V. Y. Sabaratnam v. Sri Lanka Insurance Corporation Ltd.

RTICAppeal(In-Person)/117/2018 - *Order under Section 32 (1) of the Right to Information Act, No 12 of 2016 and Record of Proceedings under Rule 28 of the Right to Information Rules of 2017 (Fees and Appeal Procedure)* – heard as part of a formal meeting of the Commission on 09.05.2018

Chairperson: Mr. Mahinda Gammampila
Commission Members: Ms Kishali Pinto-Jayawardena
Dr. Selvy Thiruchandran
Justice Rohini Walgama

Director-General: Mr. Piyathissa Ranasinghe

Appellant: Dr. V.Y. Sabaratnam
Notice Issued to: Mr. Hemaka D. S. Amarasuriya, Chairman, Sri Lanka Insurance Corporation Ltd.

Appearance/ Represented by:
Appellant - N/A
Public Authority - A.D. Perera – DGM (Life)
A.A.D.C.P. Athauda – AGM (Life)
R. Hewavitharanage – Manager (Legal)
N. R. Sivendran, PC (Counsel for PA)

RTI Request filed on	17.12.2017
IO responded on	26.12.2017
First Appeal to DO filed on	03.01.2018
DO responded on	04.01.2018
Appeal to RTIC filed on	03.01.2018

Brief Background Facts
An information request dated 17.12.2017 had been filed by the Appellant asking for the following information relating to his insurance claim;

1. The names of the persons who had made the decisions on his claim. If a medical team or a doctor was involved their names, designation and qualifications as well.
2. Certified copies of all the relevant decision-making documents

This was in the context of the Appellant stating that he had been diagnosed with cancer on 31.10.2017 and stating further, that he needed the said information expeditiously and that the Public Authority (PA) has asked him for another medical report in 6 months. He therefore requested,

On 26.12.2017, the Information Officer responded to him denying the information sought on the panelists who decided on the claims under Section 5 (1) (f) of the RTI Act, No.12 of 2016. Dissatisfied with this response the Appellant appealed to the Designated Officer (DO), on 03.01.2018 and he received a response on 04.01.2018 that the decision to withhold the names of the panelists was based on the recommendation of the Chief Officer-Life and as decided by the Board on 28.12.2017. Therefore it was stated that the decision was not taken by the IO arbitrarily but was a collective decision of the Chief Officer-Life and the Board. It was unclear whether the response dated 04.01.2018 was a follow up to the IO's previous response or a response to the Appellant's appeal to the DO. The Appellant then preferred an appeal to the RTI Commission on 03.01.2018.

Matters Arising During the Hearing

The Appellant had sent an email excusing himself from the appeal hearing as he was undergoing chemotherapy for his illness. The PA was present and represented by legal counsel. Counsel for the PA stated that the insurance policy stipulated a 6 months grace period to decide if this was a permanent disability and that this period would be over in approximately two months' time and that therefore it was premature to decide on the Appellant's claim since it yet had to be evaluated. It further submitted that this related to information that might have to be presented to courts if the matter went to court and that therefore, the PA had denied the release of the information.

The PA reiterated that the 6 months grace period was to evaluate the claim on the claimant and till the evaluation was over the claimant was not entitled to any information and that a decision could not be taken without evaluating the claim. The PA emphasized that no decision had been taken on the Appellant's claim as yet.

Order

The Public Authority's argument that the matter relates to a potential dispute which may go to court is not a valid exemption to deny information to an information requestor. Section 5 (1) of the RTI Act No.12 of 2016 provides for specific exemptions and *sub judice* or a pending court case itself is not one of these exemptions. Consequently, the likelihood of a court case arising in the future cannot be construed as a valid exemption to deny information on an information request submitted under the Act.

The Commission records the submission of the Public Authority that no decision has been taken as yet on the Appellant's claim due to the fact that the 6 month time period for evaluation of the claim is yet to be completed. The Public Authority is directed to convey that position to the Appellant and to call for any documents that may be needed for the said evaluation.

The Appeal is adjourned.

Next date of hearing: 26/06/2018
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RTICAppeal (In-Person)/117/2018 - *Order under Section 32 (1) of the Right to Information Act, No 12 of 2016 and Record of Proceedings under Rule 28 of the Right to Information Rules of 2017 (Fees and Appeal Procedure)* – heard as part of a formal meeting of the Commission on 26.06.2018

Chairperson:	Mahinda Gammampila
Commission Members:	Kishali Pinto-Jayawardena
	S.G. Punchihewa
	Dr. Selvy Thiruchandran
	Justice Rohini Walgama

Present: Director-General Mr. Piyathissa Ranasinghe

Appellant: Dr. V.Y. Sabaratnam
Notice Issued to: Mr. Hemaka D. S. Amarasuriya, Chairman, Sri Lanka Insurance Corporation Ltd.

Appearance/ Represented by:

Appellant	-	Dr. V.Y. Sabaratnam
		Ms. B. A. M. Wickramasinghe
Public Authority	-	A.D. Perera – DGM (Life)
		A.A.D.C.P. Athauda – AGM (Technical)
		R. Hewavitharanage – Manager (Legal)
		N. R. Sivendran, P.C. (Counsel for PA)

Matters Arising During the Course of the Hearing:

The PA submitted that it had called for certain information from the Appellant, subsequent to the last hearing which were necessary for the purposes of re-insurance and further clarification had been sought which was submitted on 25.06.2018 and stated that if the matter is called in another two weeks, the matter may be concluded.

The Appellant contended that the information request is independent of the claim and that, until 25.06.2018 he had been unaware of the fact that he had been reinsured by another party. The Appellant further submitted the one Mr. Chaminda who co-ordinated matters in relation to this insurance policy did not inform him of this and that the PA was using the reason of reinsurance to deny him the information. The Appellant further referred to Paragraph 16 of the Statement of Objections filed by the PA dated 03.05.2018 which reads

> "The Respondent [the PA] states that the Claim Form consists of several inaccuracies and therefore, the matters stated in the Claim Form are false."

The Appellant alleges that Mr. Chaminda who was responsible for the agreement between the himself and the PA had not drafted the agreement properly and inaccuracies arise due to errors such as including the wrong date and changing certain conditions, all of which the Appellant stated, had been pointed out to the Public Authority.

The PA submitted that reinsurance was a normal course of action in respect of all applicants who have been insured for life for over Rs. 10 million. The PA submitted that accordingly it is waiting on the decision of the reinsurer who the PA submits has no reason to deny what an applicant is entitled to and that within the next two weeks the matter should come to an end and the Appellant will receive his entitlement. The PA submitted the Appellant's reference to names is irrelevant to the present matter and the only issue is whether or not his claim will be met. The PA submitted that this is exactly why, as submitted even on the last occasion, the insurance policy stipulates a 6 months grace period to decide if this was a permanent disability.

The Appellant counter responded that clause 78 which contains this stipulation of the 6 month grace period was included in his policy after he paid the money. The Appellant submitted that the Insurance Agent who sold it to him did not say that the policy was subject to this clause nor did he send the Appellant a copy of clause 78. He submitted that the PA has delayed this decision and keeps asking for one or two weeks each time that the matter came up for decision and pointed out that a delay of 6 months had already occurred.

The PA stated that this representation by the Appellant was incorrect and that the PA had no direct dealings in relation to this particular scheme as the PA issued the Policy of Life Insurance consequent to an application made by the Appellant for a Mortgage Protection Assurance to the Bank of Ceylon. The PA further submitted that there was no reason to "smuggle" in clause 78 on its part.

Order:

The assurance by the PA that a decision on the matter will be provided within the two weeks is noted of record.

The matter will be called on 26.06.2018 for the above stated purpose.

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RTICAppeal(In-Person)/117/2018 - *Order under Section 32 (1) of the Right to Information Act, No 12 of 2016 and Record of Proceedings under Rule 28 of the Right to Information Rules of 2017 (Fees and Appeal Procedure)* – heard as part of a formal meeting of the Commission on 17.07.2018

Chairperson:	Mahinda Gammampila
Commission Members:	Kishali Pinto-Jayawardena
	S.G. Punchihewa
	Dr. Selvy Thiruchandran
	Justice Rohini Walgama
Director-General:	Piyathissa Ranasinghe
Appellant:	Dr. V.Y. Sabaratnam
Notice Issued to:	Mr. Hemaka D. S. Amarasuriya, Chairman, Sri Lanka Insurance Corporation Ltd.

Appellant	-	Dr. V.Y. Sabaratnam
Public Authority	-	N. R. Sivendran P.C. (Counsel for PA)

Matters Arising During the Hearing:

The PA submitted that the re-insurers had responded by letter dated 18.06.2018 refusing the claim on the basis that it is not admissible for total or partial disability benefit. The PA submitted that this was because the nature of the disability was not established during the reassessment which took place 6 months subsequent to the previous assessment. The PA read out the letter by the re-insurer which stated that the claim of the Applicant based on the document submitted and evidence provided in the re-insurer's opinion the claim is not admissible for the disability benefit claimed. It was further stated that the total and permanent nature of the disability had not been established.

As the Appellant was asking for the basis of the opinion, Counsel on behalf of the PA provided the re-insurer's details from whom the basis may be inquired from.

The Appellant submitted that he needs all the documents on which the decision with respect to his claim was based. The Appellant submitted that the PA has denied his claim 6 months late and alleged that two doctors within Sri Lanka, working on behalf of the PA, assessed his claim and dismissed it. He further alleged that these are not doctors registered with the Sri Lanka Medical Council. The Appellant alleged that all these practices were contradictory to the principles of transparency and accountability.

The PA was queried as to whether it had the medical report provided of the Appellant to which Counsel on behalf of the PA responded that it had been forwarded to the re-insurers. He further submitted that for a payment on a disability to be made certain conditions have to be fulfilled. Counsel for the PA once again read out the letter by the re-insurer however the basis on which the claim was refused was not evident. It was noted that the re-insurer may be questioned in relation to the basis on which the decision was made.

The Appellant reiterated the allegation that the persons providing the opinion on which the insurance decision is based are not qualified medical personnel/ doctors.

The PA was queried as to whether the decision arrived at with respect to the claim was not by the PA but by the re-insurer to which Counsel for the PA responded in the affirmative. Counsel on behalf of the PA further submitted that in relation to certain claims a longer time is required for a decision to be reached. In that respect his particular category of insurance is a loan protection insurance. He further submitted that thousands of claims are submitted all which have to be evaluated. Similarly with respect to the type of insurance obtained by the Appellant re-insurance is required.

The Appellant further alleged that at the inquiry/interview held at the Sri Lanka Insurance Regulatory Commission it was revealed that the doctors working with the PA had provided documentation based on which the decision was made. The Appellant submitted that the doctors in question are not authorized to do so. The Appellant submitted that this has been stated for the record and is evident in the proceedings of the inquiry held at the Sri Lanka Insurance Regulatory Commission.

Orders:

The response (dated 18.06.2018) and details of the re-insurer provided by the PA are noted of record.

The Appellant is directed to submit the documentation with respect to the interview had with the Sri Lanka Insurance Regulatory Commission which will contain evidence of the fact that the Appellant's claim was assessed by medical personnel in Sri Lanka whom according to the Appellant are unqualified, and based on which the decision to deny the Appellant's claim was made.

The Appeal is adjourned.

Next date of hearing: 28.08.2018

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RTICAppeal(In-Person)/117/2018 - *Order under Section 32 (1) of the Right to Information Act, No 12 of 2016 and Record of Proceedings under Rule 28 of the Right to Information Rules of 2017 (Fees and Appeal Procedure)* – heard as part of a formal meeting of the Commission on 28.08.2018

Chairperson:	Mahinda Gammampila
Commission Members:	Kishali Pinto-Jayawardena
	S.G. Punchihewa
	Dr. Selvy Thiruchandran
	Justice Rohini Walgama
Director-General:	Piyathissa Ranasinghe

Appellant: Dr. V.Y. Sabaratnam
Notice Issued to: Mr. Hemaka D. S. Amarasuriya, Chairman, Sri Lanka Insurance Corporation Ltd.

Appellant	-	Dr. V.Y. Sabaratnam
Public Authority	-	N. R. Sivendran P.C. (Counsel for PA)

Matters Arising During the Hearing:

The Appellant submitted that the PA is deceiving the Commission and that insurance companies make profit by the failure and delay on their part citing varied reasons, in meeting claims until the death of the individual claiming the insurance. The Appellant submitted that this is the strategy practiced by the PA in this instance and that repeated requests for medical reports are made to achieve this goal. The Appellant submitted that without transparency in the process the officials at the PA are free to commit crimes with impunity with regard to all claims submitted.

Counsel on behalf of the PA reiterated his submission that the reinsurer having decided that the Appellant is not suffering from a permanent disability in the first instance requires that the claimant wait another 6 months before the claim is reassessed and that this is the procedure followed by the reinsurer.

The Appellant submitted that the reinsurer is a pharmacist by qualification and his experience is only as a reinsurer and no other qualifications which enable him to assess a claim whose contact details had been provided on the previous occasion. The Appellant submitted that subsequent to the obtaining of this information the Appellant contacted the re-insurer who stated that he is not going to assess the Appellant's claim before the lapse of the six month time period and further that he as the re-insurer is not answerable to the law of Sri Lanka and that no court in Sri Lanka has jurisdiction over him. The Appellant submitted that the re-insurer was based in India. The Appellant accordingly submitted that his claim has nothing to do with the re-insurer and that it is the PA in this instance that is under obligation to provide him with his claim. The Appellant reiterated that he was never informed of this process of re-insurance.

The PA was then queried as to the function of a reinsurer to which the PA responded stating that in general all insurance except motor vehicle insurance is subject to re-insurance as required by law. Further that the Appellant is not being singled out but rather that he is being subjected to a process that all claimants are required to go through. Counsel submitted that the PA accordingly, once the re-insurer communicates its decision, would decide on the claim.

The PA was queried as to whether the fact of reinsurance is communicated to persons at the point of obtaining insurance to which the PA responded that although it may not be communicated per se it is requirement by law that every insurer complies with. For example in relation to insurance obtained as protection against terrorist activities a fund is created by the State which acts as the reinsurer and when a claim resulting from damage caused due to a terrorist activity is made, the claim is referred to the Fund for an assessment to be made and for the claim to be met or otherwise.

The Commission noted that the Appellant is within his right to make the claim. It was submitted on behalf of the PA that although the Appellant has a right to make this claim, the PA has acted in accordance with the law in this instance and that if the Appellant denies this he has to file legal action. In the present instance the Appellant has asked for information in relation to the

decision taken by the PA with respect to his claim to which the response of the PA is that it has not made a decision as the re-insurer has decided to reassess the claim in six months being dissatisfied that there is a permanent disability warranting the payment of the claim. Counsel on behalf of the PA reiterated that the PA cannot by pass the re-insurer and arrive at a decision which will have implications with regard to all other claims. The PA further submitted that the reinsurer arrives at this decision using its own doctors and investigators. The Appellant queried as to who these persons are to which counsel for the PA responded stating that the PA is not aware of this but may be ascertained by the re-insurer's representatives. Further what is generally assessed is whether the claimant is suffering from a permanent disability as a result of his illness i.e. him being unable to work and earn.

It was submitted on behalf of the PA that based on the information available the Appellant is drawing his salary. The Appellant responded stating that at present he does not draw a salary but is on medical leave during which period he is entitled to medical pay. The Appellant insisted that the decision with respect to the non-payment of his claim was taken by the PA. The Appellant submitted that he had spoken to the re-insurer whose details were provided on the previous occasion who as per the Appellant's submissions had stated that the decision had been made subsequent to consulting with a specialist doctor.

The PA submitted that on the information available at this point re the Appellant's claim a decision could not be arrived at which is the reason for the re-insurer seeking a further 6 months. The Appellant submitted that the PA was reiterating the same point and that he wants the process to be transparent so that he can take the next step in the process. The Appellant submitted that the PA had not responded to the queries by the Attorney-General's Department on the issue. However, it was submitted on behalf of the PA that they had in fact responded. The PA submitted that the re-insurers in general have their own personnel to assess claims as is the practice in any part of the world. Further it was up to the Appellant to file action if he was dissatisfied with the manner in which the claim is assessed. The Appellant responded stating that this is the manner in which insurance companies act by pushing persons already aggrieved by the decisions of the companies to file action to their detriment. The Appellant submitted that his objective in this instance was to have the process by which a claim is assessed, to be made transparent.

The PA stated for the record that no assessment was made by the PA and that therefore no documentation in relation to such is available within its custody, control and possession.

Order reserved.