu, which ruled against him.

ISSUES

1. Whether the binding deposit receipt constituted a temporary contract of the life insurance in question
2. Whether Ngo Hing concealed the state of health and physical condition of Helen Go, which rendered void the policy

RULING

1. NO. The receipt was intended to be merely a provisional insurance contract. Its perfection was subject to compliance of the following conditions: (1) that the company shall be satisfied that the applicant was insurable on standard rates; (2) that if the company does not accept the application and offers to issue a policy for a different plan, the insurance contract shall not be binding until the applicant accepts the policy offered; otherwise, the deposit shall be refunded; and (3) that if the company disapproves the application, the insurance applied for shall not be in force at any time, and the premium paid shall be returned to the applicant.

The receipt is merely an acknowledgment that the latter's branch office had received from the applicant the insurance premium and had accepted the application subject for processing by the insurance company. There was still approval or rejection the same on the basis of whether or not the applicant is "insurable on standard rates." Since Pacific Life disapproved the insurance application of respondent Ngo Hing, the binding deposit receipt in question had never become in force at any time. The binding deposit receipt is conditional and does not insure outright. This was held in *Lim v Sun*.

The deposit paid by private respondent shall have to be refunded by Pacific Life.

2. YES. Ngo Hing had deliberately concealed the state of health of his daughter Helen Go. When he supplied data, he was fully aware that his one-year old daughter is typically a mongoloid child. He withheld the fact material to the risk insured.

"The contract of insurance is one of perfect good faith *uberrima fides* meaning good faith, absolute and perfect candor or openness and honesty; the absence of any concealment or demotion, however slight." The concealment entitles the insurer to rescind the contract of insurance.

- *Tan vs. Court of Appeals*, 174 SCRA 403 (1989)

EMILIO TAN, JUANITO TAN, ALBERTO TAN and ARTURO TAN, *Petitioners*, -versus- THE COURT OF APPEALS and THE PHILIPPINE AMERICAN LIFE INSURANCE COMPANY, *Respondents*.

G.R. No. 48049, June 29, 1989, Gutierrez, J.

The so-called “incontestability clause” precludes the insurer from raising the defenses of false representations or concealment of material facts insofar as health and previous diseases are concerned if the insurance has been in force for at least two years during the insured’s lifetime. The phrase “during the lifetime” found in Section 48 of the Insurance Law simply means that the policy is no longer considered in force after the insured has died. The key phrase in the second paragraph of Section 48 is “for a period of two years”. The policy was issued on November 6, 1973 and the insured died on April 26, 1975. The policy was thus in force for a period of only one year and five months. Considering that the insured died before the two-year period has lapsed, respondent company is not, therefore, barred from proving that the policy is void ab initio by reason of the insured’s fraudulent concealment or misrepresentation.

FACTS

Tan Lee Siong, father of herein petitioners, applied for life insurance in the amount of P80,000.00 with respondent company Philippine American Life Insurance Company. Said application was approved and a corresponding policy was issued effective November 5, 1973, with petitioners as the beneficiaries. On April 26, 1975, Tan Lee Siong died of hepatoma. Hence, petitioners filed with respondent company their claim for the proceeds of the life insurance policy. However, the insurance company denied the said claim and rescinded the policy by reason of the alleged misrepresentation and concealment of material facts made by the deceased Tan Lee Siong in his application for insurance. The premiums paid on the policy were thereupon refunded. The petitioners contend that the respondent company no longer had the right to rescind the contract of insurance as rescission must allegedly be done during the lifetime of the insured within two years and prior to the commencement of action.

ISSUE

Whether or not the insurance company has the right to rescind the contract of insurance despite the presence of an incontestability clause

RULING

YES. The so-called “incontestability clause” precludes the insurer from raising the defenses of false representations or concealment of material facts insofar as health and previous diseases are concerned if the insurance has been in force for at least two years during the insured’s lifetime. The phrase “during the lifetime” found in Section 48 of the Insurance Law simply means that the policy is no longer considered in force after the insured has died. The key phrase in the second paragraph of Section 48 is “for a period of two years”. The policy was issued on November 6, 1973 and the insured died on April 26, 1975. The policy was thus in force for a period of only one year and five months. Considering that the insured died before the two-year period has lapsed, respondent company is not,

therefore, barred from proving that the policy is void ab initio by reason of the insured's fraudulent concealment or misrepresentation.

Moreover, respondent company rescinded the contract of insurance and refunded the premiums paid on November 11, 1975, previous to the commencement of this action on November 27, 1975.

- Sun Insurance Office, Ltd. vs. Court of Appeals, G.R. No. 92383, July 17, 1992

**SUN INSURANCE OFFICE, LTD., *Petitioner*, -versus- THE HON. COURT OF APPEALS and
NERISSA LIM, *Respondents*.**

G.R. No. 92383, July 17, 1992, Cruz, J.

Accident/Accidental" in Insurance Contracts are construed and considered according to the ordinary understanding and common usage and speech: That which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual, and unforeseen.

There was no "willful exposure to needless peril" for the part of Lim when he pointed the gun to his temple, because he thought it was not unsafe to do so (having removed the magazine).

FACTS

Sun Insurance issued a Personal Accident Policy to Felix Lim, Jr. with a face value of Php 200,000.00 (with his wife Nerissa as beneficiary).

On Oct. 6, 1982, Lim "accidentally" shot himself in the head and was killed on the spot. According to his secretary, Lim pointed the gun at her as a joke and assured her that it was not loaded (the magazine was removed), then he put the gun to his temple and fired it.

Sun Insurance agreed that it was not suicide, but argued that it was not an accident and is therefore not covered by Insurance. Sun Insurance argued that one of the four exceptions in the said Insurance contract includes bodily injury consequent upon the insured person attempting to commit suicide or "willfully exposing himself to needless peril" except in an attempt to save a human life, and that the mere act of pointing the gun to his temple showed that Felix willfully exposed himself to danger.

ISSUE

Whether or not Lim's death was an accident.

RULING

YES. "Accident/Accidental" in Insurance Contracts are construed and considered according to the ordinary understanding and common usage and speech: That which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual, and unforeseen.

The SC defines an accident as an event that takes place without one's foresight or expectation - an event that proceeds from an unknown cause, or is an unusual effect of a known case, and therefore not expected; an event which happens without any human agency or, if happening through human agency, an event which, under the circumstances, is unusual to and not expected by the person to

whom it happens. It is also defined as an injury which happens by reason of some violence or casualty to the insured without his design, consent, or voluntary co-operation.

There was no "willful exposure to needless peril" for the part of Lim when he pointed the gun to his temple, because he thought it was not unsafe to do so (having removed the magazine). He was unquestionably negligent but it should not prevent Nerissa from recovering the insurance policy that Lim obtained "precisely against accident."

Suicide and exposure to needless peril are similar in the sense that both signify disregard for one's life. The firing of the gun was deemed to be the unexpected and independent and unforeseen occurrence that led to Lim's death (he did not know that the gun was still loaded). There is nothing in the Insurance policy that relieves Sun Insurance of the responsibility to pay the indemnity agreed upon if the insured is shown to have "contributed to his own accident."

Accident insurance policies were never meant to reward the insured for his tendency to show off or for his miscalculations. They were intended to provide for contingencies. Moreover, insurance contracts are supposed to be interpreted liberally in favor of the assured. There is no reason to deviate from this rule.

- Heirs of Loreto C. Maramag vs. Maramag, GR No. 181132, June 5, 2009

HEIRS OF LORETO C. MARAMAG, represented by surviving spouse VICENTA PANGILINAN MARAMAG, *Petitioners*, -versus- EVA VERNA DE GUZMAN MARAMAG, ODESSA DE GUZMAN MARAMAG, KARL BRIAN DE GUZMAN MARAMAG, TRISHA ANGELIE MARAMAG, THE INSULAR LIFE ASSURANCE COMPANY, LTD., and GREAT PACIFIC LIFE ASSURANCE CORPORATION, *Respondents*.

G.R. No. 181132, June 5, 2009, Nachura, J.

Because no legal proscription exists in naming as beneficiaries the children of illicit relationships by the insured, the shares of Eva in the insurance proceeds, whether forfeited by the court in view of the prohibition on donations under Article 739 of the Civil Code or by the insurers themselves for reasons based on the insurance contracts, must be awarded to the said illegitimate children, the designated beneficiaries, to the exclusion of petitioners. It is only in cases where the insured has not designated any beneficiary, or when the designated beneficiary is disqualified by law to receive the proceeds, that the insurance policy proceeds shall redound to the benefit of the estate of the insured.

FACTS

The case stems from a petition filed against respondents with the RTC for revocation and/or reduction of insurance proceeds for being void and/or inofficious.

The petition alleged that: (1) petitioners were the legitimate wife and children of Loreto Maramag (Loreto), while respondents were Loreto's illegitimate family; (2) Eva de Guzman Maramag (Eva) was a concubine of Loreto and a suspect in the killing of the latter, thus, she is disqualified to receive any proceeds from his insurance policies from Insular Life Assurance Company, Ltd. (Insular) and Great Pacific Life Assurance Corporation (Grepalife) (3) the illegitimate children of Loreto—Odessa,

Karl Brian, and Trisha Angelie—were entitled only to one-half of the legitime of the legitimate children, thus, the proceeds released to Odessa and those to be released to Karl Brian and Trisha Angelie were inofficious and should be reduced; and (4) petitioners could not be deprived of their legitimes, which should be satisfied first.

Insular admitted that Loreto misrepresented Eva as his legitimate wife and Odessa, Karl Brian, and Trisha Angelie as his legitimate children, and that they filed their claims for the insurance proceeds of the insurance policies; that when it ascertained that Eva was not the legal wife of Loreto, it disqualified her as a beneficiary and divided the proceeds among Odessa, Karl Brian, and Trisha Angelie, as the remaining designated beneficiaries; and that it released Odessa's share as she was of age, but withheld the release of the shares of minors Karl Brian and Trisha Angelie pending submission of letters of guardianship.

Insular alleged that the complaint or petition failed to state a cause of action insofar as it sought to declare as void the designation of Eva as beneficiary, because Loreto revoked her designation as such in Policy No. A001544070 and it disqualified her in Policy No. A001693029; and insofar as it sought to declare as inofficious the shares of Odessa, Karl Brian, and Trisha Angelie, considering that no settlement of Loreto's estate had been filed nor had the respective shares of the heirs been determined.

Insular further claimed that it was bound to honor the insurance policies designating the children of Loreto with Eva as beneficiaries pursuant to Section 53 of the Insurance Code. Grepalife alleged that Eva was not designated as an insurance policy beneficiary; that the claims filed by Odessa, Karl Brian, and Trisha Angelie were denied because Loreto was ineligible for insurance due to a misrepresentation in his application form that he was born on December 10, 1936 and, thus, not more than 65 years old when he signed it in September 2001; that the case was premature, there being no claim filed by the legitimate family of Loreto; and that the law on succession does not apply where the designation of insurance beneficiaries is clear.

ISSUE

Whether or not illegitimate children can be beneficiaries in an insurance contract.

RULING

YES. Section 53 of the Insurance Code states that the insurance proceeds shall be applied exclusively to the proper interest of the person in whose name or for whose benefit it is made unless otherwise specified in the policy. Pursuant thereto, it is obvious that the only persons entitled to claim the insurance proceeds are either the insured, if still alive; or the beneficiary, if the insured is already deceased, upon the maturation of the policy. The exception to this rule is a situation where the insurance contract was intended to benefit third persons who are not parties to the same in the form of favorable stipulations or indemnity. In such a case, third parties may directly sue and claim from the insurer.

Petitioners are third parties to the insurance contracts with Insular and Grepalife and, thus, are not entitled to the proceeds thereof. Accordingly, respondents Insular and Grepalife have no legal obligation to turn over the insurance proceeds to petitioners. The revocation of Eva as a beneficiary in one policy and her disqualification as such in another are of no moment considering

that the designation of the illegitimate children as beneficiaries in Loreto's insurance policies remains valid. **Because no legal proscription exists in naming as beneficiaries the children of illicit relationships by the insured, the shares of Eva in the insurance proceeds, whether forfeited by the court in view of the prohibition on donations under Article 739 of the Civil Code or by the insurers themselves for reasons based on the insurance contracts, must be awarded to the said illegitimate children, the designated beneficiaries, to the exclusion of petitioners.** It is only in cases where the insured has not designated any beneficiary, or when the designated beneficiary is disqualified by law to receive the proceeds, that the insurance policy proceeds shall redound to the benefit of the estate of the insured.

vi. Compulsory Motor Vehicle Liability Insurance

- Vda. De Maglana vs. Hon. Consolacion (212 SCRA 268 [1992])

FIGURACION VDA. DE MAGLANA, EDITHA M. CRUZ, ERLINDA M. MASESAR, LEONILA M. MALLARI, GILDA ANTONIO and the minors LEAH, LOPE, JR., and ELVIRA, all surnamed MAGLANA, herein represented by their mother, FIGURACION VDA. DE MAGLANA, Petitioners, -versus- HONORABLE FRANCISCO Z. CONSOLACION, Presiding Judge of Davao City, Branch II, and AFISCO INSURANCE CORPORATION, Respondents.
G.R. No. 60506, August 6, 1992, Romero, J.

Although the insurance policy clearly provides that AFISCO can be held directly liable by petitioners on the basis of the insurance contract, nonetheless, AFISCO may not be held solidarily liable with Destrajo since their respective liabilities are based on different grounds.

FACTS

Lope Maglana met an accident that resulted to his death while driving his motorcycle on his way to work station. He was bumped by a PUJ jeep which was driven by Pepito Into and was operated and owned by defendant Destrajo, when he overtook another passenger jeep that was going towards the city. The point of impact was on the lane of the motorcycle and the deceased was thrown from the road and met his untimely death. Thereafter, the heirs of the deceased filed an action against Destrajo and the Afisco Insurance Corporation (AFISCO) for damages and attorney's fees.

The lower court rendered a decision finding that Destrajo had not exercised extraordinary diligence as the operator of the jeepney and ordered him to pay for the damages. The second paragraph of the decision also ordered AFISCO to reimburse Destrajo whatever amounts the latter shall have paid only up to the extent of its insurance coverage, signifying only secondary liability.

The heirs however, filed a motion for reconsideration with respect to the said second paragraph arguing that AFISCO should not merely be held secondarily liable because the Insurance Code provides that the insurer's liability is "direct and primary and/or jointly and severally with the operator of the vehicle", although only up to the extent of the insurance coverage.

ISSUE

Whether or not AFISCO's liability is solidary with Destrajo.

RULING

NO. Although the insurance policy clearly provides that AFISCO can be held directly liable by petitioners on the basis of the insurance contract, nonetheless, AFISCO may not be held solidarily liable with Destrajo since their respective liabilities are based on different grounds. The liability of the insurer is based on contract; that of the insured is based on tort. As such, petitioners have the option either to claim from AFISCO to the extent agreed upon in the contract and the balance from Destrajo or enforce the entire judgment from Destrajo subject to reimbursement from AFISCO to the extent of the insurance coverage.

- The Heirs of George Y. Poe vs. Malayan Insurance Company, Inc., G.R. No. 156302, April 7, 2009

THE HEIRS OF GEORGE Y. POE, *Petitioners* –versus- MALAYAN INSURANCE COMPANY, *Respondent*

G.R. No. 156302, April 7, 2009, Chico- Nazario, J.

It is settled that where the insurance contract provides for indemnity against liability to third persons, the liability of the insurer is direct and such third persons can directly sue the insurer. The direct liability of the insurer under indemnity contracts against third party liability does not mean, however, that the insurer can be held solidarily liable with the insured and/or the other parties found at fault, since they are being held liable under different obligations. The liability of the insured carrier or vehicle owner is based on tort, in accordance with the provisions of the Civil Code; while that of the insurer arises from contract, particularly, the insurance policy. The third-party liability of the insurer is only up to the extent of the insurance policy and that required by law; and it cannot be held solidarily liable for anything beyond that amount.

FACTS

Poe was run over by a truck. Such truck was insured with Malayan Insurance. The heirs of Poe then filed a complaint against the owner of the truck and the Insurer. Malayan Insurance does not deny that it is the insurer of the truck. Nevertheless, it asserts that its liability is limited, and it should not be held solidarily liable with the owner for all the damages awarded to the aggrieved parties.

ISSUE

Whether or not the Insurer is solidarily liable with the Insured for the damages awarded to third persons.

RULING

NO. It is settled that where the insurance contract provides for indemnity against liability to third persons, the liability of the insurer is direct and such third persons can directly sue the insurer. The direct liability of the insurer under indemnity contracts against third party liability does not mean,

however, that the insurer can be held solidarily liable with the insured and/or the other parties found at fault, since they are being held liable under different obligations. The liability of the insured carrier or vehicle owner is based on tort, in accordance with the provisions of the Civil Code; while that of the insurer arises from contract, particularly, the insurance policy. The third-party liability of the insurer is only up to the extent of the insurance policy and that required by law; and it cannot be held solidarily liable for anything beyond that amount. Any award beyond the insurance coverage would already be the sole liability of the insured and/or the other parties at fault. However, Malayan did not produce evidence to prove its limited liability so the Court concluded that it had agreed to fully indemnify third-party liabilities.

- Jewel Villacorta vs. Insurance Commission, et al., G.R. No. 54171. October 28, 1980

JEWEL VILLACORTA, assisted by her husband, GUERRERO VILLACORTA, *Petitioner*, -versus- THE INSURANCE COMMISSION and EMPIRE INSURANCE COMPANY, *Respondents*.

G.R. No. L-54171, October 28, 1980, Teehankee, Acting C.J.

Where the insured's car is wrongfully taken without the insured's consent from the car service and repair shop to whom it had been entrusted for check-up and repairs, respondent insurer is liable and must pay insured for the total loss of the insured vehicle under the Theft Clause of the policy.

FACTS

Villacorta had her Colt Lancer car insured with Empire Insurance Company against own damage, theft and 3rd party liability. While the car was in the repair shop, one of the employees of the said repair shop took it out for a joyride after which it figured in a vehicular accident. This resulted to the death of the driver and some of the passengers as well as to extensive damage to the car.

Villacorta filed a claim for total loss with the said insurance company. However, it denied the claim on the ground that the accident did not fall within the provisions of the policy either for the Own Damage or Theft coverage, invoking the policy provision on "Authorized Driver Clause".

This was upheld by the Insurance Commission further stating that the car was not stolen and therefore not covered by the Theft Clause because it is not evident that the person who took the car for a joyride intends to permanently deprive the insured of his/ her car.

ISSUE

Whether or not the insurer company should pay the said claim.

RULING

YES. Where the insured's car is wrongfully taken without the insured's consent from the car service and repair shop to whom it had been entrusted for check-up and repairs (assuming that such taking was for a joy ride, in the course of which it was totally smashed in an accident), respondent insurer is liable and must pay insured for the total loss of the insured vehicle under the Theft Clause of the policy.

Assuming, despite the totally inadequate evidence, that the taking was "temporary" and for a "joy ride", the Court sustains as the better view which holds that when a person, either with the object of

going to a certain place, or learning how to drive, or enjoying a free ride, takes possession of a vehicle belonging to another, without the consent of its owner, he is guilty of theft because by taking possession of the personal property belonging to another and using it, his intent to gain is evident since he derives therefrom utility, satisfaction, enjoyment and pleasure.

ACCORDINGLY, the appealed decision is set aside and judgment is hereby rendered sentencing private respondent to pay petitioner the sum of P35,000.00 with legal interest from the filing of the complaint until full payment is made and to pay the costs of suit.

- James Stokes, as Attorney-in-Fact of Daniel Stephen Adolfson vs. Malayan Insurance Co., Inc., G.R. No. L-34768. February 24, 1984

JAMES STOKES, as Attorney-in-Fact of Daniel Stephen Adolfson and DANIEL STEPHEN ADOLFSON, Plaintiffs-Appellees, -versus- MALAYAN INSURANCE CO., INC., Defendant-Appellant.

G.R. No. L-34768, February 24, 1984, Plana, J.

At the time of the accident, Stokes had been in the Philippines for more than 90 days. Hence, under the law, he could not drive a motor vehicle without a Philippine driver's license. He was therefore not an "authorized driver" under the terms of the insurance policy in question, and Malayan was right in denying the claim of the insured.

Acceptance of premium within the stipulated period for payment thereof, including the agreed period of grace, merely assures continued effectivity of the insurance policy in accordance with its terms. Such acceptance does not estop the insurer from interposing any valid defense under the terms of the insurance policy.

FACTS

Daniel Adolfson had a subsisting Malayan car insurance policy with coverage against own damage as well as 3rd party liability when his car figured in a vehicular accident with another car, resulting to damage to both vehicles. At the time of the accident, Adolfson's car was being driven by James Stokes, who was authorized to do so by Adolfson. Stokes, an Irish tourist who had been in the Philippines for only 90 days, had a valid and subsisting Irish driver's license but without a Philippine driver's license.

Adolfson filed a claim with Malayan but the latter refused to pay contending that Stokes was not an authorized driver under the "Authorized Driver" clause of the insurance policy in relation to Section 21 of the Land Transportation Office.

ISSUE

Whether or not Malayan is liable to pay the insurance claim of Adolfson

RULING

NO. A contract of insurance is a contract of indemnity upon the terms and conditions specified therein. When the insurer is called upon to pay in case of loss or damage, he has the right to insist upon compliance with the terms of the contract. If the insured cannot bring himself within the terms and conditions of the contract, he is not entitled as a rule to recover for the loss or damage suffered.

For the terms of the contract constitute the measure of the insurer's liability, and compliance therewith is a condition precedent to the right of recovery.

At the time of the accident, Stokes had been in the Philippines for more than 90 days. Hence, under the law, he could not drive a motor vehicle without a Philippine driver's license. He was therefore not an "authorized driver" under the terms of the insurance policy in question, and Malayan was right in denying the claim of the insured. Acceptance of premium within the stipulated period for payment thereof, including the agreed period of grace, merely assures continued effectivity of the insurance policy in accordance with its terms. Such acceptance does not estop the insurer from interposing any valid defense under the terms of the insurance policy.

The principle of estoppel is an equitable principle rooted upon natural justice which prevents a person from going back on his own acts and representations to the prejudice of another whom he has led to rely upon them. The principle does not apply to the instant case. In accepting the premium payment of the insured, Malayan was not guilty of any inequitable act or representation. There is nothing inconsistent between acceptance of premium due under an insurance policy and the enforcement of its terms.

- Andrew Palermo vs. Pyramid Insurance Co., Inc., G.R. No. L-36480. May 31, 1988

ANDREW PALERMO, Plaintiff-appellee, -versus- PYRAMID INSURANCE CO., INC., Defendant-appellant.

G.R. No. L-36480, May 31, 1988, Griño-Aquino, J

While the Motor Vehicle Law prohibits a person from operating a motor vehicle on the highway without a license or with an expired license, an infraction of the Motor Vehicle Law on the part of the insured, is not a bar to recovery under the insurance contract. It however renders him subject to the penal sanctions of the Motor Vehicle Law.

FACTS

On March 7, 1969, the insured, appellee Andrew Palermo, filed a complaint in the Court of First Instance of Negros Occidental against Pyramid Insurance Co., Inc., for payment of his claim under a Private Car Comprehensive Policy MV-1251 issued by the defendant.

In its answer, the appellant Pyramid Insurance Co., Inc., alleged that it disallowed the claim because at the time of the accident, the insured was driving his car with an expired driver's license. After the trial, the court a quo rendered judgment on October 29, 1969 ordering the defendant "to pay the plaintiff the sum of P20,000.00, value of the insurance of the motor vehicle in question and to pay the costs." On November 26, 1969, the plaintiff filed a "Motion for Immediate Execution Pending Appeal." It was opposed by the defendant, but was granted by the trial court on December 15, 1969.

ISSUE

Whether or not plaintiff was not authorized to drive the insured motor vehicle because his driver's license had expired.

RULING

NO. There is no merit in the appellant's allegation that the plaintiff was not authorized to drive the insured motor vehicle because his driver's license had expired. The driver of the insured motor vehicle at the time of the accident was, the insured himself, hence an "authorized driver" under the policy.

While the Motor Vehicle Law prohibits a person from operating a motor vehicle on the highway without a license or with an expired license, an infraction of the Motor Vehicle Law on the part of the insured, is not a bar to recovery under the insurance contract. It however renders him subject to the penal sanctions of the Motor Vehicle Law. The requirement that the driver be "permitted in accordance with the licensing or other laws or regulations to drive the Motor Vehicle and is not disqualified from driving such motor vehicle by order of a Court of Law or by reason of any enactment or regulation in that behalf," applies only when the driver is driving on the insured's order or with his permission." It does not apply when the person driving is the insured himself.

- Agapito Gutierrez vs. Capital Insurance & Surety Co., Inc., G.R. No. L-26827, June 29, 1984

AGAPITO GUTIERREZ, Plaintiff-appellee, -versus- CAPITAL INSURANCE & SURETY CO., INC., Defendant-appellant.

G.R. No. L-26827, June 29, 1984, Aquino, J.

Paragraph 13 of the policy, already cited, is decisive and controlling in this case. It plainly provides, and we repeat, that "a driver with an expired Traffic Violation Receipt or expired Temporary Operator's permit is not considered an authorized driver within the meaning" of the policy. Obviously, Ventura was not an authorized driver. His temporary operator's permit had expired. The expiration bars recovery under the policy

FACTS

Capital Insurance & Surety Co., Inc. insured on December 7, 1961 for one year the jeepney of Agapito Gutierrez against passenger and third-party liability. The policy provides in item 13 that the authorized driver must be the holder of a valid and subsisting professional driver's license. "A driver with an expired Traffic Violation Receipt or *expired Temporary Operator's Permit* is not considered an authorized driver".

Item 13 is part of the "declarations" which formed part of the policy and had a promissory nature and effect and constituted "the basis of the policy".

On *May 29, 1962*, the insured jeepney figured in an accident. As a result, a passenger named Agatonico Ballega fell off the vehicle and died. At the time of the accident, Teofilo Ventura, the jeepney driver, did not have his license though he was duly licensed for the years 1962 and 1963. He had with him instead a carbon copy of a traffic violation report issued by a policeman on *February 22, 1962*. However, the said TVR was already expired because it only served as a temporary operator's permit for 15 days from receipt.

Gutierrez paid P4,000 to the passenger's widow. Capital Insurance refused to make any reimbursement, hence, Gutierrez filed in the city court of Manila an action for specific performance and damages.

ISSUE

Whether an insurance covers a jeepney whose driver's traffic violation report or temporary operator's permit had already expired.

RULING

NO. The insurance does not cover a jeepney whose driver's traffic violation report or temporary operator's permit had already expired.

Paragraph 13 of the policy, already cited, is decisive and controlling in this case. It plainly provides, and we repeat, that "a driver with an expired Traffic Violation Receipt or expired Temporary Operator's permit is not considered an authorized driver within the meaning" of the policy. Obviously, Ventura was not an authorized driver. His temporary operator's permit had expired. The expiration bars recovery under the policy. In liability insurance, "the parties are bound by the terms of the policy and the right of insured to recover is governed thereby". It may be that for purposes of the Motor Vehicle Law the TVR is coterminous with the confiscated license. That is why the Acting Administrator of the Motor Vehicles Office and the Manila deputy chief of police ventured the opinion that a TVR does not suspend the erring driver's license, that it serves as a temporary license and that it may be renewed but should in no case extend beyond the expiration date of the original license. But the instant case deals with an insurance policy which definitively fixed the meaning of "authorized driver".

- Lao vs. Standard Insurance Company, Inc., 409 SCRA 43

RUDY LAO, *Petitioner*, -versus- STANDARD INSURANCE CO., INC., *Respondent*.

G.R. No. 140023, August 14, 2003, Quisumbing, J.

Entries in police records made by a police officer in the performance of the duty especially enjoined by law are prima facie evidence of the fact therein stated, and their probative value may be either substantiated or nullified by other competent evidence. 21 Although police blotters are of little probative value, they are nevertheless admitted and considered in the absence of competent evidence to refute the facts stated therein.

FACTS

Petitioner Rudy Lao is the owner of a Fuso truck. The truck was insured with respondent Standard Insurance Co., Inc. for the maximum amount of P200,000 and an additional sum of P50,000 to cover any damages that might be caused to his goods.

While the policy was in effect, an accident occurred. At around 8:00 p.m. of April 24, 1985, in Barangay Buhang, Jaro, Iloilo City, the insured truck bumped another truck, also owned by petitioner Lao. The latter truck was running ahead of the insured truck and was bumped from the rear. The insured truck sustained damages estimated to be around P110,692. 00.

Petitioner filed a claim with the insurance company for the proceeds from his policy. However, the claim was denied by the insurance company on the ground that when its adjuster went to investigate

the matter, it was found that the driver of the insured truck, Leonardo Anit, did not possess a proper driver's license at the time of the accident. The restriction 4 in Leonardo Anit's driver's license provided that he can only drive four-wheeled vehicles weighing not more than 4,500 kgs. Since the insured truck he was driving weighed more than 4,500 kgs., he therefore violated the "authorized driver" clause 5 of the insurance policy.

Petitioner claims that at the time of the accident, it was in fact another driver named Giddie Boy Y Coyel who was driving the insured truck. Giddie Boy possessed a driver's license authorizing him to drive vehicles such as the truck which weighed more than 4,500 kgs. However, respondent insurance company was firm in its denial of the claim.

Hence, petitioner filed the civil case before the RTC.

ISSUE

Whether or not Petitioner Lao has a cause of action against the respondent

RULING

NO. Entries in police records made by a police officer in the performance of the duty especially enjoined by law are prima facie evidence of the fact therein stated, and their probative value may be either substantiated or nullified by other competent evidence. 21 Although police blotters are of little probative value, they are nevertheless admitted and considered in the absence of competent evidence to refute the facts stated therein.

In this case, the entries in the police blotter reflected the information subject of the controversy. Stated therein was the fact that Leonardo Anit was driving the insured truck with plate number FCG-538. This is unlike *People v. Mejia*, 22 where we said that "entries in the police blotters should not be given undue significance or probative value," since the Court there found that "the entries in question are sadly wanting in material particulars".

- *Perla Compania De Seguros, Inc., vs. Hon. Constante A. Ancheta, Presiding Judge of the Court of First Instance of Camarines Norte, Branch III, et al., G.R. No. L-49699, August 8, 1988*

PERLA COMPANIA de SEGUROS, INC., Petitioner, -versus- HON. CONSTANTE A. ANCHETA, Presiding Judge of the Court of First instance of Camarines Norte, Branch III, ERNESTO A. RAMOS and GOYENA ZENAROSA-RAMOS, for themselves and as Guardian Ad Litem for Minors JOBET, BANJO, DAVID and GRACE all surnamed RAMOS, FERNANDO M. ABCEDE, SR., for himself and Guardian Ad Litem for minor FERNANDO G. ABCEDE, JR., MIGUEL JEREZ MAGO as Guardian Ad Litem for minors ARLEEN R. MAGO, and ANACLETA J. ZENAROSA., Respondents.

G.R. No. L-49699, August 8, 1988, Cortes, J.

Under Sec. 378, the claim shall lie against the insurer of the vehicle in which the occupant is riding and no other. The claimant is not free to choose from which insurer he will claim the "no fault indemnity" as the law uses the term "shall." That said vehicle might not be the one that caused the accident is of no moment since the law itself provides that the party paying the claim may recover against the owner

of the vehicle responsible for the accident.

FACTS

There was a collision between the IH Scout (in which private respondents were riding) and a Superlines bus. Private respondents sustained injuries. A complaint for damages was filed against Superlines, the bus driver and petitioner insurance company, the insurer of the bus. The vehicle in which the private respondents were riding was insured with Malayan Insurance Co. Even before summons could be served, the judge issued an order for the Insurance Company to pay immediately within 5 days the P5,000 under the “no-fault clause” as provided for in Section 378 of the Insurance Code.

Petitioner moved for the reconsideration of the order; it was denied. Petitioner contends that under Sec. 378 of the Insurance Code, the insurer liable to pay the P5,000 is the insurer of the vehicle in which private respondents were riding, not petitioner.

ISSUE

Whether or not petitioner is the insurer liable to indemnify the private respondents under Sec. 378 of the Insurance Code.

RULING

NO. Supreme Court says that the provision is clear and unambiguous. Under Sec. 378, the claim shall lie against the insurer of the vehicle in which the occupant is riding and no other. The claimant is not free to choose from which insurer he will claim the “no fault indemnity” as the law uses the term “shall.” That said vehicle might not be the one that caused the accident is of no moment since the law itself provides that the party paying the claim may recover against the owner of the vehicle responsible for the accident.

Essence of “no fault indemnity” clause: to provide victims of vehicular accidents or their heir’s immediate compensation pending final determination of who is responsible for the accident. The “no fault indemnity” provision is part and parcel of the Insurance Code provisions on compulsory motor vehicle liability insurance (Secs. 373-389) and should be read together with the requirement for compulsory passenger and/or third party liability insurance (Sec. 377).

m. Insurable Interest

i. In Life/Health

- *Philamcare Health System vs. Court of Appeals* (379 SCRA 356 [2002])

PHILAMCARE HEALTH SYSTEMS, INC., *Petitioner*, -versus- COURT OF APPEALS and JULITA TRINOS, *Respondents*.

G.R. No. 125678, March 18, 2002, YNARES-SANTIAGO, *J.*

FACTS

Ernani Trinos applied for a health care coverage with Philam. He answered no to a question asking if he or his family members were treated to heart trouble, asthma, diabetes, etc.

The application was approved for 1 year. He was also given hospitalization benefits and out-patient benefits. After the period expired, he was given an expanded coverage for Php 75,000. During the period, he suffered from heart attack and was confined at MMC.

The wife tried to claim the benefits but the petitioner denied it saying that he concealed his medical history by answering no to the aforementioned question. She had to pay for the hospital bills amounting to 76,000. Her husband subsequently passed away. She filed a case before the trial court for the collection of the amount plus damages.

ISSUE

Whether or not a health care agreement is not an insurance contract; hence the “incontestability clause” under the Insurance Code does not apply.

RULING

NO. Petitioner claimed that it granted benefits only when the insured is alive during the one-year duration. It contended that there was no indemnification unlike in insurance contracts. It supported this claim by saying that it is a health maintenance organization covered by the DOH and not the Insurance Commission. Lastly, it claimed that the Incontestability clause didn't apply because two-year and not one-year effectivity periods were required.

Section 2 (1) of the Insurance Code defines a contract of insurance as “an agreement whereby one undertakes for a consideration to indemnify another against loss, damage or liability arising from an unknown or contingent event.”

Section 3 states: every person has an insurable interest in the life and health:
(1) of himself, of his spouse and of his children.

In this case, the husband's health was the insurable interest. The health care agreement was in the nature of non-life insurance, which is primarily a contract of indemnity. The provider must pay for the medical expenses resulting from sickness or injury.

While petitioner contended that the husband concealed material fact of his sickness, the contract stated that:

“that any physician is, by these presents, expressly authorized to disclose or give testimony at anytime relative to any information acquired by him in his professional capacity upon any question affecting the eligibility for health care coverage of the Proposed Members.”

This meant that the petitioners required him to sign authorization to furnish reports about his medical condition. The contract also authorized Philam to inquire directly to his medical history. Hence, the contention of concealment isn't valid.

They can't also invoke the "Invalidation of agreement" clause where failure of the insured to disclose information was a grounds for revocation simply because the answer assailed by the company was the heart condition question based on the insured's opinion. He wasn't a medical doctor, so he can't accurately gauge his condition.

In *Henrick vs. Fire* it was held, "*in such case the insurer is not justified in relying upon such statement, but is obligated to make further inquiry.*"

Fraudulent intent must be proven to rescind the contract. This was incumbent upon the provider. "Having assumed a responsibility under the agreement, petitioner is bound to answer the same to the extent agreed upon. In the end, the liability of the health care provider attaches once the member is hospitalized for the disease or injury covered by the agreement or whenever he avails of the covered benefits which he has prepaid."

Section 27 of the Insurance Code- "a concealment entitles the injured party to rescind a contract of insurance." As to cancellation procedure- Cancellation requires certain conditions:

1. Prior notice of cancellation to insured;
2. Notice must be based on the occurrence after effective date of the policy of one or more of the grounds mentioned;
3. Must be in writing, mailed or delivered to the insured at the address shown in the policy;
4. Must state the grounds relied upon provided in Section 64 of the Insurance Code and upon request of insured, to furnish facts on which cancellation is based

None were fulfilled by the provider.

- *Lalican vs. Insular Life Assurance Company Ltd* [597 SCRA 159 [2009]]

VIOLETA R. LALICAN, *Petitioner*, -versus- THE INSULAR LIFE ASSURANCE COMPANY LIMITED, AS REPRESENTED BY THE PRESIDENT VICENTE R. AVILON, *Respondent*.

G.R. No. 183526, August 25, 2009, Chico-Nazario, J.

True, Eulogio, before his death, managed to file his Application for Reinstatement and deposit the amount for payment of his overdue premiums and interests thereon with Malaluan; but Policy No. 9011992 could only be considered reinstated after the Application for Reinstatement had been processed and approved by Insular Life during Eulogios lifetime and good health.

FACTS

Violeta is the widow of the deceased Eulogio C. Lalican (Eulogio). During his lifetime, Eulogio applied for an insurance policy with Insular Life. On 24 April 1997, Insular Life, through Josephine Malaluan (Malaluan), its agent in Gapan City, issued in favor of Eulogio Policy No. 9011992, which contained a 20-Year Endowment Variable Income Package Flexi Plan worth P500,000.00, with two riders valued at P 500,000.00 each. Thus, the value of the policy amounted to P1,500,000.00. Violeta was named as the primary beneficiary.

Under the terms of Policy No. 9011992, Eulogio was to pay the premiums on a quarterly basis in the

amount of 8,062.00, payable every 24 April, 24 July, 24 October and 24 January of each year, until the end of the 20-year period of the policy. According to the Policy Contract, there was a grace period of 31 days for the payment of each premium subsequent to the first. If any premium was not paid on or before the due date, the policy would be in default, and if the premium remained unpaid until the end of the grace period, the policy would automatically lapse and become void.

Eulogio paid the premiums due on 24 July 1997 and 24 October 1997. However, he failed to pay the premium due on 24 January 1998, even after the lapse of the grace period of 31 days. Policy No. 9011992, therefore, lapsed and became void. Eulogio submitted to the Cabanatuan District Office of Insular Life, through Malaluan, on 26 May 1998, an Application for Reinstatement of Policy No. 9011992, together with the amount of P 8,062.00 to pay for the premium due on 24 January 1998. In a letter dated 17 July 1998, Insular Life notified Eulogio that his Application for Reinstatement could not be fully processed because, although he already deposited P8,062.00 as payment for the 24 January 1998 premium, he left unpaid the overdue interest thereon amounting to P322.48. Thus, Insular Life instructed Eulogio to pay the amount of interest and to file another application for reinstatement. Eulogio was likewise advised by Malaluan to pay the premiums that subsequently became due on 24 April 1998 and 24 July 1998, plus interest.

On 17 September 1998, Eulogio went to Malaluan's house and submitted a second Application for Reinstatement of Policy No. 9011992, including the amount of P17,500.00, representing payments for the overdue interest on the premium for 24 January 1998, and the premiums which became due on 24 April 1998 and 24 July 1998. As Malaluan was away on a business errand, her husband received Eulogio's second Application for Reinstatement and issued a receipt for the amount Eulogio deposited. A while later, on the same day, 17 September 1998, Eulogio died of cardio-respiratory arrest secondary to electrocution.

ISSUE

Whether or not Eulogio had an existing insurable interest in his own life until the day of his death in order to have the insurance policy validly reinstated.

RULING

NO. An insurable interest is one of the most basic and essential requirements in an insurance contract. In general, an insurable interest is that interest which a person is deemed to have in the subject matter insured, where he has a relation or connection with or concern in it, such that the person will derive pecuniary benefit or advantage from the preservation of the subject matter insured and will suffer pecuniary loss or damage from its destruction, termination, or injury by the happening of the event insured against. The existence of an insurable interest gives a person the legal right to insure the subject matter of the policy of insurance. Section 10 of the Insurance Code indeed provides that every person has an insurable interest in his own life. Section 19 of the same code also states that an interest in the life or health of a person insured must exist when the insurance takes effect, but need not exist thereafter or when the loss occurs.

In the instant case, Eulogio's death rendered impossible full compliance with the conditions for reinstatement of Policy No. 9011992. True, Eulogio, before his death, managed to file his Application for Reinstatement and deposit the amount for payment of his overdue premiums and interests thereon with Malaluan; but Policy No. 9011992 could only be considered reinstated after the

Application for Reinstatement had been processed and approved by Insular Life during Eulogios lifetime and good health.

The stipulation in a life insurance policy giving the insured the privilege to reinstate it upon written application does not give the insured absolute right to such reinstatement by the mere filing of an application. The insurer has the right to deny the reinstatement if it is not satisfied as to the insurability of the insured and if the latter does not pay all overdue premium and all other indebtedness to the insurer. After the death of the insured the insurance Company cannot be compelled to entertain an application for reinstatement of the policy because the conditions precedent to reinstatement can no longer be determined and satisfied.

Malaluan did not have the authority to approve Eulogios Application for Reinstatement. Malaluan still had to turn over to Insular Life Eulogios Application for Reinstatement and accompanying deposits, for processing and approval by the latter.

Violeta did not adduce any evidence that Eulogio might have failed to fully understand the import and meaning of the provisions of his Policy Contract and/or Application for Reinstatement, both of which he voluntarily signed. While it is a cardinal principle of insurance law that a policy or contract of insurance is to be construed liberally in favor of the insured and strictly as against the insurer company, yet, contracts of insurance, like other contracts, are to be construed according to the sense and meaning of the terms, which the parties themselves have used. If such terms are clear and unambiguous, they must be taken and understood in their plain, ordinary and popular sense.

- El Oriente Fabrica de Tabacos vs. Posada (56 Phil 147 [1931])

**EL ORIENTE FABRICA DE TABACOS, INC., Plaintiff-appellant, -versus- JUAN POSADAS,
Collector of Internal Revenue, Defendant-appellee.**

G.R. No. 34774, September 21, 1931, Malcolm, J.

It is certain that the proceeds of life insurance policies paid to individual beneficiaries upon the death of the insured are exempt. It is not so certain that the proceeds of life insurance policies paid to corporate beneficiaries upon the death of the insured are likewise exempt. But at least, it may be said that the law is indefinite in phraseology and does not permit us unequivocally to hold that the proceeds of life insurance policies received by corporations constitute income which is taxable

FACTS

El Oriente, in order to protect itself against the loss that it might suffer by reason of the death of its manager, A. Velhagen, who had had more than thirty-five (35) years of experience in the manufacture of cigars in the Philippines, procured from the Manufacturers Life Insurance Co., of Toronto, Canada, thru its local agent E. E. Elser, an insurance policy on the life of the said A. Velhagen for the sum of \$50,000, United States currency designating itself as the beneficiary.

El Oriente paid for the premiums due thereon and charged as expenses of its business all the said premiums and deducted the same from its gross incomes as reported in its annual income tax returns, which deductions were allowed upon a showing that such premiums were legitimate expenses of its business.

Upon the death of A. Velhagen in 1929, the El Oriente received all the proceeds of the said life

insurance policy, together with the interests and the dividends accruing thereon, aggregating P104,957.88

The CIR assessed El Oriente for deficiency taxes because El Oriente did not include as income the proceeds received from the insurance.

ISSUE

Whether or not the proceeds of insurance taken by a corporation on the life of an important official to indemnify it against loss in case of his death, are taxable as income under the Philippine Income Tax Law

RULING

NO. In Chapter I of the Tax Code, is to be found section 4 which provides that, "The following incomes shall be exempt from the provisions of this law: (a) The proceeds of life insurance policies paid to beneficiaries upon the death of the insured ..."

Section 10, as amended, in Chapter II On Corporations, provides that, "There shall be levied, assessed, collected, and paid annually upon the total net income received in the preceding calendar year from all sources by every corporation . . . a tax of three per centum upon such income . . ." Section 11 in the same chapter, provides the exemptions under the law, but neither here nor in any other section is reference made to the provisions of section 4 in Chapter I.

Under the view we take of the case, it is sufficient for our purposes to direct attention to the anomalous and vague condition of the law. It is certain that the proceeds of life insurance policies paid to individual beneficiaries upon the death of the insured are exempt. It is not so certain that the proceeds of life insurance policies paid to corporate beneficiaries upon the death of the insured are likewise exempt. But at least, it may be said that the law is indefinite in phraseology and does not permit us unequivocally to hold that the proceeds of life insurance policies received by corporations constitute income which is taxable

It will be recalled that El Oriente, took out the insurance on the life of its manager, who had had more than thirty-five years' experience in the manufacture of cigars in the Philippines, to protect itself against the loss it might suffer by reason of the death of its manager. We do not believe that this fact signifies that when the plaintiff received P104,957.88 from the insurance on the life of its manager, it thereby realized a net profit in this amount. It is true that the Income Tax Law, in exempting individual beneficiaries, speaks of the proceeds of life insurance policies as income, but this is a very slight indication of legislative intention. In reality, what the plaintiff received was in the nature of an indemnity for the loss which it actually suffered because of the death of its manager.

ii. In Property

- Spouses Nilo Cha and Stella Uy Cha vs. Court of Appeals, G.R. No. 124520, August 18, 1997

**Spouses NILO CHA and STELLA UY CHA, and UNITED INSURANCE CO., INC., *Petitioners*, -
versus- COURT OF APPEALS and CKS DEVELOPMENT CORPORATION, *Respondents*.**

G.R. No. 124520, August 18, 1997, Padilla, J.

The automatic assignment of the policy to CKS under the provision of the lease contract previously quoted is void for being contrary to law and/or public policy. The proceeds of the fire insurance policy thus rightfully belong to the spouses. The liability of the Cha spouses to CKS for violating their lease contract in that Cha spouses obtained a fire insurance policy over their own merchandise, without the consent of CKS, is a separate and distinct issue which we do not resolve in this case.

FACTS

Spouses Nilo Cha and Stella Uy-Cha and CKS Development Corporation entered a 1 year lease contract with a stipulation not to insure against fire the chattels, merchandise, textiles, goods and effects placed at any stall or store or space in the leased premises without first obtaining the written consent and approval of the lessor. But it insured against loss by fire their merchandise inside the leased premises for P500,000 with the United Insurance Co., Inc. without the written consent of CKS.

On the day the lease contract was to expire, fire broke out inside the leased premises and CKS learning that the spouses procured an insurance wrote to United to have the proceeds be paid directly to them. But United refused so CKS filed against Spouses Cha and United.

ISSUE

Whether or not CKS has insurable interest over the property insured.

RULING

NO. Sec. 18. provides that no contract or policy of insurance on property shall be enforceable except for the benefit of some person having an insurable interest in the property insured. A non-life insurance policy such as the fire insurance policy taken by petitioner-spouses over their merchandise is primarily a contract of indemnity. Insurable interest in the property insured must exist at the time the insurance takes effect and at the time the loss occurs. The basis of such requirement of insurable interest in property insured is based on sound public policy: to prevent a person from taking out an insurance policy on property upon which he has no insurable interest and collecting the proceeds of said policy in case of loss of the property. In such a case, the contract of insurance is a mere wager which is void under Section 25 of the Insurance Code.

SECTION 25. Every stipulation in a policy of Insurance for the payment of loss, whether the person insured has or has not any interest in the property insured, or that the policy shall be received as proof of such interest, and every policy executed by way of gaming or wagering, is void

Section 17. The measure of an insurable interest in property is the extent to which the insured might be damnified by loss of injury thereof

The automatic assignment of the policy to CKS under the provision of the lease contract previously quoted is void for being contrary to law and/or public policy. The proceeds of the fire insurance policy thus rightfully belong to the spouses. The liability of the Cha spouses to CKS for violating their

lease contract in that Cha spouses obtained a fire insurance policy over their own merchandise, without the consent of CKS, is a separate and distinct issue which we do not resolve in this case.

- Malayan Insurance Company vs. PAP Co. (PHIL. BRANCH), G.R. No. 200784, August 07, 2013

MALAYAN INSURANCE COMPANY, INC., Petitioner -versus- PAP CO., LTD. (PHILIPPINE BRANCH), Respondent

G.R. No. 200784, August 7, 2013, J. Mendoza

An alteration in the use or condition of a thing insured from that to which it is limited by the policy made without the consent of the insurer, by means within the control of the insured, and increasing the risks, entitles an insurer to rescind a contract of fire insurance.

FACTS

On May 13, 1996, Malayan Insurance Company (Malayan) issued a Fire Insurance Policy to PAP Co., Ltd. (PAP Co.) for the latter's machineries and equipment located at Sanyo Precision Phils. Bldg., Phase III, Lot 4, Block 15, PEZA, Rosario, Cavite (Sanyo Building). The insurance, which was for Fifteen Million Pesos (₱15,000,000.00) and effective for a period of one (1) year, was procured by PAP Co. for Rizal Commercial Banking Corporation (RCBC), the mortgagee of the insured machineries and equipment.

After the passage of almost a year but prior to the expiration of the insurance coverage, PAP Co. renewed the policy on an "as is" basis. Pursuant thereto, a renewal policy was issued by Malayan to PAP Co. for the period May 13, 1997 to May 13, 1998.

On October 12, 1997 and during the subsistence of the renewal policy, the insured machineries and equipment were totally lost by fire. Hence, PAP Co. filed a fire insurance claim with Malayan in the amount insured.

In a letter, dated December 15, 1997, Malayan denied the claim upon the ground that, at the time of the loss, the insured machineries and equipment were transferred by PAP Co. to a location different from that indicated in the policy. Specifically, that the insured machineries were transferred in September 1996 from the Sanyo Building to the Pace Pacific Bldg., Lot 14, Block 14, Phase III, PEZA, Rosario, Cavite (Pace Pacific). Contesting the denial, PAP Co. argued that Malayan cannot avoid liability as it was informed of the transfer by RCBC, the party duty-bound to relay such information. However, Malayan reiterated its denial of PAP Co.'s claim. Distraught, PAP Co. filed the complaint below against Malayan.

ISSUE

Whether or not Malayan should be held liable under the fire insurance policy

RULING

NO. The Court agrees with the position of Malayan that it cannot be held liable for the loss of the insured properties under the fire insurance policy.

The policy forbade the removal of the insured properties unless sanctioned by Malayan

Condition No. 9(c) of the renewal policy provides:

9. Under any of the following circumstances the insurance ceases to attach as regards the property affected unless the insured, before the occurrence of any loss or damage, obtains the sanction of the company signified by endorsement upon the policy, by or on behalf of the Company:

x x x x x x x x x x x

(c) If property insured be removed to any building or place other than in that which is herein stated to be insured.

Evidently, by the clear and express condition in the renewal policy, the removal of the insured property to any building or place required the consent of Malayan. Any transfer effected by the insured, without the insurer's consent, would free the latter from any liability.

The transfer from the Sanyo Factory to the PACE Factory increased the risk. The Court agrees with Malayan that the transfer to the Pace Factory exposed the properties to a hazardous environment and negatively affected the fire rating stated in the renewal policy. The increase in tariff rate from 0.449% to 0.657% put the subject properties at a greater risk of loss. Such increase in risk would necessarily entail an increase in the premium payment on the fire policy. Unfortunately, PAP chose to remain completely silent on this very crucial point. Despite the importance of the issue, PAP failed to refute Malayan's argument on the increased risk.

Malayan is entitled to rescind the insurance contract. Considering that the original policy was renewed on an "as is basis," it follows that the renewal policy carried with it the same stipulations and limitations. The terms and conditions in the renewal policy provided, among others, that the location of the risk insured against is at the Sanyo factory in PEZA. The subject insured properties, however, were totally burned at the Pace Factory. Although it was also located in PEZA, Pace Factory was not the location stipulated in the renewal policy. There being an unconsented removal, the transfer was at PAP's own risk. Consequently, it must suffer the consequences of the fire.

It can also be said that with the transfer of the location of the subject properties, without notice and without Malayan's consent, after the renewal of the policy, PAP clearly committed concealment, misrepresentation and a breach of a material warranty. Section 26 of the Insurance Code provides:

Section 26. A neglect to communicate that which a party knows and ought to communicate, is called a concealment

and under Section 27 of the Insurance Code, "a concealment entitles the injured party to rescind a contract of insurance."

Moreover, under Section 168 of the Insurance Code, the insurer is entitled to rescind the insurance contract in case of an alteration in the use or condition of the thing insured. Section 168 of the Insurance Code provides, as follows:

Section 168. An alteration in the use or condition of a thing insured from that to which it is limited by the policy made without the consent of the insurer, by means within the control of the insured, and increasing the risks, entitles an insurer to rescind a contract of fire insurance.

Accordingly, an insurer can exercise its right to rescind an insurance contract when the following conditions are present, to wit:

- 1) The policy limits the use or condition of the thing insured;
- 2) There is an alteration in said use or condition;
- 3) The alteration is without the consent of the insurer;
- 4) The alteration is made by means within the insured's control; and
- 5) The alteration increases the risk of loss

In the case at bench, all these circumstances are present. It was clearly established that the renewal policy stipulated that the insured properties were located at the Sanyo factory; that PAP removed the properties without the consent of Malayan; and that the alteration of the location increased the risk of loss.

3. Double Insurance and Over Insurance

- Armando Geagonia vs. Court of Appeals, et al., G.R. No. 114427, February 6, 1995

ARMANDO GEAGONIA, *Petitioner*, -versus- COURT OF APPEALS and COUNTRY BANKERS INSURANCE CORPORATION, *Respondents*

G.R. No. 114427, February 6, 1995, Davide, Jr. J.

Condition 3 in the private respondent's policy No. F-14622 does not absolutely declare void any violation thereof. It expressly provides that the condition "shall not apply when the total insurance or insurances in force at the time of the loss or damage is not more than P200,000.00."

FACTS

Petitioner, as the owner of Norman's Mart, obtained insurance from private respondent CBIC. The insurance policy contained the following condition:

"3. The insured shall give notice to the Company of any insurance or insurances already effected, or which may subsequently be effected, covering any of the property or properties consisting of stocks in trade, goods in process and/or inventories only hereby insured, and unless such notice be given and the particulars of such insurance or insurances be stated therein or endorsed in this policy pursuant to Section 50 of the Insurance Code, by or on behalf of the Company before the occurrence of any loss or damage, all benefits under this policy shall be deemed forfeited, provided however, that this condition shall not apply when the total insurance or insurances in force at the time of the loss or damage is not more than P200,000.00."

The building subject of fire insurance was razed by fire. Consequently, Petitioner claimed before CBIC for the proceeds. CBIC refused alleging that Petitioner did not inform of a previous insurance obtained by its creditor Cebu Tesing Textiles over the same property and in violation of Condition 3.

ISSUE

Whether or not the policy is avoided by the fact that petitioner did not inform of its other insurance policies over the subject property.

RULING

NO. It must, however, be underscored that unlike the "other insurance" clauses involved in *General Insurance and Surety Corp. vs. Ng Hua* or in *Pioneer Insurance & Surety Corp. vs. Yap*, which read:

"The insured shall give notice to the company of any insurance or insurances already effected, or which may subsequently be effected covering any of the property hereby insured, and unless such notice be given and the particulars of such insurance or insurances be stated in or endorsed on this Policy by or on behalf of the Company before the occurrence of any loss or damage, all benefits under this Policy shall be forfeited," or in the 1930 case of *Santa Ana vs. Commercial Union Assurance Co.*²⁸ which provided *"that any outstanding insurance upon the whole or a portion of the objects thereby assured must be declared by the insured in writing and he must cause the company to add or insert it in the policy, without which such policy shall be null and void, and the insured will not be entitled to indemnity in case of loss,"* **Condition 3 in the private respondent's policy No. F-14622 does not absolutely declare void any violation thereof. It expressly provides that the condition "shall not apply when the total insurance or insurances in force at the time of the loss or damage is not more than P200,000.00."**

- *Malayan Insurance Co., Inc., vs. Philippine First Insurance Co., Inc. and Reputable Forwarder Services, Inc.*, G.R. No. 184300, July 11, 2012

MALAYAN INSURANCE, *Petitioner*, -versus- PHILIPPINES FIRST INSURANCE CO., *Respondent*
GR No. 184300, July 11, 2012, Reyes, J.

Section 5 is actually the other insurance clause (also called "additional insurance" and "double insurance"). In interpreting the "other insurance clause" in Geagonia, the Court ruled that the prohibition applies only in case of double insurance. The Court ruled that in order to constitute a violation of the clause, the other insurance must be upon the same subject matter, the same interest therein, and the same risk. Thus, even though the multiple insurance policies involved were all issued in the name of the same assured, over the same subject matter and covering the same risk, it was ruled that there was no violation of the "other insurance clause" since there was no double insurance.

FACTS

Reputable is the forwarder of Wyeth's goods. Under their contract, Reputable agreed to be liable for any cause whatsoever, including that due to theft or robbery and other *force majeure*.

Pursuant to their contract of carriage, Reputable insured Wyeth's goods with Malayan. Wyeth also has its own insurance policy from Philippines First Insurance Co., Inc. (Phil First).

During the life of these insurance policies, the truck carrying Wyeth's goods were hijacked. Thus, Phil-First paid Wyeth on its policy and sued Reputable and Malayan for reimbursement. It was established

that Reputable is a private carrier and that its agreement to be liable in the manner it assumed is valid.

Seeking to avoid liability, Malayan invoked Section 5 of its SR Policy which reads:

Section 5. INSURANCE WITH OTHER COMPANIES. The insurance does not cover any loss or damage to property which at the time of the happening of such loss or damage is insured by or would but for the existence of this policy, be insured by any Fire or Marine policy or policies except in respect of any excess beyond the amount which would have been payable under the Fire or Marine policy or policies had this insurance not been effected[.]

Malayan argued that inasmuch as there was already a marine policy issued by Philippines First securing the same subject matter against loss and that since the monetary coverage/value of the Marine Policy is more than enough to indemnify the hijacked cargo, Philippines First alone must bear the loss. In the alternative, it argues that its liability should be pro rata only based on Section 12 of its SR policy which reads:

12. OTHER INSURANCE CLAUSE. If at the time of any loss or damage happening to any property hereby insured, there be any other subsisting insurance or insurances, whether effected by the insured or by any other person or persons, covering the same property, the company shall not be liable to pay or contribute more than its ratable proportion of such loss or damage.

ISSUE

Whether or not Malayan's position is tenable?

RULING

NO. Section 5 is actually the other insurance clause (also called "additional insurance" and "double insurance"). In interpreting the "other insurance clause" in *Geagonia*, the Court ruled that the prohibition applies only in case of double insurance. The Court ruled that in order to constitute a violation of the clause, the other insurance must be upon the same subject matter, the same interest therein, and the same risk. Thus, even though the multiple insurance policies involved were all issued in the name of the same assured, over the same subject matter and covering the same risk, it was ruled that there was no violation of the "other insurance clause" since there was no double insurance.

Section 12 of the SR Policy, on the other hand, is the over insurance clause. More particularly, it covers the situation where there is over insurance due to double insurance. In such case, Section 15 provides that Malayan shall "not be liable to pay or contribute more than its ratable proportion of such loss or damage." This is in accord with the principle of contribution provided under Section 94(e) of the Insurance Code, which states that "where the insured is over insured by double insurance, each insurer is bound, as between himself and the other insurers, to contribute ratably to the loss in proportion to the amount for which he is liable under is contract." Clearly, both Sections 5 and 12 presuppose the existence of a double insurance.

4. Multiple or Several Interests on Same Property

- Armando Geagonia vs. Court of Appeals, et al., G.R. No. 114427, February 6, 1995

(See above)

- Great Pacific Life vs. Court of Appeals (316 SCRA 677 [1999])

**GREAT PACIFIC LIFE ASSURANCE CORP., *Petitioner*, -versus- COURT OF APPEALS AND
MEDARDA V. LEUTERIO, *Respondents*.**

G.R. No. 113899, October 13, 1999, Quisumbing, J.

Appellant insurance company had failed to establish that there was concealment made by the insured, hence, it cannot refuse payment of the claim." The fraudulent intent on the part of the insured must be established to entitle the insurer to rescind the contract. Misrepresentation as a defense of the insurer to avoid liability is an affirmative defense and the duty to establish such defense by satisfactory and convincing evidence rests upon the insurer.

FACTS

A contract of group life insurance was executed between petitioner Great Pacific and Development Bank Grepalife agreed to insure the lives of eligible housing loan mortgagors of DBP. Wilfredo Leuterio, a physician and a housing debtor of DBP, applied for membership in the group life insurance plan. In an application form, Dr. Leuterio answered questions concerning his health condition as follows:

- "7. Have you ever had, or consulted, a physician for a heart condition, high blood pressure, cancer, diabetes, lung, kidney or stomach disorder or any other physical impairment?
8. Are you now, to the best of your knowledge, in good health?"

Grepalife issued a coverage to the value of P86,200.00 pesos. Dr. Leuterio died due to "massive cerebral hemorrhage." DBP submitted a death claim to Grepalife. Grepalife denied the claim alleging that Dr. Leuterio was not physically healthy when he applied for an insurance coverage. Grepalife insisted that Dr. Leuterio did not disclose he had been suffering from hypertension, which caused his death. Allegedly, such non-disclosure constituted concealment that justified the denial of the claim.

ISSUES

Whether or not Grepalife is liable.

RULING

YES. The medical findings were not conclusive because Dr. Mejia did not conduct an autopsy on the body of the decedent. The medical certificate stated that hypertension was "the possible cause of death." Hence, the statement of the physician was properly considered by the trial court as hearsay. Contrary to appellant's allegations, there was no sufficient proof that the insured had suffered from hypertension. Aside from the statement of the insured's widow who was not even sure if the medicines taken by Dr. Leuterio were for hypertension, the appellant had not proven nor produced any witness who could attest to Dr. Leuterio's medical history.

Appellant insurance company had failed to establish that there was concealment made by the insured, hence, it cannot refuse payment of the claim." The fraudulent intent on the part of the

insured must be established to entitle the insurer to rescind the contract. Misrepresentation as a defense of the insurer to avoid liability is an affirmative defense and the duty to establish such defense by satisfactory and convincing evidence rests upon the insurer.

A life insurance policy is a valued policy. Unless the interest of a person insured is susceptible of exact pecuniary measurement, the measure of indemnity under a policy of insurance upon life or health is the sum fixed in the policy. The mortgagor paid the premium according to the coverage of his insurance.

In the event of the debtor's death before his indebtedness with the creditor shall have been fully paid, an amount to pay the outstanding indebtedness shall first be paid to the creditor.

DBP foreclosed one of the deceased person's lots to satisfy the mortgage. Hence, the insurance proceeds shall inure to the benefit of the heirs of the deceased person or his beneficiaries.

n. Perfection of the Contract of Insurance
6. Offer and Acceptance/Consensual

- People of the Philippines vs. Yip Wai Ming, G.R. No. 120959, November 14, 1996

PEOPLE OF THE PHILIPPINES, *Plaintiff-appellee*, -versus- YIP WAI MING, *Accused-appellant*
G.R. No. 120959, November 14, 1996, Melo, J.

The proof presented does not prove that the insurance was secured, nor was there a contract since there was no proof that the company (NZI Life) approved the proposal, no proof that any premiums were paid, and no proof when such was accomplished.

FACTS

Ming and Lam Po Chun came to Manila on vacation on 10 July 1993. The two were engaged to be married. Hardly a day passed when Chun was brutally beaten up and strangled to death in their hotel room. On the day of the killing (July 11), Ming was touring Manila with Filipino welcomers while Chun was left in the hotel room allegedly because she had a headache and was not feeling well enough to do the sights. A witness and evidence were presented which pointed out to Ming as the guilty party, sentencing him to imprisonment by the RTC. Prosecution also alleged that the victim insured herself and the accused was the beneficiary, thus, giving motive to the latter to kill the victim.

ISSUE

Whether or not the insurance was sufficient to convict the accused of murder

RULING

NO. The evidence presented by the Prosecution were not enough such that the accused must be acquitted of the crime. The Prosecution presented the "Proposal for Life Insurance" as proof, but the same was a mere Xerox copy and not the original first identified.

There was no signature indicating that the victim herself applied for the insurance. Although there appears a signature of "Apple Lam", the same is not the name of the victim and nobody insures

himself under a nickname. The proof presented does not prove that the insurance was secured, nor was there a contract since there was no proof that the company (NZI Life) approved the proposal, no proof that any premiums were paid, and no proof when such was accomplished.

Furthermore, the victim was working for National Insurance Company. Why then should she insure her life with the NZI Life? The alleged premiums were also much higher than the victim's monthly salary. Why should any insurance company approve insurance, the premiums of which the supposed insured obviously cannot afford to pay? It is usually the man who insures himself with the wife as the beneficiary instead of the other way around.

- Great Pacific Life Assurance Company vs. Hon. Court of Appeals, G.R. No. L-31845. April 30, 1979
(See above)
- a. **Delay in Acceptance**
- b. **Delivery of Policy**
- c. **Cancellation of policy**
 - Malayan Insurance Co., Inc. vs. Gregoria Cruz Arnaldo, in her capacity as the Insurance Commissioner, et al., G.R. No. L-67835, October 12, 1987

MALAYAN INSURANCE CO., INC. (MICO), *Petitioner*, -versus- GREGORIA CRUZ ARNALDO, in her capacity as the INSURANCE COMMISSIONER, and CORONACION PINCA, *Respondents*.

G.R. No. L-67835, October 12, 1987, Cruz, J.

A valid cancellation must, therefore, require concurrence of the following conditions:

- (1) There must be prior notice of cancellation to the insured;*
- (2) The notice must be based on the occurrence, after the effective date of the policy, of one or more of the grounds mentioned;*
- (3) The notice must be (a) in writing, (b) mailed, or delivered to the named insured, (c) at the address shown in the policy;*
- (4) It must state (a) which of the grounds mentioned in Section 64 is relied upon and (b) that upon written request of the insured, the insurer will furnish the facts on which the cancellation is based.*

FACTS

On June 7, 1981, the petitioner issued to the private respondent, Coronacion Pinca, Fire Insurance Policy on her property. On October 15, 1981, MICO allegedly cancelled the policy for nonpayment, of the premium and sent the corresponding notice to Pinca.

On December 24, 1981, payment of the premium for Pinca was received by Domingo Adora, agent of MICO. On January 15, 1982, Adora remitted this payment to MICO, together with other payments. On January 18, 1982, Pinca's property was completely burned. On February 5, 1982, Pinca's payment was returned by MICO to Adora on the ground that her policy had been cancelled earlier. But Adora refused to accept it.

In due time, Pinca made the requisite demands for payment, which MICO rejected. She then went to

the Insurance Commission. It is because she was ultimately sustained by the public respondent that the petitioner has come to us for relief.

ISSUE

Whether or not there was notice given by the insurer that the policy was cancelled?

RULING

NO.

SEC. 64. No policy of insurance other than life shall be cancelled by the insurer except upon prior notice thereof to the insured, and no notice of cancellation shall be effective unless it is based on the occurrence, after the effective date of the policy, of one or more of the following:

- (a) non-payment of premium;*
- (b) conviction of a crime arising out of acts increasing the hazard insured against;*
- (c) discovery of fraud or material misrepresentation;*
- (d) discovery of willful, or reckless acts or commissions increasing the hazard insured against;*
- (e) physical changes in the property insured which result in the property becoming uninsurable; or*
- (f) a determination by the Commissioner that the continuation of the policy would violate or would place the insurer in violation of this Code.*

As for the method of cancellation, Section 65 provides as follows:

SEC. 65. All notices of cancellation mentioned in the preceding section shall be in writing, mailed or delivered to the named insured at the address shown in the policy, and shall state (a) which of the grounds set forth in section sixty-four is relied upon and (b) that, upon written request of the named insured, the insurer will furnish the facts on which the cancellation is based.

A valid cancellation must, therefore, require concurrence of the following conditions:

- (1) There must be prior notice of cancellation to the insured;
- (2) The notice must be based on the occurrence, after the effective date of the policy, of one or more of the grounds mentioned;
- (3) The notice must be (a) in writing, (b) mailed, or delivered to the named insured, (c) at the address shown in the policy;
- (4) It must state (a) which of the grounds mentioned in Section 64 is relied upon and (b) that upon written request of the insured, the insurer will furnish the facts on which the cancellation is based.

MICO claims it cancelled the policy in question on October 15, 1981, for nonpayment of premium. To support this assertion, it presented one of its employees, who testified that "the original of the endorsement and credit memo"-presumably meaning the alleged cancellation- "were sent to the assured by mail through our mailing section." However, **there is no proof that the notice, assuming it complied with the other requisites mentioned above, was actually mailed to and received by Pinca. All MICO offers to show that the cancellation was communicated to the insured is its employee's testimony that the said cancellation was sent "by mail through our mailing**

section," without more.

The valuation fixed in fire insurance policy is conclusive in case of total loss in the absence of fraud, which is not shown here. Loss and its amount may be determined on the basis of such proof as may be offered by the insured, which need not be of such persuasiveness as is required in judicial proceedings.

If, as in this case, the insured files notice and preliminary proof of loss and the insurer fails to specify to the former all the defects thereof and without unnecessary delay, all objections to notice and proof of loss are deemed waived under Section 90 of the Insurance Code.

The certification issued by the Integrated National Police as to the extent of Pinca's loss should be considered sufficient. Notably, MICO submitted no evidence to the contrary nor did it even question the extent of the loss in its answer before the Insurance Commission. It is also worth observing that Pinca's property was not the only building burned in the fire that razed the commercial district of Laoang, Samar, on January 18, 1982. There is nothing in the Insurance Code that makes the participation of an adjuster in the assessment of the loss imperative or indispensable, as MICO suggests. Section 325, which it cites, simply speaks of the licensing and duties of adjusters.

We see in this case an obvious design to evade or at least delay the discharge of a just obligation through efforts bordering on bad faith if not plain duplicity. We note that the motion for reconsideration was filed on the fifteenth day from notice of the decision of the Insurance Commission and that there was a feeble attempt to show that the notice of denial of the said motion was not received on June 13, 1982, to further hinder the proceedings and justify the filing of the petition with this Court fourteen days after June 18, 1982. We also look askance at the alleged cancellation, of which the insured and MICO's agent himself had no knowledge, and the curious fact that although Pinca's payment was remitted to MICO by its agent on January 15, 1982, MICO sought to return it to Adora only on February 5, 1982, after it presumably had learned of the occurrence of the loss insured against on January 18, 1982. These circumstances make the motives of the petitioner highly suspect, to say the least, and cast serious doubts upon it.

7. Premium Payment

THE CAPITAL INSURANCE & SURETY CO., INC., Petitioner, -versus- PLASTIC ERA CO., INC., AND COURT OF APPEALS, Respondent.

G.R. No. L-22375, THIRD DIVISION, July 18, 1975, MARTIN, J.

Under this provision the mere delivery of a bill of exchange in payment of a debt does not immediately effect payment. It simply suspends the action arising from the original obligation in satisfaction of which it was delivered, until payment is accomplished either actually or presumptively. Tender of draft or check in order to effect payment that would extinguish the debtor's liability should be actually cashed. If the delivery of the check of Plastic Era to Capital Insurance were to be viewed in the light of the foregoing, no payment of the premium had been effected, for it is only when the check is cashed that it is said to effect payment.

FACTS

On December 17, 1960, petitioner Capital Insurance & Surety Co., Inc. (hereinafter referred to as Capital Insurance) delivered to the respondent Plastic Era Manufacturing Co., Inc., (hereinafter referred to as Plastic Era) its open Fire Policy No. 22760 wherein the former undertook to insure the latter's building, equipments, raw materials, products and accessories located at Sheridan Street, Mandaluyong, Rizal. The policy expressly provides that if the property insured would be destroyed or damaged by fire after the payment of the premiums, at anytime between the 15th day of December 1960 and one o'clock in the afternoon of the 15th day of December 1961, the insurance company shall make good all such loss or damage in an amount not exceeding P100,000.00. When the policy was delivered, Plastic Era failed to pay the corresponding insurance premium. However, through its duly authorized representative, it executed the following acknowledgment receipt:

This acknowledged receipt of Fire Policy) NO. 22760 Premium
x x x x x) (I promise to pay)
(P2,220.00) (has been paid)
THIRTY DAYS AFTER on effective date -----
(Date)

On January 8, 1961, in partial payment of the insurance premium, Plastic Era delivered to Capital Insurance, a check for the amount of P1,000.00 postdated January 16, 1961 payable to the order of the latter and drawn against the Bank of America. However, Capital Insurance tried to deposit the check only on February 20, 1961 and the same was dishonored by the bank for lack of funds. The records show that as of January 19, 1961 Plastic Era had a balance of P1,193.41 with the Bank of America.

On January 18, 1961 or two days after the insurance premium became due, at about 4:00 to 5:00 o'clock in the morning, the property insured by Plastic Era was destroyed by fire. In due time, the latter notified Capital Insurance of the loss of the insured property by fire and accordingly filed its claim for indemnity thru the Manila Adjustment Company.⁴ The loss and/or damage suffered by Plastic Era was estimated by the Manila Adjustment Company to be P283,875. However, according to the records the same property has been insured by Plastic Era with the Philamgen Insurance Company for P200,000.00.

In less than a month Plastic Era demanded from Capital Insurance the payment of the sum of P100,000.00 as indemnity for the loss of the insured property under Policy No. 22760 but the latter refused for the reason that, among others, Plastic Era failed to pay the insurance premium.

On August 25, 1961, Plastic Era filed its complaint against Capital Insurance for the recovery of the sum of P100,000.00 plus P25,000.00 for attorney's fees and P20,000.00 for additional expenses. Capital Insurance filed a counterclaim of P25,000.00 as and for attorney's fees.

ISSUE

Whether or no a contract of insurance has been duly perfected between the petitioner, Capital Insurance, and respondent Plastic Era? (YES)

RULING

In clear and unequivocal terms the insurance policy provides that it is only upon payment of the premiums by Plastic Era that Capital Insurance agrees to insure the properties of the former against loss or damage in an amount not exceeding P100,000.00.

The crux of the problem then is whether at the time the insurance policy was delivered to Plastic Era on December 17, 1960, the latter was able to pay the stipulated premium. It appears on record that on the day the insurance policy was delivered, Plastic Era did not pay the Capital Insurance, but instead executed an acknowledgment receipt of Policy No. 22760. In said receipt Plastic Era promised to pay the premium within thirty (30) days from the effectivity date of the policy on December 17, 1960 and Capital Insurance accepted it. What then is the effect of accepting such acknowledgment receipt from the Plastic Era? Did the Capital Insurance mean to agree to make good its undertaking under the policy if the premium could be paid on or before January 16, 1961? And what would be the effect of the delivery to Capital Insurance on January 8, 1961 of a postdated check (January 16, 1961) in the amount of P1,000.00, payable to the order of the latter? Could not this have been considered a valid payment of the insurance premium? Pursuant to Article 1249 of the New Civil Code:

The delivery of promissory notes payable to order, or bills of exchange or other mercantile documents shall produce the effect of payment only when they have been cashed, or when through the fault of the creditor they have been impaired.

In the meantime, the action derived from the original obligation shall be held in abeyance.

Under this provision the mere delivery of a bill of exchange in payment of a debt does not immediately effect payment. It simply suspends the action arising from the original obligation in satisfaction of which it was delivered, until payment is accomplished either actually or presumptively. Tender of draft or check in order to effect payment that would extinguish the debtor's liability should be actually cashed. If the delivery of the check of Plastic Era to Capital Insurance were to be viewed in the light of the foregoing, no payment of the premium had been effected, for it is only when the check is cashed that it is said to effect payment.

Significantly, in the case before Us the Capital Insurance accepted the promise of Plastic Era to pay the insurance premium within thirty (30) days from the effective date of policy. By so doing, it has implicitly agreed to modify the tenor of the insurance policy and in effect, waived the provision therein that it would only pay for the loss or damage in case the same occurs after the payment of the premium. Considering that the insurance policy is silent as to the mode of payment, Capital Insurance is deemed to have accepted the promissory note in payment of the premium. This rendered the policy immediately operative on the date it was delivered. The view taken in most cases in the United States:

... is that although one of conditions of an insurance policy is that "it shall not be valid or binding until the first premium is paid", if it is silent as to the mode of payment, promissory notes received by the company must be deemed to have been accepted in payment of the premium. In other words, a requirement for the payment of the first or initial premium in advance or actual cash may be waived by acceptance of a promissory note ...

Precisely, this was what actually happened when the Capital Insurance accepted the acknowledgment receipt of the Plastic Era promising to pay the insurance premium within thirty (30) days from December 17, 1960. Hence, when the damage or loss of the insured property occurred, the insurance policy was in full force and effect. The fact that the check issued by Plastic

Era in partial payment of the promissory note was later on dishonored did not in any way operate as a forfeiture of its rights under the policy, there being no express stipulation therein to that effect.

In the absence of express agreement or stipulation to that effect in the policy, the non-payment at maturity of a note given for and accepted as premium on a policy does not operate to forfeit the rights of the insured even though the note is given for an initial premium, nor does the fact that the collection of the note had been enjoined by the insured in any way affect the policy.

... If the check is accepted as payment of the premium even though it turns out to be worthless, there is payment which will prevent forfeiture.

By accepting its promise to pay the insurance premium within thirty (30) days from the effectivity date of the policy — December 17, 1960 Capital Insurance had in effect extended credit to Plastic Era. The payment of the premium on the insurance policy therefore became an independent obligation the non-fulfillment of which would entitle Capital Insurance to recover. It could just deduct the premium due and unpaid upon the satisfaction of the loss under the policy.¹⁰ It did not have the right to cancel the policy for nonpayment of the premium except by putting Plastic Era in default and giving it personal notice to that effect. This Capital Insurance failed to do.

... Where credit is given by an insurance company for the payment of the premium it has no right to cancel the policy for nonpayment except by putting the insured in default and giving him personal notice....

On the contrary Capital Insurance had accepted a check for P1,000.00 from Plastic Era in partial payment of the premium on the insurance policy. Although the check was due for payment on January 16, 1961 and Plastic Era had sufficient funds to cover it as of January 19, 1961, Capital Insurance decided to hold the same for thirty-five (35) days before presenting it for payment. Having held the check for such an unreasonable period of time, Capital Insurance was estopped from claiming a forfeiture of its policy for non-payment even if the check had been dishonored later.

Where the check is held for an unreasonable time before presenting it for payment, the insurer may be held estopped from claiming a forfeiture if the check is dishonored.

Finally, it is submitted by petitioner that:

We are here concerned with a case of reciprocal obligations, and respondent having failed to comply with its obligation to pay the insurance premium due on the policy within thirty days from December 17, 1960, petitioner was relieved of its obligation to pay anything under the policy, without the necessity of first instituting an action for rescission of the contract of insurance entered into by the parties.

But precisely in this case, Plastic Era has complied with its obligation to pay the insurance premium and therefore Capital Insurance is obliged to make good its undertaking to Plastic Era.

PHILIPPINE PHOENIX SURETY & INSURANCE COMPANY, *Petitioner*, -versus- WOODWORK, INC, *Respondent*.

G.R. No. L-25317, FIRST DIVISION, August 6, 1979, MELENCIO-HERRERA, J.

That “no contract of insurance issued by an insurance company is valid and binding unless and until the premium thereof has been paid, notwithstanding any agreement to the contrary.” Since the premium had not been paid, the policy must be deemed to have lapsed.

FACTS

Upon WOODWORKS's application, PHIL. PHOENIX issued in its favor a fire insurance policy whereby PHIL. PHOENIX insured WOODWORKS' building, machinery and equipment for a term of one year from against loss by fire. The premium and other charges amounted to P10,593.36. It is undisputed that WOODWORKS did not pay the premium stipulated in the Policy when it was issued nor at any time thereafter.

Before the expiration of the one-year term, PHIL. PHOENIX notified WOODWORKS of the cancellation of the Policy allegedly upon request of WOODWORKS. The latter has denied having made such a request. PHIL. PHOENIX credited WOODWORKS with the amount of P3,110.25 for the unexpired period of 94 days, and claimed the balance of P7,483.11 representing , earned premium. Thereafter, PHIL. PHOENIX demanded in writing for the payment of said amount. WOODWORKS disclaimed any liability contending, in essence, that it need not pay premium “because the Insurer did not stand liable for any indemnity during the period the premiums were not paid.” For this reason, PHIL. PHOENIX commenced action in the CFI of Manila. Judgment was rendered in PHIL. PHOENIX's favor . From this adverse Decision, WOODWORKS appealed to the Court of Appeals which certified the case to SC on a question of law.

ISSUE

Whether or not the insurer collect the earned premiums? (NO)

RULING

The Courts findings are buttressed by Section 77 of the Insurance Code (Presidential Decree No. 612, promulgated on December 18, 1974), which now provides that “no contract of insurance issued by an insurance company is valid and binding unless and until the premium thereof has been paid, notwithstanding any agreement to the contrary.”

Since the premium had not been paid, the policy must be deemed to have lapsed.

The non-payment of premiums does not merely suspend but put, an end to an insurance contract, since the time of the payment is peculiarly of the essence of the contract.

In fact, if the peril insured against had occurred, PHIL. PHOENIX, as insurer, would have had a valid defense against recovery under the Policy it had issued. Explicit in the Policy itself is PHIL. PHOENIX's agreement to indemnify WOODWORKS for loss by fire only “after payment of premium,” Compliance by the insured with the terms of the contract is a condition precedent to the right of recovery.

The burden is on an insured to keep a policy in force by the payment of premiums, rather than on the insurer to exert every effort to prevent the insured from allowing a policy to elapse through a failure to make premium payments. The continuance of the insurer's obligation is conditional upon the payment of premiums, so that no recovery can be had upon a lapsed policy, the contractual relation between the parties having ceased.

Moreover, “an insurer cannot treat a contract as valid for the purpose of collecting premiums and invalid for the purpose of indemnity.”

**PACIFIC TIMBER EXPORT CORPORATION, *Petitioner*, -versus- COURT OF APPEALS, ET
AL., *Respondent*.**

G.R. No. L-38613, FIRST DIVISION, February 25, 1982, DE CASTRO, *J.*

Delay in the presentation to an insurer of notice or proof of loss is waived if caused by any act of his or if he omits to take objection promptly and specifically upon that ground.

FACTS

March 19, 1963, the plaintiff secured temporary insurance from the defendant for its exportation of 1,250,000 board feet of Philippine Lauan and Apitong logs to be shipped from the Diapitan. Bay, Quezon Province to Okinawa and Tokyo, Japan. The defendant issued on said date Cover Note No. 1010, insuring the said cargo of the plaintiff "Subject to the Terms and Conditions of the WORKMEN'S INSURANCE COMPANY, INC. printed Marine Policy form as filed with and approved by the Office of the Insurance Commissioner.

The regular marine cargo policies were issued by the defendant in favor of the plaintiff on April 2, 1963. The two marine policies bore the numbers 53 HO 1032 and 53 HO 1033. Policy No. 53 HO 1033 was for 542 pieces of logs equivalent to 499,950 board feet. Policy No. 53 HO 1033 was for 853 pieces of logs equivalent to 695,548 board feet. The total cargo insured under the two marine policies accordingly consisted of 1,395 logs, or the equivalent of 1,195,498 bd. ft.

After the issuance of Cover Note No. 1010, but before the issuance of the two marine policies Nos. 53 HO 1032 and 53 HO 1033, some of the logs intended to be exported were lost during loading operations in the Diapitan Bay. The logs were to be loaded on the 'SS Woodlock' which docked about 500 meters from the shoreline of the Diapitan Bay. The logs were taken from the log pond of the plaintiff and from which they were towed in rafts to the vessel. At about 10:00 o'clock a. m. on March 29, 1963, while the logs were alongside the vessel, bad weather developed resulting in 75 pieces of logs which were rafted together to break loose from each other. 45 pieces of logs were salvaged, but 30 pieces were verified to have been lost or washed away as a result of the accident.

In a letter dated April 4, 1963, the plaintiff informed the defendant about the loss of 'appropriately 32 pieces of log's during loading of the 'SS Woodlock'. The said letter reads as follows:
April 4, 1963

Workmen's Insurance Company, Inc. Manila, Philippines

Gentlemen:

This has reference to Insurance Cover Note No. 1010 for shipment of 1,250,000 bd. ft. Philippine Lauan and Apitong Logs. We would like to inform you that we have received advance preliminary report from our Office in Diapitan, Quezon that we have lost approximately 32 pieces of logs during loading of the SS Woodlock.

We will send you an accurate report all the details including values as soon as same will be reported to us.

Thank you for your attention, we wish to remain.

Very respectfully yours,
PACIFIC TIMBER EXPORT CORPORATION
(Sgd.) EMMANUEL S. ATILANO Asst. General Manager.

Although dated April 4, 1963, the letter was received in the office of the defendant only on April 15, 1963, as shown by the stamp impression appearing on the left bottom corner of said letter. The plaintiff subsequently submitted a 'Claim Statement demanding payment of the loss under Policies Nos. 53 HO 1032 and 53 HO 1033, in the total amount of P19,286.79.

On July 17, 1963, the defendant requested the First Philippine Adjustment Corporation to inspect the loss and assess the damage. The adjustment company submitted its 'Report on August 23, 1963. In said report, the adjuster found that 'the loss of 30 pieces of logs is not covered by Policies Nos. 53 HO 1032 and 1033 inasmuch as said policies covered the actual number of logs loaded on board the 'SS Woodlock' However, the loss of 30 pieces of logs is within the 1,250,000 bd. ft. covered by Cover Note 1010 insured for \$70,000.00.

On September 14, 1963, the adjustment company submitted a computation of the defendant's probable liability on the loss sustained by the shipment, in the total amount of P11,042.04.

On January 13, 1964, the defendant wrote the plaintiff denying the latter's claim, on the ground they defendant's investigation revealed that the entire shipment of logs covered by the two marines policies No. 53 HO 1032 and 713 HO 1033 were received in good order at their point of destination. It was further stated that the said loss may be considered as covered under Cover Note No. 1010 because the said Note had become 'null and void by virtue of the issuance of Marine Policy Nos. 53 HO 1032 and 1033'. The denial of the claim by the defendant was brought by the plaintiff to the attention of the Insurance Commissioner by means of a letter dated March 21, 1964. In a reply letter dated March 30, 1964, Insurance Commissioner Francisco Y. Mandanas observed that 'it is only fair and equitable to indemnify the insured under Cover Note No. 1010', and advised early settlement of the said marine loss and salvage claim

On June 26, 1964, the defendant informed the Insurance Commissioner that, on advice of their attorneys, the claim of the plaintiff is being denied on the ground that the cover note is null and void for lack of valuable consideration

ISSUE

Whether or not the cover note is valid despite the absence of premium payment upon it? (YES)

RULING

Petitioner contends that the Cover Note was issued with a consideration when, by express stipulation, the cover note is made subject to the terms and conditions of the marine policies, and the payment of premiums is one of the terms of the policies. From this undisputed fact, We uphold

petitioner's submission that the Cover Note was not without consideration for which the respondent court held the Cover Note as null and void, and denied recovery therefrom. The fact that no separate premium was paid on the Cover Note before the loss insured against occurred, does not militate against the validity of petitioner's contention, for no such premium could have been paid, since by the nature of the Cover Note, it did not contain, as all Cover Notes do not contain particulars of the shipment that would serve as basis for the computation of the premiums. As a logical consequence, no separate premiums are intended or required to be paid on a Cover Note. This is a fact admitted by an official of respondent company, Juan Jose Camacho, in charge of issuing cover notes of the respondent company

At any rate, it is not disputed that petitioner paid in full all the premiums as called for by the statement issued by private respondent after the issuance of the two regular marine insurance policies, thereby leaving no account unpaid by petitioner due on the insurance coverage, which must be deemed to include the Cover Note. If the Note is to be treated as a separate policy instead of integrating it to the regular policies subsequently issued, the purpose and function of the Cover Note would be set at naught or rendered meaningless, for it is in a real sense a contract, not a mere application for insurance which is a mere offer.

It may be true that the marine insurance policies issued were for logs no longer including those which had been lost during loading operations. This had to be so because the risk insured against is not for loss during operations anymore, but for loss during transit, the logs having already been safely placed aboard. This would make no difference, however, insofar as the liability on the cover note is concerned, for the number or volume of logs lost can be determined independently as in fact it had been so ascertained at the instance of private respondent itself when it sent its own adjuster to investigate and assess the loss, after the issuance of the marine insurance policies.

The adjuster went as far as submitting his report to respondent, as well as its computation of respondent's liability on the insurance coverage. This coverage could not have been no other than what was stipulated in the Cover Note, for no loss or damage had to be assessed on the coverage arising from the marine insurance policies. For obvious reasons, it was not necessary to ask petitioner to pay premium on the Cover Note, for the loss insured against having already occurred, the more practical procedure is simply to deduct the premium from the amount due the petitioner on the Cover Note. The non-payment of premium on the Cover Note is, therefore, no cause for the petitioner to lose what is due it as if there had been payment of premium, for non-payment by it was not chargeable against its fault. Had all the logs been lost during the loading operations, but after the issuance of the Cover Note, liability on the note would have already arisen even before payment of premium. This is how the cover note as a "binder" should legally operate otherwise, it would serve no practical purpose in the realm of commerce, and is supported by the doctrine that where a policy is delivered without requiring payment of the premium, the presumption is that a credit was intended and policy is valid.

The defense of delay as raised by private respondent in resisting the claim cannot be sustained. The law requires this ground of delay to be promptly and specifically asserted when a claim on the insurance agreement is made. The undisputed facts show that instead of invoking the ground of delay in objecting to petitioner's claim of recovery on the cover note, it took steps clearly indicative that this particular ground for objection to the claim was never in its mind. The nature of this specific ground for resisting a claim places the insurer on duty to inquire when the loss took place, so that it could determine whether delay would be a valid ground upon which to object to a claim against it.

As already stated earlier, private respondent's reaction upon receipt of the notice of loss, which was on April 15, 1963, was to set in motion from July 1963 what would be necessary to determine the cause and extent of the loss, with a view to the payment thereof on the insurance agreement. Thus it sent its adjuster to investigate and assess the loss in July, 1963. The adjuster submitted his report on August 23, 1963 and its computation of respondent's liability on September 14, 1963. From April 1963 to July, 1963, enough time was available for private respondent to determine if petitioner was guilty of delay in communicating the loss to respondent company. In the proceedings that took place later in the Office of the Insurance Commissioner, private respondent should then have raised this ground of delay to avoid liability. It did not do so. It must be because it did not find any delay, as this Court fails to find a real and substantial sign thereof. But even on the assumption that there was delay, this Court is satisfied and convinced that as expressly provided by law, waiver can successfully be raised against private respondent. Thus Section 84 of the Insurance Act provides:

Section 84.—Delay in the presentation to an insurer of notice or proof of loss is waived if caused by any act of his or if he omits to take objection promptly and specifically upon that ground.

ARTURO VALENZUELA, ET AL, *Petitioner*, -versus- COURT OF APPEALS, BIENVENIDO M. ARAGON, ROBERT E. PARNELL, CARLOS K. CATOLICO and THE PHILIPPINE AMERICAN GENERAL INSURANCE COMPANY, INC., *Respondent*.

G.R. No. 83122, THIRD DIVISION, October 19, 1990, GUTIERREZ, JR., J.

Under Section 77 of the Insurance Code, the remedy for the non-payment of premiums is to put an end to and render the insurance policy not binding –

"Sec. 77 . . . [N]otwithstanding any agreement to the contrary, no policy or contract of insurance is valid and binding unless and until the premiums thereof have been paid except in the case of a life or industrial life policy whenever the grace period provision applies (P.D. 612, as amended otherwise known as the Insurance Code of 1974.

In Philippine Phoenix Surety and Insurance, Inc. v. Woodworks, Inc. we held that the non-payment of premium does not merely suspend but puts an end to an insurance contract since the time of the payment is peculiarly of the essence of the contract. And in Arce v. The Capital Insurance and Surety Co., Inc., we reiterated the rule that unless premium is paid, an insurance contract does not take effect.

FACTS

Petitioner Arturo P. Valenzuela (Valenzuela for short) is a General Agent of private respondent Philippine American General Insurance Company, Inc. (Philamgen for short) since 1965. As such, he was authorized to solicit and sell in behalf of Philamgen all kinds of non-life insurance, and in consideration of services rendered was entitled to receive the full agent's commission of 32.5% from Philamgen under the scheduled commission rates. From 1973 to 1975, Valenzuela solicited marine insurance from one of his clients, the Delta Motors, Inc. (Division of Electronics Airconditioning and Refrigeration) in the amount of P4.4 Million from which he was entitled to a commission of 32%. However, Valenzuela did not receive his full commission which amounted to P1.6 Million from the P4.4 Million insurance coverage of the Delta Motors. During the period 1976 to 1978, premium payments amounting to P1,946,886.00 were paid directly to Philamgen and Valenzuela's commission to which he is entitled amounted to P632,737.00.

In 1977, Philamgen started to become interested in and expressed its intent to share in the commission due Valenzuela on a fifty-fifty basis. Valenzuela refused.

On February 8, 1978 Philamgen and its President, Bienvenido M. Aragon insisted on the sharing of the commission with Valenzuela (Exhibit E). This was followed by another sharing proposal dated June 1, 1978. On June 16, 1978, Valenzuela firmly reiterated his objection to the proposals of respondents stating that: "It is with great reluctance that I have to decline upon request to signify my conformity to your alternative proposal regarding the payment of the commission due me. However, I have no choice for to do otherwise would be violative of the Agency Agreement executed between our goodselves."

Because of the refusal of Valenzuela, Philamgen and its officers, namely: Bienvenido Aragon, Carlos Catolico and Robert E. Parnell took drastic action against Valenzuela. They: (a) reversed the commission due him by not crediting in his account the commission earned from the Delta Motors, Inc. insurance (Exhibit "J" and "2"); (b) placed agency transactions on a cash-and-carry basis; (c) threatened the cancellation of policies issued by his agency (Exhibits "H" to "H-2"); and (d) started to leak out news that Valenzuela has a substantial account with Philamgen. All of these acts resulted in the decline of his business as insurance agent. Then on December 27, 1978, Philamgen terminated the General Agency Agreement of Valenzuela

ISSUE

Whether or not PHILAMGEN could continue to hold Valenzuela jointly and severally liable with the insured for unpaid premiums? (NO)

RULING

Under Section 77 of the Insurance Code, the remedy for the non-payment of premiums is to put an end to and render the insurance policy not binding –

"Sec. 77 . . . [N]otwithstanding any agreement to the contrary, no policy or contract of insurance is valid and binding unless and until the premiums thereof have been paid except in the case of a life or industrial life policy whenever the grace period provision applies (P.D. 612, as amended otherwise known as the Insurance Code of 1974.

In Philippine Phoenix Surety and Insurance, Inc. v. Woodworks, Inc. we held that the non-payment of premium does not merely suspend but puts an end to an insurance contract since the time of the payment is peculiarly of the essence of the contract. And in Arce v. The Capital Insurance and Surety Co., Inc., we reiterated the rule that unless premium is paid, an insurance contract does not take effect.

Thus:

"It is to be noted that Delgado (Capital Insurance & Surety Co., Inc. v. Delgado, 9 SCRA 177 [1963] was decided in the light of the Insurance Act before Sec. 72 was amended by the underscored portion. Supra. Prior to the Amendment, an insurance contract was effective even if the premium had not been paid so that an insurer was obligated to pay indemnity in case of loss and correlatively he had also the right to sue for payment of the premium. But the amendment to Sec. 72 has radically changed the legal regime in that unless the premium is paid there is no insurance."

In Philippine Phoenix Surety case, we held:

"Moreover, an insurer cannot treat a contract as valid for the purpose of collecting premiums and invalid for the purpose of indemnity.

"The foregoing findings are buttressed by Section 776 of the Insurance Code (Presidential Decree No. 612, promulgated on December 18, 1974), which now provides that no contract of Insurance by an insurance company is valid and binding unless and until the premium thereof has been paid, notwithstanding any agreement to the contrary"

Perforce, since admittedly the premiums have not been paid, the policies issued have lapsed. The insurance coverage did not go into effect or did not continue and the obligation of Philamgen as insurer ceased. Hence, for Philamgen which had no more liability under the lapsed and inexistent policies to demand, much less sue Valenzuela for the unpaid premiums would be the height of injustice and unfair dealing. In this instance, with the lapsing of the policies through the non-payment of premiums by the insured there were no more insurance contracts to speak of. As this Court held in the Philippine Phoenix Surety case, (supra) — "the non-payment of premiums does not merely suspend but puts an end to an insurance contract since the time of the payment is peculiarly of the essence of the contract."

The respondent appellate court also seriously erred in according undue reliance to the report of Banaria and Banaria and Company, auditors, that as of December 31, 1978, Valenzuela owed Philamgen P1,528,698.40. This audit report of Banaria was commissioned by Philamgen after Valenzuela was almost through with the presentation of his evidence. In essence, the Banaria report started with an unconfirmed and unaudited beginning balance of account of P1,758,185.43 as of August 20, 1976. But even with that unaudited and unconfirmed beginning balance of P1,758,185.43, Banaria still came up with the amount of P3,865.49 as Valenzuela's balance as of December 1978 with Philamge. In fact, as of December 31, 1976, and December 31, 1977, Valenzuela had no unpaid account with Philamgen. But even disregarding these annexes which are records of Philamgen and addressed to Valenzuela in due course of business, the facts show that as of July 1977, the beginning balance of Valenzuela's account with Philamgen amounted to P744,159.80. This was confirmed by Philamgen itself not only once but four (4) times on different occasions, as shown by the records.

On April 3, 1978, Philamgen sent Valenzuela a statement of account with a beginning balance of P744,159.80 as of July 1977. On May 23, 1978, another statement of account with exactly the same beginning balance was sent to Valenzuela. On November 17, 1978, Philamgen sent still another statement of account with P744,159.80 as the beginning balance. And on December 20, 1978, a statement of account with exactly the same figure was sent to Valenzuela.

It was only after the filing of the complaint that a radically different statement of accounts surfaced in court. Certainly, Philamgen's own statements made by its own accountants over a long period of time and covering examinations made on four different occasions must prevail over unconfirmed and unaudited statements made to support a position made in the course of defending against a lawsuit.

It is not correct to say that Valenzuela should have presented its own records to refute the unconfirmed and unaudited finding of the Banaria auditor. The records of Philamgen itself are the best refutation against figures made as an afterthought in the course of litigation. Moreover, Valenzuela asked for a meeting where the figures would be reconciled. Philamgen refused to meet with him and, instead, terminated the agency agreement

After off-setting the amount of P744,159.80, beginning balance as of July 1977, by way of credits representing the commission due from Delta and other accounts, Valenzuela had overpaid Philamgen the amount of P530,040.37 as of November 30, 1978. Philamgen cannot later be heard to complain that it committed a mistake in its computation. The alleged error may be given credence if committed only once. But as earlier stated, the reconciliation of accounts was arrived at four (4) times on different occasions where Philamgen was duly represented by its account executives. On the basis of these admissions and representations, Philamgen cannot later on assume a different posture and claim that it was mistaken in its representation with respect to the correct beginning balance as of July 1977 amounting to P744,159.80. The Banaria audit report commissioned by Philamgen is unreliable since its results are admittedly based on an unconfirmed and unaudited beginning balance of P1,758,185.43 as of August 20, 1976.

PHILIPPINE PRYCE ASSURANCE CORPORATION, *Petitioner*, -versus- COURT OF APPEALS, et al, *Respondent*.

G.R. No. 107062, SECOND DIVISION, February 21, 1994, NOCON, J.

The Insurance Code states that: "SECTION 177. The surety is entitled to payment of the premium as soon as the contract of suretyship or bond is perfected and delivered to the obligor. No contract of suretyship or bonding shall be valid and binding unless and until the premium therefor has been paid, except where the obligee has accepted the bond, in which case the bond becomes valid and enforceable irrespective of whether or not the premium has been paid by the obligor to the surety. . . ."

The above provision outrightly negates petitioner's first defense. In a desperate attempt to escape liability, petitioner further asserts that the above provision is not applicable because the respondent allegedly had not accepted the surety bond, hence could not have delivered the goods to Sagum Enterprises.

FACTS

Petitioner, Interworld Assurance Corporation (the company now carries the corporate name Philippine Pryce Assurance Corporation), was the butt of the complaint for collection of sum of money, filed on May 13, 1988 by respondent, Gegroco, Inc. before the Makati Regional Trial Court, Branch 138. The complaint alleged that petitioner issued two surety bonds (No. 0029, dated July 24, 1987 and No. 0037, dated October 7, 1987) in behalf of its principal Sagum General Merchandise for FIVE HUNDRED THOUSAND (P500,000.00) PESOS and ONE MILLION (1,000,000.00) PESOS, respectively.

On June 16, 1988, summons, together with the copy of the complaint, was served on petitioner. Within the reglementary period, two successive motions were filed by petitioner praying for a total of thirty (30) days extension within which to file a responsive pleading.

In its Answer, dated July 29, 1988, but filed only on August 4, 1988, petitioner admitted having executed the said bonds, but denied liability because allegedly 1) the checks which were to pay for the premiums bounced and were dishonored hence there is no contract to speak of between petitioner and its supposed principal; and 2) that the bonds were merely to guarantee payment of its principal's obligation, thus, excussion is necessary. After the issues had been joined, the case was set for pre-trial conference on September 29, 1988. The petitioner received its notice on September 9,

1988, while the notice addressed to its counsel was returned to the trial court with the notation "Return to Sender, Unclaimed."

On the scheduled date for pre-trial conference, only the counsel for petitioner appeared while both the representative of respondent and its counsel were present. The counsel for petitioner manifested that he was unable to contact the Vice-President for operations of petitioner, although his client intended to file a third party complaint against its principal. Hence, the pre-trial was re-set to October 14, 1988.

On October 14, 1988, petitioner filed a "Motion with Leave to Admit Third-Party Complaint" with the Third-Party Complaint attached. On this same day, in the presence of the representative for both petitioner and respondent and their respective counsel, the pre-trial conference was re-set to December 1, 1988. Meanwhile on November 29, 1988, the court admitted the Third Party Complaint and ordered service of summons on third party defendants.

On scheduled conference in December, petitioner and its counsel did not appear notwithstanding their notice in open court. 5 The pre-trial was nevertheless re-set to February 1, 1989. However, when the case was called for pre-trial conference on February 1, 1989, petitioner was again not represented by its officer or its counsel, despite being duly notified. Hence, upon motion of respondent, petitioner was considered as in default and respondent was allowed to present evidence ex-parte, which was calendared on February 24, 1989. Petitioner received a copy of the Order of Default and a copy of the Order setting the reception of respondent's evidence ex-parte, both dated February 1, 1989, on February 15, 1989.

ISSUE

Whether or not Interworld Assurance Corp. should be liable for the surety bond that it issued as payment for the premium (YES)

RULING

There is reason to believe that petitioner does not really have a good defense. Petitioner hinges its defense on two arguments, namely: a) that the checks issued by its principal which were supposed to pay for the premiums, bounced, hence there is no contract of surety to speak of; and 2) that as early as 1986 and covering the time of the Surety Bond, Interworld Assurance Company (now Phil. Pryce) was not yet authorized by the Insurance Commission to issue such bonds.

The Insurance Code states that:

"SECTION 177. The surety is entitled to payment of the premium as soon as the contract of suretyship or bond is perfected and delivered to the obligor. No contract of suretyship or bonding shall be valid and binding unless and until the premium therefor has been paid, except where the obligee has accepted the bond, in which case the bond becomes valid and enforceable irrespective of whether or not the premium has been paid by the obligor to the surety. . . ."

The above provision outrightly negates petitioner's first defense. In a desperate attempt to escape liability, petitioner further asserts that the above provision is not applicable because the respondent allegedly had not accepted the surety bond, hence could not have delivered the goods to Sagum Enterprises. This statement clearly intends to muddle the facts as found by the trial court and which are on record.

In the first place, *Petitioner*, in its answer, admitted to have issued the bonds subject matter of the original action. Secondly, the testimony of Mr. Leonardo T. Guzman, witness for the respondent, reveals the following:

"Q. What are the conditions and terms of sales you extended to Sagum General Merchandise?

A. First, we required him to submit to us Surety Bond to guaranty payment of the spare parts to be purchased. Then we sell to them on 90 days credit. Also, we required them to issue post-dated checks.

Q. Did Sagum General Merchandise comply with your surety bond requirement?

A. Yes. They submitted to us and which we have accepted two surety bonds.

Q Will you please present to us the aforesaid surety bonds?

A. Interworld Assurance Corp. Surety Bond No. 0029 for P500,000 dated July 24, 1987 and Interworld Assurance Corp. Surety Bond No. 0037 for P1,000,000 dated October 7, 1987." 20

Likewise attached to the record are exhibits C to C-18 21 consisting of delivery invoices addressed to Sagum General Merchandise proving that parts were purchased, delivered and received.

On the other hand, petitioner's defense that it did not have authority to issue a Surety Bond when it did is an admission of fraud committed against **Respondent**. No person can claim benefit from the wrong he himself committed. A representation made is rendered conclusive upon the person making it and cannot be denied or disproved as against the person relying thereon.

AMERICAN HOME ASSURANCE, *Petitioner*, -versus- ANTONIO CHUA, *Respondent*.
G.R. No. 130421, FIRST DIVISION, June 28, 1999, DAVIDE, JR., C.J.

The general rule in insurance laws is that unless the premium is paid the insurance policy is not valid and binding. The only exceptions are life and industrial life insurance. Whether payment was indeed made is a question of fact which is best determined by the trial court.

FACTS

Chua obtained from American Home a fire insurance covering the stock-in-trade of his business. The insurance was due to expire on March 25, 1990.

On April 5, 1990, Chua issued a check for P2,983.50 to American Home's agent, James Uy, as payment for the renewal of the policy. The official receipt was issued on April 10. In turn, the latter a renewal certificate. A new insurance policy was issued where petitioner undertook to indemnify respondent for any damage or loss arising from fire up to P200,000 March 20, 1990 to March 25, 1991.

On April 6, 1990, the business was completely razed by fire. Total loss was estimated between P4,000,000 and P5,000,000. Respondent filed an insurance claim with petitioner and four other co-

insurers, namely, Pioneer Insurance, Prudential Guarantee, Filipino Merchants and Domestic Insurance. Petitioner refused to honor the claim hence, the respondent filed an action in the trial court.

American Home claimed there was no existing contract because respondent did not pay the premium. Even with a contract, they contended that he was ineligible because of his fraudulent tax returns, his failure to establish the actual loss and his failure to notify petitioner of any insurance already effected. The trial court ruled in favor of respondent because the respondent paid by way of check a day before the fire occurred and that the other insurance companies promptly paid the claims. American homes was made to pay 750,000 in damages.

The Court of Appeals found that respondent's claim was substantially proved and petitioner's unjustified refusal to pay the claim entitled respondent to the award of damages.

American Home filed the petition reiterating its stand that there was no existing insurance contract between the parties. It invoked Section 77 of the Insurance Code, which provides that no policy or contract of insurance issued by an insurance company is valid and binding unless and until the premium thereof has been paid and the case of *Arce v. Capital Insurance* that until the premium is paid there is no insurance.

ISSUE

- 1) Whether or not there was a valid payment of premium, considering that respondent's check was cashed after the occurrence of the fire? (YES)
- 2) Whether respondent violated the policy by his submission of fraudulent documents and non-disclosure of the other existing insurance contracts? (NO)

RULING

The general rule in insurance laws is that unless the premium is paid the insurance policy is not valid and binding. The only exceptions are life and industrial life insurance. Whether payment was indeed made is a question of fact which is best determined by the trial court. The trial court found, as affirmed by the Court of Appeals, that there was a valid check payment by respondent to petitioner. Well-settled is the rule that the factual findings and conclusions of the trial court and the Court of Appeals are entitled to great weight and respect, and will not be disturbed on appeal in the absence of any clear showing that the trial court overlooked certain facts or circumstances which would substantially affect the disposition of the case. We see no reason to depart from this ruling.

According to the trial court the renewal certificate issued to respondent contained the acknowledgment that premium had been paid. It is not disputed that the check drawn by respondent in favor of petitioner and delivered to its agent was honored when presented and petitioner forthwith issued its official receipt to respondent on 10 April 1990. Section 306 of the Insurance Code provides that any insurance company which delivers a policy or contract of insurance to an insurance agent or insurance broker shall be deemed to have authorized such agent or broker to receive on its behalf payment of any premium which is due on such policy or contract of insurance at the time of its issuance or delivery or which becomes due thereon. In the instant case, the best evidence of such authority is the fact that petitioner accepted the check and issued the official receipt for the payment. It is, as well, bound by its agent's acknowledgment of receipt of payment.

Section 78 of the Insurance Code explicitly provides: An acknowledgment in a policy or contract of insurance of the receipt of premium is conclusive evidence of its payment, so far as to make the policy binding, notwithstanding any stipulation therein that it shall not be binding until the premium is actually paid. This Section establishes a legal fiction of payment and should be interpreted as an exception to Section 77.

Where the insurance policy specifies as a condition the disclosure of existing co-insurers, non-disclosure thereof is a violation that entitles the insurer to avoid the policy. This condition is common in fire insurance policies and is known as the “other insurance clause.” The purpose for the inclusion of this clause is to prevent an increase in the moral hazard. We have ruled on its validity and the case of *Geagonia v. Court of Appeals* clearly illustrates such principle. However, we see an exception in the instant case.

UCPB GENERAL INSURANCE CO. INC., *Petitioner,* -versus- **MASAGANA TELEMART, INC.,**
Respondent.

G.R. No. 137172, EN BANC, April 4, 2001, VITUG., J.

Section 77 does not restate the portion of Section 72 expressly permitting an agreement to extend the period to pay the premium. But there are exceptions to Section 77. The first exception is provided by Section 77 itself. The second is that covered by Section 78 of the Insurance Code. A third exception was laid down in Makati Tuscan Condominium Corporation vs. Court of Appeals, wherein we ruled that Section 77 may not apply if the parties have agreed to the payment in installments of the premium and partial payment has been made at the time of loss, not only that. In Tuscan, we also quoted with approval the following pronouncement of the Court of Appeals in its Resolution denying the motion for reconsideration of its decision: By the approval of the aforequoted findings and conclusion of the Court of Appeals, Tuscan has provided a fourth exception to Section 77, namely, that the insurer may grant credit extension for the payment of the premium.

FACTS

In our decision of 15 June 1999 in this case, we reversed and set aside the assailed decision[1] of the Court of Appeals, which affirmed with modification the judgment of the trial court (a) allowing Respondent to consign the sum of P225,753.95 as full payment of the premiums for the renewal of the five insurance policies on Respondent's properties; (b) declaring the replacement-renewal policies effective and binding from 22 May 1992 until 22 May 1993; and (c) ordering Petitioner to pay Respondent P18,645,000.00 as indemnity for the burned properties covered by the renewal-replacement policies. The modification consisted in the (1) deletion of the trial court's declaration that three of the policies were in force from August 1991 to August 1992; and (2) reduction of the award of the attorney's fees from 25% to 10% of the total amount due the Respondent. Masagana obtained from UCPB five (5) insurance policies on its Manila properties.

The policies were effective from May 22, 1991 to May 22, 1992. On June 13, 1992, Masagana's properties were razed by fire. On July 13, 1992, plaintiff tendered five checks for P225,753.45 as renewal premium payments. A receipt was issued. On July 14, 1992, Masagana made its formal demand for indemnification for the burned insured properties. UCPB then rejected Masagana's claims under the argument that the fire took place before the tender of payment. Hence Masagana filed this case.

The Court of Appeals disagreed with UCPB's argument that Masagana's tender of payment of the premiums on 13 July 1992 did not result in the renewal of the policies, having been made beyond the effective date of renewal as provided under Policy Condition No. 26, which states:

26. Renewal Clause. -- Unless the company at least forty five days in advance of the end of the policy period mails or delivers to the assured at the address shown in the policy notice of its intention not to renew the policy or to condition its renewal upon reduction of limits or elimination of coverages, the assured shall be entitled to renew the policy upon payment of the premium due on the effective date of renewal.

Both the Court of Appeals and the trial court found that sufficient proof exists that Masagana, which had procured insurance coverage from UCPB for a number of years, had been granted a 60 to 90-day credit term for the renewal of the policies. Such a practice had existed up to the time the claims were filed. Most of the premiums have been paid for more than 60 days after the issuance. Also, no timely notice of non-renewal was made by UCPB.

The Supreme Court ruled against UCPB in the first case on the issue of whether the fire insurance policies issued by petitioner to the respondent covering the period from May 22, 1991 to May 22, 1992 had been extended or renewed by an implied credit arrangement though actual payment of premium was tendered on a later date and after the occurrence of the risk insured against. UCPB filed a motion for reconsideration.

The Supreme Court, upon observing the facts, affirmed that there was no valid notice of non-renewal of the policies in question, as there is no proof at all that the notice sent by ordinary mail was received by Masagana. Also, the premiums were paid within the grace period.

ISSUE

Whether or not Section 77 of the Insurance Code of 1978 must be strictly applied to Petitioner's advantage despite its practice of granting a 60- to 90-day credit term for the payment of premiums?
(NO)

RULING

It can be seen at once that Section 77 does not restate the portion of Section 72 expressly permitting an agreement to extend the period to pay the premium. But are there exceptions to Section 77? The answer is in the affirmative. The first exception is provided by Section 77 itself, and that is, in case of a life or industrial life policy whenever the grace period provision applies. The second is that covered by Section 78 of the Insurance Code, which provides: SEC. 78. Any acknowledgment in a policy or contract of insurance of the receipt of premium is conclusive evidence of its payment, so far as to make the policy binding, notwithstanding any stipulation therein that it shall not be binding until premium is actually paid. A third exception was laid down in *Makati Tuscan Condominium Corporation vs. Court of Appeals*, wherein we ruled that Section 77 may not apply if the parties have agreed to the payment in installments of the premium and partial payment has been made at the time of loss, not only that. In *Tuscany*, we also quoted with approval the following pronouncement of the

Court of Appeals in its Resolution denying the motion for reconsideration of its decision: By the approval of the aforequoted findings and conclusion of the Court of Appeals, *Tuscany* has provided a fourth exception to Section 77, namely, that the insurer may grant credit extension for the payment of the premium. This simply means that if the insurer has granted the insured a credit term for the payment of the premium and loss occurs before the expiration of the term, recovery on the policy should be allowed even though the premium is paid after the loss but within the credit term.

Moreover, there is nothing in Section 77 which prohibits the parties in an insurance contract to provide a credit term within which to pay the premiums. That agreement is not against the law, morals, good customs, public order or public policy. The agreement binds the parties.

Finally in the instant case, it would be unjust and inequitable if recovery on the policy would not be permitted against Petitioner, which had consistently granted a 60- to 90-day credit term for the payment of premiums despite its full awareness of Section 77. Estoppel bars it from taking refuge under said Section, since Respondent relied in good faith on such practice. Estoppel then is the fifth exception to Section 77.

MAKATI TUSCANY CONDOMINIUM CORP., Petitioner, -versus- COURT OF APPEALS, Respondent.
G.R. No. 95546, FIRST DIVISION, November 6, 1992, BELLOSILLO J.

Such acceptance of payments speaks loudly of the insurer's intention to honor the policies it issued to petitioner. Certainly, basic principles of equity and fairness would not allow the insurer to continue collecting and accepting the premiums, although paid on installments, and later deny liability on the lame excuse that the premiums were not prepaid in full.

FACTS

Sometime in early 1982, private respondent American Home Assurance Co. (AHAC), represented by American International Underwriters (Phils.), Inc., issued in favor of petitioner Makati Tuscany Condominium Corporation (TUSCANY) Insurance Policy No. AH-CPP-9210452 on the latter's building and premises, for a period beginning 1 March 1982 and ending 1 March 1983, with a total premium of P466,103.05. The premium was paid on installments on 12 March 1982, 20 May 1982, 21 June 1982 and 16 November 1982, all of which were accepted by private respondent.

On 10 February 1983, private respondent issued to petitioner Insurance Policy No. AH-CPP-9210596, which replaced and renewed the previous policy, for a term covering 1 March 1983 to 1 March 1984. The premium in the amount of P466,103.05 was again paid on installments on 13 April 1983, 13 July 1983, 3 August 1983, 9 September 1983, and 21 November 1983. All payments were likewise accepted by private respondent.

On 20 January 1984, the policy was again renewed and private respondent issued to petitioner Insurance Policy No. AH-CPP-9210651 for the period 1 March 1984 to 1 March 1985. On this renewed policy, petitioner made two installment payments, both accepted by private respondent, the first on 6 February 1984 for P52,000.00 and the second, on 6 June 1984 for P100,000.00. Thereafter, petitioner refused to pay the balance of the premium.

Consequently, private respondent filed an action to recover the unpaid balance of P314,103.05 for Insurance Policy No. AH-CPP-9210651.

In its answer with counterclaim, petitioner admitted the issuance of Insurance Policy No. AH-CPP-9210651. It explained that it discontinued the payment of premiums because the policy did not contain a credit clause in its favor and the receipts for the installment payments covering the policy for 1984-85, as well as the two (2) previous policies, stated the following reservations:

2. Acceptance of this payment shall not waive any of the company rights to deny liability on any claim under the policy arising before such payments or after the expiration of the credit clause of the policy; and
3. Subject to no loss prior to premium payment. If there be any loss such is not covered.

Petitioner further claimed that the policy was never binding and valid, and no risk attached to the policy. It then pleaded a counterclaim for P152,000.00 for the premiums already paid for 1984-85, and in its answer with amended counterclaim, sought the refund of P924,206.10 representing the premium payments for 1982-85.

After some incidents, petitioner and private respondent moved for summary judgment. On 8 October 1987, the trial court dismissed the complaint and the counterclaim upon the following findings:

While it is true that the receipts issued to the defendant contained the aforementioned reservations, it is equally true that payment of the premiums of the three aforementioned policies (being sought to be refunded) were made during the lifetime or term of said policies, hence, it could not be said, inspite of the reservations, that no risk attached under the policies. Consequently, defendant's counterclaim for refund is not justified.

As regards the unpaid premiums on Insurance Policy No. AH-CPP-9210651, in view of the reservation in the receipts ordinarily issued by the plaintiff on premium payments the only plausible conclusion is that plaintiff has no right to demand their payment after the lapse of the term of said policy on March 1, 1985. Therefore, the defendant was justified in refusing to pay the same.

Both parties appealed from the judgment of the trial court. Thereafter, the Court of Appeals rendered a decision ²modifying that of the trial court by ordering herein petitioner to pay the balance of the premiums due on Policy No. AH-CPP-921-651, or P314,103.05 plus legal interest until fully paid, and affirming the denial of the counterclaim. The appellate court thus explained —

The obligation to pay premiums when due is ordinarily as indivisible obligation to pay the entire premium. Here, the parties herein agreed to make the premiums payable in installments, and there is no pretense that the parties never envisioned to make the insurance contract binding between them. It was renewed for two succeeding years, the second and third policies being a renewal/replacement for the previous one. And the insured never informed the insurer that it was terminating the policy because the terms were unacceptable.

While it may be true that under Section 77 of the Insurance Code, the parties may not agree to make the insurance contract valid and binding without payment of premiums, there is nothing in said section which suggests that the parties may not agree to allow payment of the premiums in installment, or to consider the contract as valid and binding upon payment of the first premium. Otherwise, we would allow the insurer to renege on its liability under the contract, had a loss incurred (*sic*) before completion of payment of the entire premium, despite its voluntary acceptance of partial payments, a result eschewed by a basic considerations of fairness and equity.

To our mind, the insurance contract became valid and binding upon payment of the first premium, and the plaintiff could not have denied liability on the ground that payment was not made in full, for the reason that it agreed to accept installment payment. . . .

Petitioner now asserts that its payment by installment of the premiums for the insurance policies for 1982, 1983 and 1984 invalidated said policies because of the provisions of Sec. 77 of the Insurance Code, as amended, and by the conditions stipulated by the insurer in its receipts, disclaiming liability for loss for occurring before payment of premiums.

It argues that where the premiums is not actually paid in full, the policy would only be effective if there is an acknowledgment in the policy of the receipt of premium pursuant to Sec. 78 of the Insurance Code. The absence of an express acknowledgment in the policies of such receipt of the corresponding premium payments, and petitioner's failure to pay said premiums on or before the effective dates of said policies rendered them invalid. Petitioner thus concludes that there cannot be a perfected contract of insurance upon mere partial payment of the premiums because under Sec. 77 of the Insurance Code, no contract of insurance is valid and binding unless the premium thereof has been paid, notwithstanding any agreement to the contrary. As a consequence, petitioner seeks a refund of all premium payments made on the alleged invalid insurance policies.

ISSUE

Whether or not payment by installment of the premiums due on an insurance policy invalidates the contract of insurance (NO)

RULING

We hold that the subject policies are valid even if the premiums were paid on installments. The records clearly show that petitioner and private respondent intended subject insurance policies to be binding and effective notwithstanding the staggered payment of the premiums. The initial insurance contract entered into in 1982 was renewed in 1983, then in 1984. In those three (3) years, the insurer accepted all the installment payments. Such acceptance of payments speaks loudly of the insurer's intention to honor the policies it issued to petitioner. Certainly, basic principles of equity and fairness would not allow the insurer to continue collecting and accepting the premiums, although paid on installments, and later deny liability on the lame excuse that the premiums were not prepaid in full.

It appearing from the peculiar circumstances that the parties actually intended to make the three (3) insurance contracts valid, effective and binding, petitioner may not be allowed to renege on its obligation to pay the balance of the premium after the expiration of the whole term of the third policy (No. AH-CPP-9210651) in March 1985. Moreover, as correctly observed by the appellate court, where the risk is entire and the contract is indivisible, the insured is not entitled to a refund of the premiums paid if the insurer was exposed to the risk insured for any period, however brief or momentary.

JOSE MARQUES AND MAXILITE TECHNOLOGIES, INC., *Petitioner*, -versus- **FAR EAST BANK AND TRUST COMPANY, ET AL.,** *Respondent*.

G.R. No. 171379, FIRST DIVISION, January 10, 2011, CARPIO, J.

Absent any showing of its illegitimate or illegal functions, a subsidiary's separate existence shall be respected, and the liability of the parent corporation as well as the subsidiary shall be confined to those arising in their respective business.

FACTS

Maxilite Technologies, Inc. (Maxilite) is a domestic corporation engaged in the importation and trading of equipment for energy-efficiency systems. Jose N. Marques (Marques) is the President and controlling stockholder of Maxilite.

Far East Bank and Trust Co. (FEBTC) is a local bank which handled the financing and related requirements of Marques and Maxilite. Marques and Maxilite maintained accounts with FEBTC. Accordingly, FEBTC financed Maxilite's capital and operational requirements through loans secured with properties of Marques under the latter's name.

Far East Bank Insurance Brokers, Inc. (FEBIBI) is a local insurance brokerage corporation while Makati Insurance Company is a local insurance company. Both companies are subsidiaries of FEBTC.

On 17 June 1993, Maxilite and Marques entered into a trust receipt transaction with FEBTC, in the sum of US\$80,765.00, for the shipment of various high-technology equipment from the United States, with the merchandise serving as collateral. The foregoing importation was covered by a trust receipt document signed by Marques on behalf of Maxilite.

Sometime in August 1993, FEBIBI, upon the advice of FEBTC, facilitated the procurement and processing from Makati Insurance Company of four separate and independent fire insurance policies over the trust receipted merchandise. Maxilite paid the premiums for these policies through debit arrangement. FEBTC would debit Maxilite's account for the premium payments, as reflected in statements of accounts sent by FEBTC to Maxilite.

On 19 August 1994, Insurance Policy No. 1024439, covering the period 24 June 1994 to 24 June 1995, was released to cover the trust receipted merchandise. The policy relevantly provides that the policy including any renewal thereof and/or any endorsement thereon is not in force until the premium has been fully paid to and duly receipted by the Company in the manner provided herein. Any supplementary agreement seeking to amend this condition prepared by agent, broker or Company official, shall be deemed invalid and of no effect.

Finding that Maxilite failed to pay the insurance premium in the sum of P8,265.60 for Insurance Policy No. 1024439 covering the period 24 June 1994 to 24 June 1995, FEBIBI sent written reminders to FEBTC, dated 19 October 1994, 24 January 1995, and 6 March 1995, to debit Maxilite's account.

On 24 and 26 October 1994, Maxilite fully settled its trust receipt account. On 9 March 1995, a fire gutted the Aboitiz Sea Transport Building along M.J. Cuenco Avenue, Cebu City, where Maxilite's office and warehouse were located. As a result, Maxilite suffered losses amounting to at least P2.1 million, which Maxilite claimed against the fire insurance policy with Makati Insurance Company. Makati Insurance Company denied the fire loss claim on the ground of non-payment of premium. FEBTC and FEBIBI disclaimed any responsibility for the denial of the claim.

Maxilite and Marques sued FEBTC, FEBIBI, and Makati Insurance Company. Maxilite prayed for (1) actual damages totaling P2.3 million representing full insurance coverage and "business opportunity

losses,” (2) moral damages, and (3) exemplary damages. On the other hand, Marques sought payment of actual, moral and exemplary damages, attorney’s fees, and litigation expenses. Maxilite and Marques also sought the issuance of a preliminary injunction or a temporary restraining to enjoin FEBTC from (1) imposing penalties on their obligations; (2) foreclosing the real estate mortgage securing their straight loan accounts; and (3) initiating actions to collect their obligations.

ISSUE

Whether or not FEBTC, FEBIBI and Makati Insurance Company are jointly and severally liable to pay respondents the full coverage of the subject insurance policy (NO)

RULING

Prior to the full settlement of the trust receipt account on 24 and 26 October 1994, FEBTC had insurable interest over the merchandise, and thus had greater reason to debit Maxilite’s account. Further, as found by the trial court, and apparently undisputed by FEBTC, FEBIBI and Makati Insurance Company, Maxilite had sufficient funds at the time the first reminder, dated 19 October 1994, was sent by FEBIBI to FEBTC to debit Maxilite’s account for the payment of the insurance premium. Since (1) FEBTC committed to debit Maxilite’s account corresponding to the insurance premium; (2) FEBTC had insurable interest over the property prior to the settlement of the trust receipt account; and (3) Maxilite’s bank account had sufficient funds to pay the insurance premium prior to the settlement of the trust receipt account, FEBTC should have debited Maxilite’s account as what it had repeatedly done, as an established practice, with respect to the previous insurance policies. However, FEBTC failed to debit and instead disregarded the written reminder from FEBIBI to debit Maxilite’s account. FEBTC’s conduct clearly constitutes negligence in handling Maxilite’s and Marques’ accounts. Negligence is defined as “the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or the doing of something which a prudent man and reasonable man could not do.” As a consequence of its negligence, FEBTC must be held liable for damages pursuant to Article 2176 of the Civil Code which states “whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done.” Indisputably, had the insurance premium been paid, through the automatic debit arrangement with FEBTC, Maxilite’s fire loss claim would have been approved. Hence, Maxilite suffered damage to the extent of the face value of the insurance policy or the sum of P2.1 million.

Contrary to Maxilite’s and Marques’ view, FEBTC is solely liable for the payment of the face value of the insurance policy and the monetary awards stated in the Court of Appeals’ decision. Suffice it to state that FEBTC, FEBIBI, and Makati Insurance Company are independent and separate juridical entities, even if FEBIBI and Makati Insurance Company are subsidiaries of FEBTC. Absent any showing of its illegitimate or illegal functions, a subsidiary’s separate existence shall be respected, and the liability of the parent corporation as well as the subsidiary shall be confined to those arising in their respective business. Besides, the records are bereft of any evidence warranting the piercing of corporate veil in order to treat FEBTC, FEBIBI, and Makati Insurance Company as a single entity. Likewise, there is no evidence showing FEBIBI’s and Makati Insurance Company’s negligence as regards the non-payment of the insurance premium.

The Court agrees with the Court of Appeals in reducing the interest rate from 12% to 6% as the obligation to pay does not arise from a loan or forbearance of money. In Eastern Shipping

Lines, Inc. v. Court of Appeals, 234 SCRA 78 (1994), the Court laid down the following guidelines for the application of the proper interest rates: I. When an obligation, regardless of its source, i.e., law, contracts, quasi-contracts, delicts or quasi-delicts is breached, the contravenor can be held liable for damages. The provisions under Title XVIII on “Damages” of the Civil Code govern in determining the measure of recoverable damages. II. With regard particularly to an award of interest in the concept of actual and compensatory damages, the rate of interest, as well as the accrual thereof, is imposed, as follows: 1. When the obligation is breached, and it consists in the payment of a sum of money, i.e., a loan or forbearance of money, the interest due should be that which may have been stipulated in writing. Furthermore, the interest due shall itself earn legal interest from the time it is judicially demanded. In the absence of stipulation, the rate of interest shall be 12% per annum to be computed from default, i.e., from judicial or extrajudicial demand under and subject to the provisions of Article 1169 of the Civil Code. 2. When an obligation, not constituting a loan or forbearance of money, is breached, an interest on the amount of damages awarded may be imposed at the discretion of the court at the rate of 6% per annum. No interest, however, shall be adjudged on unliquidated claims or damages except when or until the demand can be established with reasonable certainty. Accordingly, where the demand is established with reasonable certainty, the interest shall begin to run from the time the claim is made judicially or extrajudicially (Art. 1169, Civil Code) but when such certainty cannot be so reasonably established at the time the demand is made, the interest shall begin to run only from the date the judgment of the court is made (at which time the quantification of damages may be deemed to have been reasonably ascertained). The actual base for the computation of legal interest shall, in any case, be . . . the amount finally adjudged. 3. When the judgment of the court awarding a sum of money becomes final and executory, the rate of legal interest, whether the case falls under paragraph 1 or paragraph 2, above, shall be 12% per annum from such finality until its satisfaction, this interim period being deemed to be by then an equivalent to forbearance of credit.

PHILAM INSURANCE CO., INC., NOW CHARTIS PHILIPPINES INSURANCE, INC., *Petitioner,* -
versus- **PARC CHATEAU CONDOMINIUM UNIT OWNERS ASSOCIATION, INC., AND/OR**
EDUARDO B. COLET, *Respondent.*

G.R. No. 201116 , SECOND DIVISION, March 4, 2019, REYES, J. JR., J.

The Makati Tuscany case provides that if the insurer has granted the insured a credit term for the payment of the premium, it is an exception to the general rule that premium must first be paid before the effectivity of an insurance contract. Philam argues that the 90-day payment term is a credit extension and should be considered as an exception to the general rule. However, the CA correctly determined that the Jumbo Risk Provision clearly indicates that failure to pay in full any of the scheduled installments on or before the due date shall render the insurance policy void and ineffective as of 4 p.m. of such date.

FACTS

On October 7, 2003, petitioner Philam Insurance Co., Inc. (Philam) [now Chartis Philippines Insurance, Inc.] submitted a proposal to respondent Pare Chateau Condominium Unit Owners Association, Inc. (Pare Association) to cover fire and comprehensive general liability insurance of its condominium building, Pare Chateau Condominium. I Respondent Eduardo B. Colet (Colet), as Pare Association's president, informed Philam, through a letter dated November 24, 2003, that I Parc

Association's board of directors selected it, among various insurance companies, to provide the insurance requirements of the condominium. After Philam appraised the condominium, it issued

Fire and Lightning Insurance Policy No. 0601502995 for P900 million and Comprehensive General Liability Insurance Policy No. 0301003155 for P1 Million, both covering the period from November 30, 2003 to November 30, 2004. The parties negotiated for a 90-day payment term of the insurance premium, worth P791,427.50 including taxes. This payment term was embodied in a Jumbo Risk Provision, which further provided that the premium installment payments were due on November 30, 2003, December 30, 2003, and January 30, 2004. The Jumbo Risk Provision also stated that if any of the scheduled payments are not received in full on or before said dates, the insurance shall be deemed to have ceased at 4 p.m. of such date, and the policy shall automatically become void and ineffective.³ Pare Association's board of directors found the terms unacceptable and did not pursue the transaction. Pare Association verbally informed Philam, through its insurance agent, of the board's decision. Since no premiums were paid, Philam made oral and written demands upon Pare Association, who refused to do so alleging that the insurance agent had been informed of its decision not to take up the insurance coverage. Philam sent demand letters with statement of account claiming 1,363,215.21 unpaid premium based on Short Scale Rate Period. Philam also cancelled the policies.⁴ On June 3, 2005, Philam filed a complaint against Pare Association and Colet for recovery of 1,363,215.21 unpaid premium, plus attorney's fees and costs of suit in the Metropolitan Trial Court (Me TC) of Makati, Branch 65.

ISSUE

Whether or not the CA committed a reversible error in affirming the RTC decision and ruling that Philam has no right to recover the unpaid premium based on void and ineffective insurance policies? (NO)

RULING

Rule 45 of the Rules of Court, as amended, states that only questions of law shall be raised in a petition for review on certiorari. While the rule has exceptions, they are irrelevant in this case, as Philam did not properly plead and substantiate the applicability of the exceptions. Thus, the Court applies the general rule.

In resolving whether the CA was correct in affirming the RTC decision, the Court considered the following simplified alleged errors as presented by Philam:

1. Whether or not respondents' request for terms of payment of premium after the policies were issued and the grant of said request by petitioner constitute the parties' intention to be bound by the insurance contract;
2. Whether or not the fourth exception provided for under Section 77 of the Insurance Code of the Philippines applies in the instant case; and
3. Whether or not the negotiations which the parties had were with respect to the terms of payment of premium already agreed upon by the parties and not on the lowering of the amount of premium as to negate the existence of a perfected contract of insurance

The first and third alleged errors refer to the request for the terms of payment. Does Pare Association's request and Philam's subsequent grant of the request constitute their intention to be bound by the insurance contract? Does the negotiation refer to the terms of payment or to the lowering of the premium? In arriving at the answers to the questions, the Court has to determine the intention of the parties. In doing so, the Court has to read the transcript of stenographic notes of the witnesses, and review the language or tenor of some of the documentary evidence, such as: Philam's

proposal on October 7, 2003, Colet's acceptance letter dated November 24, 2003, the Jumbo Risk Provision, and the written communications between Philam and Pare Association

In short, the Court has to re-evaluate the evidence on record. Evaluation of evidence is an indication that the question or issue posed before the Court is a question of fact or a factual issue. In *Century Iron Works, Inc. v. Bifias*, the Court differentiated between question of law and question of fact. A question of law arises when there is doubt as to what the law is on a certain state of facts, while there is a question of fact when the doubt arises as to the truth or falsity of the alleged facts. For a question to be one of law, the question must not involve an examination of the probative value of the evidence presented by the litigants or any of them. The resolution of the issue must rest solely on what the law provides on the given set of circumstances. Once it is clear that the issue invites a review of the evidence presented, the question posed is one of fact.

Thus, the test of whether a question is one of law or of fact is not the appellation given to such question by the party raising the same; rather, it is whether the appellate court can determine the issue raised without reviewing or evaluating the evidence, in which case, it is a question of law; otherwise it is a question of fact. Applying the test to this case, it is without a doubt that the questions/issues presented before the Court are factual in nature, which are not proper subjects of a petition for review on certiorari under Rule 45 of the Rules of Court, as amended. It has been repeatedly pronounced that the Court is not a trier of facts. Evaluation of evidence is the function of the trial court.

As for the second alleged error, Philam avers that this case falls under the fourth exception as explained in the *Makati Tuscany* case. The *Makati Tuscany* case provides that if the insurer has granted the insured a credit term for the payment of the premium, it is an exception to the general rule that premium must first be paid before the effectivity of an insurance contract. Philam argues that the 90-day payment term is a credit extension and should be considered as an exception to the general rule. However, the CA correctly determined that the Jumbo Risk Provision clearly indicates that failure to pay in full any of the scheduled installments on or before the due date shall render the insurance policy void and ineffective as of 4 p.m. of such date. Pare Association's failure to pay on the first due date (November 30, 2003), resulted in a void and ineffective policy as of 4 p.m. of November 30, 2003. Hence, there is no credit extension to consider as the Jumbo Risk Provision itself expressly cuts off the inception of the insurance policy in case of default. The Court resolves to deny the petition after finding that the CA did not commit any reversible error in the assailed decision and resolution.

The CA had exhaustively explained the law and jurisprudence, which are the bases of its decision and resolution. Both trial courts and the appellate court are consistent in its findings of fact that there is no perfected insurance contract, because of the absence of one of the elements, that is, payment of premium. As a consequence, Philam cannot collect 1,363,215.21 unpaid premiums of void insurance policies.

4. Non-Default Options in Life Insurance

5. Reinstatement of a Lapsed Policy of Life Insurance

JAMES MCGUIRE, *Petitioner*, -versus- THE MANUFACTURERS LIFE INSURANCE CO., *Respondent*.
G.R. No. L-3581, EN BANC, September 21, 1950, OZAETA, J.

The stipulation in a life insurance policy giving' the insured the privilege to reinstate it upon written application within three years from the date it lapses and upon production of evidence of insurability satisfactory to the insurance company and the payment of all overdue premiums and any other indebtedness to the company, does not give the insured absolute right to such reinstatement by the mere filing of an application therefor.

FACTS

On August 18, 1932, the defendant issued an insurance policy on the life of Jaime McGuire for the sum of \$5,000, and an additional sum of \$5,000 as double indemnity accident benefit, payable to the plaintiff as beneficiary. The insured paid the premiums on said policy up to and including that due on July 19, 1940. On June 22, 1940, the insured secured from the defendant a loan of \$760 on said insurance policy. The insured failed to pay the loan with the interest thereon on January 1, 1941, when it became due, or on any other date thereafter. He likewise failed to pay the premiums which fell due on July 19, 1941, as well as those payable thereafter. Paragraphs 6, 7, and 8 of the stipulation of facts read as follows:

"(6) That upon the default of the insured to pay the premiums due on July 19, 1941, and subsequent ones, the defendant insurance company applied the stipulation contained in clause 8 (Automatic Premium Loan) of the provisions of the policy Exhibit A and said policy was carried on under said nonforfeiture clause of the policy up to and including March 1, 1942, the date said policy lapsed, as shown in the letter of the defendant company of January 17, 1946, to plaintiff, a copy of which is hereto attached, marked Exhibit B and is made a part hereof;

"(7) That the insured Jaime McGuire died on August 4, 1943, in a motorcycle accident at Borongan, Samar, Philippines;

"(8) That during the interim period between March 1, 1942, the date the policy lapsed, to August 4, 1943, the date of the death of the insured, the insured attempted to reinstate the policy under the stipulation contained in clause 3 of the 'Provisions' of the same but his attempts failed because of his inability to communicate with defendant's branch office at Manila due to the then existence of war and the occupation of the Philippines by enemy forces from January 1, 1942, to February, 1945."

Upon those facts the trial court rendered judgment in favor of the plaintiff, adjudging the defendant to pay to him the sum of P20,000, minus the premiums due and unpaid up to the date of the death of the insured, with legal interest thereon from the date of the filing of the complaint, and the costs.

The trial court considered erroneous paragraph 6 of the stipulation of facts above quoted to the effect that the policy in question lapsed on March 1, 1942, for failure to pay the premiums due thereafter on account of the war, the trial court being of the opinion that the war legally suspended the obligation of the insured to pay the premiums up to the time of the death of the insured, which occurred during said war, citing the decision of the Court of Appeals to that effect in *Gubagaras v. West Coast Life Insurance Company*, CA- G. R. No. 1628, January 6, 1949.

According to the complaint, plaintiff's theory is that, although the policy lapsed on March 1, 1942, the insured had the privilege of reinstating it so as to keep it in force up to the time of his death upon a written application within three years from the date of lapse and upon production of evidence of

insurability satisfactory to the company and the payment of all overdue premiums and any other indebtedness to the company, but that the insured was unable to exercise that privilege because of the war. Adopting another theory, the trial court held that it was unnecessary for the plaintiff to invoke the reinstatement clause of the policy because it had not lapsed inasmuch as the failure to pay the premiums was due to the war.

ISSUE

Whether or not the payment of premiums was legally suspended during the war? (NO)

RULINGS

The stipulation in a life insurance policy giving' the insured the privilege to reinstate it upon written application within three years from the date it lapses and upon production of evidence of insurability satisfactory to the insurance company and the payment of all overdue premiums and any other indebtedness to the company, does not give the insured absolute right to such reinstatement by the mere filing of an application therefor. The company has the right to deny the reinstatement if it is not satisfied as to the insurability of the insured and if the latter does not pay all overdue premiums and all other indebtedness to the company. After the death of the insured the insurance company cannot be compelled to entertain an application for reinstatement of the policy because the conditions precedent to reinstatement can no longer be determined and satisfied.

As held in *Lopez de Constantino vs. Asia Life Insurance Company*, and *Peralta vs. Asia Life Insurance Company*, G. R. Nos. L-1669 and L-1670, the payment of premiums on a life insurance policy is not suspended by war. The United States rule which declares that the contract of insurance is not merely suspended, but is abrogated by reason of nonpayment of premiums, since the time of the payments is peculiarly of the essence of the contract, is adopted in this jurisdiction.

RUFINO D. ANDRES, *Petitioner*, -versus- THE CROWN LIFE INSURANCE COMPANY, *Respondent*.
G.R. No. L-10874 , EN BANC, January 28, 1958, REYES, J.B.L, J.

The stipulation in a life insurance policy giving the insured the privilege to reinstate it upon written application does not give the insured absolute right to such reinstatement by the mere filing of an application. The insurer has the right to deny the reinstatement if it is not satisfied as to the insurability of the insured and if the latter does not pay all overdue premiums and all other indebtedness to the Company. After the death of the insured, the insurance Company cannot be compelled to entertain an application for reinstatement of the policy because the conditions precedent to reinstatement can no longer be determined and satisfied.

FACTS

On April 20, 1952, Rufino D. Andres filed a complaint in the Court of First Instance of Ilocos Norte against the Crown Life Insurance Company for the recovery of the amount of P5,000, as the face value of a joint 20-year endowment insurance policy issued in favor of the plaintiff Rufino D. Andres and his wife Severa G. Andres on the 13th of February, 1950, by said insurance company. On Jun 7, 1951,

Rufino Andres presented his death claim as survivor-beneficiary of the deceased Severa G. Andres, who died May 3, 1951. Payment having been denied by the insurance company on April 20, 1952, this case was instituted.

Defendant Company filed its answer in due time disclaiming liability and setting forth the special defense that the aforementioned policy had already lapsed. Later, on March 25, 1954, the parties submitted the case for decision by the lower court upon a stipulation of facts that on October 20, 1949, plaintiff and Severa G. Andres filed an application for insurance No. 536,423. Defendant issued Crown Life Policy No. 536,423 for the sum of P5,000, in the name of Rufino D. Andres, plaintiff, and Severa G. Andres; that the premiums are to be paid as called for in the policy, semi-annually, and the amount of P165.15 for the first semester beginning November 25, 1949 to May 25, 1950 was paid on November 25, 1949, and the premium likewise in the sum of P165.15 for the second semester beginning May 25, 1950 to November 25, 1950, was paid on June 24, 1950; and the premium for the third semester beginning November 25, 1950 to May 25, 1951 was not paid;

On January 6, 1951, the defendant, thru Mr. I.B. Melendres, wrote to Mr. and Mrs. Rufino D. Andres advising them that the said Policy No. 536,423 lapsed on December 25, 1950 and the amount overdue was P165.15, giving them a period of sixty (60) days from the date of lapse to file an application for reinstatement. On February 12, 1951, the said Mr. I.B. Melendres, branch secretary of the defendant, wrote Mr. and Mrs. Rufino D. Andres, telling the latter that Policy No. 536,423 was no longer in force and it lapsed on December 25, 1950.

In the month of February, 1951, plaintiff executed a Statement of Health which is at the same time an Application for Reinstatement of the aforesaid policy and Severa G. Andres also executed in the month of February, 1951, an Application for Reinstatement. On February 20, 1951, plaintiff wrote a letter to the defendant and enclosed therewith a money order for P100, which letter was received by the defendant on February 26, 1951, wherein it is stated that the balance unpaid is the sum of P65.15.

On April 14, 1951, the said Mr. I.B. Melendres, as branch secretary for the defendant, wrote plaintiff advising him that the Home Office has approved the reinstatement of the lapsed policy, subject to the payment of P65.15 due on November, 1950 premium. Said Mr. I.B. Melendres, branch secretary, again wrote the plaintiff requesting the remittance of the balance of P65.15 due on the semi-annual premium for November, 1950, and upon receipt of the said amount, there will be sent to him the Certificate of Reinstatement of the policy.

On May 5, 1951, plaintiff sent a letter to the defendant and enclosed therewith a Money Order in the amount of P65.00 for the balance due on the Crown Life Policy No. 536,423, which letter has been received in the office of the defendant on May 11, 1951.

On May 15, 1951, said Mr. I.B. Melendres wrote a letter to Mr. and Mrs. Rufino D. Andres, enclosing an Official Receipt for the receipt of P165.15, and also enclosed therewith a Certificate of Reinstatement dated April 2, 1951, and premium notice addressed to Mr. and Mrs. Rufino D. Andres, wherein it is shown that the semi-annual premium in the sum of P165.15 on the said policy would be due on May 15, 1951.

Plaintiff presented his Death Claim as survivor-beneficiary of the deceased Severa G. Andres which has been received in the office of the defendant on June 11, 1951, and there were therein enclosed in the said letter an affidavit dated June 6, 1951 of the plaintiff, and a Certificate of Death dated May 29,

1951, issued by the Local Civil Registrar of the municipality of Sarrat, wherein it is shown that Mrs. Severa G. Andres died on May 3, 1951 of dystocia, second degree, contracted pelvis, and a medical certificate of Dr. R. de la Cuesta, senior resident physician of the Ilocos Norte Provincial Hospital, dated May 20, 1951, showing the cause of death of the said deceased, Mrs. Severa G. Andres.

On June 30, 1951, Mr. I.B. Melendres wrote to plaintiff stating defendant's reasons for its refusal to pay the death claim of the plaintiff, in which there was therein enclosed a Death Claim Discharge to be signed by the plaintiff but the plaintiff refused to sign. Mr. I.B. Melendres wrote plaintiff enclosing therewith a National City Bank of New York Check No. D-115356 for P165.00 payable to plaintiff, dated June 21, 1951.

The plaintiff wrote defendant company and enclosed therewith the aforesaid National City Bank of New York Check No. D-115356 dated June 21, 1951, and the check returned to the defendant company.

On August 5, 1954, Judge Julio Villamor rendered decision absolving the defendant from any liability on the ground that the policy having lapsed, it was not reinstated at the time the plaintiff's wife died. Not satisfied with the decision, plaintiff appealed to the Court of Appeals, but the appeal was later certified to this Court, for there is no question of fact involved therein.

ISSUE

Whether or not there is a perfected contract of reinstatement after the policy lapsed due to non-payment of premiums? (NO)

RULING

The subsequent reinstatement of the policy was provided for in the contract itself in the following terms:

If this policy lapses, it may be reinstated upon application made within three years from the date of lapse, and upon production of evidence of the good health of the injured (and also of the Beneficiary, if the rate of premium depends upon the age of the Beneficiary), and such other evidence of insurability at the date of application for reinstatement as would then satisfy the Company to issue a new Policy on the same terms as this Policy, and upon payment of all overdue premiums and other indebtedness in respect of this Policy, together with interest at six per cent, compounded annually, and provided also that no change has taken place in such good health and insurability subsequent to the date of such application and before this Policy is reinstated.

As stated by the lower court, the conditions set forth in the policy for reinstatement are the following: (a) application shall be made within three years from the date of lapse; (b) there should be a production of evidence of the good health of the insured; (c) if the rate of premium depends upon the age of the Beneficiary, there should likewise be a production of evidence of his or her good health; (d) there should be presented such other evidence of insurability at the date of application for reinstatement; (e) there should be no change which has taken place in such good health and insurability subsequent to the date of such application and before the policy is reinstated; and (f) all overdue premiums and other indebtedness in respect of the policy, together with interest at six per cent, compounded annually, should first be paid.

The plaintiff-appellant did not comply with the last condition; for he only paid P100 (on account of the over due semi-annual premium of P165.15) on February 20, 1951, before his wife's death; and, despite the Company's reminders on April 14 and 27, he remitted the balance of P65 on May 5, 1951 (received by the Company's agency on May 11), two days after his wife died. On the face of such facts, the Company had the right to treat the contract as lapsed and refuse payment of the policy.

The stipulation in a life insurance policy giving the insured the privilege to reinstate it upon written application does not give the insured absolute right to such reinstatement by the mere filing of an application. The insurer has the right to deny the reinstatement if it is not satisfied as to the insurability of the insured and if the latter does not pay all overdue premiums and all other indebtedness to the Company. After the death of the insured, the insurance Company cannot be compelled to entertain an application for reinstatement of the policy because the conditions precedent to reinstatement can no longer be determined and satisfied.

6. Refund of Premiums

GREAT PACIFIC LIFE INSURANCE CORPORATION, *Petitioner*, -versus- COURT OF APPEALS AND TEODORO CORTEZ, *Respondent*.

G.R. No. L-57308, FIRST DIVISION, April 23, 1990, GRIÑO-AQUINO, J.

Petitioner should have informed Cortez of the deadline for paying the first premium before or at least upon delivery of the policy to him, so he could have complied with what was needful and would not have been misled into believing that his life and his family were protected by the policy, when actually they were not. And, if the premium paid by Cortez was unacceptable for being late, it was the company's duty to return it. By accepting his premiums without giving him the corresponding protection, the company acted in bad faith.

FACTS

Private respondent Teodoro Cortez, upon the solicitation of Margarita Siega, an underwriter for the petitioner Great Pacific Insurance Corporation, applied for a 20-year endowment policy for P30,000. His application, with the requisite medical examination, was accepted and approved by the company and in due course, Endowment Policy No. 221944 was issued in his name. It was released for delivery on January 24, 1973, and was actually delivered to him by the underwriter, Mrs. Siega, on January 25, 1973. The effective date indicated on the face of the policy in question was December 25, 1972. The annual premium was P1,416.60. Mrs. Siega assured him that the first premium may be paid within the grace period of thirty (30) days from date of delivery of the policy. The first premium of P1,416.60 was paid by him in three (3) installments, to wit:chanrob1es virtual 1aw library

(1) P400 evidenced by Temporary Receipt No. 19422 , dated February 5, 1973 issued by Mrs. Siega and confirmed by Official Receipt No. 43543 dated March 6, 1973, issued by the Home Office of the defendant in Makati, Rizal

(2) P350 evidenced by Temporary Receipt No. 19448 dated February 17, 1973 issued by Mrs. Siega and confirmed by Official Receipt No. 43559 dated March 28, 1973 issued by defendant's Home Office and

(3) P666.60 evidenced by Temporary Receipt No. 19702 dated February 21, 1973, issued by the underwriter Mrs. Siega, and confirmed by Official Receipt No. 43563 dated March 28, 1973 issued by defendant's Home Office.

In a letter dated June 1, 1973 (Exh. E), defendant advised plaintiff that Policy No. 221944 (Exh. A) was not in force. To make it enforceable and operative, plaintiff was asked to remit the balance of P1,015.60 to complete his initial annual premium due December 15, 1972, and to see Dr. Felipe V. Remollo for another full medical examination at his own expense.

Cortez' reaction to the company's act was to immediately inform it that he was cancelling the policy and he demanded the return of his premium plus damages.

When the company ignored his demand, Cortez filed on August 14, 1973, a complaint for damages in the Court of First Instance of Negros Oriental, docketed as Civil Case No. 5709, entitled "Teodoro Cortez v. Pacific Life Assurance Corporation." He prayed for the refund of the insurance premium of P1,416.60 which he paid, plus P45,000 as moral damages, and P2,000 as attorney's fees

ISSUE

Whether or not Cortez is entitled to a refund of his premium? (YES)

RULING

When the petitioner advised private respondent on June 1, 1973, four months after he had paid the first premium, that his policy had never been in force, and that he must pay another premium and undergo another medical examination to make the policy effective, the petitioner committed a serious breach of the contract of insurance. Petitioner should have informed Cortez of the deadline for paying the first premium before or at least upon delivery of the policy to him, so he could have complied with what was needful and would not have been misled into believing that his life and his family were protected by the policy, when actually they were not. And, if the premium paid by Cortez was unacceptable for being late, it was the company's duty to return it. By accepting his premiums without giving him the corresponding protection, the company acted in bad faith.

Sections 79, 81 and 82 of P.D. 612 of the Insurance Code of 1978 provide when the insured is entitled to the return of premium paid.

"SECTION 79. A person insured is entitled to a return of premium, as follows:

"(a) To the whole premium, if no part of his interest in the thing insured be exposed to any of the perils insured against.

"(b) Where the insurance is made for a definite period of time and the insured surrenders his policy, to such portion of the premium as corresponds with the unexpired time, at a pro rata rate, unless a short period rate has been agreed upon and appears on the face of the policy, after deducting from the whole premium any claim for loss or damage under the policy which has previously accrued:

Provided, That no holder of a life insurance policy may avail himself of the privileges of this paragraph without sufficient causes as otherwise provided by law."

"SECTION 81. A person insured is entitled to a return of the premium when the contract is voidable on account of the fraud or misrepresentation of the insurer or of his agent or on account of facts the existence of which the insured was ignorant without his fault; or when, by any default of the insured other than actual fraud, the insurer never incurred any liability under the policy." Library

"SECTION 82. In case of an over-insurance by several insurers, the insured is entitled to a ratable return of the premium, proportioned to the amount by which the aggregate sum insured in all the policies exceeds the insurable value of the thing at risk."

Since his policy was in fact inoperative or ineffectual from the beginning, the company was never at risk, hence, it is not entitled to keep the premium.

o. Rescission of Insurance Contracts

1. Concealment

GREAT PACIFIC LIFE ASSURANCE COMPANY, *Petitioner*, -versus- **COURT OF APPEALS**,
Respondent.

G.R. No. L-31845, FIRST DIVISION, April 30, 1979, DE CASTRO, J.

A binding deposit receipt which is merely conditional does not insure outright. Thus, where an agreement is made between the applicant and the agent, no liability will attach until the principal approves the risk and a receipt is given by the agent. The acceptance is merely conditional, and is subordinated to the act of the company in approving or rejecting the application.

A contract of insurance, like other contracts, must be assented to by both parties either in person or by their agents. The contract, to be binding from the date of the application, must have been a completed contract, one that leaves nothing to be done, nothing to be completed, nothing to be passed upon, or determined, before it shall take effect. There can be no contract of insurance unless the minds of the parties have met in agreement.

FACTS

Ngo Hing filed an application with the Great Pacific for a twenty-year endowment policy in the amount of P50,000.00 on the life of his one-year old daughter Helen. He supplied the essential data which petitioner Mondragon, the Branch Manager, wrote on the form. The latter paid the annual premium the sum of P1,077.75 going over to the Company, but he retained the amount of P1,317.00 as his commission for being a duly authorized agent of Pacific Life.

Upon the payment of the insurance premium, the binding deposit receipt was issued Ngo Hing. Likewise, petitioner Mondragon handwrote at the bottom of the back page of the application form his strong recommendation for the approval of the insurance application. Then Mondragon received a letter from Pacific Life disapproving the insurance application. The letter stated that the said life insurance application for 20-year endowment plan is not available for minors below seven years old,

but Pacific Life can consider the same under the Juvenile Triple Action Plan, and advised that if the offer is acceptable, the Juvenile Non-Medical Declaration be sent to the company.

The non-acceptance of the insurance plan by Pacific Life was allegedly not communicated by petitioner Mondragon to private respondent Ngo Hing. Instead, on May 6, 1957, Mondragon wrote back Pacific Life again strongly recommending the approval of the 20-year endowment insurance plan to children, pointing out that since the customers were asking for such coverage.

Helen Go died of influenza. Ngo Hing sought the payment of the proceeds of the insurance, but having failed in his effort, he filed the action for the recovery before the Court of First Instance of Cebu, which ruled against him

ISSUE

- 1) Whether or not the binding deposit receipt constituted a temporary contract of the life insurance in question? (NO)
- 2) Whether or not Ngo Hing concealed the state of health and physical condition of Helen Go, which rendered void the policy? (YES)

RULING

Where the binding deposit receipt is intended to be merely a provisional or temporary insurance contract, and that the receipt merely acknowledged, on behalf of the insurance company, that the latter's branch office had received from the applicant the insurance premium and had accepted the application subject for processing by the insurance company, such binding deposit receipt does not become in force until the application is approved.

A binding deposit receipt which is merely conditional does not insure outright. Thus, where an agreement is made between the applicant and the agent, no liability will attach until the principal approves the risk and a receipt is given by the agent. The acceptance is merely conditional, and is subordinated to the act of the company in approving or rejecting the application.

A contract of insurance, like other contracts, must be assented to by both parties either in person or by their agents. The contract, to be binding from the date of the application, must have been a completed contract, one that leaves nothing to be done, nothing to be completed, nothing to be passed upon, or determined, before it shall take effect. There can be no contract of insurance unless the minds of the parties have met in agreement.

The failure of the insurance company's agent to communicate to the applicant the rejection of the insurance application would not have any adverse effect on the allegedly perfected temporary contract. In the first place, there was no contract perfected between the parties who had no meeting of their minds. Private respondent, being an authorized agent is indubitably aware that said company does not offer the life insurance applied for. When he filed the insurance application in dispute he was therefore only taking a chance that the company will approve the recommendation of the agent for the acceptance and approval of the application in question. Secondly, having an insurable interest on the life of his daughter, aside from being an insurance agent and office associate of the branch, the applicant must have known and followed the progress on the processing of such application and could not pretend ignorance of the Company's rejection of the 20-year endowment life insurance application.

The contract of insurance is one of perfect good faith (uberrima fides meaning good faith; absolute and perfect candor or openness and honesty; the absence of any concealment or deception, however slight, not for the insured alone but equally so for the insurer. Concealment is a neglect to communicate that which a party knows and ought to communicate. Whether intentional or unintentional, the concealment entitles the insurer to rescind the contract of insurance.

The failure of the father who applied for a life insurance policy on the life of his daughter to divulge the fact that his daughter is a mongoloid, a congenital physical defect that could never be disguised, constitutes such concealment as to render the policy void. And where the applicant himself is an insurance agent, he ought to know, as he surely must have known, his duty and responsibility to supply such a material fact, and his failure to divulge such significant fact is deemed to have been done in bad faith.

NG GAN ZEE, Petitioner, -versus- COURT OF APPEALS, AND TEODORO CORTEZ, Respondent.
G.R. No. L-30685, SECOND DIVISION, May 30, 1983, ESCOLIN, J.

Sec. 27 of the Insurance Law, abovequoted, nevertheless requires that fraudulent intent on the part of the insured be established to entitle the insurer to rescind the contract. And as correctly observed by the lower court, "misrepresentation as a defense of the insurer to avoid liability is an 'affirmative' defense. The duty to establish such a defense by satisfactory and convincing evidence rests upon the defendant. The evidence before the Court does not clearly and satisfactorily establish that defense."

FACTS

Kwong Nam applied for a 20-year endowment insurance on his life for the sum of P20,000.00, with his wife, appellee Ng Gan Zee as beneficiary. On the same date, Asian Crusader, upon receipt of the required premium from the insured, approved the application and issued the corresponding policy. Kwong Nam died of cancer of the liver with metastasis. All premiums had been paid at the time of his death.

Ng Gan Zee presented a claim for payment of the face value of the policy. On the same date, she submitted the required proof of death of the insured. Appellant denied the claim on the ground that the answers given by the insured to the questions in his application for life insurance were untrue.

Appellee brought the matter to the attention of the Insurance Commissioner. The latter, after conducting an investigation, wrote the appellant that he had found no material concealment on the part of the insured and that, therefore, appellee should be paid the full face value of the policy. The company refused to settle its obligation.

Appellant alleged that the insured was guilty of misrepresentation when he answered "No" to the following question appearing in the application for life insurance

Has any life insurance company ever refused your application for insurance or for reinstatement of a lapsed policy or offered you a policy different from that applied for? If, so, name company and date. The lower court ruled against the company on lack of evidence.

Appellant further maintains that when the insured was examined in connection with his application for life insurance, he gave the appellant's medical examiner false and misleading information as to his ailment and previous operation. The company contended that he was operated on for peptic ulcer 2 years before the policy was applied for and that he never disclosed such an operation.

ISSUE

Whether or not Asian Crusader was deceived into entering the contract or in accepting the risk at the rate of premium agreed upon because of insured's representation? (NO)

RULING

Thus, "concealment exists where the assured had knowledge of a fact material to the risk, and honesty, good faith, and fair dealing requires that he should communicate it to the assurer, but he designedly and intentionally withholds the same." It has also been held "that the concealment must, in the absence of inquiries, be not only material, but fraudulent, or the fact must have been intentionally withheld."

Sec. 27 of the Insurance Law, abovequoted, nevertheless requires that fraudulent intent on the part of the insured be established to entitle the insurer to rescind the contract. And as correctly observed by the lower court, "misrepresentation as a defense of the insurer to avoid liability is an 'affirmative' defense. The duty to establish such a defense by satisfactory and convincing evidence rests upon the defendant. The evidence before the Court does not clearly and satisfactorily establish that defense."

It bears emphasis that Kwong Nam had informed the appellant's medical examiner that the tumor for which he was operated on was "associated with ulcer of the stomach." In the absence of evidence that the insured had sufficient medical knowledge as to enable him to distinguish between "peptic ulcer" and "a tumor", his statement that said tumor was "associated with ulcer of the stomach," should be construed as an expression made in good faith of his belief as to the nature of his ailment and operation. Indeed, such statement must be presumed to have been made by him without knowledge of its incorrectness and without any deliberate intent on his part to mislead the appellant.

Where, "upon the face of the application, a question appears to be not answered at all or to be imperfectly answered, and the insurers issue a policy without any further inquiry, they waive the imperfection of the answer and render the omission to answer more fully immaterial. As aptly noted by the lower court, "if the ailment and operation of Kwong Nam had such an important bearing on the question of whether the defendant would undertake the insurance or not, the court cannot understand why the defendant or its medical examiner did not make any further inquiries on such matters from the Chinese General Hospital or require copies of the hospital records from the appellant before acting on the application for insurance. The fact of the matter is that the defendant was too eager to accept the application and receive the insured's premium. It would be inequitable now to allow the defendant to avoid liability under the circumstances."

NEW LIFE ENTERPRISES AND JULIAN SY, *Petitioner*, -versus- COURT OF APPEALS, ET AL.
Respondent.

G.R. No. 94071, SECOND DIVISION, March 31, 1992, REGALADO, J.

While it is a cardinal principle of insurance law that a policy or contract of insurance is to be construed liberally in favor of the insured and strictly against the insurer company, yet contracts of insurance, like other contracts, are to be construed according to the sense and meaning of the terms which the parties themselves have used. If such terms are clear and unambiguous, they must be taken and understood in their plain, ordinary and popular sense. Moreover, obligations arising from contracts have the force of law between the contracting parties and should be complied with in good faith.

FACTS

Julian Sy and Jose Sy Bang have formed a business partnership in the City of Lucena. Under the business name of New Life Enterprises, the partnership engaged in the sale of construction materials at its place of business, a two storey building situated at Iyam, Lucena City. The facts show that Julian Sy insured the stocks in trade of New Life Enterprises with Western Guaranty Corporation, Reliance Surety and Insurance Co., Inc., and Equitable Insurance Corporation.

On May 15, 1981, Western Guaranty Corporation issued Fire Insurance Policy No. 37201 in the amount of P350,000.00. This policy was renewed on May, 13, 1982.

On July 30, 1981, Reliance Surety and Insurance Co., Inc. issued Fire Insurance Policy No. 69135 in the amount of P300,000.00 (Renewed under Renewal Certificate No. 41997) An additional insurance was issued by the same company on November 12, 1981 under Fire Insurance Policy No. 71547 in the amount of P700,000.00.

On February 8, 1982, Equitable Insurance Corporation issued Fire Insurance Policy No. 39328 in the amount of P200,000.00.

Thus when the building occupied by the New Life Enterprises was gutted by fire at about 2:00 o'clock in the morning of October 19, 1982, the stocks in the trade inside said building were insured against fire in the total amount of P1,550,000.00. According to the certification issued by the Headquarters, Philippine Constabulary / Integrated National Police, Camp Crame, the cause of fire was electrical in nature. According to the plaintiffs, the building and the stocks inside were burned. After the fire, Julian Sy went to the agent of Reliance Insurance whom he asked to accompany him to the office of the company so that he can file his claim. He averred that in support of his claim, he submitted the fire clearance, the insurance policies and inventory of stocks. He further testified that the three insurance companies are sister companies, and as a matter of fact when he was following-up his claim with Equitable Insurance, the Claims Manager told him to go first to Reliance Insurance and if said company agrees to pay, they would also pay. The same treatment was given him by the other insurance companies. Ultimately, the three insurance companies denied plaintiffs' claim for payment.

In its letter of denial dated March 9, 1983, Western Guaranty Corporation through Claims Manager Bernard S. Razon told the plaintiff that his claim "is denied for breach of policy conditions." Reliance Insurance purveyed the same message in its letter dated November 23, 1982 and signed by Executive Vice-President Mary Dee Co which said that "plaintiff's claim is denied for breach of policy conditions." The letter of denial received by the plaintiff from Equitable Insurance Corporation was of the same tenor, as said letter dated February 22, 1983, and signed by Vice-President Elma R. Bondad, said "we find that certain policy conditions were violated, therefore, we regret, we have to deny your claim, as it is hereby denied in its entirety."

In relation to the case against Reliance Surety and Insurance Company, a certain Atty. Serafin D. Dator, acting in behalf of the plaintiff, sent a letter dated February 13, 1983 to Executive Vice-President Mary Dee Co asking that he be informed as to the specific policy conditions allegedly violated by the plaintiff. In her reply-letter dated March 30, 1983, Executive Vice-President Mary Dee Co informed Atty. Dator that Julian Sy violated Policy Condition No. "3" which requires the insured to give notice of any insurance or insurances already effected covering the stocks in trade.

Because of the denial of their claims for payment by the three (3) insurance companies, petitioner filed separate civil actions against the former before the Regional Trial Court of Lucena City.

ISSUE

Whether or not Conditions 3 and 27 of the Insurance Contracts were violated by petitioners thereby resulting in their forfeiture of all the benefits thereunder? (YES)

RULING

The terms of the contract are clear and unambiguous. The insured is specifically required to disclose to the insurer any other insurance and its particulars which he may have effected on the same subject matter. The knowledge of such insurance by the insurer's agents, even assuming the acquisition thereof by the former, is not the "notice" that would estop the insurers from denying the claim. Besides, the so-called theory of imputed knowledge, that is, knowledge of the agent is knowledge of the principal, aside from being of dubious applicability here has likewise been roundly refuted by respondent court whose factual findings we find acceptable.

Furthermore, when the words and language of documents are clear and plain or readily understandable by an ordinary reader thereof, there is absolutely no room for interpretation or construction anymore. Courts are not allowed to make contracts for the parties; rather, they will intervene only when the terms of the policy are ambiguous, equivocal, or uncertain. The parties must abide by the terms of the contract because such terms constitute the measure of the insurer's liability and compliance therewith is a condition precedent to the insured's right of recovery from the insurer.

While it is a cardinal principle of insurance law that a policy or contract of insurance is to be construed liberally in favor of the insured and strictly against the insurer company, yet contracts of insurance, like other contracts, are to be construed according to the sense and meaning of the terms which the parties themselves have used. If such terms are clear and unambiguous, they must be taken and understood in their plain, ordinary and popular sense. Moreover, obligations arising from contracts have the force of law between the contracting parties and should be complied with in good faith.

Petitioners should be aware of the fact that a party is not relieved of the duty to exercise the ordinary care and prudence that would be exacted in relation to other contracts. The conformity of the insured to the terms of the policy is implied from his failure to express any disagreement with what is provided for.

SUNLIFE ASSURANCE COMPANY OF CANADA, *Petitioner*, -versus- COURT OF APPEALS, ET AL.

Respondent.

G.R. No. 105135, FIRST DIVISION, June 22, 1995, QUIASON, J.

Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom communication is due, in forming his estimate of the disadvantages of the proposed contract or in making his inquiries (The Insurance Code, Sec. 31). The terms of the contract are clear. The insured is specifically required to disclose to the insurer matters relating to his health. The information which the insured failed to disclose were material and relevant to the approval and issuance of the insurance policy.

FACTS

Robert John B. Bacani procured a life insurance contract for himself from Sunlife. He was issued a policy for P100,000.00, with double indemnity in case of accidental death. The designated beneficiary was his mother, Bernarda Bacani.

The insured died in a plane crash. Respondent Bernarda Bacani filed a claim with petitioner, seeking the benefits of the insurance policy taken by her son. Petitioner conducted an investigation and its findings prompted it to reject the claim.

Sunlife informed Bacani that the insured did not disclose material facts relevant to the issuance of the policy, thus rendering the contract of insurance voidable. A check representing the total premiums paid in the amount of P10,172.00 was attached to said letter.

Petitioner claimed that the insured gave false statements in his application. The deceased answered claimed that he consulted a Dr. Raymundo of the Chinese General Hospital for cough and flu complications. The other questions were answered in the negative.

Petitioner discovered that two weeks prior to his application for insurance, the insured was examined and confined at the Lung Center of the Philippines, where he was diagnosed for renal failure. During his confinement, the deceased was subjected to urinalysis tests.

Bernarda Bacani and her husband filed an action for specific performance against petitioner with the RTC. The court ruled in favor of the spouses and ordered Sunlife to pay P100,000.00.

In ruling for private respondents, the trial court concluded that the facts concealed by the insured were made in good faith and under a belief that they need not be disclosed. The court also held that the medial history was irrelevant because it wasn't medical insurance.

The Court of Appeals affirmed the decision of the trial court. The appellate court ruled that petitioner cannot avoid its obligation by claiming concealment because the cause of death was unrelated to the facts concealed by the insured. Petitioner's motion for reconsideration was denied. Hence, this petition.

ISSUE

Whether or not the insured was guilty of misrepresentation which made the contract void? (YES)

RULING

Section 26 of The Insurance Code is explicit in requiring a party to a contract of insurance to communicate to the other, in good faith, all facts within his knowledge which are material to the contract and as to which he makes no warranty, and which the other has no means of ascertaining. Said Section provides: "A neglect to communicate that which a party knows and ought to communicate. is called concealment."

Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom communication is due, in forming his estimate of the disadvantages of the proposed contract or in making his inquiries (The Insurance Code, Sec. 31). The terms of the contract are clear. The insured is specifically required to disclose to the insurer matters relating to his health. The information which the insured failed to disclose were material and relevant to the approval and issuance of the insurance policy. The matters concealed would have definitely affected petitioner's action on his application, either by approving it with the corresponding adjustment for a higher premium or rejecting the same. Moreover, a disclosure may have warranted a medical examination of the insured by petitioner in order for it to reasonably assess the risk involved in accepting the application. In *Vda. de Canilang v. Court of Appeals*, 223 SCRA 443 (1993), we held that materiality of the information withheld does not depend on the state of mind of the insured. Neither does it depend on the actual or physical events which ensue. Thus, "good faith" is no defense in concealment. The insured's failure to disclose the fact that he was hospitalized for two weeks prior to filing his application for insurance, raises grave doubts about his bonafides. It appears that such concealment was deliberate on his part.

The argument, that petitioner's waiver of the medical examination of the insured debunks the materiality of the facts concealed, is untenable. We reiterate our ruling in *Saturnino v. Philippine American Life Insurance Company*, 7 SCRA 316 (1963), that "x x x the waiver of a medical examination [in a non-medical insurance contract renders even more material the information required of the applicant concerning previous condition of health and diseases suffered, for such information necessarily constitutes an important factor which the insurer takes into consideration in deciding whether to issue the policy or not." Moreover, such argument of private respondents would make Section 27 of the Insurance Code, which allows the injured party to rescind a contract of insurance where there is concealment, ineffective

Anent the finding that the facts concealed had no bearing to the cause of death of the insured, it is well settled that the insured need not die of the disease he had failed to disclose to the insurer. It is sufficient that his non-disclosure misled the insurer in forming his estimates of the risks of the proposed insurance policy or in making inquiries.

SUNLIFE ASSURANCE COMPANY OF CANADA, Petitioner, -versus- COURT OF APPEALS, ET AL.
Respondent.

G.R. No. 105135, FIRST DIVISION, June 22, 1995, QUIASON, J.

The concealment of the fact of the operation itself is fraudulent, as there could not have been any mistake about it, no matter what the ailment.

In this jurisdiction, a concealment, whether intentional or unintentional, entitles the insurer to rescind the contract of insurance, concealment being defined as "negligence to communicate that which a party knows and ought to communicate" (Sections 24 and 26, Act No. 2427).

FACTS

Plaintiffs, now appellants, filed this action in the Court of First Instance of Manila to recover the sum of P5,000.00, corresponding to the face value of an insurance policy issued by defendant on the life of Estefania A. Saturnino, and the sum of P1,500.00 as attorney's fees. Defendant, now appellee, set up special defenses in its answer, with a counterclaim for damages allegedly sustained as a result of the unwarranted presentation of this case. Both the complaint and the counterclaim were dismissed by the trial court; but appellants were declared entitled to the return of the premium already paid; plus interest at 6% up to January 8, 1959, when a check for the corresponding amount — P359.65 — was sent to them by appellee.

The policy sued upon is one for 20-year endowment non-medical insurance. This kind of policy dispenses with the medical examination of the applicant usually required in ordinary life policies. However, detailed information is called for in the application concerning the applicant's health and medical history. The written application in this case was submitted by Saturnino to appellee on November 16, 1957, witnessed by appellee's agent Edward A. Santos. The policy was issued on the same day, upon payment of the first year's premium of P339.25. On September 19, 1958 Saturnino died of pneumonia, secondary to influenza. Appellants here, who are her surviving husband and minor child, respectively, demanded payment of the face value of the policy. The claim was rejected and this suit was subsequently instituted.

It appears that two months prior to the issuance of the policy or on September 9, 1957, Saturnino was operated on for cancer, involving complete removal of the right breast, including the pectoral muscles and the glands found in the right armpit. She stayed in the hospital for a period of eight days, after which she was discharged, although according to the surgeon who operated on her she could not be considered definitely cured, her ailment being of the malignant type.

Notwithstanding the fact of her operation Estefania A. Saturnino did not make a disclosure thereof in her application for insurance. On the contrary, she stated therein that she did not have, nor had she ever had, among other ailments listed in the application, cancer or other tumors; that she had not consulted any physician, undergone any operation or suffered any injury within the preceding five years; and that she had never been treated for nor did she ever have any illness or disease peculiar to her sex, particularly of the breast, ovaries, uterus, and menstrual disorders. The application also recites that the foregoing declarations constituted "a further basis for the issuance of the policy."

ISSUE

Whether or not the insured made such false representations of material facts as to avoid the policy? (YES)

RULING

Are the facts then falsely represented material? The Insurance Law (Section 30) provides that "materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the proposed contract, or in making his inquiries." It seems to be the contention of appellants that the facts subject of the representation were not material in view of the "non-medical" nature of the insurance applied for, which does away with the usual requirement of medical examination before

the policy is issued. The contention is without merit. If anything, the waiver of medical examination renders even more material the information required of the applicant concerning previous condition of health and diseases suffered, for such information necessarily constitutes an important factor which the insurer takes into consideration in deciding whether to issue the policy or not. It is logical to assume that if appellee had been properly apprised of the insured's medical history she would at least have been made to undergo medical examination in order to determine her insurability.

Appellants argue that due information concerning the insured's previous illness and operation had been given to appellees agent Edward A. Santos, who filled the application form after it was signed in blank by Estefania A. Saturnino. This was denied by Santos in his testimony, and the trial court found such testimony to be true. This is a finding of fact which is binding upon us, this appeal having been taken upon questions of law alone. We do not deem it necessary, therefore, to consider appellee's additional argument, which was upheld by the trial court, that in signing the application form in blank and leaving it to Edward A. Santos to fill (assuming that to be the truth) the insured in effect made Santos her agent for that purpose and consequently was responsible for the errors in the entries made by him in that capacity.

In non-medical insurance, the waiver of medical examination renders even more material the information required of the applicant concerning previous condition of health and diseases suffered, for such information necessarily constitutes an important factor which the insurer takes into consideration in deciding whether to issue the policy or not.

The concealment of the fact of the operation itself is fraudulent, as there could not have been any mistake about it, no matter what the ailment.

In this jurisdiction, a concealment, whether intentional or unintentional, entitles the insurer to rescind the contract of insurance, concealment being defined as "negligence to communicate that which a party knows and ought to communicate" (Sections 24 and 26, Act No. 2427).

THELMA VDA. DE CANILANG, *Petitioner*, -versus- COURT OF APPEALS and GREAT PACIFIC LIFE ASSURANCE CORPORATION, *Respondent*.

G.R. No. 92492, THIRD DIVISION, June 17, 1993, FELICIANO, J.

A man's state of mind or subjective belief is not capable of proof in our judicial process, except through proof of external acts or failure to act from which inferences as to his subjective belief may be reasonably drawn. Neither does materiality depend upon the actual or physical events which ensue. Materiality relates rather to the "probable and reasonable influence of the facts" upon the party to whom the communication should have been made, in assessing the risk involved in making or omitting to make further inquiries and in accepting the application for insurance; that "probable and reasonable influence of the facts" concealed must, of course, be determined objectively, by the judge ultimately.

FACTS

Canilang consulted Dr. Claudio and was diagnosed as suffering from "sinus tachycardia." Mr. Canilang consulted the same doctor again on 3 August 1982 and this time was found to have "acute bronchitis." On the next day, 4 August 1982, Canilang applied for a "non-medical" insurance policy with Grepalife naming his wife, as his beneficiary. Canilang was issued ordinary life insurance with the face value of P19,700.

On 5 August 1983, Canilang died of "congestive heart failure," "anemia," and "chronic anemia." The wife as beneficiary, filed a claim with Grepalife which the insurer denied on the ground that the insured had concealed material information from it.

Vda Canilang filed a complaint with the Insurance Commissioner against Grepalife contending that as far as she knows her husband was not suffering from any disorder and that he died of kidney disorder.

Grepalife was ordered to pay the widow by the Insurance Commissioner holding that there was no intentional concealment on the Part of Canilang and that Grepalife had waived its right to inquire into the health condition of the applicant by the issuance of the policy despite the lack of answers to "some of the pertinent questions" in the insurance application. CA reversed.

ISSUE

Whether or not Grepalife is liable? (YES)

RULING

We agree with the Court of Appeals that the information which Jaime Canilang failed to disclose was material to the ability of Great Pacific to estimate the probable risk he presented as a subject of life insurance. Had Canilang disclosed his visits to his doctor, the diagnosis made and the medicines prescribed by such doctor, in the insurance application, it may be reasonably assumed that Great Pacific would have made further inquiries and would have probably refused to issue a non-medical insurance policy or, at the very least, required a higher premium for the same coverage.

The materiality of the information withheld by Great Pacific did not depend upon the state of mind of Jaime Canilang. A man's state of mind or subjective belief is not capable of proof in our judicial process, except through proof of external acts or failure to act from which inferences as to his subjective belief may be reasonably drawn. Neither does materiality depend upon the actual or physical events which ensue. Materiality relates rather to the "probable and reasonable influence of the facts" upon the party to whom the communication should have been made, in assessing the risk involved in making or omitting to make further inquiries and in accepting the application for insurance; that "probable and reasonable influence of the facts" concealed must, of course, be determined objectively, by the judge ultimately.

THE INSULAR LIFE ASSURANCE CO., LTD., *Petitioner, -versus- HEIRS OF ALVAREZ, Respondent.*
G.R. Nos. 207526 & 210156, THIRD DIVISION, October 3, 2018, LEONEN, J.

A representation is to be deemed false when the facts fail to correspond with its assertions or stipulations." If indeed Alvarez misdeclared his age such that his assertion fails to correspond with his factual age, he made a false representation, not a concealment.

FACTS

Alvarez and his wife, Adelina, owned a residential lot with improvements covered by Transfer Certificate of Title (TCT) No. C-315023 and registered in the Caloocan City Registry of Deeds.

On June 18, 1997, Alvarez applied for and was granted a housing loan by UnionBank in the amount of P648,000.00. This loan was secured by a promissory note, a real estate mortgage over the lot,¹¹ and

a mortgage redemption insurance taken on the life of Alvarez with UnionBank as beneficiary. Alvarez was among the mortgagors included in the list of qualified debtors covered by the Group Mortgage Redemption Insurance that UnionBank had with Insular Life.

Alvarez passed away on April 17, 1998. In May 1998, UnionBank filed with Insular Life a death claim under Alvarez's name pursuant to the Group Mortgage Redemption Insurance. In line with Insular Life's standard procedures, UnionBank was required to submit documents to support the claim. These included: (1) Alvarez's birth, marriage, and death certificates; (2) the attending physician's statement; (3) the claimant's statement; and (4) Alvarez's statement of account.

Insular Life denied the claim after determining that Alvarez was not eligible for coverage as he was supposedly more than 60 years old at the time of his loan's approval.

With the claim's denial, the monthly amortizations of the loan stood unpaid. UnionBank sent the Heirs of Alvarez a demand letter, giving them 10 days to vacate the lot. Subsequently, on October 4, 1999, the lot was foreclosed and sold at a public auction with UnionBank as the highest bidder.

On February 14, 2001, the Heirs of Alvarez filed a Complaint for Declaration of Nullity of Contract and Damages against UnionBank, a certain Alfonso P. Miranda (Miranda), who supposedly benefitted from the loan, and the insurer which was identified only as John Doe. The Heirs of Alvarez denied knowledge of any loan obtained by Alvarez.

The Heirs of Alvarez claimed that after Alvarez's death, they came upon a document captioned "Letter of Undertaking," which appeared to have been sent by UnionBank to Miranda. In this document, UnionBank bound itself to deliver to Miranda P466,000.00 of the approved P648,000.00 housing loan, provided that Miranda would deliver to it TCT No. C-315023, "free from any liens and/or encumbrances."

The Complaint was later amended and converted into one for specific performance to include a demand against Insular Life to fulfill its obligation as an insurer under the Group Mortgage Redemption Insurance.

In its defense, UnionBank asserted that the Heirs of Alvarez could not feign ignorance over the existence of the loan and mortgage considering the Special Power of Attorney²⁴ executed by Adelina in favor of her late husband, which authorized him to apply for a housing loan with UnionBank.

For its part, Insular Life maintained that based on the documents submitted by UnionBank, Alvarez was no longer eligible under the Group Mortgage Redemption Insurance since he was more than 60 years old when his loan was approved.

ISSUE

- 1) Whether or not petitioner The Insular Life Assurance Co., Ltd. is obliged to pay Union Bank of the Philippines the balance of Jose H. Alvarez's loan given the claim that he lied about his age at the time of the approval of his loan? (YES)
- 2) Whether or not petitioner Union Bank of the Philippines was correct in proceeding with the foreclosure following Insular Life Assurance Co., Ltd.'s refusal to pay? (YES)

RULING

Fraud is not to be presumed, for "otherwise, courts would be indulging in speculations and surmises." Moreover, it is not to be established lightly. Rather, "[i]t must be established by clear and convincing evidence . . . [; a] mere preponderance of evidence is not even adequate to prove fraud." These precepts hold true when allegations of fraud are raised as grounds justifying the invalidation of contracts, as the fraud committed by a party tends to vitiate the other party's consent.

Citing Section 27 of the Insurance Code, however, Insular Life asserts that in cases of rescission due to concealment, i.e., when a party "neglect[s] to communicate that which [he or she] knows and ought to communicate," proof of fraudulent intent is not necessary.

Section 27 reads:

Section 27. A concealment *whether intentional or unintentional* entitles the injured party to rescind a contract of insurance.

The statutory text is unequivocal. Insular Life correctly notes that proof of fraudulent intent is unnecessary for the rescission of an insurance contract on account of concealment.

This is neither because intent to defraud is intrinsically irrelevant in concealment, nor because concealment has nothing to do with fraud. To the contrary, it is because in insurance contracts, concealing material facts⁵¹ is inherently fraudulent: "if a material fact is actually known to the [insured], its concealment must of itself necessarily be a fraud." When one knows a material fact and conceals it, "it is difficult to see how the inference of a fraudulent intent or intentional concealment can be avoided." Thus, a concealment, regardless of actual intent to defraud, "is equivalent to a false representation."

In *Vda. de Canilang v. Court of Appeals*, this Court considered an alternative version of Section 27, i.e., prior to the Insurance Code's amendment by Batas Pambansa Blg. 874, which omitted the qualifier "whether intentional or unintentional." *Vda. de Canilang* clarified that even without this qualifier, Section 27 still covers "'any concealment' without regard to whether such concealment is intentional or unintentional," thus:

The Insurance Commissioner had also ruled that the failure of Great Pacific to convey certain information to the insurer was not "intentional" in nature, for the reason that Jaime Canilang believed that he was suffering from minor ailment like a common cold. Section 27 of the Insurance Code of 1978 as it existed from 1974 up to 1985, that is, throughout the time range material for present purposes, provided that:

Sec. 27. A concealment entitles the injured party to rescind a contract of insurance.

The *preceding* statute, Act No. 2427, as it stood from 1914 up to 1974, had provided:

Sec. 26. A concealment, *whether intentional or unintentional*, entitles the injured party to rescind a contract of insurance.

Upon the other hand, in 1985, the Insurance Code of 1978 was amended by B.P. Blg. 874. This subsequent statute modified Section 27 of the Insurance Code of 1978 so as to read as follows:

Sec. 27. A concealment *whether intentional or unintentional* entitles the injured party to rescind a contract of insurance.

While Insular Life correctly reads Section 27 as making no distinction between intentional and unintentional concealment, it erroneously pleads Section 27 as the proper statutory anchor of this case.

The Insurance Code distinguishes representations from concealments. Chapter 1, Title 4 is on concealments. It spans Sections 26 to 35 of the Insurance Code; it is where Section 27 is found. Chapter 1, Title 5 is on representations. It spans Sections 36 to 48 of the Insurance Code.

Section 26 defines concealment as "[a] *neglect to communicate* that which a party knows and ought to communicate." However, Alvarez did not withhold information on or neglect to state his age. He made an actual declaration and assertion about it.

What this case involves, instead, is an allegedly false representation. Section 44 of the Insurance Code states, "A representation is to be deemed false when the facts fail to correspond with its assertions or stipulations." If indeed Alvarez misdeclared his age such that his assertion fails to correspond with his factual age, he made a false representation, not a concealment.

At no point does Chapter 1, Title 5 of the Insurance Code replicate Section 27's language negating the distinction between intentional and unintentional concealment. Section 45 is Chapter 1, Title 5's counterpart provision to Section 27, and concerns rescission due to false representations. It reads: Section 45. If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time when the representation becomes false.

Not being similarly qualified as rescission under Section 27, rescission under Section 45 remains subject to the basic precept of fraud having to be proven by clear and convincing evidence. In this respect, *Ng Gan Zee's* and similar cases' pronouncements on the need for proof of fraudulent intent in cases of misrepresentation are logically sound, albeit the specific reference to *Argente* as ultimate authority is misplaced. Thus, while *Great Pacific Life* confounded concealment with misrepresentation by its citation of *Ng Gan Zee*, it nevertheless acceptably stated that:

The fraudulent intent on the part of the insured must be established to entitle the insurer to rescind the contract. Misrepresentation as a defense of the insurer to avoid liability is an affirmative defense and the duty to establish such defense by satisfactory and convincing evidence rests upon the insurer.

2. Misrepresentation/Omissions

MA. LOURDES S. FLORENDO, *Petitioner*, -versus- **PHILAM PLANS, INC., ET AL.**, *Respondent*.
G.R. No. 186983, THIRD DIVISION, February 22, 2012, LEONEN, J.

Assuming that it was the insurance agent Perla who filled up the application form, Manuel is still bound by what it contains since he certified that he authorized her action. Therefore, any concealment made by the insurance agent binds him and therefore, the insurer, in the case at bar has every right to deny liability.

FACTS

Manuel Florendo filed an application for comprehensive pension plan with respondent Philam Plans, Inc. Ma. Lourdes S. Florendo, his wife, was stated as beneficiary. On October 30, 1997 Philam Plans issued Pension Plan Agreement. Eleven months later or on September 15, 1998, Manuel died of blood poisoning.

Subsequently, Lourdes filed a claim with Philam Plans for the payment of the benefits under her husband's plan. Because Manuel died before his pension plan matured and his wife was to get only the benefits of his life insurance, Philam Plans forwarded her claim to Philam Life. Philam Life declined the claim and found that Manuel was on maintenance medicine for his heart and had an implanted pacemaker. Further, he suffered from diabetes mellitus and was taking insulin. Lourdes contends that Manuel had concealed nothing since Perla, the soliciting agent, knew that Manuel had a pacemaker implanted on his chest in the 70s or about 20 years before he signed up for the pension plan and that it is the soliciting agent who filled up the form.

ISSUE

Whether or not there was misrepresentation on the part of Manuel that would avoid the policy? (YES)

RULING

As already stated, Manuel had been taking medicine for his heart condition and diabetes when he submitted his pension plan application. These clearly fell within the five-year period. More, even if Perla's knowledge of Manuel's pacemaker may be applied to Philam Plans under the theory of imputed knowledge, it is not claimed that Perla was aware of his two other afflictions that needed medical treatments. Pursuant to Section 27 of the Insurance Code, Manuel's concealment entitles Philam Plans to rescind its contract of insurance with him.

As the Court said in *New Life Enterprises v. Court of Appeals*, 207 SCRA 669 (1992): It may be true that x x x insured persons may accept policies without reading them, and that this is not negligence *per se*. But, this is not without any exception. It is and was incumbent upon petitioner Sy to read the insurance contracts, and this can be reasonably expected of him considering that he has been a businessman since 1965 and the contract concerns indemnity in case of loss in his money-making trade of which important consideration he could not have been unaware as it was precisely the reason for his procuring the same. The same may be said of Manuel, a civil engineer and manager of a construction company. He could be expected to know that one must read every document, especially if it creates rights and obligations affecting him, before signing the same. Manuel is not unschooled that the Court must come to his succor. It could reasonably be expected that he would not trifle with something that would provide additional trifle with something that would provide additional financial security to him and to his wife in his twilight years.

In a final attempt to defend her claim for benefits under Manuel's pension plan, Lourdes points out that any defect or insufficiency in the information provided by his pension plan application should be deemed waived after the same has been approved, the policy has been issued, and the premiums have been collected. The Court cannot agree. The comprehensive pension plan that Philam Plans issued contains a one-year incontestability period. It states: **VIII. INCONTESTABILITY** After this Agreement has remained in force for one (1) year, we can no longer contest for health reasons any claim for insurance under this Agreement, except for the reason that installment has not been paid

(lapsed), or that you are not insurable at the time you bought this pension program by reason of age. If this Agreement lapses but is reinstated afterwards, the one (1) year contestability period shall start again on the date of approval of your request for reinstatement. The above incontestability clause precludes the insurer from disowning liability under the policy it issued on the ground of concealment or misrepresentation regarding the health of the insured after a year of its issuance. Since Manuel died on the eleventh month following the issuance of his plan, the one year incontestability period has not yet set in. Consequently, Philam Plans was not barred from questioning Lourdes' entitlement to the benefits of her husband's pension plan.

EMILIO TAN, JUANITO TAN, ALBERTO TAN AND ARTURO TAN, *Petitioner*, -versus- THE COURT OF APPEALS AND THE PHILIPPINE AMERICAN LIFE INSURANCE COMPANY, *Respondent*.

G.R. No. L-48049, THIRD DIVISION, June 29, 1989, GUTIERREZ, JR, J.

The insurer has two years from the date of issuance of the insurance contract or of its last reinstatement within which to contest the policy, whether or not, the insured still lives within such period. After two years, the defenses of concealment or misrepresentation, no matter how patent or well founded, no longer lie.

FACTS

Tan Lee Siong applied for life insurance in the amount of P80,000.00 with Philam Life. Said application was approved and Policy No. 1082467 was issued effective November 6, 1973 with the petitioners as beneficiaries. On April 26, 1975, Tan Lee Siong died of hepatoma. Petitioners then filed with Philam Life their claim. However, respondent company denied petitioners' claim and rescinded the policy by reason of the alleged misrepresentation and concealment of material facts made by the deceased Tan Lee Siong in his application for insurance. The premiums paid on the policy were thereupon refunded. Petitioners filed a complaint before the Insurance Commissioner. The latter dismissed their claim of procees. On appeal before the Court of Appeals, it was also dismissed.

ISSUE

Whether or not Philam Life no longer had the right to rescind the contract of insurance based on misrepresentation as rescission must allegedly be done during the lifetime of the insured within two years and prior to the commencement of action? (NO)

RULING

As noted by the Court of Appeals, to wit: "The policy was issued on November 6, 1973 and the insured died on April 26, 1975. The policy was thus in force for a period of only one year and five months.

Considering that the insured died before the two-year period had lapsed, respondent company is not, therefore, barred from proving that the policy is void ab initio by reason of the insured's fraudulent concealment or misrepresentation. Moreover, respondent company rescinded the contract of insurance and refunded the premiums paid on September 11, 1975, previous to the commencement of this action on November 27, 1975."

The insurer has two years from the date of issuance of the insurance contract or of its last reinstatement within which to contest the policy, whether or not, the insured still lives within such period.

After two years, the defenses of concealment or misrepresentation, no matter how patent or well founded, no longer lie. Congress felt this was a sufficient answer to the various tactics employed by insurance companies to avoid liability.

The petitioners' interpretation would give rise to the incongruous situation where the beneficiaries of an insured who dies right after taking out and paying for a life insurance policy, would be allowed to collect on the policy even if the insured fraudulently concealed material facts.

MANILA BANKERS LIFE INSURANCE CORPORATION, Petitioner, -versus- CRESENCIA P. ABAN, Respondent.

G.R. No. 175666, SECOND DIVISION, July 29, 2013, DEL CASTILLO, J.

The so-called "incontestability clause" precludes the insurer from raising the defenses of false representations or concealment of material facts insofar as health and previous diseases are concerned if the insurance has been in force for at least two years during the insured's lifetime.

The phrase "during the lifetime" found in Section 48 simply means that the policy is no longer considered in force after the insured has died. The key phrase in the second paragraph of Section 48 is "for a period of two years."

FACTS

Delia Sotero took out a life insurance policy from Manila Bankers Life Insurance Corporation, designating respondent Cresencia P. Aban, her niece, as her beneficiary. Petitioner issued Insurance Policy No. 747411 (the policy), with a face value of P100,000.00, in Sotero's favor on August 30, 1993, after the requisite medical examination and payment of the insurance premium. On April 10, 1996, when the insurance policy had been in force for more than two years and seven months, Sotero died.

Respondent filed a claim for the insurance proceeds on July 9, 1996. Petitioner investigated the claim and found that Sotero did not personally apply for insurance coverage, as she was illiterate. Petitioner filed a civil case for rescission and/or annulment of the policy and alleged that the policy was obtained by fraud, concealment and/or misrepresentation. Respondent filed a Motion to Dismiss, claiming that petitioner's cause of action was barred by prescription pursuant to Section 48. The trial court granted the motion to dismiss by Aban. On appeal, it affirmed the trial court.

ISSUE

Whether or not there was misrepresentation on the part of the insured that would avoid the policy in relation to the prescription period in Section 48? (NO)

RULING

As borne by the records, the policy was issued on August 30, 1993, the insured died on April 10, 1996, and the claim was denied on April 16, 1997. The insurance policy was thus in force for a period of 3 years, 7 months, and 24 days. Considering that the insured died after the two-year period, the plaintiff-appellant is, therefore, barred from proving that the policy is void ab initio by reason of the insured's fraudulent concealment or misrepresentation or want of insurable interest on the part of the beneficiary, herein defendant-appellee.

The "incontestability clause" is a provision in law that after a policy of life insurance made payable on the death of the insured shall have been in force during the lifetime of the insured for a period of two (2) years from the date of its issue or of its last reinstatement, the insurer cannot prove that the policy is void ab initio or is rescindible by reason of fraudulent concealment or misrepresentation of the insured or his agent.

The purpose of the law is to give protection to the insured or his beneficiary by limiting the rescinding of the contract of insurance on the ground of fraudulent concealment or misrepresentation to a period of only two (2) years from the issuance of the policy or its last reinstatement.

The insurer is deemed to have the necessary facilities to discover such fraudulent concealment or misrepresentation within a period of two (2) years. It is not fair for the insurer to collect the premiums as long as the insured is still alive, only to raise the issue of fraudulent concealment or misrepresentation when the insured dies in order to defeat the right of the beneficiary to recover under the policy.

At least two (2) years from the issuance of the policy or its last reinstatement, the beneficiary is given the stability to recover under the policy when the insured dies. The provision also makes clear when the two year period should commence in case the policy should lapse and is reinstated, that is, from the date of the last reinstatement. After two years, the defenses of concealment or misrepresentation, no matter how patent or well-founded, will no longer lie.

The so-called "incontestability clause" precludes the insurer from raising the defenses of false representations or concealment of material facts insofar as health and previous diseases are concerned if the insurance has been in force for at least two years during the insured's lifetime. The phrase "during the lifetime" found in Section 48 simply means that the policy is no longer considered in force after the insured has died. The key phrase in the second paragraph of Section 48 is "for a period of two years."

THE INSULAR LIFE ASSURANCE CO., LTD., *Petitioner, -versus- HEIRS OF ALVAREZ, Respondent.*
G.R. Nos. 207526 & 210156, THIRD DIVISION, October 3, 2018, LEONEN, J.

A representation is to be deemed false when the facts fail to correspond with its assertions or stipulations." If indeed Alvarez misdeclared his age such that his assertion fails to correspond with his factual age, he made a false representation, not a concealment.

FACTS

Alvarez and his wife, Adelina, owned a residential lot with improvements covered by Transfer Certificate of Title (TCT) No. C-315023 and registered in the Caloocan City Registry of Deeds.

On June 18, 1997, Alvarez applied for and was granted a housing loan by UnionBank in the amount of P648,000.00. This loan was secured by a promissory note, a real estate mortgage over the lot,¹¹ and a mortgage redemption insurance taken on the life of Alvarez with UnionBank as beneficiary. Alvarez was among the mortgagors included in the list of qualified debtors covered by the Group Mortgage Redemption Insurance that UnionBank had with Insular Life.

Alvarez passed away on April 17, 1998. In May 1998, UnionBank filed with Insular Life a death claim under Alvarez's name pursuant to the Group Mortgage Redemption Insurance. In line with Insular Life's standard procedures, UnionBank was required to submit documents to support the claim. These included: (1) Alvarez's birth, marriage, and death certificates; (2) the attending physician's statement; (3) the claimant's statement; and (4) Alvarez's statement of account.

Insular Life denied the claim after determining that Alvarez was not eligible for coverage as he was supposedly more than 60 years old at the time of his loan's approval.

With the claim's denial, the monthly amortizations of the loan stood unpaid. UnionBank sent the Heirs of Alvarez a demand letter, giving them 10 days to vacate the lot. Subsequently, on October 4, 1999, the lot was foreclosed and sold at a public auction with UnionBank as the highest bidder.

On February 14, 2001, the Heirs of Alvarez filed a Complaint for Declaration of Nullity of Contract and Damages against UnionBank, a certain Alfonso P. Miranda (Miranda), who supposedly benefitted from the loan, and the insurer which was identified only as John Doe. The Heirs of Alvarez denied knowledge of any loan obtained by Alvarez.

The Heirs of Alvarez claimed that after Alvarez's death, they came upon a document captioned "Letter of Undertaking," which appeared to have been sent by UnionBank to Miranda. In this document, UnionBank bound itself to deliver to Miranda P466,000.00 of the approved P648,000.00 housing loan, provided that Miranda would deliver to it TCT No. C-315023, "free from any liens and/or encumbrances."

The Complaint was later amended and converted into one for specific performance to include a demand against Insular Life to fulfill its obligation as an insurer under the Group Mortgage Redemption Insurance.

In its defense, UnionBank asserted that the Heirs of Alvarez could not feign ignorance over the existence of the loan and mortgage considering the Special Power of Attorney²⁴ executed by Adelina in favor of her late husband, which authorized him to apply for a housing loan with UnionBank.

For its part, Insular Life maintained that based on the documents submitted by UnionBank, Alvarez was no longer eligible under the Group Mortgage Redemption Insurance since he was more than 60 years old when his loan was approved.

ISSUE

- 1) Whether or not petitioner The Insular Life Assurance Co., Ltd. is obliged to pay Union Bank of the Philippines the balance of Jose H. Alvarez's loan given the claim that he lied about his age at the time of the approval of his loan? (YES)

- 2) Whether or not petitioner Union Bank of the Philippines was correct in proceeding with the foreclosure following Insular Life Assurance Co., Ltd.'s refusal to pay? (YES)

RULING

Fraud is not to be presumed, for "otherwise, courts would be indulging in speculations and surmises." Moreover, it is not to be established lightly. Rather, "[i]t must be established by clear and convincing evidence . . . [; a] mere preponderance of evidence is not even adequate to prove fraud." These precepts hold true when allegations of fraud are raised as grounds justifying the invalidation of contracts, as the fraud committed by a party tends to vitiate the other party's consent. Citing Section 27 of the Insurance Code, however, Insular Life asserts that in cases of rescission due to concealment, i.e., when a party "neglect[s] to communicate that which [he or she] knows and ought to communicate," proof of fraudulent intent is not necessary.

Section 27 reads:

Section 27. A concealment *whether intentional or unintentional* entitles the injured party to rescind a contract of insurance.

The statutory text is unequivocal. Insular Life correctly notes that proof of fraudulent intent is unnecessary for the rescission of an insurance contract on account of concealment.

This is neither because intent to defraud is intrinsically irrelevant in concealment, nor because concealment has nothing to do with fraud. To the contrary, it is because in insurance contracts, concealing material facts⁵¹ is inherently fraudulent: "if a material fact is actually known to the [insured], its concealment must of itself necessarily be a fraud." When one knows a material fact and conceals it, "it is difficult to see how the inference of a fraudulent intent or intentional concealment can be avoided." Thus, a concealment, regardless of actual intent to defraud, "is equivalent to a false representation."

In *Vda. de Canilang v. Court of Appeals*, this Court considered an alternative version of Section 27, i.e., prior to the Insurance Code's amendment by Batas Pambansa Blg. 874, which omitted the qualifier "whether intentional or unintentional." *Vda. de Canilang* clarified that even without this qualifier, Section 27 still covers "'any concealment' without regard to whether such concealment is intentional or unintentional," thus:

The Insurance Commissioner had also ruled that the failure of Great Pacific to convey certain information to the insurer was not "intentional" in nature, for the reason that Jaime Canilang believed that he was suffering from minor ailment like a common cold. Section 27 of the Insurance Code of 1978 as it existed from 1974 up to 1985, that is, throughout the time range material for present purposes, provided that:

Sec. 27. A concealment entitles the injured party to rescind a contract of insurance.

The *preceding* statute, Act No. 2427, as it stood from 1914 up to 1974, had provided:

Sec. 26. A concealment, *whether intentional or unintentional*, entitles the injured party to rescind a contract of insurance.

Upon the other hand, in 1985, the Insurance Code of 1978 was amended by B.P. Blg. 874. This subsequent statute modified Section 27 of the Insurance Code of 1978 so as to read as follows:

Sec. 27. A concealment *whether intentional or unintentional* entitles the injured party to rescind a contract of insurance.

While Insular Life correctly reads Section 27 as making no distinction between intentional and unintentional concealment, it erroneously pleads Section 27 as the proper statutory anchor of this case.

The Insurance Code distinguishes representations from concealments. Chapter 1, Title 4 is on concealments. It spans Sections 26 to 35 of the Insurance Code; it is where Section 27 is found. Chapter 1, Title 5 is on representations. It spans Sections 36 to 48 of the Insurance Code.

Section 26 defines concealment as "[a] *neglect to communicate* that which a party knows and ought to communicate." However, Alvarez did not withhold information on or neglect to state his age. He made an actual declaration and assertion about it.

What this case involves, instead, is an allegedly false representation. Section 44 of the Insurance Code states, "A representation is to be deemed false when the facts fail to correspond with its assertions or stipulations." If indeed Alvarez misdeclared his age such that his assertion fails to correspond with his factual age, he made a false representation, not a concealment.

At no point does Chapter 1, Title 5 of the Insurance Code replicate Section 27's language negating the distinction between intentional and unintentional concealment. Section 45 is Chapter 1, Title 5's counterpart provision to Section 27, and concerns rescission due to false representations. It reads: Section 45. If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time when the representation becomes false.

Not being similarly qualified as rescission under Section 27, rescission under Section 45 remains subject to the basic precept of fraud having to be proven by clear and convincing evidence. In this respect, *Ng Gan Zee's* and similar cases' pronouncements on the need for proof of fraudulent intent in cases of misrepresentation are logically sound, albeit the specific reference to *Argente* as ultimate authority is misplaced. Thus, while *Great Pacific Life* confounded concealment with misrepresentation by its citation of *Ng Gan Zee*, it nevertheless acceptably stated that:

The fraudulent intent on the part of the insured must be established to entitle the insurer to rescind the contract. Misrepresentation as a defense of the insurer to avoid liability is an affirmative defense and the duty to establish such defense by satisfactory and convincing evidence rests upon the insurer.

3. Breach of Warranties

QUA CHEE GAN, *Petitioner*, -versus- LAW UNION AND ROCK INSURANCE CO., LTD. represented by its agent, WARNER, BARNES, AND CO., LTD., *Respondent*.
G.R. No. L-4611, EN BANC, December 17, 1955, REYES, J.B.L., J.

Insurer is barred by waiver (or rather estoppel) to claim violation of warranties for the reason that knowing fully all that the number of hydrants demanded therein never existed from the very beginning, respondent nevertheless issued the policies in question subject to such warranty, and received the

corresponding premiums. It is a well settled rule of law that an insurer which with knowledge of facts entitling it to treat a policy as no longer in force, receives and accepts a premium on the policy, estopped to take advantage of the forfeiture.

FACTS

Qua Chee Gan obtained fire insurance policies from Law Union and Rock Insurance for his four warehouses used for storing copra and hemp. Under the policies, Qua Chee Gan should install fire hydrants every 150 feet or 11 hydrants in the warehouse premises, however, he installed only 2 hydrants.

Nevertheless, Law Union proceeded with the insurance and collected premiums from Qua Chee Gan. In the 1940s, three of the warehouses were razed by fire prompting Qua Chee Gan to demand insurance payment from Law Union. The insurance company refused, alleging that the policies should have been avoided for breach of warranties.

ISSUE

Whether or not the insurance company may avoid liability and void the policies it issued due to insured's breach of warranty? (NO)

RULING

Respondent insurance company is now barred by waiver (or rather estoppel) to claim violation of the so-called fire hydrants warranty, for the reason that knowing fully all that the number of hydrants demanded therein never existed from the very beginning, respondent nevertheless issued the policies in question subject to such warranty, and received the corresponding premiums. It would be perilously close to conniving at fraud upon the insured to allow respondent to claim now as void ab initio the policies that it had issued to the plaintiff without warning of their fatal defect, of which it was informed, and after it had misled it into believing that the policies were effective.

American jurisprudence provides the reason for this rule: To allow a company to accept one's money for a policy of insurance which it knows to be void and of no effect, though it knows as it must that the insured believes it to be valid and binding is so contrary to the dictates of honesty and fair dealing, as so closely related to positive fraud, as to be abhorrent to fair-minded men. It would be to allow the company to treat the policy as valid long enough to get the premium on it, and leave it at liberty to repudiate it the next moment.

It is a well settled rule of law that an insurer which with knowledge of facts entitling it to treat a policy as no longer in force, receives and accepts a premium on the policy, estopped to take advantage of the forfeiture.

MALAYAN INSURANCE COMPANY, INC., *Petitioner*, -versus- **PAP CO. , LTD.,** *Respondent*.
G.R. No. 200784, THIRD DIVISION, August 7, 2013, MENDOZA, J.

Section 168 of the Insurance Code provides that the insurer is entitled to rescind the insurance contract in case of an alteration in the use or condition of the thing insured. The insured's act of removing the insured properties from the location different from that indicated in the policy without the insurer's

consent entitles the latter to rescind the insurance policy because such act amounts to concealment, misrepresentation and breach of warranty.

FACTS

Respondent PAP Co. procured a fire insurance policy from petitioner Malayan Insurance for its machineries and equipment which was mortgaged to RCBC. The policy was renewed on an “as is” basis after a year. The insured machineries and equipment were lost by fire prompting PAP Co. to file an insurance claim from Malayan. Malayan, however, denied the claim upon the ground that, at the time of the loss, the insured machineries and equipment were transferred by PAP Co. to a location different from that indicated in the policy in violation of their affirmative warranty. Contesting the denial, PAP Co. argued that Malayan cannot avoid liability as it was informed of the transfer by RCBC.

ISSUE

Whether or not the Court of Appeals erred in affirming the lower court’s ruling holding Malayan Insurance liable despite PAP Co.’s alleged concealment, misrepresentation, and breach of an affirmative Warranty? (YES)

RULING

The appellate court erred in holding Malayan Insurance liable. By the clear and express condition in the renewal policy, the removal of the insured property to any building or place required the consent of Malayan. Any transfer effected by the insured, without the insurer’s consent, would free the latter from any liability. The records, however, are bereft of any convincing and concrete evidence that Malayan was notified of the transfer of the insured properties from the Sanyo factory to the Pace factory. What PAP did to prove that Malayan was notified was to show that it relayed the fact of transfer to RCBC, the entity which made the referral and the named beneficiary in the policy. Malayan and RCBC might have been sister companies, but such fact did not make one an agent of the other.

The fact that RCBC referred PAP to Malayan did not clothe it with authority to represent and bind the said insurance company. After the referral, PAP dealt directly with Malayan. The Court noted that PAP’s Branch Manager, Mr. Yoneda only admitted that the insured properties were transferred to a different location only after the renewal of the fire insurance policy.

There being an uncontested removal, the transfer was at PAP’s own risk. Malayan is thus entitled to rescind the insurance contract as it clearly committed concealment, misrepresentation and a breach of warranty. Moreover, under Section 168 of the Insurance Code, the insurer is entitled to rescind the insurance contract in case of an alteration in the use or condition of the thing insured.

NEW LIFE ENTERPRISES AND JULIAN SY, *Petitioner*, -versus- COURT OF APPEALS, EQUITABLE INSURANCE CORPORATION, RELIANCE SURETY AND INSURANCE CO., INC. AND WESTERN GUARANTY CORPORATION, *Respondent*.

G.R. No. 94071, SECOND DIVISION, March 31, 1992, REGALADO, J.

The terms of the contract are clear and unambiguous. The insured is specifically required to disclose to the insurer any other insurance and its particulars which he may have effected on the same subject matter. The insured’s failure to disclose such information justifies forfeiture of the benefits provided in

the policy. The knowledge of such insurance by the insurer's agents, even assuming the acquisition thereof by the former, is not the "notice" that would estop the insurers from denying the claim.

FACTS

Petitioner New Life Enterprises is a partnership formed by Julian Sy and Jose Sy Bang. Julian Sy insured the stocks in trade of the partnership with Western Guaranty Corporation, Reliance Surety and Insurance Co. and Equitable Insurance Corporation. These three insurance corporations issued fire insurance policies on different dates. When the building occupied by New Life Enterprises was gutted by fire, Julian Sy demanded payment from the insurance companies. The insurance companies, however, denied his claim for payment; their letters of denial are all of the same tenor, explaining that the denial is due to breach of policy conditions otherwise known as the "Otherwise Insurance Clause". Petitioner contends that they are not to be blamed for the omissions, alleging that the agent Alvarez for Western and Yap Kam Chuan for Reliance and Equitable knew about the existence of the additional insurance coverage and that they were not informed about the requirement that such other or additional insurance should be stated in the policy, as they have not read the policy.

ISSUE

Whether or not conditions in the insurance contracts were violated by petitioners thereby resulting in their forfeiture of all the benefits thereunder? (YES)

RULING

The terms of the contract are clear and unambiguous.

The insured is specifically required to disclose to the insurer any other insurance and its particulars which he may have effected on the same subject matter. The knowledge of such insurance by the insurer's agents, even assuming the acquisition thereof by the former, is not the "notice" that would estop the insurers from denying the claim. Besides, the so-called theory of imputed knowledge, that is, knowledge of the agent is knowledge of the principal, aside from being of dubious applicability here has likewise been refuted by the appellate court whose factual findings we find acceptable.

While it is a cardinal principle of insurance law that a policy or contract of insurance is to be construed liberally in favour of the insured and strictly against the insurer company, yet contracts of insurance, like other contracts, are to be construed according to the sense and meaning of the terms which the parties themselves have used. If such terms are clear and unambiguous, they must be taken and understood in their plain, ordinary, and popular sense. Moreover, obligations arising from contracts have the force of law between the contracting parties and should be complied with in good faith.

K. S. YOUNG, Petitioner, -versus- MIDLAND TEXTILE INSURANCE COMPANY, Respondent.
G.R. No. 9370, EN BANC, March 31, 1915, JOHNSON, J.

If the insured cannot bring himself within the terms and conditions of the contract, he is not entitled to recover for any loss suffered. The terms of the contract constitute the measure of the insurer's liability. If the contract has been terminated, by a violation of its terms on the part of the insured, there can be no recovery. Compliance with the terms of the contract is a condition precedent to the right of recovery.

FACTS

K.S. Young has a business of a candy and fruit store in Escolta and occupied a building as a residence and bodega. Young entered into a contract of insurance with Midland Textile Insurance in case said residence and bodega and its contents should be destroyed by fire. One of the conditions of said contract of insurance is found in "warranty B" and is as follows: "Warranty B. It is hereby declared and agreed that during the pendency of this policy no hazardous goods be stored or kept for sale, and no hazardous trade or process be carried on, in the building to which this insurance applies, or in any building connected therewith." On the 4th or 5th of February 1913, the plaintiff placed in said residence and bodega three boxes filled with fireworks intended to be used in the celebration of Chinese New Year. A few days after, the insured building got partially destroyed by fire. The said fireworks, however, were found in the part of the building not destroyed by the fire and that they in no way contributed to the fire or to the loss occasioned thereby.

ISSUE

Whether or not the placing of said fireworks in the building insured, being hazardous goods, is a violation of the terms of the contract of insurance and especially of Warranty B? (YES)

RULING

It is a breach of warranty. Contracts of insurance are contracts of indemnity upon the terms and conditions specified in the policy. The parties have a right to impose such reasonable conditions at the time of the making of the contract as they may deem wise and necessary. If the insured cannot bring himself within the conditions of the policy, he is not entitled to recover for the loss. The terms of the policy constitute the measure of the insurer's liability, and in order to recover the insured must show himself within those terms; and if it appears that the contract has been terminated by a violation, on the part of the insured, of its conditions, then there can be no right of recovery. The compliance of the insured with the terms of the contract is a condition precedent to the right of recovery. If the insured has violated or failed to perform the conditions of the contract, and such a violation or want of performance has not been waived by the insurer, then the insured cannot recover.

Appellant's argument that the "storing" of the fireworks on the premises did not contribute in any way to the damage occasioned by the fire is untenable. The violation of the terms of the contract, by virtue of the provisions of the policy itself, terminated, at the election of either party, the contractual relations. The plaintiff paid a premium based upon the risk at the time the policy was issued. [T]he placing of the firecrackers in the building insured increased the risk. x x x The plaintiff was enjoying, if his contention may be allowed, the benefits of an insurance policy upon one risk, whereas, as a matter of fact, it was issued upon an entirely different risk.

E. M. BACHRACH, *Petitioner*, -versus- **BRITISH AMERICAN ASSURANCE COMPANY**, *Respondent*.
G.R. No. L-5715, EN BANC, December 20, 1910, JOHNSON, J.

The keeping of inflammable oils in the insured premises, though prohibited by the policy, does not void it if such keeping is incidental to the business. Moreover, there was no provision in the policy prohibiting the keeping of paints and varnishes upon the premises where the insured property was stored. If the

[insurance] company intended to rely upon a condition of that character, it ought to have been plainly expressed in the policy.

FACTS

Plaintiff Bachrach commenced an action against defendant British American Assurance Company to recover a certain sum of money based on the fire insurance policy. The defendant answered the complaint, admitting some of the facts alleged by the plaintiff and denying others. The defendant also alleged certain facts under which it claimed that it was released from all obligations whatever under said policy. Among others, it alleged that the plaintiff maintained a paint and varnish shop in the said building where the goods which were insured were stored; immediately preceding the outbreak of the alleged fire, plaintiff willfully placed a gasoline can containing 10 gallons of gasoline in the upper story of said building in close proximity to a portion of said goods, which can was so placed as to permit the gasoline to run on the floor of said second story, and after so placing said gasoline, the plaintiff, placed in close proximity to said escaping gasoline a lighted lamp containing alcohol, thereby greatly increasing the risk of fire.

ISSUE

Whether or not using the building as a paint and varnish shop annulled the policy and the keeping of gasoline and alcohol was a violation of the conditions of the policy as to render the same null and void? (NO)

RULING

NO, the policy is not avoided and consequently the insurer should still be held liable. The lower court in its decision said “It is well settled that the keeping of inflammable oils on the premises, though prohibited by the policy, does not void it if such keeping is incidental to the business. Thus, where a furniture factory keeps benzine for the purposes of operation, or where it is used for the cleaning machinery, the insurer cannot on that ground avoid payment of loss, though the keeping of the benzine on the premises is expressly prohibited.” It may be added that there was no provision in the policy prohibiting the keeping of paints and varnishes upon the premises where the insured property was stored. If the company intended to rely upon a condition of that character, it ought to have been plainly expressed in the policy.

p. Claims Settlement and Subrogation

PERLA COMPANIA DE SEGUROS, INC., *Petitioner,* -versus- **HONORABLE COURT OF APPEALS and MILAGROS CAYAS,** *Respondent.*

G.R. No. 78860, THIRD DIVISION, May 28, 1990, FERNAN, C.J.

The stipulation or condition in the insurance contract requiring the insured to secure the written permission of the insurer before effecting payment in settlement of a claim against the former is valid and binding. There is nothing unreasonable, arbitrary or objectionable in this stipulation as would

warrant its nullification. The same was obviously designed to safeguard the insurer's interest against collusion between the insured and the claimants.

FACTS

Private respondent Milagros Cayas was the registered owner of a Mazda bus insured with Perla Compania De Seguros, Inc. (PCSI). The bus figured in an accident in Naic, Cavite and one of its passengers sued Milagros for damages. Three other injured passengers agreed to settle for P4,000 each with Cayas.

While the decision in this civil case was to be executed against Cayas, she filed a complaint with the Office of the Insurance Commissioner praying that PCSI be ordered to pay for all the claims against her arising from the vehicular accident. Realizing her procedural mistake, she later withdrew her complaint and consequently filed a complaint for a sum of money and damages against PCSI in the CFI of Cavite. She alleged therein that to satisfy the judgment in Civil Case No. NC-794, her house and lot were levied upon and sold at public auction. She further alleged that she sought reimbursement from PCSI, which notwithstanding the fact that her claim was within its contractual liability under the insurance policy, refused to make such reimbursement and that she suffered moral damages as a consequence of such refusal, and that she was constrained to secure the services of counsel to protect her rights. Petitioner however seeks to limit its liability to private respondent.

ISSUE

Whether or not petitioner may validly limit its liability to the insured? (YES)

RULING

The insurance policy involved explicitly limits petitioner's liability to P12,000.00 per person and to P50,000.00 per accident. Under the law, the minimum liability is P12,000 per passenger. Petitioner's liability under the insurance contract not being less than P12,000.00, and therefore not contrary to law, morals, good customs, public order or public policy, said stipulation must be upheld as effective, valid and binding as between the parties.

In like manner, we rule as valid and binding upon private respondent the condition above-quoted requiring her to secure the written permission of petitioner before effecting any payment in settlement of any claim against her. There is nothing unreasonable, arbitrary or objectionable in this stipulation as would warrant its nullification. The same was obviously designed to safeguard the insurer's interest against collusion between the insured and the claimants. It being specifically required that petitioner's written consent be first secured before any payment in settlement of any claim could be made, private respondent is precluded from seeking reimbursement of the payments made to the three other injured passengers in view of her failure to comply with the condition contained in the insurance policy.

MALAYAN INSURANCE CO., Petitioner, -versus- RODELIO ALBERTO and ENRICO ALBERTO REYES, Respondent.

G.R. No. 194320, THIRD DIVISION, February 1, 2012, VELASCO, JR. J.

Consistent with the ruling in Keppel Cebu Shipyard v. Pioneer Insurance “payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies that the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of, any privity of contract. It accrues simply upon payment by the insurance company of the insurance claim.”

FACTS

A vehicular accident occurred involving 4 vehicles, a Nissan Bus operated by Aladdin transit, an Isuzu Tanker, a Fuzo Cargo Truck, and a Mitsubishi Galant. Malayan Insurance insured the Mitsubishi Galant against third party liability, own damage and theft, among others. Having insured the vehicle against such risks, Malayan Insurance claimed in its Complaint that it paid the damages sustained by the assured amounting to PhP 700,000. Maintaining that it has been subrogated to the rights and interests of the assured by operation of law upon its payment to the latter, Malayan Insurance sent several demand letters to respondents Rodelio Alberto and Enrico Alberto Reyes, the registered owner and the driver, respectively, of the Fuzo Cargo Truck, requiring them to pay the amount it had paid to the assured. Respondents refused to settle their liability. Respondents claim that the documents presented by Malayan Insurance do not indicate certain important details that would show proper subrogation.

ISSUE

Whether or not the subrogation of Malayan Insurance is impaired and/or deficient? (NO)

RULING

Malayan Insurance has been properly subrogated to the rights of the assured. Malayan Insurance contends that there was a valid subrogation in the instant case, as evidenced by the claim check voucher and the Release of Claim and Subrogation Receipt presented by it before the trial court. Subrogation is the substitution of one person by another with reference to a lawful claim or right, so that he who is substituted succeeds to the rights of the other in relation to a debt or claim, including its remedies or securities. Payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies that the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of, any privity of contract. It accrues simply upon payment by the insurance company of the insurance claim.

i. Notice and Proof of Loss

FGU INSURANCE CORPORATION., *Petitioner*, -versus- **THE COURT OF APPEALS, SAN MIGUEL CORPORATION, and ESTATE OF ANG GUI,** represented by **LUCIO, JULIAN, and JAIME,** all surnamed **ANG, and CO TO,** *Respondent*.

G.R. No. 137775, SECOND DIVISION, March 31, 2005, CHICO-NAZARIO, J.

It is a basic rule in insurance that the carelessness and negligence of the insured or his agents constitute no defense on the part of the insurer. However, when evidence show that the insured's negligence or recklessness is so gross as to be sufficient to constitute a willful act, the insurer must be exonerated.

FACTS:

Anco Enterprises Company owned the M/T ANCO tugboat and the D/B Lucio barge which were operated as common carriers. San Miguel Corporation entered into agreement with ANCO wherein the latter will shipped its cargoes on board the D/B Lucio, for towage by M/T ANCO. They further agreed that SMC will insure the cargoes in order to recover indemnity in case of loss, hence the cargoes was insured with FGU Insurance Corporation.

ANCO failed to deliver to SMC's consignee the cargoes. As a consequence of the incident, SMC filed a complaint for Breach of Contract of Carriage and Damages against ANCO.

Subsequently, ANCO, with leave of court, filed a Third-Party Complaint against FGU on the ground that the loss of said cargoes occurred as a result of risks insured against in the insurance policy and during the existence and lifetime of said insurance policy. ANCO went on to assert that in case the court will order ANCO to pay SMC's claim, FGU should be held liable to indemnify or reimburse ANCO whatever amounts, or damages, it may be required to pay to SMC.

The trial court found ANCO liable to pay SMC and consequently FGU is liable to bear the 53% of the amount of the lost cargoes because the risk insured against was the cause of the loss. The appellate court affirmed in toto the decision of the lower court. Hence, the petition.

ISSUE

Whether or not FGU can be held liable under the insurance policy to reimburse ANCO for the loss of the Cargoes? (NO)

RULING

It is a basic rule in insurance that the carelessness and negligence of the insured or his agents constitute no defense on the part of the insurer. This rule however presupposes that the loss has occurred due to causes which could not have been prevented by the insured, despite the exercise of due diligence.

However, when evidence show that the insured's negligence or recklessness is so gross as to be sufficient to constitute a willful act, the insurer must be exonerated.

In the case at bar, ANCO's representatives had failed to exercise extraordinary diligence required of common carriers in the shipment of SMC's cargoes. Such blatant negligence being the proximate cause of the loss of the cargoes and is of such gross character that it amounts to a wrongful act which must exonerate FGU from liability under the insurance contract.

UNITED MERCHANTS CORPORATION., Petitioner, -versus- COUNTRY BANKERS INSURANCE CORPORATION, Respondent.

G.R. No. 198588, SECOND DIVISION, July 11, 2012, CARPIO, J.

It has long been settled that a false and material statement made with an intent to deceive or defraud voids an insurance policy. In fire insurance policies, which contain provisions such as Condition No. 15 of the Insurance Policy, a fraudulent discrepancy between the actual loss and that claimed in the proof of loss voids the insurance policy. Mere filing of such a claim will exonerate the insurer.

FACTS

UMC's General Manager Alfredo Tan insured UMC's stocks in trade of Christmas lights against fire with Country Bankers Insurance Corporation. A fire gutted the warehouse rented by UMC. Consequently, UMC, through the appointed adjuster of Country Bankers, submitted its Sworn Statement of Formal Claim, with proofs of its loss. It demanded for at least 50% payment of its claim from Country Bankers. However, Country Bankers rejected the claim due to breach of Condition No. 15 of the Insurance Policy which states that:

If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof, or if any fraudulent means or devices are used by the Insured or anyone acting in his behalf to obtain any benefit under this Policy; or if the loss or damage be occasioned by the willful act, or with the connivance of the Insured, all the benefits under this Policy shall be forfeited.

UMC filed a Complaint with the RTC of Manila. The RTC rendered a Decision in favor of UMC. However, the CA reversed the said decision. Hence, this petition.

ISSUE

Whether or not UMC is entitled to claim from Country Bankers the full coverage of its fire insurance policy? (NO)

RULING

It has long been settled that a false and material statement made with an intent to deceive or defraud voids an insurance policy. Furthermore, the Insurance Code provides that a policy may declare that a violation of specified provisions thereof shall avoid it. Thus, in fire insurance policies, which contain provisions such as Condition No. 15 of the Insurance Policy, a fraudulent discrepancy between the actual loss and that claimed in the proof of loss voids the insurance policy. Mere filing of such a claim will exonerate the insurer.

In the present case, the claim is twenty five times the actual claim proved. The most liberal human judgment cannot attribute such difference to mere innocent error in estimating or counting but to a deliberate intent to demand from insurance companies payment for indemnity of goods not existing at the time of the fire. This constitutes the so called fraudulent claim which, by express agreement between the insurers and the insured, is a ground for the exemption of insurers from civil liability.

Considering that all the circumstances point to the inevitable conclusion that UMC padded its claim and was guilty of fraud, UMC violated Condition No. 15 of the Insurance Policy. Thus, UMC forfeited whatever benefits it may be entitled under the Insurance Policy, including its insurance claim.

FINMAN GEN. ASSURANCE, *Petitioner*, -versus- COUNTRY BANKERS INSURANCE CORPORATION, *Respondent*.

G.R. No. 100970, SECOND DIVISION, September 2, 1992, NOCON, J.

The submission of a written notice of the loss is a condition precedent in claiming the proceeds of the policy. Indeed, as regards the submission of documents to prove loss, substantial compliance with the requirements will always be deemed sufficient.

FACTS

Pursuant to the fire insurance policy, Usiphil Incorporated filed with Finman General Assurance an insurance claim for the loss of the insured properties due to fire. Usiphil also submitted its Sworn Statement of Loss and Formal Claim together with Proof of Loss as compliance with the requirements of H.H. Bayned, the adjuster appointed by Finman General.

However, Finman General refused to pay the insurance claim on the ground that Usiphil Incorporated failed to comply with Policy Condition No. 13 regarding the submission of certain documents to prove the loss. Thus, Usiphil Incorporated filed a complaint for the unpaid insurance claim. The trial court rendered judgment in favor of Usiphil Incorporated, such judgment was affirmed by the CA. Hence, this petition.

ISSUE

Whether or not Usiphil Incorporated has complied with the condition of the policy as regards the submission of documents to prove loss? (YES)

RULING

Under the Policy Condition No. 13, the insured was required to submit to the insurer written notice of the loss; and a complete inventory of the properties damaged within 60 days after the fire, as well as a signed and sworn statement of Proof of Loss.

A perusal of the records shows that private respondent, after the occurrence of the fire, immediately notified petitioner thereof. Thereafter, private respondent submitted the following documents: (1) Sworn Statement of Loss and Formal Claim and; (2) Proof of Loss. The submission of these documents constitutes substantial compliance with the above provision. Indeed, as regards the submission of documents to prove loss, substantial compliance with the requirements will always be deemed sufficient.

In any case, petitioner itself acknowledged its liability when through its Finance Manager, it signed the document indicating that the amount due private respondent. Hence, even assuming that Usiphil Incorporated indeed failed to submit certain required documents as proof of loss per Section 13, such violation was waived by the insurer Finman when it signed the document. By such act, Finman acknowledged its liability under the insurance policy.

TAN IT, Petitioner, -versus- SUN INSURANCE OFFICE, Respondent.
G.R. No. L-27847, EN BANC, December 12, 1927, MALCOLM, J.

A false and material statement made with an intent to defraud avoids an insurance policy. In this case, the serious discrepancy between the true value of the property and that sworn to in the proofs of loss is to be considered as bearing upon the presence of fraud. It is more than an honest misstatement, more than inadvertence or mistake, more than a mere error in opinion, more than a slight exaggeration, and in connection with all the surrounding circumstances, discloses a material overvaluation made intentionally and willfully.

FACTS

This is an action on policy of fire insurance for the recovery of the sum of P23,895.64. Sun Insurance Office pleaded false swearing and fraud by way of defense. It claimed that there is a serious discrepancy between the actual value of the property and that sworn in the proof of loss. The Court of First Instance of Manila ordered Sun Insurance Office to pay Tan It the amount of P13,113. Both parties filed their appeal, Tan It seeks to obtain the full amount sued for, while Sun Insurance Office to avoid any recovery.

ISSUE

Whether or not Tan It's claim is fraudulent and thus voidable as contended by the Sun Insurance Office.

RULING

Clause 13 of the contract of insurance provides that:

"If the claim be in any respect fraudulent, or if any false declaration be made or used in support thereof, all benefit under this Policy shall be forfeited."

A false and material statement made with an intent to defraud avoids an insurance policy. It should not now be departed from out of a spirit of sympathy in one particular case. It is well for those who are unfortunate enough to have losses by fire to know that they can only hope to recoup themselves by fair dealing. No court could subscribe to a confirmation of a fire insurance claim dishonesty made.

In this case, the serious discrepancy between the true value of the property and that sworn to in the proofs of loss is to be considered as bearing upon the presence of fraud. It is more than an honest misstatement, more than inadvertence or mistake, more than a mere error in opinion, more than a slight exaggeration, and in connection with all the surrounding circumstances, discloses a material overvaluation made intentionally and willfully. Since Tan It's claim is fraudulent, all the benefits in the policy shall be forfeited. Therefore, he cannot claim from the policy.

INDUSTRIAL PERSONNEL AND MANAGEMENT SERVICES, INC., Petitioner, -versus- COUNTRY BANKERS INSURANCE CORP., Respondent.
G.R. No. 194126, SECOND DIVISION, October 17, 2018, MENDOZA, J.

Under the Insurance Code, all defects in the proof of loss, which the insured might remedy, are waived as grounds for objection when the insurer omits to specify to him without unnecessary delay.

FACTS

In 2000, Industrial Personnel and Management Services, Inc. (IPAMS) began recruiting registered nurses for work deployment in the United States of America (U.S.). It takes eighteen (18) to twenty four (24) months for the entire immigration process to complete. As the process requires huge amounts of money, such amounts are advanced [to] the nurse applicants.

By reason of the advances made to the nurse applicants, the latter were required to post surety bond. The purpose of the bond is to guarantee the following during its validity period: (a) that they will comply with the entire immigration process, (b) that they will complete the documents required, and (c) that they will pass all the qualifying examinations for the issuance of immigration visa. The Country Bankers Insurance Corporation (Country Bankers for brevity) and IPAMS agreed to provide bonds for the said nurses. Under the agreement of IPAMS and Country Bankers, the latter will provide surety bonds and the premiums therefor were paid by IPAMS on behalf of the nurse applicants.

A Memorandum of Agreement (MOA) was executed by the said parties on February 1, 2002 which stipulated the various requirements for collecting claims from Country Bankers.

On the basis of the MOA, IPAMS submitted its claims under the surety bonds issued by Country Bankers. For its part, Country Bankers, upon receipt of the documents enumerated under the MOA, paid the claims to IPAMS. According to IPAMS, starting 2004, some of its claims were not anymore settled by Country Bankers.

In 2004, Country Bankers was not able to pay six (6) claims of IPAMS. The claims were not denied by Country Bankers, which instead asked for time within which to pay the claims, as it alleged to be cash strapped at that time. Thereafter, the number of unpaid claims increased. By February 16, 2007, the total amount of unpaid claims was P11,309,411.56.

IPAMS took the matter up with the General Manager of Country Bankers, Mr. Ignacio Ong (Ong). In response, Country Bankers, through its letter dated November 14, 2005 signed by Mr. Ong, acknowledged the obligations of Country Bankers, apologized for the delay in the payment of claims, and proposed to amortize the settlement of claims by paying a semi-monthly amount of P850,000.00. In addition, Country Bankers promised to pay future claims within a ninety (90)-day period. That commitment made by Country Bankers was not fulfilled and IPAMS had to deal with Country Bankers' new General Manager, Ms. Tess Valeriano (Valeriano). Ms. Valeriano assured IPAMS that the obligations of Country Bankers would be paid promptly.

However, the counsel of Country Bankers, Atty. Marisol Caleja, started to oppose the payment of claims and insisted on the production of official receipts of IPAMS on the expenses it incurred for the application of nurses. IPAMS opposed this, saying that the Country Bankers' insistence on the production of official receipts was contrary to, and not contemplated in, the MOA and was an impossible condition considering that the U.S. authorities did not issue official receipts. In lieu of official receipts, IPAMS submitted statements of accounts, as provided in the MOA.

Then, in a letter dated August 22, 2006, Country Bankers limited the authority of its agent [assigned to the accounts of IPAMS,] Mr. Jaime C. Lacaba [(Lacaba),] to transact business with IPAMS.

Due to the unwillingness of Country Bankers to settle the claims of IPAMS, the latter sought the intervention of the IC, through a letter-complaint dated February 9, 2007.

Country Bankers on the other hand alleged that until the third quarter of 2006, it never received any complaint from IPAMS. Due to remarkable high loss ratio of IPAMS, the latter's accounts were evaluated and audited by the Country Bankers. The IPAMS was informed of the same problem. Instead of complying with the requirements for claim processes, IPAMS insisted that the supporting documents cannot be produced.

ISSUE

Whether or not the CA erred in issuing its assailed Decision which reversed and set aside the rulings of the IC, DOF, and OP, which found that respondent Country Bankers has no ground to refuse the payment of petitioner IPAMS' claims and shall accordingly be subjected to disciplinary action pursuant to Sections 241 (now Section 247) and 247 (now Section 254) of the Insurance Code if the latter does not settle the subject claims of petitioner IPAMS? (YES)

RULING

While placing utmost concentration on Article 2199 of the Civil Code in ruling that competent proof is required for the payment of the subject claims, the assailed Decision of the CA failed to take into consideration the applicable provisions of the Insurance Code.

The subject agreement of the parties indubitably contemplates a surety agreement, which is governed mainly by the Insurance Code, considering that a contract of suretyship shall be deemed an insurance contract within the contemplation of the Insurance Code if made by a surety which is doing an insurance business. In this case, the surety, *i.e.*, respondent Country Bankers, is admittedly an insurance company engaged in the business of insurance. In fact, the CA itself in its assailed Decision mentioned that a contract of suretyship is defined and covered by the Insurance Code.

Moreover, the Insurance Code specifically provides applicable provisions on suretyship, stating that pertinent provisions of the Civil Code shall only apply *suppletorily* whenever necessary in interpreting the provisions of a contract of suretyship. Jurisprudence also holds that a specific law should prevail over a law of general character.

Hence, in the resolution of the instant case, the CA erred in not considering the applicable provisions under the Insurance Code on the required proof of loss and when such requirement is waivable.

Therefore, Section 92 of the Insurance Code must be taken into consideration. The said provision states that all defects in the proof of loss, which the insured might remedy, are **waived as grounds for objection** when the insurer omits to specify to him without unnecessary delay. It is the duty of the insurer to indicate the defects on the proofs of loss given, so that the deficiencies may be supplied by the insured. When the insurer recognizes his liability to pay the claim, there is waiver by the insurer of any defect in the proof of loss.

In the instant case, it must be emphasized that respondent Country Bankers, through its General Manager, Mr. Ong, issued a letter dated November 14, 2005 which readily acknowledged the obligations of Country Bankers under the surety agreement, apologized for the delay in the payment of claims, and proposed to amortize the settlement of claims by paying a semi-monthly amount of P850,000.00. In addition, Country Bankers promised to pay future claims within a 90-day period:

First of all, allow us to apologize for the delay in our response to you considering that we still had to do some reconciliation of our records with that of Mr. Lacaba. After evaluating the total number of claims filed by IPAMS, we have come up with the final figure of P20,575,492.25.

In this regard, we wish to propose to amortize the settlement of the said amount by paying you the semi-monthly amount of P850,000.00 until the entire amount of P20,575,492.25 is fully paid. With respect to future claims (after the cut-off date, October 28, 2005), we shall see to it that they are settled within the 90 days time frame allowed us.

It bears stressing that respondent Country Bankers, after undergoing an evaluation of the total number of claims of petitioner IPAMS, undertook the settlement of such claims even **WITHOUT** the submission of official receipts.

In fact, respondent Country Bankers raised up the issue on the missing official receipts and other evidence to prove the expenses incurred by petitioner IPAMS only when the latter requested the intervention of the IC in 2007. If respondent Country Bankers truly believed that the submission of official receipts was critical in providing proof as to petitioner IPAMS' claims, then it would have raised the issue on the lack of official receipts at the earliest possible opportunity. This only shows that the argument of respondent Country Bankers on the lack of official receipts was a mere afterthought to evade its obligation to pay the claims presented by petitioner IPAMS.

While not denying the existence of the said letter, respondent Country Bankers attempts to downplay it by arguing that the claims covered by the letter and the claims raised by petitioner IPAMS before the IC are different and distinct from each other. Such argument deserves scant consideration.

While the claims in the said letter may be different from the specific claims presented before the IC, both sets of claims were similarly made under the same suretyship agreement between the parties. Thus, the fact still remains that respondent Country Bankers had previously acknowledged the validity of a set of claims under a surety bond within the purview of the Requirements for Claim Clause despite the lack of official receipts and other pieces of evidence aside from the required documents enumerated in the MOA. To be sure, it must also be pointed out that the representations of respondent Country Bankers in the said letter likewise refer to future and similar claims of petitioner IPAMS. Hence, respondent Country Bankers' attempt to downplay the ramifications of its letter dated November 14, 2005 is puerile.

Also, it must be emphasized that the IC, after holding a series of conferences between the parties and after the assessment of the respective position papers and evidence from both parties, made the factual finding in its Resolution dated June 26, 2007 that respondent Country Bankers committed certain acts constituting a waiver of its right to require the presentation of additional documents to prove the expenses incurred by petitioner IPAMS, such as the issuance of the letter dated November 14, 2005 and the acceptance by respondent Country Bankers of reimbursement from the nurse applicants of petitioner IPAMS on the basis of the Statements of Accounts presented, even without

any official receipt attached. **In fact, the records show that respondent Country Bankers does not deny the fact that it accepted the reimbursements from the nurse applicants based on the Statements of Accounts of petitioner IPAMS.**

Furthermore, the DOF likewise factually determined that respondent Country Bankers, through its new General Manager, Ms. Valeriano, had assured IPAMS that the obligations of Country Bankers would be paid promptly, again, even without the submission of official receipts and other pieces of evidence. The DOF similarly found that the proposal by respondent Country Bankers to amortize the settlement of petitioner IPAMS' claims by paying the latter the semi-monthly amount of P850,000.00 and respondent Country Bankers' acceptance of reimbursements from the nurse applicants based on the mere Statements of Accounts submitted by petitioner IPAMS are tantamount to an acknowledgment on the part of respondent Country Bankers of its liability for claims under the surety bonds.

Moreover, the OP also factually found that respondent Country Bankers "knew as a matter of IPAMS' regular course of business that these covered transactions are generally not issued official receipts by US government and its agencies and the US based professional organizations and institutions involved to complete the requirements for the issuance of an immigrant visa."

These factual findings of three separate administrative agencies, **which were not at all reversed or refuted by the CA in its assailed Decision**, should not be perturbed by the Court without any compelling countervailing reason. The Court has continuously adopted the policy of respecting the findings of facts of specialized administrative agencies.

In *Villafor v. Court of Appeals*, the Court held that the findings of fact of an administrative agency must be respected as long as they are supported by substantial evidence, even if such evidence might not be overwhelming or even preponderant, because it is not the task of an appellate court to weigh once more the evidence submitted before the administrative body and to substitute its own judgment for that of the administrative agency in respect of sufficiency of evidence.

Hence, considering that the IC, through the Insurance Commissioner, is particularly tasked by the Insurance Code to issue such rulings, instructions, circulars, orders and decisions as may be deemed necessary to secure the enforcement of the provisions of the law, to ensure the efficient regulation of the insurance industry, and considering that there are no compelling reasons provided by respondent Country Bankers to overthrow the IC's factual findings, the Court upholds the findings of the IC, as concurred in by both the DOF and OP, that respondent Country Bankers committed certain acts constituting a waiver of its right to require the presentation of additional documents to prove the expenses incurred by petitioner IPAMS.

Accordingly, under Section 92 of the Insurance Code, the failure to attach official receipts and other documents evidencing the expenses incurred by petitioner IPAMS, even assuming that it can be considered a defect on the required proof of loss, is therefore considered waived as ground for objecting the claims of petitioner IPAMS.

ii. Guidelines on Claims Settlement

d. Unfair Claims Settlement; Sanctions

e. Prescription of Action

SUMMIT GUARANTY AND INSURANCE COMPANY, INC., *Petitioner*, -versus- **HON. JOSE C. DE GUZMAN, IN HIS CAPACITY AS PRESIDING JUDGE OF BRANCH III, CFI OF TARLAC, ET AL.,**
Respondent.

G.R. No. L-50997, EN BANC, June 30, 1987, GANCAYCO, J.

The plaintiff's cause of action did not accrue until his claim was finally rejected by the insurance company. The one-year period should be counted from the date of rejection by the insurer as this is the time when the cause of action accrues. In the cases at bar, no denial of the claims was ever made and hence there has yet been no accrual of cause of action. Therefore, the prescription has not yet set in.

FACTS

These three consolidated cases arose from three separate complaints filed against Summit Guaranty and Insurance Company, Inc. for the payment of insurance on insurance policies issued by the latter.

Private respondents Jose Ledesma, Geronima Pulmano and Amelia Generao were insured with Summit Guaranty and Insurance Company for purposes of Third Party Liability. They all filed, in separate cases, notice of claim with Summit Guaranty. However, the petitioner failed to act on their claim. Consequently, Ledesa and Pulmano filed a complaint before the Insurance Commission. Summit Guaranty claims that the complaints of private respondents, having been filed beyond the one-year period provided in Section 384 of the Insurance Code, can no longer prosper.

ISSUE

Whether or not the causes of action of private respondents have already prescribed? (NO)

RULING

The plaintiff's cause of action did not accrue until his claim was finally rejected by the insurance company. This is because, before such final rejection, there was no real necessity for bringing suit. Since a "cause of action" requires, as essential elements, not only a legal right of the plaintiff and a correlative obligation of the defendant but also "an act or omission of the defendant in violation of said legal right," the cause of action does not accrue until the party obligated refuses, expressly or impliedly, to comply with its duty.

In the cases at bar, no denial of the claims was ever made and on the contrary, private respondents were made to believe that they will be paid by petitioner company. The alleged delay was not caused by herein private respondents but by the petitioner company itself.

The one-year period should instead be counted from the date of rejection by the insurer as this is the time when the cause of action accrues. Since in these cases there has yet been no accrual of cause of action, the Court holds that prescription has not yet set in.

SUN INSURANCE OFFICE, LTD. v. COURT OF APPEALS and EMILIO TAN
G.R. No. 89741, March 13, 1991, PARAS, J.

The cause of action in an insurance contract does not accrue until the insured's claim is finally rejected by the insurer. But rejection referred to should be construed as the rejection, in the first instance and not rejection of a petition for reconsideration. To uphold the latter view will run counter to the declared purpose for requiring that an action or suit be filed in the Insurance Commission or in a court of competent jurisdiction from the denial of the claim.

FACTS

Emilio Tan took from Sun Insurance a property insurance policy to cover his interest in the electrical supply store of his brother housed in a building. Four (4) days after the issuance of the policy, the building was burned including the insured store. Tan filed his claim for fire loss with petitioner, but on February 29, 1984, petitioner denied his claim. Tan wrote petitioner, seeking reconsideration of the denial of his claim but petitioner answered on October 11, 1985, advising that the Insurer's denial of claim remained unchanged.

On November 20, 1985, Tan filed Civil Case with the RTC but petitioner filed a motion to dismiss on the alleged ground that the action had already prescribed. The said motion was denied which was thereafter affirmed by the CA. Hence, the instant petition. The contention of Sun Life Insurance is that the complaint of Emilio Tan was filed beyond the one year prescriptive period counting from the denial of his claim on February 29, 1984 and not from the denial of his motion for reconsideration.

ISSUE

Whether or not the filing of a motion for reconsideration interrupts the one year prescriptive period to contest the denial of the insurance claim.

RULING

No. The right of the insured to the payment of his loss accrues from the happening of the loss. However, the cause of action in an insurance contract does not accrue until the insured's claim is finally rejected by the insurer. This is because before such final rejection there is no real necessity for bringing suit. But rejection referred to should be construed as the rejection, in the first instance, for if what is being referred to is a reiterated rejection conveyed in a resolution of a petition for reconsideration, such should have been expressly stipulated.

The contention of the respondents that the one-year prescriptive period does not start to run until the petition for reconsideration had been resolved by the insurer, runs counter to the declared purpose for requiring that an action or suit be filed in the Insurance Commission or in a court of competent jurisdiction from the denial of the claim. To uphold respondents' contention would contradict and defeat the very principle which this Court had laid down. Therefore, the final rejection cannot be taken to mean the rejection of a petition for reconsideration as insisted by Emilio Tan instead, it should be the rejection in the first instance as in this case, on February 29, 1984.

COUNTRY BANKERS INSURANCE CORP. (Formerly Country Bankers Insurance & Surety Co. Inc.) v. THE TRAVELLERS INSURANCE AND SURETY CORP., and THE HONORABLE COURT OF APPEALS

G.R. No. 82509, August 16, 1989, CORTES, J.

Where the delay in bringing the suit against the insurance company was not caused by the insured or its subrogee but by the insurance company itself, it is unfair to penalize the insured or its subrogee by dismissing its action against the insurance company on the ground of prescription.

FACTS

Country Bankers Insurance is the insurer of PTCI for its Toyota Land Cruiser, while Travellers Insurance is the insurer of Avelino Matundan for his Isuzu Cargo truck. Country Bankers paid PTCI for the damage and loss it suffered from a vehicular accident caused by the Isuzu Cargo Truck. Thereafter, as subrogee, Country Bankers Insurance Corporation demanded reimbursement from Travellers Insurance. However, one year after such demand, Travellers refused to pay Country Bankers.

Consequently, Country Bankers filed a complaint in the RTC of Manila. The RTC ordered Travellers Insurance to pay the petitioner. The CA, however, dismissed the complaint on the ground that petitioner's cause of action had prescribed for having filed beyond the one year period for filing a court action against the insurer.

ISSUE

Whether or not Country Bankers Insurance's cause of action had prescribed.

RULING

Country Bankers Insurance's cause of action has not prescribed. The one-year period should be counted from the date of the rejection of the claim by the insurer. It is only from the rejection of the claim by the insurer that the insured's cause of action accrued since a cause of action does not accrue until the party obligated refuse, expressly or impliedly, to comply with its duty.

However, where the delay in bringing the suit against the insurance company was not caused by the insured or its subrogee but by the insurance company itself, it is unfair to penalize the insured or its subrogee by dismissing its action against the insurance company on the ground of prescription.

In the instant case, petitioner sent a notice of claim to respondent insurance company two months after the accident. However, it was only a year later that respondent replied to petitioner's letter informing it that they could not take appropriate action on petitioners claim because the attending adjuster was still negotiating the case.

H.H. HOLLERO CONSTRUCTION, INC. v. GOVERNMENT SERVICE INSURANCE SYSTEM and POOL OF MACHINERY INSURERS

G.R. No. 152334, September 24, 2014, PERLAS-BERNABE, J.

The prescriptive period for the insured's action for indemnity should be reckoned from the final rejection of the claim. The final rejection simply means denial by the insurer of the claims of the insured and not the rejection or denial by the insurer of the insured's motion or request for reconsideration. The rejection referred to should be construed as the rejection in the first instance.

FACTS

The GSIS and H.H. Hollero Construction entered into a Project Agreement whereby the latter undertook the development of a GSIS housing project. It also obligated itself to insure the Project, including all the improvements, upon the execution of the Agreement under a Contractors' All Risks Insurance with the GSIS General Insurance Department.

Under the policies, it was provided that, among others, all benefits thereunder shall be forfeited if no action is instituted within twelve (12) months after the rejection of the claim for loss, damage or liability. During the construction, three typhoons hit the country which caused considerable damage to the Project. Accordingly, petitioner filed several claims for indemnity with the GSIS. However, GSIS rejected petitioner's indemnity claims for the damages. Consequently, the petitioner filed a Complaint for Sum of Money and Damages before the RTC. GSIS filed a Motion to Dismiss on the ground that the causes of action stated therein are barred by the twelve-month limitation because the complaint was filed more than one(1) year from the rejection of the indemnity claims.

The RTC denied the said motion and granted petitioner's indemnity claims, but it was set aside and reversed by the CA. Hence, this petition.

ISSUE

Whether or not the claim for indemnity of H.H. Hollero Construction has prescribed.

RULING

The complaint filed by H.H. Hollero Construction for indemnity was already barred by prescription. The right of the insured to the payment of his loss accrues from the happening of the loss. However, the cause of action in an insurance contract does not accrue until the insured's claim is finally rejected by the insurer. This is because before such final rejection there is no real necessity for bringing suit. In this relation, the prescriptive period for the insured's action for indemnity should be reckoned from the final rejection of the claim. The final rejection simply means denial by the insurer of the claims of the insured and not the rejection or denial by the insurer of the insured's motion or request for reconsideration. The rejection referred to should be construed as the rejection in the first instance.

In light of the foregoing, it is thus clear that petitioner's causes of action for indemnity respectively accrued from its receipt of the letters dated April 26, 1990 and June 21, 1990, or the date the GSIS rejected its claims in the first instance. Consequently, given that it allowed more than twelve (12) months to lapse before filing the necessary complaint before the RTC on September 27, 1991, its causes of action had already prescribed.

a. Subrogation

PAN MALAYAN INSURANCE CORPORATION COURT OF APPEALS, ERLINDA FABIE AND HER UNKNOWN DRIVER

G.R. No. 81026 April 3, 1990 CORTES, J.

Payment by the insurer to the assured operates as an equitable assignment to the former of all remedies which the latter may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of, any privity of contract or upon written assignment of claim. It accrues simply upon payment of the insurance claim by the insurer

FACTS

PANMALAY filed a complaint for damages against private respondents Erlinda Fabie and her driver. PANMALAY averred the following that: it insured a vehicle registered in the name of Canlubang Automotive Resources Corporation [CANLUBANG]; due to the "carelessness, recklessness, and imprudence" of the driver of the pick-up and his employer, Erlinda Fabie, the insured car was hit and suffered damages; PANMALAY defrayed the cost of repair of the insured car and, therefore, was subrogated to the rights of CANLUBANG against the driver of the pick-up and his employer, Erlinda Fabie.

ISSUE

Whether PANMALAY is subrogated to the rights of CANLUBANG upon payment of the former to the latter.

RULING

Yes. Article 2207 of the Civil Code is founded on the well-settled principle of subrogation. If the insured property is destroyed or damaged through the fault or negligence of a party other than the assured, then the insurer, upon payment to the assured, will be subrogated to the rights of the assured to recover from the wrongdoer to the extent that the insurer has been obligated to pay. Payment by the insurer to the assured operates as an equitable assignment to the former of all remedies which the latter may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of, any privity of contract or upon written assignment of claim. It accrues simply upon payment of the insurance claim by the insurer.

ABOITIZ SHIPPING CORPORATION -versus- INSURANCE COMPANY OF NORTH AMERICA

G.R. No. 168402 August 6, 2008 REYES, R.T., J.

The right of subrogation attaches upon payment by the insurer of the insurance claims by the assured. As subrogee, the insurer steps into the shoes of the assured and may exercise only those rights that the assured may have against the wrongdoer who caused the damage.

FACTS

MSAS Cargo International Limited and/or Associated and/or Subsidiary Companies (MSAS) procured a marine insurance policy from respondent ICNA UK Limited of London. The insurance was for a transshipment of certain wooden work tools and workbenches purchased for the consignee Science Teaching Improvement Project (STIP). ICNA issued an "all-risk" open marine policy. The cargo was shipped by various carriers without any issue until said cargo was received by Aboitiz Shipping Corporation (Aboitiz). The cargo was withdrawn by STIP and delivered to Don Bosco Technical High School where it was found that the cargo sustained water damage. It was received by Mr. Bernhard Willig and filed a formal claim with Aboitiz.

Aboitiz refused to settle the claim. ICNA paid the consignee and a subrogation receipt was duly signed by Willig. ICNA formally advised Aboitiz of the claim and subrogation receipt executed in its favor.

Despite follow-ups, however, no reply was received from Aboitiz.

ISSUE

Whether ICNA is subrogated to the rights of the consignee upon payment of the claim the former to the latter.

RULING:

Yes. Upon payment to the consignee of indemnity for damage to the insured goods, ICNA's entitlement to subrogation equipped it with a cause of action against petitioner in case of a contractual breach or negligence. This right of subrogation, however, has its limitations. First, both the insurer and the consignee are bound by the contractual stipulations under the bill of lading. Second, the insurer can be subrogated only to the rights as the insured may have against the wrongdoer. If by its own acts after receiving payment from the insurer, the insured releases the wrongdoer who caused the loss from liability, the insurer loses its claim against the latter.

None of the said limitations are present.

MALAYAN INSURANCE CO., INC. -versus- RODELIO ALBERTO and ENRICO ALBERTO REYES

G.R. No. 194320 February 1, 2012 VELASCO, JR., J.

Subrogation is the substitution of one person by another with reference to a lawful claim or right, so that he who is substituted succeeds to the rights of the other in relation to a debt or claim, including its remedies or securities. The principle covers a situation wherein an insurer has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy. It contemplates full substitution such that it places the party subrogated in the shoes of the creditor, and he may use all means that the creditor could employ to enforce payment.

FACTS

An accident occurred involving four (4) vehicles, to wit: (1) a Nissan Bus; (2) an Isuzu Tanker; (3) a Fuzo Cargo Truck; and (4) a Mitsubishi Galant. The Isuzu Tanker was in front of the Mitsubishi Galant with the Nissan Bus on their right side shortly before the vehicular incident. All three (3) vehicles were at a halt along EDSA facing the south direction when the Fuzo Cargo Truck simultaneously bumped the rear portion of the Mitsubishi Galant and the rear left portion of the Nissan Bus. Due to the strong impact, these two vehicles were shoved forward and the front left portion of the Mitsubishi Galant rammed into the rear right portion of the Isuzu Tanker.

Malayan Insurance issued a Car Insurance Policy in favor of First Malayan Leasing and Finance Corporation (the assured), insuring the aforementioned Mitsubishi Galant against third party liability, own damage and theft, among others. Having insured the vehicle against such risks, Malayan Insurance claimed that it paid the damages sustained by the assured.

ISSUE

Whether or not Malayan Insurance is subrogated to the rights of assured upon payment of the former to the latter.

RULING

Yes. The Court held that payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies that the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of, any privity of contract. It accrues simply upon payment by the insurance company of the insurance claim. The doctrine of subrogation has its roots in equity. It is designed to promote and to accomplish justice; and is the mode that equity adopts to compel the ultimate payment of a debt by one who, in justice, equity, and good conscience, ought to pay.

Considering the above ruling, it is only but proper that Malayan Insurance be subrogated to the rights of the assured.

**THE PHILIPPINE AMERICAN GENERAL INSURANCE COMPANY, INC. v. SHIPPING LINES COURT
OF APPEALS and FELMAN**

G.R. No. 116940 June 11, 1997 BELLOSILLO, J.

If the plaintiff's property has been insured, and he has received indemnity from the insurance company for the injury or loss arising out of the wrong or breach of contract complained of, the insurance company shall be subrogated to the rights of the insured against the wrongdoer or the person who has violated the contract. If the amount paid by the insurance company does not fully cover the injury or loss, the aggrieved party shall be entitled to recover the deficiency from the person causing the loss or injury.

FACTS

Coca-Cola Bottlers Philippines, Inc., loaded on board "MV Asilda," a vessel owned and operated by respondent Felman Shipping Lines, cases of 1-liter Coca-Cola softdrink bottles for consignee Coca-Cola Bottlers Philippines, Inc., Cebu. The shipment was insured with petitioner Philippine American General Insurance Co., Inc. (PHILAMGEN), under a Marine Insurance Policy. The vessel sank bringing down her entire cargo with her including the subject cases of 1-liter Coca-Cola softdrink bottles.

Coca-Cola Bottlers Philippines, Inc., Cebu plant, filed a claim with respondent FELMAN for recovery of damages it sustained as a result of the loss of its softdrink bottles that sank with "MV Asilda." Respondent denied the claim thus prompting the consignee to file an insurance claim with PHILAMGEN which paid its claim. Claiming its right of subrogation PHILAMGEN sought recourse against respondent FELMAN which disclaimed any liability for the loss.

ISSUE

Whether or not PHILAMGEN is subrogated to the rights of Coca-Cola Bottlers Philippines, Inc. Cebu upon payment of the former to the latter.

RULING

Yes. Payment by the assurer to the assured operates as an equitable assignment to the assurer of all the remedies which the assured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of any privity of contract or upon payment by the insurance company of the insurance claim. It accrues simply upon payment by the insurance company of the insurance claim.

The doctrine of subrogation has its roots in equity. It is designed to promote and to accomplish justice and is the mode which equity adopts to compel the ultimate payment of a debt by one who in justice, equity and good conscience ought to pay. Therefore, the payment made by PHILAMGEN to Coca-Cola Bottlers

Philippines, Inc., gave the former the right to bring an action as subrogee against FELMAN. Having failed to rebut the presumption of fault, the liability of FELMAN for the loss of the cases of 1-liter Coca-Cola softdrink bottles is inevitable.

FIREMAN'S FUND INSURANCE COMPANY and FIRESTONE TIRE AND RUBBER COMPANY OF THE PHILIPPINES, plaintiffs-appellants, -versus- JAMILA & COMPANY, INC. and FIRST QUEZON CITY INSURANCE CO., INC., defendants-appellees.

G.R. No. L-27427, April 7, 1976, AQUINO, J.

The right of subrogation, which is founded on principles of justice and equity, does not depend upon privity of contract.

FACTS

Jamila & Company, Inc. (Jamila) contracted with Firestone Tire & Rubber Company of the Philippines (Firestone) to supply the latter with security guards. It also assumed responsibility for the acts of its guards. The properties of Firestone were insured with Fireman's Fund Insurance Company (Fireman's Fund). Later on, Firestone's properties were allegedly stolen by its employees who connived with Jamila's guards. Fireman's Fund paid Firestone the amount of the loss. Claiming right of subrogation, Fireman's Fund sought to collect from Jamila but to no avail, prompting Fireman's Fund to file a collection suit against Jamila, which moved to dismiss the complaint, arguing that Fireman's Fund had no cause of action, because it failed to allege that Jamila consented to the subrogation.

ISSUE

Whether or not Jamila's consent is necessary for Fireman's Fund to avail of the right of subrogation.

RULING

No. When the insurance company pays for the loss, such payment operates as an equitable assignment to the insurer of the property and all remedies which the insured may have for the recovery thereof. That right is not dependent upon, nor does it grow out of, any privity of contract, or upon written assignment of claim, and payment to the insured makes the insurer an assignee in equity.

**ST. PAUL FIRE & MARINE INSURANCE CO., plaintiff-appellant, vs. MACONDRAY & CO., INC.,
BARBER STEAMSHIP LINES, INC., WILHELM WILHELMSSEN MANILA PORT SERVICE and/or
MANILA RAILROAD COMPANY, defendants-appellees.**

G.R. No. L-27796, March 25, 1976, ANTONIO, J.

When exercising its right of subrogation, an insurance company cannot recover beyond what its insured was entitled to.

FACTS

Winthrop Products, Inc. (Shipper) of New York shipped aboard a vessel owned by Wilhelm Wilhelmsen (Carrier) cartons and drums of drugs and medicine. The shipment was covered by a bill of lading which stipulated, among others, that the carrier's liability with respect to lost or damaged shipments are expressly limited to the C.I.F. value of the goods. It was also insured with St. Paul Fire & Marine Insurance Co. (Insurer). Upon arrival at the Port of Manila, several cartons were received in bad order condition, hence the consignee filed a claim with the carrier, as well as Macondray & Co., Barber Steamship Lines, Inc., and Manila Railroad Company, in the amount of P1,109.67 representing the C.I.F. value of the damaged goods, but they refused, so it was the insurer that paid the value of the insured goods, including other expenses in connection therewith, in the total amount of US\$1,134.46. Thereafter, the insurer sued the carrier, Macondray, Barber, and Manila Railroad (defendants) to collect US\$1,134.46. The defendants argued that their liability should be limited to what was stipulated in the bill of lading. The trial court ruled in favor of the defendants. Hence, this appeal.

ISSUE

Whether or not the insurer can collect an amount bigger than what was stipulated in the bill of lading.

RULING

No. A stipulation fixing or limiting the sum that may be recovered from the carrier on the loss or deterioration of the goods is valid, provided it is (a) reasonable and just under the circumstances, and (b) has been fairly and freely agreed upon. In this case, it appears that the condition in the bill of lading was reasonable and was freely and fairly agreed upon, hence the shipper and consignee are bound by such stipulation. St. Paul Fire & Marine Insurance Co., as insurer, after paying the claim of the insured for damages under the insurance, is subrogated merely to the rights of the assured. As subrogee, it can recover only the amount that is recoverable by the latter. Since the right of the assured, in case of loss or damage to the goods, is limited or restricted by the provisions in the bill of lading, a suit by the insurer as subrogee necessarily is subject to like limitations and restrictions.

**MANILA MAHOGANY MANUFACTURING CORPORATION, petitioner, v. COURT OF APPEALS
AND ZENITH INSURANCE CORPORATION, respondents.**

G.R. No. L-52756, October 12, 1987, PADILLA, J.

The insurer's right of subrogation may be defeated when the insured releases the wrongdoer from liability, in which case the insurer may recover whatever it has paid to the insured.

FACTS

Manila Mahogany Manufacturing Corporation (Manila Mahogany) insured its Mercedes Benz car with Zenith Insurance Corporation. The car was bumped and damaged by a truck owned by San Miguel Corporation (SMC). For the damage caused, Zenith Insurance paid Manila Mahogany P5,000. However, Zenith Insurance was not able to collect from SMC, because it so happened that SMC already paid Manila Mahogany for which it executed a release claim discharging SMC from all actions or claims. Hence, Zenith Insurance demanded for the return of the money it paid Manila Mahogany, but the latter refused prompting Zenith Insurance to file a complaint against Manila Mahogany.

ISSUE

Whether or not Zenith Insurance is entitled to the return of the money it paid Manila Mahogany.

RULING

Yes. The right of subrogation can only exist after the insurer has paid the insured. If the insurance proceeds are not sufficient to cover the damages suffered by the insured, then he may sue the party responsible for the damage for the remainder. Since the insurer can be subrogated to only such rights as the insured may have, should the insured, after receiving payment from the insurer, release the wrongdoer who caused the loss, the insurer loses his rights against the latter. But in such a case, the insurer will be entitled to recover from the insured whatever it has paid to the latter, unless the release was made with the consent of the insurer.

DELSAN TRANSPORT LINES, INC., petitioner, v. THE HON. COURT OF APPEALS and AMERICAN HOME ASSURANCE CORPORATION, respondents.
G.R. No. 127897, November 15, 2001, DE LEON, JR., J.

The right of subrogation accrues simply upon payment by the insurance company of the insurance claim.

FACTS

Caltex entered into a contract of affreightment with Delsan Transport Lines whereby the latter agreed to transport Caltex's oils from Batangas to different parts of the country. Caltex's shipment was insured with American Homes Assurance Corporation. Delsan's vessel set sail, but unfortunately it sank along with the entire cargo of fuel oil. American Homes paid Caltex the amount representing the insured value of the lost cargo. Exercising its right of subrogation, American Homes demanded reimbursement from Delsan but failed, hence it filed a collection suit against the latter. In its defense, Delsan invoked Sec. 113 of the Insurance Code, which states that in every marine insurance upon a ship or freight, or freightage, or upon any thin which is the subject of marine insurance there is an implied warranty by the shipper that the ship is seaworthy. Consequently, the insurer will not be liable to the assured for any loss under the policy in case the vessel would later on be found as not seaworthy at the inception of the insurance. Delsan theorized that American Homes' payment to Caltex of the value of its lost cargo is tantamount to a tacit recognition that the vessel was seaworthy, which would mean that Delsan is not liable.

ISSUE

Whether or not the payment made by the American Homes to Caltex for the insured value of the lost cargo amounted to an admission that the vessel was seaworthy, thus precluding any action for recovery against Delsan.

RULING

No. The payment made by American Homes for the insured value of the lost cargo operates as waiver of its right to enforce the term of the implied warranty against Caltex under the marine insurance policy. However, the same cannot be validly interpreted as an automatic admission of the vessel's seaworthiness by American Homes as to foreclose recourse against Delsan for any liability under its contractual obligation as a common carrier. The fact of payment grants American Homes subrogatory right which enables it to exercise legal remedies that would otherwise be available to Caltex as owner of the lost cargo against Delsan, the common carrier. The right of subrogation has its roots in equity. It is designed to promote and to accomplish justice and is the mode which equity adopts to compel the ultimate payment of a debt by one who in justice and good conscience ought to pay. It is not dependent upon, nor does it grow out of, any privity of contract or upon written assignment of claim. It accrues simply upon payment by the insurance company of the insurance claim. Consequently, the payment made by American Homes (insurer) to Caltex (assured) operates as an equitable assignment to the former of all the remedies which the latter may have against Delsan.

EASTERN SHIPPING LINES, INC. v. PRUDENTIAL GUARANTEE AND ASSURANCE, INC.

G.R. No. 174116, September 11, 2009, DEL CASTILLO, J.

Presentation or attaching the insurance policy in a complaint filed by the insurance company against another on account of its right of subrogation is an indispensable requirement. Failure to present the policy would warrant the dismissal of the complaint.

FACTS

The petitioner Eastern Shipping Lines is being sued by the respondent Prudential Guarantee and Assurance Inc. through its right of subrogation. This is on account of the damage sustained by the policy holder, Nissan Corp.

It is the contention of the petitioner that the respondent cannot sue based on its right of subrogation because the insurance policy was never presented by the respondent. Hence, the petitioner argues that there was no proper subrogation.

ISSUE

Whether or not the respondent can, by right of subrogation, sue the petitioner for damages despite the fact that the insurance policy was never presented.

RULING

No. Marine insurance policy needs to be presented in evidence before the trial court or even belatedly before the appellate court. The presentation of the marine insurance policy was necessary, as the issues raised therein arose from the very existence of an insurance contract between the insurer and the insured. Presentation or attaching the insurance policy in a complaint filed by the insurance company against another on account of its right of subrogation is an indispensable requirement. Failure to present the policy would warrant the dismissal of the complaint.

ASIAN TERMINALS, INCORPORATED -versus- FIRST LEPANTO-TAISHO INSURANCE CORPORATION

G.R. No. 185964, June 16, 2014, REYES, J.

The general rule that presentation of an insurance policy is indispensable in exercising the right of subrogation admits of an exception. When the defendant fails to timely put in issue the need for the presentation of the insurance policy to prove one's right to subrogation, it is deemed barred from pleading the absence of the insurance policy on appeal.

FACTS

Exercising its right of subrogation, the respondent First Lepanto-Taisho Insurance Corporation sued the petitioner for damages. It is the contention of the petitioner that there was no proper subrogation that took place. Hence, the complaint must be dismissed because of the failure of the respondent to present the insurance policy upon its filing of the complaint.

ISSUE

Whether or not the complaint must be dismissed because of the failure of the respondent to present the insurance policy.

RULING

No. While as a general rule, the marine insurance policy needs to be presented in evidence before the insurer may recover the insured value of the lost/damaged cargo in the exercise of its subrogatory right. The presentation of the contract constitutive of the insurance relationship between the consignee and insurer is critical because it is the legal basis of the latter's right to subrogation. Nevertheless, the rule is not inflexible. By way of exception, when the defendant fails to timely put in issue the need for the presentation of the insurance policy to prove one's right to subrogation, it is deemed barred from pleading the absence of the insurance policy on appeal.

LOADSTAR SHIPPIN COMPANY, INCORPORATED and LOADSTAR INTERNATIONAL SHIPPING COMPANY, INCORPORATED -versus- MALAYAN INSURANCE COMPANY, INCORPORATED

G.R. No. 185565, November 26, 2014, REYES, J.

A subrogee in effect steps into the shoes of the insured and can recover only if the insured likewise could have recovered.

FACTS

Exercising its right of subrogation, the respondent Malayan Insurance Company sued the petitioner Loadstar for reimbursement. It is the contention of Loadstar that Malayan cannot recover from it because its claims were never substantiated. No evidence was presented to prove that the insured sustained damages and must therefore be indemnified.

ISSUE

Whether or not the respondent, by right of subrogation, can recover from the petitioner.

RULING

No. Upon failure of Malayan to present sufficient proof that the subrogor sustained damages and must therefore be indemnified, Malayan cannot be entitled to reimbursement. The rights of a subrogee cannot be superior to the rights possessed by a subrogor. "Subrogation is the substitution of one person in the place of another with reference to a lawful claim or right, so that he who is substituted succeeds to the rights of the other in relation to a debt or claim, including its remedies or securities. The rights to which the subrogee succeeds are the same as, but not greater than, those of the person for whom he is substituted, that is, he cannot acquire any claim, security or remedy the subrogor did not have. In other words, a subrogee cannot succeed to a right not possessed by the subrogor. A subrogee in effect steps into the shoes of the insured and can recover only if the insured likewise could have recovered." Consequently, an insurer indemnifies the insured based on the loss or injury the latter actually suffered from. If there is no loss or injury, then there is no obligation on the part of the insurer to indemnify the insured. Should the insurer pay the insured and it turns out that indemnification is not due, or if due, the amount paid is excessive, the insurer takes the risk of not being able to seek recompense from the alleged wrongdoer. This is because the supposed subrogor did not possess the right to be indemnified and therefore, no right to collect is passed on to the subrogee.

LOADSTAR SHIPPING COMPANY, INCORPORATED and LOADSTAR INTERNATIONAL SHIPPING COMPANY, INCORPORATED v. MALAYAN INSURANCE COMPANY, INCORPORATED

G.R. No. 185565 (Resolution), April 26, 2017

As common carriers, the petitioners are bound to observe extraordinary diligence in their vigilance over the goods they transport, as required by the nature of their business and for reasons of public policy.[16] "Extraordinary diligence is that extreme measure of care and caution which persons of unusual prudence and circumspection use for securing and preserving their own property or rights."

When the copper concentrates delivered were contaminated with seawater, the petitioners have failed to exercise extraordinary diligence in the carriage thereof.

FACTS

This resolves the Motion for Reconsideration[1] of the Decision[2] dated November 26, 2014 of the Court in the above-captioned case filed by respondent Malayan Insurance Company, Incorporated (Malayan). Malayan alleges that in ruling in favor of Loadstar Shipping Company, Incorporated and

Loadstar International Shipping Company, Incorporated (petitioners), the Court disregarded the conclusion of the Court of Appeals that the petitioners acted as a common carrier; that there was a breach of the contract of affreightment; and that the petitioners failed to produce evidence of a calamity to be exculpated from liability.[3] In their Comment,[4] the petitioners contend that the grounds raised by Malayan are no longer relevant because as found by the Court, Malayan did not adduce proof of pecuniary loss to the insured Philippine Associated Smelting and Refining Corporation (PASAR).[5] PASAR has not established by an iota of evidence the amount of loss or actual damage it suffered by reason of seawater wetting of the 777.29 metric tons of copper concentrates. In spite of no proof of loss, Malayan, with seeming hastiness paid the claim of PASAR in the amount of P33,934,948.75.[6] According to the petitioners, Malayan cannot make them answerable for its mistake in indemnifying PASAR.[7] On June 10, 2015, Malayan filed a Motion to Refer the Case to the Court en banc[8] alleging that the Decision dated November 26, 2014 of the Third Division deviated from the doctrine enunciated in *Delsan Transport Lines, Inc., v. CA*. [9] Malayan contends that in *Delsan*, the Court held that upon payment by the insurance company of the insurance claim, the insurance company should be subrogated to the rights of the insured; it is not even necessary to present the insurance policy because subrogation is a matter of equity.

ISSUE

Whether or not the common carrier liable to the insurance company that paid the insured owner of the lost cargo as the latter's subrogee.

RULING

In comparison with *Delsan*, the facts of the instant case are not as straightforward. Here, the copper concentrates were delivered by the petitioners to the consignee PASAR although part thereof was contaminated with seawater. To be clear, PASAR did not simply reject the contaminated goods (on the basis that these were no longer fit for the intended purpose), claim the value thereof from Malayan and leave things at that - it bought back the goods which it had already rejected. Meanwhile, Malayan opted to cash in the situation by selling the contaminated copper concentrates to the very same consignee who already rejected the goods as total loss. After denying the petitioners of opportunity to participate in the disposal or sale of the goods,[11] Malayan sought to recover the total value of the wet copper concentrates from them. Malayan and PASAR's extraneous actuations are inconsistent with the alleged fact of total loss. Verily, *Delsan* cannot be applied given the contradistinctive circumstances obtaining in this case.

The Court reiterates the principle that actual damages are not presumed; it cannot be anchored on mere surmises, speculations or conjectures.[14] As the Court discussed in the Decision dated November 26, 2014, Malayan was not able to prove the pecuniary loss suffered by PASAR for which the latter was indemnified. This is in line with the principle that a subrogee steps into the shoes of the insured and can recover only if the insured likewise could have recovered.

As common carriers, the petitioners are bound to observe extraordinary diligence in their vigilance over the goods they transport, as required by the nature of their business and for reasons of public policy.[16] "Extraordinary diligence is that extreme measure of care and caution which persons of unusual prudence and circumspection use for securing and preserving their own property or rights." When the copper concentrates delivered were contaminated with seawater, the petitioners have failed to exercise extraordinary diligence in the carriage thereof.

The Court deems it proper to award nominal damages to Malayan in recognition of the breach of contract committed by the petitioners. "So long as there is a violation of the right of the plaintiff—whether based on law, contract or other sources of obligations—an award of nominal damages is proper."

Article 2221. Nominal damages are adjudicated in order that a right of the plaintiff, which has been violated or invaded by the defendant, may be vindicated or recognized, and not for the purpose of indemnifying the plaintiff for any loss suffered by him. Article 2222. The court may award nominal damages in every obligation arising from any source enumerated in Article 1157, or in every case where any property right has been invaded.

"Nominal damages are recoverable where a legal right is technically violated and must be vindicated against an invasion that has produced no actual present loss of any kind or where there has been a breach of contract and no substantial injury or actual damages whatsoever have been or can be shown."

"The amount of such damages is addressed to the sound discretion of the court, taking into account the relevant circumstances."... the amount of P1,769,374.725, which is equivalent to six percent (6%) of the sum being claimed by Malayan less the residual value of the copper concentrates, is sufficient as damages.

Finally, the Court also takes the opportunity to make it clear that this disposition does not in any way undermine the principle of subrogation; rather, the Court takes into consideration all the circumstances in this case, inasmuch as Malayan and PASAR's dealings post-delivery of the copper concentrates were unwarranted. While the breach of contract committed by the petitioners should not be tolerated, the undue haste, as well as the other doubtful circumstances under which the sale of the wet copper concentrates was made, is not lost on the Court.

EQUITABLE INSURANCE CORPORATION v. TRANSMODAL INTERNATIONAL, INC.

G.R. No. 223592, August 7, 2017, PERALTA, J.

The payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies which the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of any privity of contract or upon payment by the insurance company of the insurance claim. It accrues simply upon payment by the insurance company of the insurance claim.²⁰

FACTS

Sytengco Enterprises Corporation (*Sytengco*) hired respondent Transmodal International, Inc. (*Transmodal*) to clear from the customs authorities and withdraw, transport, and deliver to its warehouse, cargoes consisting of 200 cartons of gum Arabic with a total weight of 5,000 kilograms valued at US21,750.00.

The said cargoes arrived in Manila on August 14, 2004 and were brought to Ocean Links Container

Terminal Center, Inc. pending their release by the Bureau of Customs (BOC) and on September 2, 2004, respondent Transmodal withdrew the same cargoes and delivered them to Sytengco's warehouse. It was noted in the delivery receipt that all the containers were wet.

In a preliminary survey conducted by *Elite Surveyors*, it was found that 187 cartons had water marks and the contents of the 13 wet cartons were partly hardened. A re-inspection was conducted and it was found that the contents of the randomly opened 20 cartons were about 40% to 60% hardened, while 8 cartons had marks of previous wetting. In its final report, Elite Surveyor fixed the computed loss payable at P728,712.00 after adjustment of 50% loss allowance.

Thus, Sytengco demanded from respondent Transmodal the payment of P1,457,424.00 as compensation for total loss of shipment. Petitioner Equitable Insurance, as insurer of the cargoes per Marine Open Policy paid Sytengco's claim for P728,712.00. Sytengco then signed a subrogation receipt and loss receipt in favor of petitioner Equitable Insurance. As such, petitioner Equitable Insurance demanded from respondent Transmodal reimbursement of the payment given to Sytengco.

Thereafter, petitioner Equitable Insurance filed a complaint for damages invoking its right as subrogee after paying Sytengco's insurance claim and averred that respondent Transmodal's fault and gross negligence were the causes of the damages sustained by Sytengco's shipment.

Respondent Transmodal denied knowledge of an insurance policy and claimed that petitioner Equitable Insurance has no cause of action against it because the damages to the cargoes were not due to its fault or gross negligence. According to the same respondent, the cargoes arrived at Sytengco's warehouse around 11:30 in the morning of September 1, 2004, however, Sytengco did not immediately receive the said cargoes and as a result, the cargoes got wet due to the rain that occurred on the night of September 1, 2004. Respondent Transmodal also questioned the timeliness of Sytengco's formal claim for payment which was allegedly made more than 14 days from the time the cargoes were placed at its disposal in contravention of the stipulations in the delivery receipts.

RTC ruled in favor of Equitable Insurance. According to the RTC, petitioner Equitable Insurance was able to prove by substantial evidence its right to institute an action as subrogee of Sytengco. It also ruled that petitioner Equitable Insurance's non-presentation of the insurance policy and non-compliance with Section 7, Rule 8 of the Rules of Court on actionable document were raised for the first time in respondent Transmodal's memorandum and also noted that petitioner Equitable Insurance had, in fact, submitted a copy of the insurance contract.

Respondent Transmodal appealed to the CA. On September 15, 2015, the CA reversed the RTC's decision. The CA ruled that there was no proof of insurance of the cargoes at the time of the loss and that the subrogation was improper. According to the CA, the insurance contract was neither attached in the complaint nor offered in evidence for the perusal and appreciation of the RTC, and what was presented was just the marine risk note.

ISSUE

Whether or not the petitioner's subrogation right is improper.

RULING

In ruling that petitioner's subrogation right is improper, the CA stated that it found no proof of insurance of the cargoes at the time of their loss. It also found that what was presented in court was the marine risk note and not the insurance contract or policy.

As such, according to the CA, the case of *Eastern Shipping Lines, Inc. v. Prudential Guarantee and Assurance, Inc.*¹⁰ is applicable, wherein this Court held that a marine risk note is not an insurance policy. The CA also found applicable this Court's ruling in *Malayan Insurance Co., Inc. v. Regis Brokerage Corp.*,¹¹ stating that a marine policy is constitutive of the insurer-insured relationship, thus, such document should have been attached to the complaint as mandated by Section 7,¹² Rule 8 of the Rules of Court.

Petitioner, however, insists that the CA erred in applying the case of *Malayan* because the plaintiff therein did not present the marine insurance policy whereas in the present case, petitioner has presented not only the marine risk note but also Marine Open Policy No. MN-MOP-HO-0000099¹³ which were all admitted in evidence.

Indeed, a perusal of the records would show that petitioner is correct in its claim that the marine insurance policy was offered as evidence. In fact, in the questioned decision of the CA, the latter, mentioned such policy.

As such, respondent had the opportunity to examine the said documents or to object to its presentation as pieces of evidence. The records also show that respondent was able to cross-examine petitioner's witness regarding the said documents. Thus, it was well established that petitioner has the right to step into the shoes of the insured who has a direct cause of action against herein respondent on account of the damages sustained by the cargoes. "Subrogation is the substitution of one person in the place of another with reference to a lawful claim or right, so that he who is substituted succeeds to the rights of the other in relation to a debt or claim, including its remedies or securities."¹⁵ The right of subrogation springs from Article 2207 of the Civil Code which states:

Art. 2207. If the plaintiffs property has been insured, and he has received indemnity from the insurance company for the injury or loss arising out of the wrong or breach of contract complained of, the insurance company shall be subrogated to the rights of the insured against the wrongdoer or the person who has violated the contract. If the amount paid by the insurance company does not fully cover the injury or loss, the aggrieved party shall be entitled to recover the deficiency from the person causing the loss or injury.

The records further show that petitioner was able to accomplish its obligation under the insurance policy as it has paid the assured of its insurance claim in the amount of P728,712,00 as evidenced by, among others, the Subrogation Receipt,¹⁶ Loss Receipt,¹⁷ Check Voucher,¹⁸ and Equitable PCI Bank Check.¹⁹ The payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies which the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of any privity of contract or upon payment by the insurance company of the insurance claim. It accrues simply upon payment by the insurance company of the insurance claim.²⁰

KEIHIN-EVERETT FORWARDING CO., INC., Petitioner – versus- TOKIO MARINE MALAYAN INSURANCE CO., INC. and SUNFREIGHT FORWARDERS & CUSTOMS BROKERAGE, INC.,

Respondents.**G.R. No. 212107, SECOND DIVISION, October 28, 2019, REYES, J. JR., J.**

Since the insurance claim for the loss sustained by the insured shipment was paid by Tokio Marine as proven by the Subrogation Receipt — showing the amount paid and the acceptance made by Honda Trading, it is inevitable that it is entitled, as a matter of course, to exercise its legal right to subrogation as provided under Article 2207 of the Civil Code as follows:

Art. 2207. If the plaintiffs property has been insured, and he has received indemnity from the insurance company for the injury or loss arising out of the wrong or breach of contract complained of, the insurance company shall be subrogated to the rights of the insured against the wrongdoer or the person who has violated the contract. If the amount paid by the insurance company does not fully cover the injury or loss, the aggrieved party shall be entitled to recover the deficiency from the person causing the loss or injury.

The payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies which the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of any privity of contract or upon payment by the insurance company of the insurance claim. It accrues simply upon payment by the insurance company of the insurance claim.

Indeed, the right of subrogation has its roots in equity. It is designed to promote and to accomplish justice and is the mode which equity adopts to compel the ultimate payment of a debt by one who, in justice and good conscience, ought to pay. Consequently, the payment made by Tokio Marine to Honda Trading operates as an equitable assignment to the former of all the remedies which the latter may have against Keihin-Everett.

FACTS

In 2005, Honda Trading Phils. Ecozone Corporation (Honda Trading) ordered 80 bundles of Aluminum Alloy Ingots. The goods were loaded in two container vans which were, in turn, received in Jakarta, Indonesia by Nippon Express Co., Ltd. for shipment to Manila.

Aside from insuring the entire shipment with Tokio Marine & Nichido Fire Insurance Co., Inc. (TMNFIC), Honda Trading also engaged the services of petitioner Keihin-Everett to clear and withdraw the cargo from the pier and to transport and deliver the same to its warehouse at Laguna. Meanwhile, petitioner Keihin-Everett had an Accreditation Agreement with respondent Sunfreight Forwarders whereby the latter undertook to render common carrier services for the former and to transport inland goods within the Philippines.

The shipment arrived in Manila on November 3, 2005. On November 8, 2005, the shipment was caused to be released from the pier by petitioner Keihin-Everett and turned over to respondent Sunfreight Forwarders for delivery to Honda Trading. En route to the latter's warehouse, the truck carrying the containers was hijacked and the container van with Serial No. TEXU 389360-5 was reportedly taken away. As a consequence, Honda Trading suffered losses in the total amount of representing the value of the lost 40 bundles of Aluminum Alloy Ingots.

Claiming to have paid Honda Trading's insurance claim for the loss it suffered, respondent Tokio Marine commenced the instant suit on October 10, 2006 with the filing of its complaint for damages

against petitioner Keihin-Everett. Respondent Tokio Marine maintained that it had been subrogated to all the rights and causes of action pertaining to Honda Trading.

Served with summons, petitioner Keihin-Everett denied liability for the lost shipment on the ground that the loss thereof occurred while the same was in the possession of respondent Sunfreight Forwarders. Hence, petitioner Keihin-Everett filed a third-party complaint against the latter, who, in turn, denied liability on the ground that it was not privy to the contract between Keihin-Everett and Honda Trading.

On October 27, 2011, the RTC rendered a Decision finding petitioner Keihin-Everett and respondent Sunfreight Forwarders jointly and severally liable to pay respondent Tokio Marine's claim.

The CA modified the ruling of the RTC insofar as the solidary liability of Keihin-Everett and Sunfreight Forwarders is concerned. The CA went to rule that solidarity is never presumed. There is solidary liability when the obligation so states, or when the law or the nature of the obligation requires the same. Thus, because of the lack of privity between Honda Trading and Sunfreight Forwarders, the latter cannot simply be held jointly and severally liable with Keihin-Everett for Tokio Marine's claim as subrogee.

ISSUE

Whether Tokio Marine has the right institute the action.

RULING

Yes. Keihin-Everett insisted that Tokio Marine is not the insurer but TMNFIC, hence, it argued that Tokio Marine has no right to institute the present action. As it pointed out, the Insurance Policy shows in its face that Honda Trading procured the insurance from TMNFIC and not from Tokio Marine.

While this assertion is true, Insurance Policy No. 83-00143689 itself expressly made Tokio Marine as the party liable to pay the insurance claim of Honda Trading pursuant to the Agency Agreement entered into by and between Tokio Marine and TMNFIC. As properly appreciated by both the RTC and the CA, the Agency Agreement shows that TMNFIC had subsequently changed its name to that of Tokio Marine. By agreeing to this stipulation in the Insurance Policy, Honda Trading binds itself to file its claim from Tokio Marine and thereafter to accept payment from it.

At any rate, even if we consider Tokio Marine as a third person who voluntarily paid the insurance claims of Honda Trading, it is still entitled to be reimbursed of what it had paid. As held by this Court in the case of *Pan Malayan Insurance Corp. v. Court of Appeals*, the insurer who may have no rights of subrogation due to "voluntary" payment may nevertheless recover from the third party responsible for the damage to the insured property under Article 1236 of the Civil Code. Under this circumstance, Tokio Marine's right to sue is based on the fact that it voluntarily made payment in favor of Honda Trading and it could go after the third party responsible for the loss (Keihin-Everett) in the exercise of its legal right of subrogation.

Setting aside this assumption, Tokio Marine nonetheless was able to prove by the following documentary evidence, such as Insurance Policy, Agency Agreement and Subrogation Receipt, their right to institute this action as subrogee of the insured. Keihin-Everett, on the other hand, did not

present any evidence to contradict Tokio Marine's case.

Third. Since the insurance claim for the loss sustained by the insured shipment was paid by Tokio Marine as proven by the Subrogation Receipt — showing the amount paid and the acceptance made by Honda Trading, it is inevitable that it is entitled, as a matter of course, to exercise its legal right to subrogation as provided under Article 2207 of the Civil Code as follows:

Art. 2207. If the plaintiffs property has been insured, and he has received indemnity from the insurance company for the injury or loss arising out of the wrong or breach of contract complained of, the insurance company shall be subrogated to the rights of the insured against the wrongdoer or the person who has violated the contract. If the amount paid by the insurance company does not fully cover the injury or loss, the aggrieved party shall be entitled to recover the deficiency from the person causing the loss or injury.

It must be stressed that the Subrogation Receipt only proves the fact of payment. This fact of payment grants Tokio Marine subrogatory right which enables it to exercise legal remedies that would otherwise be available to Honda Trading as owner of the hijacked cargoes as against the common carrier (Keihin-Everett). In other words, the right of subrogation accrues simply upon payment by the insurance company of the insurance claim. As the Court held:

The payment by the insurer to the insured operates as an equitable assignment to the insurer of all the remedies which the insured may have against the third party whose negligence or wrongful act caused the loss. The right of subrogation is not dependent upon, nor does it grow out of any privity of contract or upon payment by the insurance company of the insurance claim. It accrues simply upon payment by the insurance company of the insurance claim.

]Indeed, the right of subrogation has its roots in equity. It is designed to promote and to accomplish justice and is the mode which equity adopts to compel the ultimate payment of a debt by one who, in justice and good conscience, ought to pay. Consequently, the payment made by Tokio Marine to Honda Trading operates as an equitable assignment to the former of all the remedies which the latter may have against Keihin-Everett.

I. Miscellaneous Topics

1. Liability of Insurer

PACIFIC TIMER EXPORT CORPORATION VS. COURT OF APPEALS

112 SCRA 199, February 25, 1982, DE CASTRO, J.

No separate premiums are intended or required to be paid on a Cover Note. If the Note is to be treated as a separate policy instead of integrating it to the regular policies subsequently issued, the purpose and function of the Cover Note would be set at naught or rendered meaningless, for it is in a real sense a contract, not a mere application for insurance which is a mere offer. Hence, an insurer may be held liable under a Cover Note.

FACTS

Because it sustained damages, the petitioner sent a demand letter to the respondent insurance company to seek payment under a Cover Note previously executed between the parties. The claim of the petitioner was denied by the respondent. It reasoned that the Cover Note under which the petitioner bases its claim is null and void for lack of valuable consideration.

ISSUE

Whether or not the respondent may be held liable under a Cover Note.

RULING

Yes. The petitioner can claim under a Cover Note. The fact that no separate premium was paid on the Cover Note before the loss insured against occurred, does not militate against the validity of petitioner's claim, for no such premium could have been paid, since by the nature of the Cover Note, it did not contain, as all Cover Notes do not contain particulars of the shipment that would serve as basis for the computation of the premiums. As a logical consequence, no separate premiums are intended or required to be paid on a Cover Note. If the Note is to be treated as a separate policy instead of integrating it to the regular policies subsequently issued, the purpose and function of the Cover Note would be set at naught or rendered meaningless, for it is in a real sense a contract, not a mere application for insurance which is a mere offer.

ZENITH INSURANCE CORPORATION, v. COURT OF APPEALS and LAWRENCE FERNANDEZ

G.R. No. 85296, May 14, 1990, MEDIALDEA, J.:

In case of unreasonable delay in the payment of the proceeds of an insurance policy, the damages that may be awarded are: 1) attorney's fees; 2) other expenses incurred by the insured person by reason of such unreasonable denial or withholding of payment; 3) interest at twice the ceiling prescribed by the Monetary Board of the amount of the claim due the injured; and 4) the amount of the claim.

FACTS

Lawrence Fernandez insured his car for "own damage" under private car Policy No. 50459 with petitioner Zenith Insurance Corporation. The car figured in an accident and suffered actual damages in the amount of P3,640.00. After allegedly being given a run around by Zenith for two (2) months, Fernandez filed a complaint with the Regional Trial Court of Cebu for sum of money and damages resulting from the refusal of Zenith to pay the amount claimed. Zenith filed an answer alleging that it offered to pay the claim of Fernandez pursuant to the terms and conditions of the contract which, the private respondent rejected.

A decision was rendered by the Trial Court in favor of private respondent Fernandez awarding actual moral damages, exemplary damages and attorney's fees. The Court of Appeals rendered its decision affirming *in toto* the decision of the Trial Court.

ISSUE

Whether or not the award of moral damages, exemplary damages and attorney's fees is proper.

RULING

Yes. The award of damages in case of unreasonable delay in the payment of insurance claims is governed by the Philippine Insurance Code, which provides, Sec. 244. In case of any litigation for the enforcement of any policy or contract of insurance, it shall be the duty of the Commissioner or the Court, as the case may be, to make a finding as to whether the payment of the claim of the insured has been unreasonably denied or withheld; and in the affirmative case, the insurance company shall be adjudged to pay damages which shall consist of attorney's fees and other expenses incurred by the insured person by reason of such unreasonable denial or withholding of payment plus interest of twice the ceiling prescribed by the Monetary Board of the amount of the claim due the insured, from the date following the time prescribed in section two hundred forty-two or in section two hundred forty-three, as the case may be, until the claim is fully satisfied; Provided, That the failure to pay any such claim within the time prescribed in said sections shall be considered prima facie evidence of unreasonable delay in payment.

NORMAN NODA, v. HONORABLE GREGORIA CRUZ-ARNALDO, in her capacity as Insurance Commissioner, and ZENITH INSURANCE CORPORATION
G.R. NO. L-57322, June 22, 1987, FERNAN, J.

While the insurer, and the Insurance Commissioner for that matter, have the right to reject proofs of loss if they are unsatisfactory, they may not set up for themselves an arbitrary standard of satisfaction. Substantial compliance with the requirements will always be deemed sufficient.

FACTS

Norman R. Noda obtained from respondent Zenith Insurance Corporation two fire insurance policies. While both policies were in force, fire destroyed petitioner's insured properties at the market site and at Barreda St. When petitioner failed to obtain indemnity on his claims from respondent Zenith, he filed a complaint with the Insurance Commission praying that respondent company be ordered to pay him "the sum of P130,000 representing the value of the two [2] policies insured by respondent with interest at 12% per annum, plus damages, attorney's fees and other expenses of litigation. In its answer Zenith interposed that petitioner had no cause of action; that Policy No. F-03724 was not in full force and effect at the time of the fire because the premium on the policy was not paid; that Zenith's liability under Policy No. F-03734, if any, was limited to P15,472.50 in view of the co-insurance; and that petitioner failed to substantiate his claim as to the value of the goods reputedly destroyed by fire and consequently, Zenith could not be held answerable for the same.

Insurance Commissioner did not allowed Noda to recover under said policy and the actual, moral and exemplary damages prayed for.

ISSUE

Whether or not Zenith Insurance Corporation is liable.

RULING

Yes. We find that respondent Commissioner acted with grave abuse of discretion when she denied petitioner's claim for indemnity under Policy No. F-03734 because of what she perceived as insufficient proof. To prove the existence of the stocks in trade covered by Policy No. F-03734, petitioner offered his testimony and that of his wife as well as documentary exhibits. The foregoing evidence for petitioner preponderantly showed the presence of some P590,000 worth of goods in his retail store during the fire of November 9, 1977. The report even took into account the appraisals of the other adjusters and concluded that the total loss sustained by petitioner in his household effects and stocks in trade reached P379,302.12. But after apportioning said amount among petitioner's six different insurers [the co-insurance being known to Zenith], the liability of Zenith was placed at P60,592.10. It therefore recommended that Zenith pay the petitioner the amount of P60,592.10. While the insurer and the Insurance Commissioner for that matter, have the right to reject proofs of loss if they are unsatisfactory, they may not set up for themselves an arbitrary standard of satisfaction. Substantial compliance with the requirements will always be deemed sufficient. The denial of petitioner's demand for exemplary damages by respondent Commissioner must, however, be sustained.

There is no showing that Zenith, in contesting payment, had acted in a wanton, oppressive or malevolent manner to warrant the imposition of corrective damages.

FIGURACION VDA. DE MAGLANA, EDITHA M. CRUZ, ERLINDA M. MASESAR, LEONILA M. MALLARI, GILDA ANTONIO and the minors LEAH, LOPE, JR., and ELVIRA, all surnamed MAGLANA, herein represented by their mother, FIGURACION VDA. DE MAGLANA, v. HONORABLE FRANCISCO Z. CONSOLACION, Presiding Judge of Davao City, Branch II, and AFISCO INSURANCE CORPORATION
G.R. No. 60506, August 6, 1992, ROMERO, J.:

Where the insurance contract provides for indemnity against liability to third persons, such third persons can directly sue the insurer, however, the direct liability of the insurer under indemnity contracts against third party liability does not mean that the insurer can be held solidarily liable with the insured and/or the other parties found at fault. The liability of the insurer is based on contract; that of the insured is based on tort.

FACTS

Lope Maglana was on his way to his work station, driving a motorcycle owned by the Bureau of Customs. At Km. 7, Lanang, he met an accident that resulted in his death. He died on the spot. The PUJ jeep that bumped the deceased was driven by Pepito Into, operated and owned by defendant Destrajo. From the investigation conducted by the traffic investigator, the PUJ jeep was overtaking another passenger jeep that was going towards the city poblacion. Consequently, the heirs of Lope Maglana, Sr., here petitioners, filed an action for damages and attorney's fees against operator Patricio Destrajo and the Afisco Insurance Corporation (AFISCO for brevity) before the then Court of First Instance of Davao. Lower court rendered a decision finding that Destrajo had not exercised sufficient diligence as the operator of the jeepney. Petitioners filed a motion for the reconsideration of the decision contending that AFISCO should not merely be held secondarily liable because the Insurance Code provides that the insurer's liability is "direct and primary and/or jointly and severally with the operator of the vehicle, although only up to the extent of the insurance coverage.

ISSUE

Whether or not AFISCO should be held directly liable with the operator of the vehicle.

RULING

Insurance policy on which petitioners base their claim is as follows, Sec. 1 — LIABILITY TO THE PUBLIC 1. The Company will, subject to the Limits of Liability, pay all sums necessary to discharge liability of the insured in respect of (a) death of or bodily injury to any THIRD PARTY (b) xxx 2. xxx3. In the event of the death of any person entitled to indemnity under this Policy, the Company will, in respect of the liability incurred to such person indemnify his personal representatives in terms of, and subject to the terms and conditions hereof.

The above-quoted provision leads to no other conclusion but that AFISCO can be held directly liable by petitioners. However, We cannot agree that AFISCO is likewise solidarily liable with Destrajo.

In *Malayan Insurance Co., Inc. v. Court of Appeals*, this Court had the opportunity to resolve the issue as to the nature of the liability of the insurer and the insured vis-a-vis the third party injured in an accident.

While it is true that where the insurance contract provides for indemnity against liability to third persons, such third person can directly sue the insurer, however, *the direct liability of the insurer under indemnity contract against third party liability does not mean that the insurer can be held solidarily liable with the insured and/or the other parties found at fault. The liability of the insurer is based on contract; that of the insured is based on tort.*

Since under both the law and the insurance policy, AFISCO's liability is only up to P20,000.00, the second paragraph of the dispositive portion of the decision in question may have unwittingly sown confusion among the petitioners and their counsel. What should have been clearly stressed as to leave no room for doubt was the liability of AFISCO under the explicit terms of the insurance contract. In fine, we conclude that the liability of AFISCO based on the insurance contract is direct, but not solidary.

GOVERNMENT SERVICE INSURANCE SYSTEM (GSIS), vs. COURT OF APPEALS (former Tenth Division), VICTORIA JAIME VDA. DE KHO, for herself and minor ROY ROLAND, GLORIA KHO VDA. DE CALABIA for herself and minors MARY GRACE, WILLIE, JR., VOLTAIRE, GLENN, and MAY, all surnamed CALABIA, DANIEL KHO, JOSEFINA KHO, EMERITA KHO APEGO, ANTONIO KHO and TERESITA KHO

G.R. No. 101439, June 21, 1999, QUISUMBING, J.

The liability of GSIS based on the insurance contract is direct, but not solidary with that of the NFA.

FACTS

National Food Authority (NFA) was the owner of a Chevrolet truck which was insured against liabilities for death of and injuries to third persons with the GSIS. Thereafter, it collided with a public utility vehicle, a Toyota Tamaraw. The Toyota Tamaraw was owned and operated by Victor Uy, under the name and style of "Victory Line." Civil case for damages, was filed by an injured passenger, Librado Taer, against Uy, the operator of the public utility vehicle, and insurer, Mabuhay Insurance and Guaranty Co. (MIGC). Trial court rendered its decision holding that Corbeta's negligence was the

proximate cause of the, awarded Uy the total amount of P109,100.00 for damages and ordered MIGC, Corbeta and NFA to pay plaintiff Taer, jointly and severally, the total amount of P40,559.94 for actual, compensatory, and moral damages plus attorney's fees. Petitioner denies solidary liability with the NFA or the negligent operator of the cargo truck because it claims that they are liable under different obligations and since neither the provision of the contract nor the insurance law provides for solidary liability, petitioner asserts that the presumption is that its obligation arising from a contract of insurance is joint.

ISSUE

Whether the GSIS is solidarily liable with the negligent insured/owner-operator of the Chevrolet truck for damages awarded to private respondents which are beyond the limitations of the insurance policy and the Insurance Memorandum Circular No. 5-78.

RULING

No. It is now established that the injured or the heirs of a deceased victim of a vehicular accident may sue directly the insurer of the vehicle. Common carriers are required to secure Compulsory Motor Vehicle Liability Insurance [CMVLI] coverage as provided under Sec. 374 of the Insurance Code. The general purpose of statutes enabling an injured person to proceed directly against the insurer is to protect injured persons against the insolvency of the insured who causes such injury, and to give such injured person a certain beneficial interest in the proceeds of the policy. However, although the victim may proceed directly against the insurer for indemnity, the third party liability is only up to the extent of the insurance policy and those required by law. While it is true that where the insurance contract provides for indemnity against liability to third persons, and such third persons can directly sue the insurer, the direct liability of the insurer under indemnity contracts against third party liability does not mean that the insurer can be held liable in solidum with the insured and/or the other parties found at fault. For the liability of the insurer is based on contract; that of the insured carrier or vehicle owner is based on tort. The liability of GSIS based on the insurance contract is direct, but not solidary with that of the NFA. At the time of the incident, the schedule of indemnities for death and/or bodily injuries, professional fees, hospital and other charges payable under a CMVLI coverage was provided under the Insurance Memorandum Circular was twelve thousand (P12,000.00) pesos per victim.

WILLIAM TIU, doing business under the name and style of D Rough Riders, and VIRGILIO TE LAS PIAS v. PEDRO A. ARRIEGADO, BENJAMIN CONDOR, SERGIO PEDRANO and PHILIPPINE PHOENIX SURETY AND INSURANCE, INC.

G.R. 5643726, January 16, 2004, CALLEJO, SR., J.

Although the victim may proceed directly against the insurer for indemnity, the third party liability is only up to the extent of the insurance policy and those required by law.

FACTS

One of the rear tires of the cargo truck marked Condor Hollow Blocks and General Merchandise exploded. The driver, Sergio Pedrano, then parked along the right side of the national highway and removed the damaged tire to have it vulcanized while he trucks tail lights were also left on. As the bus was approaching the bridge, Laspias saw the stalled truck, which was then about 25 meters away.

He applied the break and tried to swerve to the left to avoid hitting the truck but it was too late; the bus rammed into the trucks left rear. The impact damaged the right side of the bus and left several passengers injured.

Respondent Pedro A. Arriesgado then filed a complaint for breach of contract of carriage, damages and attorney's fees before the Regional Trial Court of Cebu City alleging that the passenger bus in question was cruising at a fast and high speed along the national road, and that petitioner Laspias did not take precautionary measures to avoid the accident. The petitioners, for their part, filed a Third-Party Complaint against the following: respondent Philippine Phoenix Surety and Insurance, Inc. (PPSII), petitioner Tius insurer.

Trial court rendered in favor of plaintiff as against defendant William Tiu ordering the latter to pay the plaintiff. According to the trial court, there was no dispute that petitioner William Tiu was engaged in business as a common carrier. The appellate court rendered judgment affirming the trial.

ISSUE

Whether the third party defendants are jointly and severally liable directly to plaintiff-appellee.

RULING

As can be gleaned from the Certificate of Cover, such insurance contract was issued pursuant to the Compulsory Motor Vehicle Liability Insurance Law. It was expressly provided therein that the limit of the insurers liability for each person was P12,000, while the limit per accident was pegged at P50,000. An insurer in an indemnity contract for third party liability is directly liable to the injured party up to the extent specified in the agreement but it cannot be held solidarily liable beyond that amount.

Indeed, the nature of Compulsory Motor Vehicle Liability Insurance is such that it is primarily intended to provide compensation for the death or bodily injuries suffered by innocent third parties or passengers as a result of the negligent operation and use of motor vehicles. The victims and/or their dependents are assured of immediate financial assistance, regardless of the financial capacity of motor vehicle owners. As the Court explained in *Government Service Insurance System v. Court of Appeals*:

However, although the victim may proceed directly against the insurer for indemnity, the third party liability is only up to the extent of the insurance policy and those required by law. While it is true that where the insurance contract provides for indemnity against liability to third persons, and such persons can directly sue the insurer, the direct liability of the insurer under indemnity contracts against third party liability does not mean that the insurer can be held liable in solidum with the insured and/or the other parties found at fault. For the liability of the insurer is based on contract; that of the insured carrier or vehicle owner is based on tort.

2. Insurance Agent

MAPALAD AISPORA v. COURT OF APPEALS and THE PEOPLE OF THE PHILIPPINES
G.R. No. L-39419, April 12, 1982, DE CASTRO, J.

The definition of an insurance agent as found in the second paragraph of Section 189 is intended to define the word “agent” mentioned in the first and second paragraphs of the aforesaid section. Considering that the definition is applicable to the agent in the first paragraph, to receive compensation by the agent is an essential element for a violation of the first paragraph.

FACTS

Mapalad’s husband, Rodolfo Aisporna was duly licensed by the Insurance Commission as an agent to Perla Compania de Seguros, with license to expire on June 30, 1970. On that date, Perla thru Aisporna issued at Cabanatuan City a Personal Accident Policy for 12 months in the name of Eugenio Isidro for P5,000. The insured died by violence during his lifetime. For reasons not explained in the record, an Information was filed against Rodolfo’s wife, Mapalad for violation of Section 189 of the Insurance Law for “having feloniously acted as agent in the solicitation of insurance from Eugenio Isidro without having secured a certificate of authority from the Insurance Commission”. During the trial, the prosecution presented evidence that the policy was issued with the active participation of Mapalad. In her defense, she averred that as the wife of the true agent Rodolfo, she naturally helped him in his work as a clerk and that the policy issued was only a renewal. She averred that Isidro called by telephone to renew and she left a note for the renewal on top of her husband’s desk since the latter was absent at that time. The trial court found Mapalad guilty. The CA affirmed. Before the SC, the Solicitor General made a manifestation that Mapalad had not violated Section 189 of the Insurance Act.

ISSUE

Whether Mapalad Aisporna violated Sec. 189 of the Insurance Act.

RULING

No, there was no violation of Sec. 189 of the Insurance Act. The first paragraph of Section 189 prohibits a person from acting as agent, sub-agent or broker in the solicitation or procurement of applications for insurance without first procuring a certificate of authority so to act from the Insurance Commissioner, while its second paragraph defines who is an insurance agent within the intent of this section and, finally, the third paragraph thereof prescribes the penalty to be imposed for its violation.

The CA implied that the definition of an insurance agent under the second paragraph of Section 189 is not applicable to the insurance agent mentioned in the first paragraph. It concluded that under the second paragraph of Section 189, a person is an insurance agent if he solicits and obtains an insurance for compensation, but, in its first paragraph, there is no necessity that a person solicits an insurance for compensation in order to be called an insurance agent.

We find this to be a reversible error. As correctly pointed out by the Solicitor General, the definition of an insurance agent as found in the second paragraph of Section 189 is intended to define the word “agent” mentioned in the first and second paragraphs of the aforesaid section. More significantly, in its second paragraph, it is explicitly provided that the definition of an insurance agent is within the intent of Section 189. Hence — “Any person who for compensation ... shall be an insurance agent within the intent of this section, ...”

Considering that the definition of an insurance agent is also applicable to the agent in the first paragraph, to receive a compensation by the agent is an essential element for a violation of the first paragraph of Sec. 189. The CA established that Aisporna did not receive any compensation for the issuance of the insurance policy of Eugenio Isidro. Nevertheless, she was convicted by the CA for, according to the latter, the receipt of compensation for issuing an insurance policy is not an essential element for a violation of the first paragraph of Section 189 of the Insurance Act.

We rule otherwise. Under the Texas Penal Code 1911, Article 689, making it a misdemeanor for any person for direct or indirect compensation to solicit insurance without a certificate of authority to act as an insurance agent, an information, failing to allege that the solicitor was to receive compensation either directly or indirectly, charges no offense. In the case at bar, the Information does not allege that the negotiation of an insurance contract by the accused with Eugenio Isidro was one for compensation. This allegation is essential, and having been omitted, a conviction of the accused could not be sustained. It is well-settled in Our jurisprudence that to warrant conviction, every element of the crime must be alleged and proved.

**GREAT PACIFIC LIFE ASSURANCE CORPORATION (Grepalife) v. HONORATO JUDICO
and NATIONAL LABOR RELATIONS COMMISSION**

G.R. No. 73887, December 21, 1989, J. Paras

An insurance company may have two classes of agents who sell its insurance policies: (1) salaried employees who keep definite hours and work under the control and supervision of the company; and (2) registered representatives who work on commission basis.

FACTS

In 1976, Judico entered into an agreement of agency with Grepalife to become a debit agent attached to the industrial life agency in Cebu. A debit agent had definite work assignments including but not limited to collection of premiums from policy holders and selling insurance to prospective clients. He was paid with an allowance at P200 regardless of production and a sales reserve for his total collections but not less than P200. He was promoted to Zone Supervisor and given an additional allowance of P110 per week. However, he was reverted to a debit agent but without the sales reserve. Finally, his contract was terminated in 1982. He filed a complaint for illegal dismissal, separation pay and unpaid pay with the NLRC. The Labor Arbiter ruled that no employee-employer relationship existed between them. However, the NLRC reversed and held that Judico was a regular employee. Grepalife argues that Judico's compensation was not based on a fixed number of hours but rather based on production and results.

ISSUE

Whether an employer-employee relationship existed between Judico and Grepalife.

RULING

Yes, an employer-employee relationship existed between the parties. An insurance company may have two classes of agents who sell its insurance policies: (1) salaried employees who keep definite hours and work under the control and supervision of the company; and (2) registered representatives who work on commission basis. An insurance company may have two classes of

agents who sell its insurance policies: (1) salaried employees who keep definite hours and work under the control and supervision of the company; and (2) registered representatives who work on commission basis.

The agents who belong to the second category are not required to report for work at anytime, they do not have to devote their time exclusively to or work solely for the company since the time and the effort they spend in their work depend entirely upon their own will and initiative; they are not required to account for their time nor submit a report of their activities; they shoulder their own selling expenses as well as transportation; and they are paid their commission based on a certain percentage of their sales. One salient point in the determination of employer-employee relationship is the fact that the compensation that these agents on commission received is not paid by the insurance company but by the investor (or the person insured). After determining the commission earned by an agent on his sales the agent directly deducts it from the amount he received from the investor or the person insured and turns over to the insurance company the amount invested after such deduction is made.

The test to determine employer-employee relationship is whether the "employer" controls or has reserved the right to control the "employee" not only as to the result of the work to be done but also as to the means and methods by which the same is to be accomplished.

In the case at bar, the element of control over Judico was present. He is an agent in the first sense, a salaried employee of Grepalife. Judico received a definite minimum amount per week as his wage known as "sales reserve". He was assigned a definite place in the office to work on when he is not in the field; and in addition to his canvassing work he was burdened with the job of collection. He was required to make regular report to the company regarding these duties, and for which an anemic performance would mean a dismissal.

Conversely faithful and productive service earned him a promotion to Zone Supervisor with additional supervisor's allowance, a definite amount of P110.00 aside from the regular P 200.00 weekly "allowance".

Furthermore, his contract of services with petitioner is not for a piece of work nor for a definite period. Jaudico was controlled by Grepalife not only as to the kind of work; the amount of results, the kind of performance but also the power of dismissal. By nature of his position and work, Jaudico had been a regular employee of Grepalife.

**GREAT PACIFIC LIFE ASSURANCE CORPORATION v. NATIONAL LABOR RELATIONS
COMMISSION, ERNESTO RUIZ and RODRIGO RUIZ**

G.R. No. 80750-51, July 23, 1990, J. Cortes

In determining who is considered an employee, the Court has time and again applied the "four-fold" test, with control being the most crucial and determinative indicator of an employer-employee relationship. It cannot be gainsaid that Grepalife had control over private respondents' performance as well as the result of their efforts. True, it cannot be denied that based on the definition of an "insurance agent" in the Insurance Code [Art. 300] some of the functions performed by private respondents were those of insurance agents. Nevertheless, it does not follow that they are not employees of Grepalife. The Insurance Code may govern the licensing requirements and other particular duties of insurance agents, but it does not bar the application of the Labor Code with regard to labor standards and labor relations.

FACTS

Rodrigo and Ernesto Ruiz entered into individual agency agreements with Grepalife in 1977, each starting out as trainee-agents and later promoted to higher positions. In 1981, Ernesto was designated as district manager under a three-year Agreement of Managership. Two years thereafter but before the lapse of the period fixed in the contract, he was dismissed. Rodrigo, on the other hand, was designated as the officer-in charge to take over the functions of district manager in the Butuan district in addition to his responsibilities then as zone supervisor. After such designation, he was recalled in 1984. In the consolidated illegal dismissal cases filed by them, the Labor Arbiter found that they were employees of Grepalife and were dismissed without first being afforded due process by way of a notice in writing of the grounds for their dismissal. The NLRC affirmed the factual findings of the labor arbiter but reversed the order of reinstatement on the ground that Grepalife cannot be compelled to retain an employee found guilty of acts inimical to its interest.

ISSUE

Whether or not Ernesto and Rodrigo are employees of Grepalife.

RULING

Yes, Ernesto and Rodrigo are employees of Grepalife. Article 280 of the Labor Code provides that "the provisions of written agreement to the contrary notwithstanding and regardless of the oral agreements of the parties, an employment shall be deemed to be regular where the employee has been engaged to perform activities which are usually necessary or desirable in the usual business or trade of the employer..." Furthermore, in determining who is considered an employee, the Court has time and again applied the "four-fold" test, with control being the most crucial and determinative indicator of an employer-employee relationship. The employer must have control or must have reserved the right to control not only over the result of the "employee's" work but also the means and methods by which it is to be accomplished. (See *Brotherhood Labor Unity Movement of the Philippines v. Zamora*, 147 SCRA 49, 1987).

In this case, their work at the time of their dismissal as zone supervisor and district manager are necessary and desirable to the usual business of the insurance company. They were entrusted with supervisory, sales and other functions to guard Grepalife's business interests and to bring in more clients to the company, and even with administrative functions to ensure that all collections, reports and data are faithfully brought to the company. Furthermore, it cannot be gainsaid that Grepalife had control over private respondents' performance as well as the result of their efforts. A cursory reading of their respective functions as enumerated in their contracts reveals that the company practically dictates the manner by which their jobs are to be carried out.

True, it cannot be denied that based on the definition of an "insurance agent" in the Insurance Code [Art. 300] some of the functions performed by private respondents were those of insurance agents. Nevertheless, it does not follow that they are not employees of Grepalife. The Insurance Code may govern the licensing requirements and other particular duties of insurance agents, but it does not bar the application of the Labor Code with regard to labor standards and labor relations.

LUZ PINEDA, MARILOU MONTENEGROO, VIRGINIA ALARCON, DINA LORENA AYO, CELIA CALUMBAG and LUCIA LONTOK v. HON. COURT OF APPEALS and THE INSULAR LIFE ASSURANCE COMPANY, LIMITED

G.R. No. 105562, September 27, 1993, DAVIDE, SR., J.

Group insurance is essentially a single insurance contract that provides coverage for many individuals. The coverage terms for group insurance are usually stated in a master agreement or policy that is issued by the insurer to a representative of the group or to an administrator of the insurance program, such as an employer. The employer acts as a functionary in the collection and payment of premiums and in performing related duties. The Court held that PMSI, through its President and General Manager, Capt. Nuval, acted as the agent of Insular Life. The latter is thus bound by the misconduct of its agent.

FACTS

Petitioners, beneficiaries in the life insurance benefits under a group policy, sought to recover these benefits from Insular Life but the latter denied their claim on the ground that its liability was already extinguished upon delivery to and receipt by Prime Marine Services, Inc. of the checks issued in their names. Capt. Roberto Nuval, President and General Manager of PMSI, the employer of seamen who died, allegedly received the checks through the special power of attorney issued by petitioners and these checks were deposited in his account. Petitioners then filed a complaint against Insular Life with the Insurance Commission praying that it be ordered to pay their insurance claims. The Commission rendered its decision in favour of complainants. However, the CA ruled that the powers of attorney relied upon by Insular Life were sufficient to authorize Capt. Nuval to receive the insurance pertaining to the beneficiaries.

ISSUE

Whether or not Captain Nuval has the authority to receive insurance proceeds in behalf of the beneficiaries from Insular Life.

RULING

No. The Court agrees with the Insurance Commission that the special powers of attorney do not contain in unequivocal and clear terms authority to Capt. Nuval to obtain and receive from respondent company insurance proceeds arising from the death of the seaman-insured. On the contrary, the said powers of attorney are couched in terms which could easily arouse suspicion of an ordinary man." Insular Life knew that a power of attorney in favor of Capt. Nuval for the collection and receipt of such proceeds was a deviation from its practice with respect to group policies.

Group insurance is essentially a single insurance contract that provides coverage for many individuals. In its original and most common form, group insurance provides life or health insurance coverage for the employees of one employer. The coverage terms for group insurance are usually stated in a master agreement or policy that is issued by the insurer to a representative of the group or to an administrator of the insurance program, such as an employer. The employer acts as a functionary in the collection and payment of premiums and in performing related duties.

Although the employer may be the titular or named insured, the insurance is actually related to the life and health of the employee. Indeed, the employee is in the position of a real party to the master policy, and even in a non-contributory plan, the payment by the employer of the entire premium is a part of the total compensation paid for the services of the employee.

PMSI, through its President and General Manager, Capt. Nuval, acted as the agent of Insular Life. The latter is thus bound by the misconduct of its agent. Unfortunately, Insular Life, through its official, Mr. Urbano, acted imprudently and negligently in the premises by relying without question on the special power of attorney.

PHILIPPINE AMERICAN LIFE INSURANCE COMPANY and RODRIGO DE LOS REYES v. HON. ARMANDO ANSALDO, in his capacity as Insurance Commissioner, and RAMON MONTILLA PATERNO, JR.

G.R. No. 76452, July 26, 1994, Quiason, J.

Since the contract of agency entered into between Philamlife and its agents is not included within the meaning of an insurance business, Section 2 of the Insurance Code cannot be invoked to give jurisdiction over the same to the Insurance Commissioner. Expressio unius est exclusio alterius. The Insurance Code does not have provisions governing the relations between insurance companies and their agents. The relationship between the insurance company and its agents who are salaried employees is governed by the Contract of Employment and the provisions of the Labor Code, while the relationship of the former and its registered representatives who work on commission basis is governed by the Contract of Agency and the provisions of the Civil Code on the Agency. Disputes involving the latter are cognizable by the regular courts.

FACTS

Ramon Paterno filed a letter-complaint against Philippine American Life Insurance Company (Philamlife) to the Insurance Commissioner alleging certain problems encountered by agents, supervisors, managers and public consumers as a result of certain practices by said company. Manuel Ortega, Philamlife's Senior Assistant Vice-President and Executive Assistant to the President filed a motion to quash raising as one of the grounds that the Insurance Commission has no jurisdiction over the subject or nature of the action and over the parties involved. The Insurance Commissioner denied the motion to quash. Hence, this petition.

ISSUE

Whether or not the resolution of the legality of the contract of agency falls within the jurisdiction of the Insurance Commissioner.

RULING

No. The general regulatory authority of the Insurance Commissioner is described in Section 414 of the Insurance Code which shows that the Insurance Commissioner has the authority to regulate the business of insurance. Section 2 of the said law defines the term "doing an insurance business" or "transacting an insurance business." Since the contract of agency entered into between Philamlife and its agents is not included within the meaning of an insurance business, Section 2 of the Insurance Code cannot be invoked to give jurisdiction over the same to the Insurance Commissioner. Expressio unius est exclusio alterius.

A reading of Section 416 shows that the quasi-judicial power of the Insurance Commissioner is limited by law "to claims and complaints involving any loss, damage or liability for which an insurer may be answerable under any kind of policy or contract of insurance, . . ." Hence, this power does not cover the relationship affecting the insurance company and its agents but is limited to adjudicating claims and complaints filed by the insured against the insurance company. The Insurance Code does not have provisions governing the relations between insurance companies and their agents. It follows that the Insurance Commissioner cannot, in the exercise of its quasi-judicial powers, assume jurisdiction over controversies between the insurance companies and their agents.

An insurance company may have two classes of agents who sell its insurance policies: (1) salaried employees who keep definite hours and work under the control and supervision of the company; and (2) registered representatives, who work on commission basis. Under the first category, the relationship between the insurance company and its agents is governed by the Contract of Employment and the provisions of the Labor Code, while under the second category, the same is governed by the Contract of Agency and the provisions of the Civil Code on the Agency. Disputes involving the latter are cognizable by the regular courts.

**SOUTH SEA SURETY AND INSURANCE COMPANY, INC. v. HON. COURT OF APPEALS and
VALENZUELA HARDWOOD AND INDUSTRIAL SUPPLY, INC.**

G.R. No. 102253, June 2, 1995, Vitug J.

Section 306 of the Insurance Code provides that any insurance company which delivers to an insurance agent or insurance broker a policy or contract of insurance shall be deemed to have authorized such agent or broker to receive on its behalf payment of any premium which is due on such policy or contract of insurance at the time of its issuance or delivery or which becomes due thereon. When the appellant South Sea Surety and Insurance Co., Inc. delivered to Mr. Chua the marine cargo insurance policy for the logs of Hardwood, he is deemed to have been authorized by the South Sea Surety and Insurance Co., Inc. to receive the premium which is due on its behalf.

FACTS

Valenzuela Hardwood and Industrial Supply, Inc. insured with South Sea Surety and Insurance Company, Inc. the logs to be shipped to Manila on board the vessel owned by Seven Brothers. On January 20, 1984, Marine Cargo Insurance Policy No. 84/24229 was issued by South Sea. On January 24, Hardwood gave the check in payment of the premium on the insurance policy to Mr. Victorio Chua, an agent of Columbia Insurance Brokers, Ltd. On January 25, the said vessel sank resulting in the loss of the insured logs. Payment of the proceeds of the policy was demanded from South Sea but the latter denied liability under the policy. Seven Brothers Shipping Corporation also denied the claim filed by Hardwood.

Hardwood filed with the RTC a complaint for the recovery of the value of lost logs and freight charges from Seven Brothers Shipping Corporation or, to the extent of its alleged insurance cover, from South Sea Surety and Insurance Company. The trial court rendered judgment in favor of Hardwood. The CA absolved the shipping entity from liability holding only South Sea liable. South Sea Surety and Insurance Co., Inc. faults the appellate court for holding Victorio Chua to have been an authorized representative of the insurer.

ISSUE

Whether or not Victorio Chua, in receiving the check for the insurance premium prior to the occurrence of the risk insured against has so acted as an agent of petitioner.

RULING

Yes. The Court adopts the findings of the CA. Section 306 of the Insurance Code provides that any insurance company which delivers to an insurance agent or insurance broker a policy or contract of insurance shall be deemed to have authorized such agent or broker to receive on its behalf payment of any premium which is due on such policy or contract of insurance at the time of its issuance or delivery or which becomes due thereon. When the appellant South Sea Surety and Insurance Co., Inc. delivered to Mr. Chua the marine cargo insurance policy for the logs of Hardwood, he is deemed to have been authorized by the South Sea Surety and Insurance Co., Inc. to receive the premium which is due on its behalf. When therefore the insured logs were lost, the insured had already paid the premium to an agent of the South Sea Surety and Insurance Co., Inc., which is consequently liable to pay the insurance proceeds under the policy it issued to the insured.

SMITH, BELL & CO. , INC v. COURT OF APPEALS and JOSEPH BENZON CHUA

G. R. No. 110668. February 6, 1997, PANGANIBAN, J.

The scope and extent of the functions of an adjustment and settlement agent do not include personal liability. His functions are merely to settle and adjust claims in behalf of his principal if those claims are proven and undisputed, and if the claim is disputed or is disapproved by the principal, like in the instant case, the agent does not assume any personal liability. The recourse of the insured is to press his claim against the principal.

FACTS

Joseph Bengzon Chua, doing business under the style of Tic Hin Chiong, filed a case against Smith, Bell, and Co., Inc. and the latter's principal, First Insurance Co. Ltd., to recover the value of the losses sustained by him when the his cargo arrived in apparent bad order condition. The First Insurance Co. Ltd. did not file an answer, hence it was declared in default. Petitioner denied any liability alleging that it is merely a settling or claim agent of the insurance company and as such agent, it is not personally liable under the policy in which it has not even taken part of. The trial court ruled that Chua has fully established the liability of the insurance firm on the subject insurance contract. It also held that since Smith, Bell & Co. is admittedly a claim agent of the foreign insurance firm doing business in the Philippines, justice is better served if said agent is made liable without prejudice to its right of action against its principal, the insurance firm.

ISSUE

Whether or not a local claim or settling agent is personally and/or solidarily liable upon a marine insurance policy issued by its disclosed foreign principal.

RULING

No. An adjustment and settlement agent is no different from any other agent from the point of view of his responsibility for he also acts in a representative capacity. Whenever he adjusts or settles a claim, he does it in behalf of his principal and his action is binding not upon himself but upon his principal. An insurance adjuster is ordinarily a special agent for the person or company for whom he acts and his authority is prima facie coextensive with the business intrusted to him. He does not discharge functions of a quasi - judicial nature, but represents his employer, to whom he owes faithful service, and for his acts, in the employer's interest, the employer is responsible so long as the acts are done while the agent is acting within the scope of his employment (See *Salonga vs. Warner, Barnes & Co., Ltd.*, G.R. L-2246, 1951).

It, therefore, clearly appears that the scope and extent of the functions of an adjustment and settlement agent do not include personal liability. His functions are merely to settle and adjust claims in behalf of his principal if those claims are proven and undisputed, and if the claim is disputed or is disapproved by the principal, like in the instant case, the agent does not assume any personal liability. The recourse of the insured is to press his claim against the principal. Being a mere agent and representative, petitioner is also not the real party - in - interest in this case. An action is brought for a practical purpose, that is, to obtain actual and positive relief.

3. Reinsurance

IVOR ROBERT DAYTON GIBSON v. HON. PEDRO A. REVILLA, in his official capacity as Presiding Judge of Branch XIII, Court of First Instance of Rizal, and LEPANTO CONSOLIDATED MINING COMPANY

G.R. No. L-41432, July 30, 1979, GUERRERO , J.

The general rule in the law of reinsurance is that the re-insurer is entitled to avail itself of every defense which the re-insured (which is Malayan) might urge in an action by the person originally insured (which is Lepanto).

FACTS

Lepanto Consolidated Mining Company filed a complaint with a plea for preliminary mandatory injunction against Malayan Insurance Company, Inc. founded on the Marine Open Policy issued by the latter in favor of Lepanto. Ivor Robert Dayton Gibson, one of re-insurers in the reinsurance contract obtained abroad by Malayan through Sedgwick, Collins & Co., Limited, filed a motion to intervene. He claimed that he has a legal interest in the subject matter of litigation in that he stands to be held liable to pay on its re- insurance contract should judgment be rendered requiring the Malayan to pay the claim of the Lepanto. The trial court denied his motion for intervention. The Supreme Court denied his petition for lack of merit, but upon his motion for reconsideration, the petition was allowed.

ISSUE

Whether or not Ivor Robert Dayton Gibson, as reinsurer, may intervene in the suit between Lepanto and Malayan.

RULING

No. Notwithstanding the presence of a legal interest, permission to intervene is subject to the sound discretion of the court. The Supreme Court agreed with the holding of the trial court that since movant Ivor Robert Dayton Gibson appears to be only one of several re-insurers of the risks and liabilities assumed by Malayan Insurance Company, Inc., it is highly probable that other re-insurers may likewise intervene. The trial between Lepanto and Malayan would be definitely disrupted and would certainly unduly delay the proceedings between the parties especially at the stage where Lepanto had already rested its case and that the issues would also be compounded as more parties and more matters will have to be litigated. In other words, the Court's discretion is justified and reasonable.

The rights, if any, of petitioner are not prejudiced by the present suit and will be fully protected in a separate action against him and his co-insurers by Malayan. The general rule in the law of reinsurance is that the re-insurer is entitled to avail itself of every defense which the re-insured (which is Malayan) might urge in an action by the person originally insured (which is Lepanto). The clause "to pay as may be paid thereon" contained in petitioner's re-insurance contract does not preclude the reinsurer from insisting upon proper proof that a loss strictly within the terms of the original policy has taken place.

AVON INSURANCE PLC, et al vs. COURT OF APPEALS

G.R. No. 97642, August 29, 1997, TORRES, JR., J.

A corporation to qualify as duly engaged in reinsurance business, it must comply with the requirements provided by Philippine law. If a foreign corporation does not do business here, there would be no reason for it to be subject to the State's regulation. In so far as the State is concerned, such foreign corporation has no legal existence. Therefore, to subject such corporation to the courts' jurisdiction would violate the essence of sovereignty.

FACTS

Yupangco Cotton Mills engaged to secure with Worldwide Security and Insurance Co. Inc., several of its properties under Policy No. 20719 for a coverage of P100,000,000.00 and under Policy No. 25896, also for P100,000,000.00. Both contracts were covered by reinsurance treaties between Worldwide Surety and Insurance and several foreign reinsurance companies, including the petitioners. The reinsurance arrangements had been made through international broker C.J. Boatwright and Co. Ltd., acting as agent of Worldwide Surety and Insurance. Within the respective effectivity periods of the 2 policies, the properties therein insured were razed by fire. Partial payments were made by Worldwide Surety and Insurance and some of the reinsurance companies. Worldwide Surety and Insurance, in a Deed of Assignment, acknowledged a remaining balance of P19,444,447.75 still due Yupangco Cotton Mills, and assigned to the latter all reinsurance proceeds still collectible from all the foreign reinsurance companies. Thus, in its interest as assignee and being the original insured, Yupangco Cotton Mills instituted this collection suit against the petitioners. In a Petition for Certiorari filed with the CA, petitioners submitted that respondent Court has no jurisdiction over them, being all foreign corporations not doing business in the Philippines with no office, place of business or agents in the Philippines. The CA found the petition devoid of merit. Hence, this petition.

ISSUE

Whether or not Petitioners, being foreign corporations not doing business in the Philippines, are subject to the jurisdiction of Philippine courts.

RULING

NO. To qualify the petitioners business of reinsurance within the Philippine forum, resort must be made to established principles in determining what is meant by doing business in the Philippines. A foreign corporation, is one which owes its existence to the laws of another state, and generally, has no legal existence within the state in which it is foreign. It was held that corporations have no legal status beyond the bounds of the sovereignty by which they are created. Nevertheless, it is widely accepted that foreign corporations are, by reason of state comity, allowed to transact business in other states and to sue in the courts of such fora. In the Philippines, before a foreign corporation can transact business, it must first obtain a license to transact business here and secure the proper authorizations under existing law. The purpose of the law for the same is to subject the foreign corporations doing business in the Philippines to the jurisdiction of the courts.

Indeed, if a foreign corporation does not do business here, there would be no reason for it to be subject to the State's regulation. In so far as the State is concerned, such foreign corporation has no legal existence. Therefore, to subject such corporation to the courts' jurisdiction would violate the essence of sovereignty. As we have found, there is no showing that petitioners had performed any act in the country that would place it within the sphere of the court's jurisdiction.

COMMUNICATION and INFORMATION SYSTEM v. MARK SENSING AUSTRALIA, ET AL

G.R. No. 192159, January 25, 2017

A contract of reinsurance is one by which an insurer (the "direct insurer" or "cedant") procures a third person (the "reinsurer") to insure him against loss or liability by reason of such original insurance. It is a separate and distinct arrangement from the original contract of insurance, whose contracted risk is insured in the reinsurance agreement. The reinsurer's contractual relationship is with the direct insurer, not the original insured, and the latter has no interest in and is generally not privy to the contract of reinsurance. Put simply, reinsurance is the "insurance of an insurance."

FACTS

Petitioner Communication and Information Systems Corporation (CISC) and respondent Mark Sensing Australia Pty. Ltd. (MSAPL) entered into a Memorandum of Agreement^[4] (MOA) dated March 1, 2002 whereby MSAPL appointed CISC as "the exclusive AGENT of [MSAPL] to PCSO during the [lifetime] of the recently concluded Memorandum of Agreement entered into between [MSAPL], PCSO and other parties." The recent agreement referred to in the MOA is the thermal paper and bet slip supply contract (the Supply Contract) between the Philippine Charity Sweepstakes Office (PCSO), MSAPL, and three other suppliers, namely Lamco Paper Products Company, Inc. (Lamco Paper), Consolidated Paper Products, Inc. (Consolidated Paper) and Trojan Computer Forms Manufacturing Corporation (Trojan Computer Forms).^[5] As consideration for CISC's services, MSAPL agreed to pay CISC a commission of 24.5% of future gross sales to PCSO, exclusive of duties and taxes, for six years.^[6]

After initially complying with its obligation under the MOA, MSAPL stopped remitting commissions to CISC during the second quarter of 2004. As a result of MSAPL's refusal to pay, CISC filed a complaint before the RTC in Quezon City for specific performance against MSAPL, Mark Sensing Philippines, Inc.

(MSPI), Atty. Ofelia Cajigal, and PCSO.^[9] CISC prayed that private respondents be ordered to comply with its obligations under the MOA. It also asked the RTC to issue a writ of preliminary mandatory injunction and/or writ of attachment.^[10]

RTC granted CISC's application for issuance of a writ of preliminary attachment, stating that "the non-payment of the agreed commission constitutes fraud on the part of the defendant MSAPL in their performance of their obligation to the plaintiff."^[15] The RTC found that MSAPL is a foreign corporation based in Australia, and its Philippine subsidiary, MSPI, has no other asset except for its collectibles from PCSO. Thus, the RTC concluded that CISC may be left without any security if ever MSAPL is found liable.^[16] But the RTC limited the attachment to P4,861,312.00, which is the amount stated in the complaint, instead of the amount sought to be attached by CISC, *i.e.*, P113,197,309.10.^[17] The RTC explained that it "will have to await the Supreme Court judgment over the issue of whether [it] has jurisdiction on the amounts in the excess of the amount prayed for by the plaintiff in their complaint" since MSAPL appealed the adverse judgment in CA-G.R. SP No. 96620 to us.^[18] We later denied MSAPL's petition for review assailing the CA Decision

On July 8, 2009, CISC posted a bond in the amount of P113,197,309.10 through Plaridel Surety and Insurance Company (Plaridel) in favor of MSAPL, which the RTC approved on the same date.^[24] Two days later, MSAPL filed a motion to determine the sufficiency of the bond because of questions regarding the financial capacity of Plaridel.^[25] But before the RTC could act on this motion, MSAPL, apparently getting hold of Plaridel's latest financial statements, moved to recall and set aside the approval of the attachment bond on the ground that Plaridel had no capacity to underwrite the bond pursuant to Section 215 of the old Insurance Code^[26] because its net worth was only P214,820,566.00 and could therefore only underwrite up to P42,964,113.20.^[27] RTC denied MSAPL's motion, finding that although Plaridel cannot underwrite the bond by itself, the amount covered by the attachment bond "was likewise reinsured to sixteen other insurance companies."^[28] However, "for the best interest of both parties," the RTC ordered Plaridel to submit proof that the amount of P95,819,770.91 was reinsured. Plaridel submitted its compliance on September 11, 2009, attaching therein the reinsurance contracts.

MSAPL, MSPI and Atty. Ofelia Cajigal filed a petition for *certiorari*. CA held that the RTC exceeded its authority when it "ordered the issuance of the writ [of preliminary attachment] despite a dearth of evidence to clearly establish [CISC's] entitlement thereto, let alone the latter's failure to comply with all requirements therefor."^[32] Noting that the posting of the attachment bond is a jurisdictional requirement, the CA concluded that since Plaridel's capacity for single risk coverage is limited to 20% of its net worth, or P57,866,599.80, the RTC "should have set aside the second writ outright for non-compliance with Sections 3 and 4 of Rule 57."^[33]

After the CA perfunctorily denied CISC's motion for reconsideration on April 23, 2010,^[34] it filed this petition for review on *certiorari*.

ISSUE

Whether the RTC committed grave abuse of discretion when it approved the attachment bond whose face amount exceeded the retention limit of the surety.

RULING

Section 215 of the old Insurance Code, the law in force at the time Plaridel issued the attachment bond, limits the amount of risk that insurance companies can retain to a maximum of 20% of its net

worth. However, in computing the retention limit, risks that have been ceded to authorized reinsurers are *ipso jure* deducted. In mathematical terms, the amount of retained risk is computed by deducting ceded/reinsured risk from insurable risk. If the resulting amount is below 20% of the insurer's net worth, then the retention limit is not breached. In this case, both the RTC and CA determined that, based on Plaridel's financial statement that was attached to its certificate of authority issued by the Insurance Commission, its net worth is P289,332,999.00. Plaridel's retention limit is therefore P57,866,599.80, which is below the P113,197,309.10 face value of the attachment bond. However, it only retained an insurable risk of P17,377,938.19 because the remaining amount of P98,819,770.91 was ceded to 16 other insurance companies. Thus, the risk retained by Plaridel is actually P40 Million below its maximum retention limit. Therefore, the approval of the attachment bond by the RTC was in order. Contrary to MSAPL's contention that the RTC acted with grave abuse of discretion, we find that the RTC not only correctly applied the law but also acted judiciously when it required Plaridel to submit proof of its reinsurance contracts after MSAPL questioned Plaridel's capacity to underwrite the attachment bond. Apparently, MSAPL failed to appreciate that by dividing the risk through reinsurance, Plaridel's attachment bond actually became more reliable — as it is no longer dependent on the financial stability of one company — and, therefore, more beneficial to MSAPL.

In cancelling Plaridel's insurance bond, the Court of Appeals (CA) also found that because the reinsurance contracts were issued in favor of Plaridel, and not MSAPL, these failed to comply with the requirement of Section 4, Rule 57 of the Rules of Court requiring the bond to be executed to the adverse party. This led the CA to conclude that "the bond has been improperly and insufficiently posted." We reverse the CA and so hold that the reinsurance contracts were correctly issued in favor of Plaridel. A contract of reinsurance is one by which an insurer (the "direct insurer" or "cedant") procures a third person (the "reinsurer") to insure him against loss or liability by reason of such original insurance. It is a separate and distinct arrangement from the original contract of insurance, whose contracted risk is insured in the reinsurance agreement. The reinsurer's contractual relationship is with the direct insurer, not the original insured, and the latter has no interest in and is generally not privy to the contract of reinsurance. Put simply, reinsurance is the "insurance of an insurance."

4. Documentary Stamp Tax on Insurance Policy

PHILIPPINE HOME ASSURANCE CORPORATION, PHILIPPINE AMERICAN ACCIDENT INSURANCE COMPANY, PHILIPPINE AMERICAN GENERAL INSURANCE COMPANY and AMERICAN INTERNATIONAL UNDERWRITERS (Phils.), INC. v. COURT OF APPEALS, and COMMISSIONER OF INTERNAL REVENUE

G.R. No. 119446, January 21, 1999, MENDOZA, J.

It is thus settled that the life and non-life insurance policies in question are subject to documentary stamp taxes pursuant to Secs. 183 and 184 of the National Internal Revenue Code by their mere issuance, and the fact that the policies have not become effective for non-payment of the corresponding premiums as required by Sec. 77 of the Insurance Code cannot affect petitioners liability for payment of documentary stamp taxes. Their claim for refund was correctly denied.

FACTS

Petitioners are domestic corporations engaged in the insurance business. From January to June 1986, they paid under protest the total amount of P10,456,067.83 as documentary stamp taxes on various life and non-life insurance policies issued by them. They alleged that the premiums thereon had not been paid. Thus, in accordance with Sec. 77 of the Insurance Code, no documentary stamp taxes were due on the policies. Separate claims for refund from the Bureau of Internal Revenue were filed as a consequence. As the BIR failed to act on their claims, the petitioners appealed to the Court of Tax Appeals but the Tax Court denied their claims. Petitioners filed a joint appeal in the Court of Appeals which, however, affirmed the decision of the Court of Tax Appeals. Hence, this appeal.

ISSUE

Whether or not documentary stamps tax is still due on premiums on the subject life and non-life insurance policies which were not paid.

RULING

YES. In general, documentary stamp taxes are levied on the exercise by persons of certain privileges conferred by law for the creation, revision, or termination of specific legal relationships through the execution of specific instruments. Documentary stamp taxes are thus levied on the exercise of these privileges through the execution of specific instruments, independently of the legal status of the transactions giving rise thereto. The documentary stamp taxes must be paid upon the issuance of the said instruments, without regard to whether the contracts which gave rise to them are rescissible, void, voidable, or unenforceable (See Secs. 183 and 184 of the NIRC).

As the Supreme Court of the United States held in *Du Pont v. United States*: The tax is not upon the business transacted but is an excise upon the privilege, opportunity, or facility offered at exchanges for the transaction of the business. It is an excise upon the facilities used in the transaction of the business separate and apart from the business itself. In this view it is immaterial whether the transfer of the account constituted a sale.

It is thus settled that the life and non-life insurance policies in question are subject to documentary stamp taxes pursuant to Sections 183 and 184 of the National Internal Revenue Code by their mere issuance, and the fact that the policies have not become effective for non-payment of the corresponding premiums as required by Sec. 77 of the Insurance Code cannot affect petitioners liability for payment of documentary stamp taxes. Their claim for refund was correctly denied.

COMMISSIONER OF INTERNAL REVENUE v. LINCOLN PHILIPPINE LIFE INSURANCE COMPANY, INC. (now JARDINE-CMA LIFE INSURANCE COMPANY, INC.) and THE COURT OF APPEALS

G.R. No. 119176, March 19, 2002, KAPUNAN, J.

To claim that the increase in the amount insured (by virtue of the automatic increase clause incorporated into the policy at the time of issuance) should not be included in the computation of the documentary stamp taxes due on the policy would be a clear evasion of the law requiring that the tax be computed on the basis of the amount insured by the policy.

FACTS

Lincoln Philippine Life Insurance Co., Inc. is a domestic corporation engaged in life insurance business. It issued the Junior Estate Builder Policy which contains a clause providing for an automatic increase in the amount of life insurance coverage upon attainment of a certain age by the insured without the need of issuing a new policy. The clause was to take effect in the year 1984. Documentary stamp taxes due on the policy were paid only on the initial sum assured. Lincoln also issued shares of stock with a total par value of P5,000,000.00. The actual value of said shares, represented by its book value, was P19,307,500.00. Documentary stamp taxes were paid based only on the par value of P5,000,000.00. Subsequently, the CIR issued deficiency documentary stamps tax assessment for the year 1984 corresponding to the amount of automatic increase of the sum assured on the policy and to the book value in excess of the par value of the stock dividends. Lincoln questioned the deficiency assessments and sought their cancellation in a petition filed in the Court of Tax Appeals which ruled in its favor. The CA affirmed the CTA's decision insofar as it nullified the deficiency assessment on the insurance policy but validated the deficiency assessment on the stock dividends. Both parties appealed to the SC. Hence, this petition.

ISSUE

Whether or not the automatic increase clause in the subject insurance policy is separate and distinct from the main agreement and involves another transaction.

RULING

YES. The subject insurance policy at the time it was issued contained an automatic increase clause. Although the clause was to take effect on a later date, it was written into the policy at the time of its issuance. Section 173 of the NIRC provides that the payment of documentary stamp taxes is done at the time the act is done. Section 183 of the NIRC provides that the tax base for the computation of documentary stamp taxes on life insurance policies is the amount fixed in policy. Here, although the automatic increase in the amount of life insurance coverage was to take effect later on, the amount of the increase was already definite at the time of the issuance of the policy. Thus, the amount insured by the policy at the time of its issuance necessarily included the additional sum covered by the automatic increase clause because it was already determinable at the time the transaction was entered into and formed part of the policy. The additional insurance was an obligation subject to a suspensive obligation, but still a part of the insurance sold to which respondent was liable for the payment of the documentary stamp tax. The deficiency of documentary stamp tax imposed on respondent is not on the amount of the original insurance coverage, but on the increase of the amount insured upon the effectivity of the Junior Estate Builder Policy. Thus, to claim that the increase in the amount insured should not be included in the computation of the documentary stamp taxes due on the policy would be a clear evasion of the law requiring that the tax be computed on the basis of the amount insured by the policy.