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REPUBLIC OF THE PHILIPPINES
Supreme Court
Manila
FIRST DIVISION

G.R. No. 125678 March 18, 2002

PHILAMCARE HEALTH SYSTEMS, INC., petitioner,
vs.
COURT OF APPEALS and JULITA TRINOS, respondents.

YNARES-SANTIAGO, *J.:*

Ernani Trinos, deceased husband of respondent Julita Trinos, applied for a health care coverage with petitioner 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).[1]

The application was approved for a period of one year from March 1, 1988 to March 1, 1989. Accordingly, he was issued Health Care Agreement No. P010194. Under the agreement, respondent's husband was entitled to avail of hospitalization benefits, whether ordinary or emergency, listed therein. He was also entitled to avail of "out-patient benefits" such as annual physical examinations, preventive health care and other out-patient services.

Upon the termination of the agreement, the same was extended for another year from March 1, 1989 to March 1, 1990, then from March 1, 1990 to June 1, 1990. The amount of coverage was increased to a maximum sum of P75,000.00 per disability.[2]

During the period of his coverage, Ernani suffered a heart attack and was confined at the Manila Medical Center (MMC) for one month beginning March 9, 1990. While her husband was in the hospital, respondent tried to claim the benefits under the health care agreement. However, petitioner denied her claim saying that the Health Care Agreement was void. According to petitioner, 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. Thus, respondent paid the hospitalization expenses herself, amounting to about P76,000.00.

After her husband was discharged from the MMC, he was attended by a physical therapist at home. Later, he was admitted at the Chinese General Hospital. Due to financial difficulties, however, respondent brought her husband home again. In the morning of April 13, 1990, Ernani had fever and was feeling very weak. Respondent 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 petitioner and its president, Dr. Benito Reverente, which was docketed as Civil Case No. 90-53795. She asked for reimbursement of her expenses plus moral damages and attorney's fees. After trial, the lower court ruled against petitioners, *viz:*

> WHEREFORE, in view of the forgoing, the Court renders judgment in favor of the plaintiff Julita Trinos, ordering:
>
> 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.

SO ORDERED.[3]

On appeal, the Court of Appeals affirmed the decision of the trial court but deleted all awards for damages and absolved petitioner Reverente.[4] Petitioner's motion for reconsideration was denied.[5] Hence, petitioner brought the instant petition for review, raising the primary argument that a health care agreement is not an insurance contract; hence the "incontestability clause" under the Insurance Code[6] does not apply.

Petitioner argues that the agreement grants "living benefits," such as medical check-ups and hospitalization which a member may immediately enjoy so long as he is alive upon effectivity of the agreement until its expiration one-year thereafter. Petitioner also points out that only medical and hospitalization benefits are given under the agreement without any indemnification, unlike in an insurance contract where the insured is indemnified for his loss. Moreover, since Health Care Agreements are only for a period of one year, as compared to insurance contracts which last longer,[7] petitioner argues that the incontestability clause does not apply, as the same requires an effectivity period of at least two years. Petitioner further argues that it is not an insurance company, which is governed by the Insurance Commission, but a Health Maintenance Organization under the authority of the Department of Health.

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.[8]

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.[9] 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.

Petitioner argues that respondent's husband concealed a material fact in his application. It appears that in the application for health coverage, petitioners required respondent's husband to sign an express authorization for any person, organization or entity that has any record or knowledge of his health to furnish any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination.[10] Specifically, the Health Care Agreement signed by respondent's husband states:

We hereby declare and agree that all statement and answers contained herein and in any addendum annexed to this application are full, complete and true and bind all parties in interest under the Agreement

> herein applied for, that there shall be no contract of health care coverage unless and until an Agreement is issued on this application and the full Membership Fee according to the mode of payment applied for is actually paid during the lifetime and good health of proposed Members; that no information acquired by any Representative of PhilamCare shall be binding upon PhilamCare unless set out in writing in the application; 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 and that the acceptance of any Agreement issued on this application shall be a ratification of any correction in or addition to this application as stated in the space for Home Office Endorsement.[11] (Underscoring ours)

In addition to the above condition, petitioner additionally required the applicant for authorization to inquire about the applicant's medical history, thus:

> I hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of _____ to give to the PhilamCare Health Systems, Inc. any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination. This authorization is in connection with the application for health care coverage only. A photographic copy of this authorization shall be as valid as the original.[12] (Underscoring ours)

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.[13]

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.[14] 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.[15] (Underscoring ours)

The fraudulent intent on the part of the insured must be established to warrant rescission of the insurance contract.[16] 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.

Under 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.[17] 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:

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.[18]

None of the above pre-conditions was fulfilled in this case. When the terms of 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.[19] Being a contract of adhesion, the terms of an insurance contract are to be construed strictly against the party which prepared the contract – the insurer.[20] By reason of the exclusive control of the insurance company over the terms and phraseology of the insurance contract, ambiguity must be strictly interpreted against the insurer and liberally in favor of the insured, especially to avoid forfeiture.[21] This is equally applicable to Health Care Agreements. The phraseology used in medical or hospital service contracts, such as the one at bar, must be liberally construed in favor of the subscriber, and if doubtful or reasonably susceptible of two interpretations the construction conferring coverage is to be adopted, and exclusionary clauses of doubtful import should be strictly construed against the provider.[22]

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.[23]

Finally, petitioner alleges that respondent was not the legal wife of the deceased member considering that at the time of their marriage, the deceased was previously married to another woman who was still alive. The health care agreement is in the nature of a contract of indemnity. Hence, payment should be made to the party who incurred the expenses. It is not controverted that respondent paid all the hospital and medical expenses. She is therefore entitled to reimbursement. The records adequately prove the expenses incurred by respondent for the deceased's hospitalization, medication and the professional fees of the attending physicians.[24]

WHEREFORE, in view of the foregoing, the petition is **DENIED**. The assailed decision of the Court of Appeals dated December 14, 1995 is **AFFIRMED**.

SO ORDERED.

Davide, Jr., C.J., Puno, and Kapunan, JJ., concur.

Footnote

[1] Record, p. 28.

[2] Exhibit "4", Record, p. 156.

[3] Dated November 16, 1993; penned by Judge Lolita Gal-lang; Rollo, pp. 134-135.

[4] Dated December 14, 1995, penned by Associate Justice Fidel P. Purisima, concurred in by Associate Justices Fermin A. Martin, Jr. and Conchita Carpio Morales; Rollo, p. 45.

[5] Resolution dated July 23, 1996; Rollo, p. 48.

[6] Section 48 of P.D. No. 1460 otherwise known as the Insurance Code.

[7] Petition, pp. 13-14; Rollo, pp. 22-23.

[8] See Vance pp. 1-2 cited in Agbayani, Commercial Laws of the Philippines, vol. 2, 1986 ed. p. 6.

[9] Cha *v.* Court of Appeals, 270 SCRA 690, 694 (1997).

[10] Record, p. 28.

[11] *Ibid.*

[12] *Ibid.*

[13] *Ibid.,* p. 13.

[14] Bryant v. Modern Woodmen of America, 86 Neb 372, 125 NW 621.

[15] Herrick v. Union Mut. Fire Ins. Co., 48 Me 558; Bryant v. Modern Woodmen of America, *supra*; Boutelle v. Westchester Fire Ins. Co., 51 Vt 4 cited in 43 Am Jur 2d § 1016.

[16] Great Pacific Life v. Court of Appeals, 316 SCRA 677 [1999], citing Ng Gan Zee v. Asian Crusader Life Assurance Corp., 122 SCRA 461 [1983].

[17] Section 48, Insurance Code.

[18] Malayan Insurance v. Cruz Arnaldo, 154 SCRA 672 [1987].

[19] Heirs of Ildefonso Cosculluela, Sr. v. Rico General Insurance Corporation, 179 SCRA 511 [1989].

[20] Landicho v. GSIS, 44 SCRA 7 [1972]; Western Guaranty Company v. Court of Appeals, 187 SCRA 652 [1990].

[21] 44 C.J.S. pp. 1166-1175; 29 Am. Jur. 180. See also Aetna Insurance Co. v. Rhodes, 170 F2d 111; Insurance Co. v. Norton, 96 U.S. 234, 24 L ed 689; Pfeiffer v. Missouri State Life Ins. Co., 174 Ark 783, 297 SW 847.

[22] See Myers v. Kitsap Physicians Service, 78 Wash 2d 286, 474 P2d 109, 66 ALR3d 1196; Hunt v. Hospital Service Plan, 81 ALR 2d 919 cited in 43 Am Jur 2d § 289.

[23] Record, p. 257.

[24] Exhibit "B", Exhibits "D" to "D-7"; Record, pp. 88-97.

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