INSURANCE-POLICY

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. 41702 September 4, 1935

FORTUNATA LUCERO VIUDA DE SINDAYEN, plaintiff-appellant,
vs.
THE INSULAR LIFE ASSURANCE CO., LTD., defendant-appellee.

Jos. N. Wolfson for appellant.
Araneta, Zaragoza and Araneta for appellee.

BUTTE, *J.:*

This if, an appeal from a judgment of the Court of First Instance of Manila in an action brought by the plaintiff-appellant as beneficiary to recover P1,000 upon a life insurance policy issued by the defendant on the life of her deceased husband, Arturo Sindayen.

The essential facts upon which this case turns are not in dispute and may be stated as follows:

Arturo Sindayen, up to the time of his death on January 19, 1933, was employed as a linotype operator in the Bureau of Printing at Manila and had been such for eleven years prior thereto. He and his wife went to Camiling, Tarlac, to spend the Christmas vacation with his aunt, Felicidad Estrada. While there he made a written application on December 26, 1932, to the defendant Insular Life Assurance Co., Ltd., through its agent, Cristobal Mendoza, for a policy of insurance on his life in the sum of P1,000 and he paid to the agent P15 cash as part of the first premium. It was agreed with the agent that the policy, when and if issued, should be delivered to his aunt. Felicidad Estrada, with whom Sindayen left the sum of P26.06 to complete the payment of the first annual premium of P40.06. On January 1, 1933, Sindayen, who was then twenty-nine years of age, was examined by the company's doctor who made a favorable report, to the company. On January 2, 1933, Sindayen returned to Manila and resumed his work a linotype operator in the Bureau of Printing. On January 11, 1933, The company accepted the risk and issued policy No. 47710 dated back to December 1, 1932, and mailed the same to its agent, Cristobal Mendoza, in Camiling, Tarlac, for delivery to the insured. On January 11, 1933, Sindayen was at work in the Bureau of Printing. On January 12, he complained of a severe headache and remained at home. On January 15, he called a physician who found that he was suffering from acute nephritis and uremia. His illness did not yield to treatment and on January 19, 1933, he died.

The policy which the company issued and mailed in Manila on January 11, 1933, was received by its agent in Camiling, Tarlac, on January 16, 1933. On January 18, 1933, the agent, in accordance with his agreement with the insured, delivered the policy to Felicidad Estrada upon her payment of the balance of the first year's annual premium. The agent asked Felicidad Estrada if her nephew was in good health and she replied that she believed so because she had no information that he was sick and he thereupon delivered to her the policy.

On January 20, 1933, the agent learned of the death of Arturo Sindayen and called on Felicidad Estrada and asked her to return the policy. He testified: "pedia a ella que me devolviera a poliza para traerla a Manila para esperar la de decision de la compañia" (t. s. n. p. 19). But he did not return or offer to return the premium paid. Felicidad Estrada on his aforesaid statement gave him the policy.

On February 4, 1933, under circumstances which it is not necessary to relate here, the company obtained from the beneficiary, the widow of Arturo Sindayen, her signature to a legal document entitled "ACCORD, SATISFACTION AND RELEASE" whereby in consideration of the sum of P40.06 paid to her by a check of the company, she "assigns, releases and forever discharges said Isular Life Assurance Co., Ltd., its successors and assigns, of all claims, obligation in or indebtedness which she, as such beneficiary ever had or now has, hereafter ca, shall, or may have, for, upon, or by reason of said policy of life insurance numbered 47710 upon the life of said Arturo Sindayen, the latter now deceased, or arising therefrom or connected therewith in any manner", which appears in the record as Exhibit A, attached to the deposition of the notary who executed th fraudulent acknowledgment to Exhibit A. The said check for P40.06 was never cashed but returned to the company and appears in the record of this case as Exhibit D. Thereupon this action was brought to enforce payment of the policy.

By the terms of the policy, an annual premium of P40.06 is due on the first day of December of each year, the first premium already paid by the insured covering the period from December 1, 1932. It is to December 1, 1933. It is to be noted that the policy was not issued and the company assumed no actual risk prior to January 11, 1933.

The policy contains the following paragraph:

> THE CONTRACT. This Policy and the application herefor constitute the entire contract between the parties hereto. All statements made by the Insured shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall void the Policy unless it is contained in the written application, a copy of which is attached to this Policy. Only the President, or the Manager, acting jointly with the Secretary or Assistant Secretary (and then only in writing signed by them) have power in behalf of the Company to issue permits, or to modify this or any contract, or to extend the time for making any premium payment, and the Company shall t bound by any promise or representation heretofore hereafter

> given by any person other than the above-named officials, and by them only in writing and signed conjointly as stated.".

The application which the insured signed in Camiling, Tarlac, on December 26, 1932, contained among others the following provisions:

> 2. That if this application is accepted and a policy issued in my favor, I bind myself to accept the same and to pay at least the first year's premium thereon in the City of Manila.
>
> 3. That the said policy shall not take effect until the first premium has been paid and the policy has been delivered to and accepted by me, while I am in good health.
>
> 4. That the agent taking this application has no authority to make, modify or discharge contracts, or to waive any of the Company's right or requirements.".

The insurance company does not set up any defense of fraud, misconduct or omission of duty of the insured or his agent, Felicidad Estrada or of the beneficiary. In its answer it pleads the "ACCORD, SATISFACTION AND RELEASE" (Exhibit A) signed by the widow of Arturo Sindayen, the plaintiff-appellant. With respect to Exhibit A, it suffices to say that this release is so inequitable, not to say fraudulent, that we are pleased to note that counsel for the defendant company, on page 51 of their brief, state: "si resultara que la poliza aqui en cuestion es valida la apelada seria la primera en no dar validez alguno al documento Exhibit A aunque la apelante hubiera afirmado que lo otorgo con conocimiento de causa."

It is suggested in appellee's brief that fhere was no delivery of the policy in this case because the policy was not delivered to and accepted by the insured in person. Delivery to the insured in person is not necessary. Delivery may be made by mail or to a duly constituted agent. Appellee cites no authorities to support its proposition and none need be cited to refute it.

We come now to the main defense of the company in this case, namely, that the said policy never took effect because of paragraph 3 of the application above quoted, for at the time of its delivery by the agent as aforesaid the insured was not in good health. We have not heretofore been called upon to interpret and apply this clause in life insurance application, but identical or substantially identical clauses have been construed and applied in a number of cases in the United States and the decisions thereon are far from uniform or harmonious. We do not find it practicable to attempt to determine where the weight of the authority lies and propose to resolve this case on its own facts.

There is one line of cases which holds that the stipulation contained in paragraph 3 is in the nature of a condition precedent, that is to say, that there can be no valid delivery to the insured *unless* he is in good health at the time; that this condition precedent goes to the very essence of the contract and cannot be waived by the agent making delivery of the policy, (Rathbun is. New York Life Insurance Co., 30 Idaho, 34; 165 Pac., 997; American Bankers Insurance Co. *vs.* Thomas, 53 Okla., 11; 154 Pac., 44; Gordon *vs.* Prudential Insurance Co., 231 Pa., 404; Reliance Life Insurance Co. *vs.* Hightower, 148 Ga., 843; 98 S.E., 469.)

On the other hand, a number of American decisions hold that an agent to whom a life insurance policy similar to the one here involved was sent with instructions to deliver it to the insured has authority to bind the company by making such delivery, although the insured was not in good health at the time of delivery, on the theory that the delivery of the policy being the final act to the consummation of the contract, the condition as to the insurer's good health was waived by the company. (Kansas City Life Insurance Co. *vs.* Ridout, 147 Ark., 563; 228 S.W., 55; Metropolitan Life Insurance Co. *vs.* Willis, 37 Ind. App., 48; 76 N.E., 560; Grier *vs.* Mutual Life Insurance Co. of New York, 132 N.C., 543; 44 S.E., 38; Bell *vs.* Missouri State Life Insurance Co., 166 Mo. App., 390; 149 S.W., 33.)

A number of these cases go to the of holding that the delivery of the policy by the agent to the insured consummates the contract even though the agent knew that the insured was not in good health at the time, the theory being that his knowledge is the company's knowledge and his delivery of the policy is the company's delivery; that when the delivery is made notwithstanding this knowledge of the defect, the company is deemed to have waived the defect. Although that appears to be the prevailing view in the American decisions (14 R.C.L., 900) and leads to the same conclusion, namely, that the act of delivery of the policy in the absence of fraud or other ground for recission consummates the insurance, we are inclined to the view that it is more consonant with the well known practice of life insurance companies and the evidence in the present case to rest our decision on the proposition that Mendoza was authorized by the company to make the delivery of the policy when he received the payment of the first premium and he was satisfied that the insured was in good health. As was well said in the case of MeLaurin *vs.* Mutual Life Insurance Co. (115 S.C., 59; 104 S.E., 327):

> So much comes from the necessity of the case; the president, the vice-president, and the secretary cannot solicit, or collect, or deliver; they must commit that to others, and along with it the discretions we have adverted to. . . . The power in the local agent to withhold the policy involves the power to deliver it; there is no escape from that conclusion.
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> But the appellant says, even though the local agent should have concluded that the applicant was in good health, yet, if the fact be the contrary, then the policy never operated. The parties intended to make a contract, and that involved the doing of everything necessary to carry it into operation, to wit, the acceptance of the applicant as a person in good health. They never intended to leave open that one essential element of the contract, when the parties dealth fairly one with the other. It is plain, therefore, that upon the facts it is not necessarily a case of waiver or of estoppel, but a case where the local agents, in the exercise of the powers lodged in

them, accepted the premium and delivered the policy. That act binds their principal, the defendant.

Mendoza was duly licensed by the Insurance Commissioner to act as the agent of the defendant insurance company. The well known custom of the insurance business and the evidence in this case prove that Mendoza was not regarded by the company as a mere conduit or automaton for the performance of the physical act of placing the policy in the hands of the insured. If Mendoza were only an automaton then the legally effective delivery of the policy and the consummation of the contract occurred when the company expressed its will to release the policy by mailing it to its agent, namely, on January 11, 1933. In such a case the agent would perform a purely ministerial act and have no discretion. He could do nothing but make unconditional delivery. The legal result would be the same as if the company had mailed the policy on January 11, 1933, to the insured directly using the post-office as its conduit for delivery. On January 11, 1933, the insured was in good health performing his regular duties in the Bureau of Printing.

But we are not inclined to take such a restrictive view of the agent's authority because the evidence in the record shows that Mendoza had the authority, given him by the company, to withhold the delivery of the policy to the insured "until the first premium has been paid and the policy has been delivered to and accepted by me (the insured) while I am in good health". Whether that condition had been met or not plainly calls for the exercise of discretion. Granted that Mendoza's decision that the condition had been met by the insured and that it was proper to make a delivery of the policy to him is just as binding on the company as if the decision had been made by its board of directors. Granted that Mendoza made a mistake of judgement because he acted on insufficient evidence as to the state of health of the insured. But it is not charged that the mistake was induced by any misconduct or omission of duty of the insured.

It is the interest not only the applicant but of all insurance companies as well that there should be some act which gives the applicant the definite assurance that the contract has been consummated. This sense of security and of peace of mind that one's defendants are provided for without risk either of loss or of litigation is the bedrock of life insurance. A cloud will be thrown over the entire insurance business if the condition of health of the the insured at the time of delivery of the policy may be required into years afterwards with the view to avoiding the policy on the ground that it never took effect because of an alleged lack of good health, at the time of delivery. Suppose in the present instance that Sindayen had recovered his health, but was killed in an automobile accident six months after the delivery of the policy; and that when called on to pay the loss, the company learns of Sindayen's grave illness on January 18, 1933, and alleges that the policy had never taken effect. It is difficult to imagine that the insurance company would take such a position in the face of the common belief of the insuring public that when the policy is delivered, in the absence of fraud or other grounds for rescission, the contract of insurance is consummated. The insured rests and acts on that faith. So does the insurance company, for that matter, for from the date of delivery of the policy it appropriates to its own use the premium paid by the insured. When the policy is issued and delivered, in the absence of fraud or other grounds for rescission, it is plainly not within the intention of the parties that there should be any questions held in abeyance or reserved for future determination that leave the very existence of the contract in suspense and doubt. If this were not so, the entire business world which deals so voluminously in insurance would be affected by this uncertainly. Policies that have been delivered to the insured are constantly being assigned for credit and other purposes. Although such policies are not negotiable instruments and are subject to defenses for fraud, it would be a most serious handicap to business if the very existence of the contract remains in doubt even though the policy has been issued and delivered with all the formalities required by the law. It is therefore in the public interest, for the public is profoundly and generally interested in life insurance, as well as in the interest of the insurance companies themselves by giving certainly and security to their policies, that we are constrained to hold, as we, do, that the delivery of the policy to the insured by an agent of the company who is authorized to make delivery or without delivery is the final act which binds the company (and the insured as well) in the absence of fraud or other legal ground for rescission. The fact that the agent to whom it has entrusted this duty (and corporation can only act through agents) is derelict or negligent or even dishonest in the performance of the duty which has been entrusted to him would create a liability of the agent to the company but does not resolve the company's obligation based upon the authorized acts of the agent toward a third party who was not in collusion with the agent.

Paragraph 4 of the application to the effect "that the agent taking this application has no authority to make, modify or discharge contracts or to waive any of the company's rights or requirements" is not in point. Mendoza neither waived nor pretended to waive any right or requirement of the company. In fact, his inquiry as to the state of health of the insured discloses that he was endeavoring to assure himself that this requirement of the company had been satisfied. In doing so, he acted within the authority conferred on him by his agency and his acts within that authority bind the company. The company therefore having decided that all the conditions precedent to the taking effect of the policy had been complied with and having accepted the premium and delivered the policy thereafter to the insured, the company is now estopped to assert that it never intended that the policy should take effect. (Cf. Northwestern Life Association *vs.* Findley, 29 Tex. Civ. App., 494; 68 S.W, 695; McLaurin *vs.* Mutual Life Insurance Co., 115 S.C., 59; 104 S.E., 327; 14 Aal. Jur., par. 12, pages 425-427.)

In view of the premises, we hold that the defendant company assumed the risk covered by policy No. 47710 on the life of Arturo Sindayen on January 18, 1933, the date when the policy was delivered to the insured. The judgment appealed from is therefore reversed with directions to enter judgment against the appellee in the sum of P1,000 together with interest at the legal rate from and after May 4, 1933, with costs in both instances against the appellee.

Malcolm. Villa-Real, Abad Santos, Hull, Vickers, Goddard, and Recto, JJ., concur.

Separate Opinions

AVANCEÑA, *C.J.,* concurring:

I concur in the result of this decision. I agree with the conclusion arrived in the majority opinion in the sense that the contract in question was consummated. I am of the opinion, however, that this contract was consummated by the defendant due to an error regarding an essential condition, to wit: the the good health of the insured. There is no doubt but that the defendant would not have consummated the contract had it known that the insured was hopelessly ill, inasmuch as this consideration is essential in this kind of contracts. It is not true that the defendant or its agent had waived this condition inasmuch as it consummated the contract in the belief that this condition had been compiled with, in view of the information given to it in good faith by the agent of the insured to the effect that the latter might continue to be in good health for the reason that she had not received any information from him to the contrary. This being so, the defendant's consent is vitiated by error, and, inasmuch as it affects an essential condition of the contract, it may give rise to the nullity thereof.

However, inasmuch as the nullity of the contract has not been set up as a a defense in this case, I concur with the majority in the result.

IMPERIAL, *J.,* dissenting:

The plaintiff, as beneficiary brought this action recover from the defendant, an insurance Company, the sum of P1,000, the value of a life insurance policy issued the name of Arturo Sindayen, the plaintiff's husband.

The plaintiff appealed from the judgment dismissing the complaint, without special pronouncement as to costs.

On December 26, 1932, Arturo Sindayen signed Exhibit 6 wherein he applied for life insurance in the sum of P1,000 under certain conditions, among others, the following:

> 3. That the said policy shall not take effect until the first premium has been paid and the policy has been delivered to and accepted by me, while I am in good health.
>
> 4. That the agent taking this application has no authority to make, modify or discharge contracts, or to waive any of the company's right or requirements.

On the back of the policy said conditions were endorsed as follows:

> THE CONTRACT. This Policy and the application herefor constitute the entire contract between the parties hereto. All statements made by the Insured shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall void the Policy unless it is contained in the written application, a copy of which is attached to this Policy. Only the President, or the Manager, acting jointly with the Secretary or Assistant Secretary (and then only in writing signed by them) have power in behalf of the Company to issue permits, or to modify this or any contract, or to extend the time for making any premium payment, and the Company shall not be bound by any promise or representation heretofore or hereafter given by any person other than the above-named officials, and by them only in writing and signed conjointly as stated.

The insurance was secured by the defendant's agent Cristobal Mendoza in Camiling, Tarlac. The first premium to be paid by the insured amounted to P40.06 and on account of this sum he paid the agent P15 after he signed the application, with the understanding between them that the balance of P25.06 would be paid in the same town on the date the policy would be delivered. The insured designated his aunt Felicidad Estrada to act as his representative and to receive in his name the policy and to pay the balance of the premium. On January 11, 1933, the defendant issued insurance policy No. 47710, dated December 1, 1932 and sent it by registered mail to its agent in Camiling, Tarlac. On January 16th the agent got the policy from the post office and on the 18th he looked for the insured, but Felicidad Estrada informed him that the insured had returned to Manila. The agent asked her whether the insured continued to be sound and in good health, to which she replied that she believed that he was in good health inasmuch as she received no information that he was sick, whereupon the agent delivered the policy to Felicidad Estrada with instruction to hand it to the insured and, after receiving the sum of P25.06, he issued the receipt for the payment of the premium of P40.06, signing it as defendant's agent. On January 19th Felicidad Estrada came to Manila, to the home of the insured at No. 14 Teresa Street, to deliver the policy, but she found that he died a few hours before her arrival and there she saw his lifeless body. Felicidad Estrada delivered the policy to the plaintiff as beneficiary. On January 20th of the same year the agent had knowledge of the death of the insured and went to see Felicidad Estrada whom be requested to return the policy so that the defendant would decide what was to be done. On that occasion the agent conveyed to Felicidad Estrada his belief that the insured was not in good health when he delivered the policy to her. Felicidad Estrada returned the policy to the agent on the afternoon of said date. The agent gave notice to the defendant of the death of the insured and of the circumstances under which, he had delivered the policy, and the defendant on February 4th of the same year returned to the plaintiff by check all the premium theretofore received, and furthermore secured from her Exhibit A (Accord, Satisfaction and Release), by virtue of which said plaintiff acknowledged having received the aforesaid premium and that in further consideration thereof she formally waived whatever right she might have, as beneficiary, in the insurance policy issued in the name of her deceased husband.

With respect to the sickness of the deceased, it appears that on January 1, 1933 he was examined by the physician of the defendant company. On the 12th of the same month he felt ill and consulted Dr. Alfredo L. Guerrero who, after an examination, found him suffering from

nephritis. On the 15th he was treated for the second time by the physician, who found him seriously ill and with fever. In the afternoon of January 19, 1933, he died from nephritis and uremia in his home in Manila.

In its answer the defendant set up two special defenses:

(1) That the plaintiff bas lost any and an right to collect the value of the policy because at the time the first premium was paid and the policy was delivered to the insured, the latter was not in good health, thus violating clause 3 of the application which he signed and was made an integral part of the policy as one of the conditions thereof; and (2) that the plaintiff by means of the document known as "Accord, Satisfaction and Release" has waived whatever right she might derive from the insurance policy.

A stipulation or contract between the company and the applicant in the sense that the insurance policy will produce no effect or will not be binding on the company unless the first premium shall have been paid while the applicant is alive and in good health, is valid will will be enforced in accordance with the terms thereof; it is a condition precedent to the liability of the company, and compliance therewith or its waiver are necessary for the enforcement and fulfillment of the insurance contract, unless the case should come under the provisions of an uncontestable clause. ([Perry *vs.* Security L., etc., Co., 150 N.C., 143; 63 S.E., 679; Rathbun *vs.* New York L. Ins. Co, 30 Ida., 34; 165 P., 997; Hawley *vs.* Michigan Mut. L. Ins. Co., 92 Iowa, 593; 61 N.W., 201; Whiting *vs.*Massachusetts Mut. L. Ins. Co., 129 Mass., 240; 37 Am. Rep., 317; Missouri State L. Ins. Co. *vs.* Salisbury, 279 Mo., 40; 213 S.W., 786; Ormond *vs.* Fidelity Life Assoc., 96 N.C., 158; 1 S.E., 796; Bowen *vs.* New York Mut. L. Ins. Co., 20 S.D., 103; 104 N.W., 1040; Rositer *vs.* Aetna L. Ins. Co., 91 Wis., 121; 64 N.W., 876; Anders *vs.* Life Ins. Clearing Co., 62 Neb., 585; 87 N.W., 331; Reliance L. Ins. Co. *vs.* Hightower, 148 Ga., 843; 98 S. E., 469; Clark *vs.*Mutual L. Ins. Co., 129 Ga., 571; 59 S.E., 283; Reese *vs.* Fidelity Mut. Life Assoc., 111 Ga., 482; 36 S.E., 637 [foll. Williams *vs.* Empire L. Ins. Co., 146 Ga., 246; 91 S.E., 44); Oliver *vs.* New York Mut. L. Ins. Co., 97 Va., 134; 33 S.E., 526; Reese *vs.* Fidelity Mut. Life Assoc., 111 Ga., 482; 36 S.E., 637; Anders *vs.* Life Ins. Clearing Co., 62 Neb., 585; 87 N.W., 331; Perry *vs.* Security L. etc., Co., 150 N.C., 143; 63 S.E., 679; Strigham *vs.* Mutual Ins. Co., 44 Ore., 447; 75 Pac., 822; Dibble *vs.* Reliance L. Ins. Co., 170 Cal., 199; 149 Pac., 171.] Ann. Cas. 1917E, 34.)

In the case of Reliance Life Ins. Co. vs. Hightower, *supra*, the Supreme Court of Georgia, in a similar case, said the following:

> . . . An application for life insurance, signed by the applicant, contained a provision as follows:
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> "I hereby declare and agree that all statements and answers written in this application . . . are true, full, and complete, and are offered to the company as a consideration for the contract of insurance, which I hereby agree to accept, and which shall not take effect until the first premium shall have been actually paid while I am in good health and the policy shall have been signed by the duly authorized officers of the company and issued."
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> The policy itself contained, among others, the following provisions:
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> "Agents are not authorized to modify this policy or to extend the time for paying a premium . . .. All insurance provided by this policy is based upon the application therefore, a copy of which is hereto attached and made a part of this policy."
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Applying to the facts above stated the principles recognized in Reese *vs.* Fidelity Mutual Life Association (111 Ga., 482; 36 S. E., 637), it must be ruled: (1) It was within the power of the insurance company, as between itself and its agent, to define and limit the powers of the latter. Limitations upon the power of the agent affect all third persons dealing with him, who have knowledge or notice thereof; and any notice of limitations upon the agent's power which a prudent man is bound to regard, is the equivalent of knowledge to the insured; (2) the stipulation in the signed application, that the insurance "shall not take effect until the first premium shall have been actually paid while I am in good health," coupled with the words in the policy, "Agents are not authorized to modify this policy or to extend the time for paying a premium," were sufficient to charge the applicant with notice that he was dealing with a special agent with limited powers; (3) the actual payment of the first premium during the good health of the applicant was a condition precedent to liability under the policy, and the agent of the company could not waive such condition.

In the case of Missouri State Life Ins. Co. *vs.* Salisbury, *supra*, the Supreme Court of Missouri, in another similar case, said:

The application has this clause:

"6. That the insurance hereby applied for shall not take effect unless the first premium is paid and the policy delivered to and accepted by me during and lifetime and good health."

Another reason why the contract was never completed was because the first premium was na paid nor tendered during the good health of Mrs. Salisbury, as required by the stipulation in the application quoted above.

> A stipulation of that character, requiring the payment of a first premium in advance as a condition upon which the policy was to take effect, is is always recognized and enforced by the courts. The policy, in such case, is not effective until that condition is complied with. (Kilcullen *vs.* Life Ins. Co., 108 Mo. App., 61; 82 S.W., 966; Wallingford *vs.* Home Mut. Fire & Marine Ins. Co., 30 Mo., 46; Ormond *vs.* Insurance Co., 96 N.C., 158; 1 S.E., 796; Bowen *vs.* Mutual Life Ins. Co., 20 S.D., 103; 104 N.W., 1040.)

In the case of Rathbun *vs.* New York Life Ins. Co., *supra*, the Supreme Court of Idaho said:

> In its answer and on the trial of the case, the main contention of the insurance company were: First, that under, the terms of the contract the first premium was to be paid in cash; and, second, the policy was not to take effect until the insured was in good health at the time it was delivered to him. Said contentions are partly based upon the stipulations above quoted from the application for said insurance.
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> The court in its findings of fact, among other things, found as follows.
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> "The court further finds that Ernest C. Rathbun, the applied in writing for insurance on his life, that the insurance thereby applied for effect unless the first premium was paid and the policy was delivered to and received by him during his lifetime and good health. After applying for the policy and before its delivery, the applicant was taken with appendicitis, from which he died. While he was in the hospital, the soliciting agent at Spoken, in total ignorance of the changed condition of the applicant's health, mailed him the policy. The applicant's friends thereafter paid the first premium, which the company promptly returned when it discovered facts."
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> The evidence is clearly sufficient to sustain this finding of fact.
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> Then if the parties understood and agreed that the policy should not become effective unless the first premium was paid and the policy was delivered to and received by the applicant during his lifetime and while he was in good health, and both of those conditions failed, the contract of insurance was never completed, and the policy was of no force and effect. It is a well-recognized rule that life insurance results from contract, and that the true rule is that no other or different rule is to be applied to a contract of insurance than is applied to other contracts. (Quinlan *vs.* Providence-Washington Ins. Co., 133 N.Y., 356; 28 Am. St. Rep., 645; 31 N.E., 31.) In life insurance contracts, the assent of both parties is required as in any other contract. (Stephens *vs.* Capital Ins. Co., 87 Iowa, 283; 54 N.W., 136; Weidenaar *vs.* N.Y. Life Ins. Co., 36 Mont., 592; 122 Am. St., 330; 94 Pac., 1.)
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> In the determination of this case, the application and the policy itself must be examined and considered in order to ascertain the true situation of the parties under the negotiations and agreements between them. (Iowa Life Ins. Co. *vs.* Lewis, 187 U.S., 335; 23 Sup. Ct., 126; 47 Law. ed. 204; Behling *vs.* N.W. Nat. Life Ins. Co., 117 Wis., 24; 93 N.W., 80O.)
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> If we concede in this case that the premium was paid by the payment of the $5 and the delivery of the insured's promissory note to the agent of the company for the balance, the plaintiffs would not be entitled to recover, for the reason that the policy was not delivered to and received by the applicant while he was in good health, but hen he was fatally ill. He became ill with appendicitis on the 28th of April, 1913, was operated on that day and thereafter died on the 10th day of May, 1918, five days after receiving the policy.

In the case of Gordon *vs.* Prudential Insurance Company (231 Pa., 404), the Supreme Court of Pennsylvania said:

> . . . In the case at bar, the policy was issued and handed to the agent, who delivered it to the insured before payment of the premium, and upon the insured giving a receipt, in which it was stated that the policy was "received for the purpose of inspection only and upon the understanding that it is not to be in force until the first premium payable thereunder has been paid by me and the official receipt of the company delivered to me during my lifetime and in good health, as provided in my application upon which the above numbered policy was issued." This, therefore, was a conditional delivery of the policy and the contract could not be consummated except upon performance of that condition, namely, payment of the premium, thereafter, while the insured was alive and in good health, as provided in both the application and receipt for the policy.
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> It is therefore undisputed that on the day of the payment of the premium, Mr. Gordon was ill of the disease which caused his death within sixty-four hours after such payment. There was no dispute, nor contradictory testimony as to the condition of Mr. Gordon's health on the day of payment, and, therefore, nothing for the jury to pass upon in this respect.
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> In the case at bar, there was no question of the condition of the health of the insured on the day of the payment of the premium, and and no conflicting testimony as to the serious nature of his illness on that day, nor as to any other material fact in the cause. No person testified that Mr. Gordon was in "good health" on Saturday, May 16, the day the premium was paid, but on the witness who had knowledge of his condition and who was asked the question, including the, plaintiff herself, said that he was not in "good health" on that day. How, then, can a jury be permitted to find that he was in "good heath" at the time of the payment of the premium in the absence of any evidence to warrant or support such finding?
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>
> In this case it is impossible to find from the evidence that on Saturday, May 16, the day of the payment of the premium, and at the time of such payment, the applicant had no grave, important or serious disease, or that he was free from any

> ailment that seriously affected the general soundness and healthfulness of his system, or that he suffered a mere temporary indisposition which did not tend to weaken or undermine his constitution at the time of paying the premium. Nor is it possible to find that he enjoyed such health and strength as to justify a reasonable belief that he was free from derangement of organic functions, or free from symptoms calculated to cause a reasonable apprehension of such derangement, and that to ordinary observation and outward appearance his health was reasonably such that he might, with ordinary safety, be insured and upon ordinary terms which only would satisfy the requirement of "good health". But on the contrary, the testimony conclusively shows that on Saturday May 16,1908, at the time of the payment of the premium, the condition of Mr. Gordon's health was both a serious and a dangerous one, and such as would preclude the possibility of any life insurance company, with knowledge of his condition, issuing its policy upon his life for anything like the ordinary premium; in other words, his condition at that time was such as to render him a hazardous and dangerous risk, which would not be assumed by any insurance company upon receipt of the of the ordinary premium for insurance upon the life of an ordinary risk.
>
> With the question of good faith on the part of the insured at the time of paying the premium, we have nothing to do. The fact is that his physical condition was not disclosed to the company or its agent at the time of the payment of the premium; and that his condition was not at that time such as, in his application for insurance, he stated it to be. This being true, it is no leader hardship upon the beneficiary in the policy to say that the premium paid under such conditions does not entitle her to recover the amount of insurance from the defendant company.

In the case of Powell *vs.* Prudential Insurance Co. of America (153 Ala., 611), the Supreme Court of Alabama, in a similar cause, said:

> On June 22, 1904, Claude D. Powell applied to the defendant company for insurance on his life for $1,000. In his application for insurance, he stated: "I am in good health, . . . and all the statements and answers to the above questions are complete and true, and that the foregoing, together with this declaration, shall constitute the application, and become a part of the contract for insurance hereby applied for. And it is agreed that the policy herein applied for shall be accepted subject to the privileges and provisions therein contained, and said policy shall not take effect until the same shall be issued and delivered by the said company, and the first premium paid thereon in full, while my health is in the same condition as described in this application."
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> xxx xxx xxx
>
> Here we find that two absolute conditions precedent of the contract of insurance, were set aside or annulled, in what the friends of the deceased attempted to do, in that, the the firsts premium was never paid by the assured one any one for him, and if, by any possible construction, it could be held that it was not totally sick at the time, of which fact the company was ignorant; and further, it is not denied that the policy was never delivered — if was done could possibly amount to delivery — until after the death of the assured. To hold that the policy was good under such circumstances, would be to abrogate and set aside the contract of insurance, and hold the company liable for a payment of the policy against the very terms of its contract.

The same principle controls and applies when, as in the instant case, it is stipulated that the policy shall be of no effect if at the time of its delivery to the insured he is not in good health.

The condition is valid and binding when its refers only to the payment of the first premium as well as to the delivery of the policy, or to both.

In the case of Nyman *vs.* Manufactures' & Merchants' Life Ass'n.

(104 N.E., 653), the Supreme Court of Illinois said:

> . . . The proof is direct and positive that on the last-named date she was not in good health, and that two months and three months day later she died from the disease the proof showed she was suffering from on that day. If there had been no proof of the condition of Mrs. Nyman's health on the day the certificate was delivered, then there would be some force in plaintiff's contention that the inference might be indulged that, if she was in good health on April 11th, she so continued until the 19th. But no such inference can be indulged, when the uncontradicted proof shows she was in bad health the day the certificate was delivered, and so continued until her death. Defendant proved its third special plea, and, in our opinion, plaintiff offered no evidence that legitimately tended to rebut defendant's evidence. The trial court therefore erred in refusing to direct a verdict in favor of defendant under the issue made by the third special plea. (Libby, McNeill & Libby *vs.* Cook, 222 Ill., 206; 78 N.E., 599.)

In the case of American Bankers' Ins. Co. *vs.* Themas (53 Okla. Rep., 11), the Supreme Court of Oklahoma said:

> That part of the policy which provides that the same shall not take effect until it is delivered by the company while the insured is in good health prescribes a condition precedent to the attachment of the risk under the policy. (1 Cooley's Briefs on the Law of Insurance, p. 451.) Recognizing it to be such, plaintiff properly pleaded a waiver thereof by setting up the facts as stated. (Western, etc., Ins. Co. *vs.* Coon, 38 Okla., 453; 134 Pac., 22; Anders *vs.* Life Ins. Clearing Co., 62 Neb., 585; 87 N.W., 33 1.)

In the case of Steinsultz *vs.* Illinois Bankers Life Association (229 Ill. App. Rep., 199), the third district of the Appellate Courts, in a similar cause, said:

> The policy of insurance contains the following clause:
>
> "I agree to accept the Policy issued hereon and that the same shall not take effect until the first payment shall have been made and the Policy issued and actually delivered to me during my continuance in good health."
>
> The main question in this case, in the opinion of this court, is the question as to whether a valid and legal policy ever was issued and actually delivered to the insured, Myrtle May Steinsultz. It is argued that the clause in question is a condition precedent and requires that the insured shall be in good health at the time of the payment of the first premium and the actual delivery of the policy to her, otherwise that the policy never became operative and for the purposes of this suit is void. It will be noticed that plaintiff in representing his main case made no effort to submit or show anything as to the health of the insured prior to the claimed delivery of the policy. If the clause in question is a condition precedent to recovery, which we shall discuss later, the general issue filed by the defendant denied the existence of a valid policy and raised this question and required proof on the part of the plaintiff to show that the insured was in good health at the time of the claimed delivery of the policy. No much proof was shown and the defendant, appellant, at the close of plaintiff's case, moved the court to instruct the jury, under the pleadings and evidence in the case, to find verdict for the defendant and form a verdict was submitted with the motion. This motion the court overruled, to which ruling appellant duly excepted and this issue is therefore squarely raised by the proceedings as the existence of legal and binding policy in the case under the terms of said contract.
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> In Ellis *vs.* State Mut. Life Assur. Co. of Worcester (206 III. App., 226), the appellant insurance company filed a plea of the general issue with notice of special matter of defense, the special matter being that the policy was not to be in effect until actually delivered and the first premium paid during the lifetime of the assured, and while he was in the same condition of health as when his application was signed, and that the policy was not so delivered. There was a trial, verdict and judgment in favor of appellee, being the amount of the policy and interest. To reverse said judgment the appellant prosecuted appeal. In this case the application, signed by Ellis, contained, among other things, the following provision: "That the contract or policy applied for shall not take effect until the first premium thereon shall have been actually paid and the policy delivered to me during my lifetime and the present condition of health."
>
> The policy issued thereon contained this provision: "This policy shall not take effect until actually delivered and the first premium paid thereon during the lifetime of the insured."
>
> Said policy contained the further provisions: "This policy and the application therefor shall constitute the entire contract between the parties hereto."
>
> In this case, likewise, the appellant at the close of appellee's evidence and then again at the close of all the evidence, moved the court to direct a verdict in its favor. Appellant objected to the admission of the policy sued upon, in evidence. In this case on December 14, 1914, the insured was injured and was carried to his home and died between 4:30 and 5 p.m. on that day, and it appears that the policy of insurance had been returned to the office of the agent of the insurance company the evening before but had not been delivered personally to the insured at the time of his death. In this case the contention was made by the holders of the policy and that the delivery to the agent was a delivery to the insured.
>
> The court goes into the question in the Ellis case very exhaustively, quoting from a great many cases and qouting from Devine *vs.* Federal Life Ins. Co. (250 III., 203), in which the Supreme Court in discussing the question of the delivery of an insurance policy, at page 206, says:
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> "The application may or not provide that the insurance shall effect only upon the delivery of the policy to the insured. Unless expressly made so by the contract itself, an actual delivery of a policy of insurance to the insured is not essential to the validity of the contract, and the rule under such circumstances is that a policy becomes binding upon the insurer when signed and that forwarded to the insurance broker to whom the application as made, to be delivered to the insured."
>
> And quoting 25 Cyc 718, 719, it is stated with reference to the delivery of insurance policies that: "The placing of the completed policy on hands of the agent for the delivery, without condition, to the insured completes the contract, though the actual delivery by the agent to the insured is not made before the death of the insured. But if the delivery to the agent of the company is with the understanding that it is to be delivered by the agent to the insured only after the performance of some condition, then until the condition is performed and it becomes the duty of the agent to deliver the policy to the insured, the contract is not complete. . . . It is usual condition of a life insurance policy that the delivery shall not be effectual to create a binding contract unless the insured is alive in good health when the policy is delivered and the first premium paid, and under such conditions the death of the insured before the delivery of the policy will prevent its becoming effectual.
>
> It was held in the Ellis case that in view of foregoing authorities, numerous of which we have not cited here, that the policy sued on was never delivered and that the court erred in not directing a verdict in favor of appellant and reversed the judgment with a finding of fact.
>
> The language in the policy in question, "I agree to accept the Policy issued hereon and that the same shall not take effect until the first payment shall have been

> made and the Policy issued and actually delivered to me during may continuance in good health," is a condition precedent to the existence of any binding legal contract of insurance upon the appellant. It means just what its says and it was entered into signed by the insured. The statement was a warranty that the insured was in good health at the time she signed said application and further was a binding obligation that she should continue in good health at the time the policy was delivered to her, otherwise the policy never should become binding and obligatory. It is condition that goes to the very existence of the policy and its validity, and under the facts in this case it is insisted strenuously that no binding policy was ever issued and delivered by the appellant.

And in the case of Federal Life Ins. Co. *vs.* Wright (230 S.W., 795), the Civil Appellate Court of Texas said:

> . . . The application and the policy contain the entire contract between the parties, and it is not only agreed in the application that all of the statements therein "are full, true, and complete," but it is stipulated therein, as above shown, that the policy of insurance applied for shall not take effect until the policy shall have been actually delivered to the insured and the premium paid during his life and while he was in good health. The purpose and meaning of this provision, standing alone or taken in connection with any or all other provisions of the contract, is clear, without ambiguity, and not to open to construction. It unquestionably means that the policy should not take effect as a contract of insurance unless actually delivered to the applicant therefor while he was in good health. This being the meaning of the provision, and the appellee having admitted in her pleadings and in open court at the trial that the applicant or insured was afflicted with tuberculosis of the lungs at the time the policy was delivered to him, and that such disease caused his death, the policy by its terms never became an obligation of the appellant.
>
> Applications for policies of life insurance frequently provide, as in the present instance, that the policy shall not take effect unless it is delivered to the insured and the premium paid while he is in good health, and the great weight of authority is to the effect that such provision is valid, and that if the insured was not in fact in good health on the date the policy was delivered the company is not liable. (Gallant *vs.* Metropolitan L. Ins. Co., 167 Mass., 79; 44 N.E. 1073; Murphy *vs.* Metropolitan Life Ins. Co., 106 Minn., 112; 118 N. W., 365; Logan *vs.* New York L. Insurance Co., 107 Wash., 253; 181 Pac., 906; Metropolitan L. Insurance Co. *vs.*Willis, 37 Ind. App., 48; 76 N.E., 560; Gallop *vs.* Royal Neighbors of America, 167 Mo. App., 85; 150 S.W., 1118; Metropolitan L. Insurance Co. *vs.* Betz, 44 Tex. Civ. App., 557; 99 S.W., 1140; American Nat. Insurance Co. *vs.* Anderson, 179 S.W, 66; Security Mut. L. Ins. Co. *vs.* Calvert, 39 Tex. Civ. App., 382; 87 S.W., 889; Seaback *vs.* Metropolitan L. Ins. Co., 274 Ill., 516; 113 N.E., 862; Mutual L. Insurance Co. *vs.*Willey, 133 Md., 665; 106 Atl., 163.) It is also held that it is immaterial that the condition of the insurer's health has changed since his application was made, or that he was ignorant of his condition. (Carmichael *vs.*Hancock Mut. Ins. Co., 116 App. Div., 291; 101 N. Y. Supp., 602; Metropolitan L. Ins. Co. *vs.* Howle, 62 Ohio, 204; 56 N.E. 908, Id., 68 Ohio, 614; 68 N.E., 4; Oliver *vs.* Matual L. Ins. Co., 97 Va., 134; 33 S.E., 536; Packard *vs.* Metropolitan L. Ins. Co., 72 N.H., 1; 54 Atl., 287.)

This defense, as we now view it, is separate and distinct from the defense that misrepresentations were made in the application for the policy, and our conclusion is that the failure of the appellant to give notice to the insured or beneficiary, within a reasonable time after discovering that the insured had tuberculosis of the lungs, that it would not be bound by the contract of insurance did not render unavailing the provision that unless the policy was delivered while the insured was in good health the contract should not take effect. Under article 4948 of the statute, it was necessary for the appellant, in order to avail itself of the defense based upon misrepresentations made in the application to secure the policy, to show that it gave the insured or beneficiary notice within a reasonable time after discovering the falsity of such representations that it would not be bound by the contract of insurance; but in order to sustain the first-mentioned defense, the same having been asserted within the contestable period, it was necessary only to show that the insured was not in good health when the policy was delivered. We do not agree with the contention to the effect that by pleading and proving that the first premium was paid and received when the application for the policy was made, which was a few days prior to the delivery of the policy, the appellee showed an express waiver of the provision in the application making the assumption of any liability on the part of appellant dependent upon the good health of the insured at the time the policy was delivered.

The provision, as before stated, is clear and unambiguous and susceptible of but one construction. By its plain and unmistakable terms the insured agrees that all the statements and answers contained in the application are full, true, and complete in every respect, and are offered to the insurance company as a consideration a contract of insurance, which shall not take effect unless the policy shall have been actually delivered to him while he was in good health. Nor shall it take effect unless the first premium shall have been actually during his life and paid while he was in good health. In other words, if the insure was not in good health at the time the policy was delivered to him, or if he was dead or in bad health when the first premium was paid, then, in either event, no obligation on the part of the insurance company was assumed, and, of course, there was no contract of insurance. It was as much a condition precedent to the taking effect of the contract that the first premium be paid during the life of the insured and while he was in good health, as that the policy be delivered while he was in good health, and the fact that the premium was paid when the application was made, and a few days in advance of the delivery of the policy, can furnish no basis for the holding that thereby the other condition was abrogated or waived. We can see no good reason for saying that the provision relative to good health at the time of the payment of the first premium of the policy was inserted to cover cases "when the first premium was collected at a time subsequent to the issuance of the policy, either at

or prior to the delivery thereof." The provision under consideration is not one which the insurance company may avail itself of to avoid an executed contract, or one which in the ordinary sense constitutes a warranty of the good health of the insured, but its effect was to prevent the taking effect of the contemplated contract, unless there was a compliance with the conditions precedent named therein. Differently stated, with such a provision in the application for the policy the contract is not a completed one, is not absolute but conditional, and in this case it is the fact of sound health, etc., in the insured on the date of the delivery of the policy that determines the liability of the appellant.

In her motion for a rehearing the appellee asserts that our holding on the appellant's motion for rehearing, to the effect that since the application for the policy sued on, which as a part of the contract of insurance, stipulated that the policy should not take effect until the same was actually delivered to the insured and the first premium paid during his life and while he was in good health, and since it was admitted by the appellee and conclusively shown that the insured had tuberculosis of the lungs at the time the policy was delivered to him the first premium paid, the policy its terms never became an obligation of the and the appellant, is different from or in conflict with the decision in the cases of American National Life Insurance Co. *vs.* Rowell (175 S.W., 170); American National Insurance Co. *vs.* Burnside (175 S. W., 169) ; American National Life Insurance Co. *vs.* Fawcett (162 S.W. 169); National Fire Ins. Co. *vs.* Carter (199 S.W., 507); and Mecca Fire Insurance Co. *vs.* Stricker (136 S.W., 599)

The first three of the cases mentioned were decided by this court, the fourth by the Court of Civil Appeals for the First District, and the fifth by the Court of Civil Appeals for the Third District. Our conclusion is that neither of these cases is in conflict with the decision in the first case referred to and the present case, but it seems manifest, from a careful examination and analysis of the opinion in that case, that the court did not have in mind the precise question here involved, and did not there expressly pass on it. There it was urged that the trial court erred in over ruling the insurance company's demurrers to Rowell's petition, because it was not alleged that the insured was in sound health at the time the policy sued on was issued, and this court held that there was no error in overruling the demurrers, since, if the insured was not, in fact, in sound health at that time, such fact was a matter of defense to be pleaded by the company. It was further there held that while the defendant averred that the insured was not in sound health when the policy was issued, such defense was not sufficiently pleaded to justify the isffitc of testimony to establish it. The opinion also indicates that the insurance company in its pleadings and assignments of error treated the provision in the policy, that no obligation was assumed by it unless on the date of issuance the insured was in good health, as a representation or warranty, and that this court, discussing the matter as presented, after stating in substance the provisions of article 4948 of the statute said that the failure to give the notice prescribed in that statute absolutely barred the insurance company from defending in action on the policy because of alleged misrepresentations. We also declared that said statute applied to

> covenants of warranty as well as to statements in the application not made warranties by the contract, citing Mecca Fire Ins. Co. *vs.* Stricker,*supra*.

Moreover, the stipulation that the insurance contract shall produce no effect unless the payment of the first premium and the delivery of the policy be made when the insured is in good health, is not in conflict with any provision of the Insurance Law now in force, nor with any other law of a general character; neither is said stipulation contrary to morals or public order, and therefore the same is valid and binding upon the parties. (Articles 1255, 1257 and 1258, Civil Code.)

The majority opinion states that the delivery of the policy by the agent after he has made use of the discretion conferred upon him by the defendant to deliver or to withhold said policy, is binding upon the defendant and the latter cannot evade the consequences thereof. This same legal question has been raised before various appellate courts of several states of the Union, which made a distinction between agents whose only power consisted in soliciting insurance and in delivering policies and those who, in addition to such power, were authorized to issue policies and accept risks on behalf of insurance companies. In the first case the doctrine is uniform that the acts of agents with limited powers are not binding upon the insurance companies, whereas in the second case the acts of the agents bind and prejudice the insurance companies represented by them. This legal question has been extensively considered and squarely decided in the case American Bankers' Ins. Co. *vs.* Thomas, *supra*, as follows:

> Favoring liability, she contends that the knowledge of Martin of the ill health of the insured at the time the policies were delivered was the knowledge of the company and waiver of the condition. Not so Assuming that Martin, was the agent of the company at that time, with authority to deliver the policies, it failing to appear that he had anything to do with the execution thereof or the acceptance of the risk, his knowledge was not that of the company. In Merchants' & Planters' Ins. Co. *vs.* Marsh (34 Okla., 453; 125 Pac., 1100), we held that the knowledge of the agent was the knowledge of the company only where the authority of such agent, derived from the company, was to solicit applications and execute and deliver contracts of insurance as an alter ego of the company, and that it was only in such case that he had power to waive the conditions of the policy. In that case the agent was, as here, a local or soliciting agent, and there the policy sued on was, as here, a 'home office policy", or one issued direct by the president and secretary of the company as distinguished from one issued by the local agent. There, in the syllabus, we said:
>
> "A local agent of an insurance company, whose only power is to solicit applications for insurance, and forward them to the company for approval, when, if approved to the insured, has no power to waive any of the provision of the policy so delivered.". . .

Also in keeping with this rule is Des Moines Ins. Co. *vs.* Moon (33 Okla., 437; 126 Pac., 753). There we said:

". . . Where the local agent has the power to accept a risk and deliver a policy of insurance, and is advised and has full knowledge, at the time of the delivery of the policy, that certain conditions of the policy, which may be waived, are violated, such policy is binding upon the company, notwithstanding the fact that it contains a provision that none of the company's officers or agents can waive any of its provisions, except in writing, in upon the policy. This case (referring to Western National Ins. Co, Marsh, 34 Okla., 414; 125 Pac., 1049), unanimously concurred in by the members of the courts, settles the rule in this jurisdiction as to contracts of insurance written after the administration of the state: . . ."

Of course, if the local agent had not power, as here, to accept the risk, he had no power to waive the condition precedent in the policy. Cases relied on by plaintiff which hold the contrary practically under the same state of facts fail to draw this distinction, and seem to hold that the knowledge of a mere soliciting agent of the company of the ill health of the insured at the time of the delivery of the policy is the knowledge of the company, and hence a delivery with such knowledge constitutes a waiver of the condition under consideration. They are Roe *vs.* National Life, etc. Co. (137 Iowa, 696,: 115 N.W., 500: 17 L.R.A. [N.S.], 1144); Connecticut, etc. Ins. Co. *vs.* Grogan ([Ky.] 52 S.W., 959); N.W. Life Ins. Co. *vs.* Findley (29 Tex. Civ. App., 494; 68 S. W., 695) ; National Life Ins. Co. *vs.* Twiddel ([Ky.), 58 S.W,, 699) ; Home Forum Ben. Order*vs.* Varnado ([Tex. Civ. App.], 55 S.W., 364), and others. But the distinction is referred to in Bell *vs.* Ins. Co. (166 Mo. App., 390; 149 S.W. 33). In that case the insured, who was plaintiff's brother, died at Nogales, Ariz., as a result of injuries received while working as a telegraph lineman. On July 17, 1909, he made application to defendant for policy of life insurance, payable in event of his death to plaintiff. He made it to defendants' soliciting agents at that place, and paid the first annual premium cash in hand. The application was forwarded to defendant by mail, and duly received in St. Louis, Mo., on July 23, 1909. The policy was conditioned the same as here. On July 27, the application was duly accepted, and the policy issued and was mailed August 4, 1909, to the soliciting agents for delivery to the insured. Upon its arrival on August 8, 1909, pursuant to instructions, the policy was deposited for him in the safe of the soliciting agents, along with other private papers of the insured kept there by him. Two days before that died on the night of August 11th. On August 6th, one of the soliciting agents visited the insured and knew of his injury. The court said:

"There can be no doubt that it is competent for the parties to stipulate in the application for insurance, as here, that the policy shall not be affective or binding until delivered to, and accepted by the insured while in good health and the payment of the first premium is made. It is said that a contract of life insurance is not complete until the last act necessary to the done by the insured, under the conditions of the contract after acceptance of the application by the company, has been done by him, and the courts, therefore, in proper cases, sustain such agreements which operate to postpone the taking effect of the policy until the delivery and premium payment while the insured is in good health. (See I Bacon, Life Ins. [3d ed.], see. 272; Kilcullen*vs.* Met. Life Ins. Co., 108 Mo. App., 61; 82 S.W. 966; Misselhorn *vs.* Mutual Reserve, etc., Life Ins. Co., 30 Mo. App., 589; McGregor *vs.* Met. Life Ins. Co. [143 Ky., 488], 136 S. W., 889.) But though such be true, the provision for thus suspending the policy, as an effective contract, until the premium is paid and its delivery, while the insured is in good health, is for the benefit of the insurer, and obviously may be waived by it or by it or by its agent possessing authority with respect to that matter. (See Rhodus *vs.* Kansas City, etc., Ins. Co., 156 Mo. App. 281; 137 S.W., 907.) . . . But it is insisted that a mere soliciting agent, such as Cummings, is without authority to waive the condition in the policy here relied upon, and, for the purpose of the case, the proposition may be conceded as true.

Whereupon the court proceeded to consider whether the company, under the facts in that case, had waived the condition in the policy relied upon. We are therefore of opinion that Martin was without authority to waive the condition relied on, and that plaintiff cannot recover unless defendant is stopped to deny that liability attached by in the petition. Joining issue on these allegations, defendant by answer in effect admitted accepting the premiums back to representative of the assured and demanded a return of the policies, which was refused, and the for the reason, it is urged, defendant is not estopped to assert that no liability attached under the policies.

It is clear, therefore, that the delivery of the policy by Mendoza does not bind the defendant, nor is the defendant estopped from alleging its defense, for the simple reason that Mendoza was not an agent with authority to issue policies or to accept risks in the name of his principle.

There is another ground upon which the majority opinion is based, namely, that the defendant waived the defense it now invokes, by reason of the delivery of the policy by its invokes, by reason of the delivery of the policy by its agent. It is admitted that if the delivery of the policy was due to fraud, legally there could have been no waiver. In view of the facts established and admitted, there is no doubt, as to the existence of the fraud. A restatement of the facts will show such existence. It will be remembered that before the delivery of the policy Mendoza asked Estrada whether the insured continued enjoying good health, to which she answered that she thought he was in good health because she had had no information that he was sick. It will likewise be noted that the information, far from being correct or truthful, was incorrect and misleading because, it reality, on that occasion the insured was seriously ill from nephritis and uremia, almost in a moribund state. Estrada, as a representative of the insured was not only bound to give a truthful information on the state of health of the insured, but it was her duty to find out it his true state of health in order to give true and correct information. When she gave Mendoza as incorrect information tending to create the impression that the insured was well when in fact he was seriously ill, there is

no doubt that she committed fraud and imparted a deceitful information to the defendant agent. It matters not that the fraud was involuntary and not chargeable to Estrada ; the truth is that it existed and that by reason of such fraud the policy was delivered, and both the agent and the defendant were misled into believing that the insured was enjoying good health. In case of Cable *vs.* United States Life ins. co. (111 Fed. Rep., 19), the seventh circuit of the United States Circuit Courts of Appeals, in deciding the same question of waiver, said:

> It is, however, urged that sufficient information was disclosed by Lord to McCabe to put the company upon inquiry, and that, with such notice, McCabe delivered the policy and received the premium; that McCabe was the agent of the company, and notice to him was notice to the company, and the delivery of the policy constituted a waiver of the condition and warrant. Upon the assumption that McCabe was such agent of the company, and that his action must be treated as the action of the company, and that his question which we do not determine, — it becomes us to inquire of the sufficiency of the notice given, and whether the act of the delivery of the policy involved a waiver of the warranty.
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> . . . The holder of the policy cannot be permitted to conceal from the company an important fact like that of the assured being in extremes, and then to claim a waiver of the forfeiture created by the act which brought the insured to that condition to permit such concealment and yet to give to the action of the company the same effect as though no concealment were made, would tend to sanction fraud on the part of the policy holder, instead of protecting him against the commission of one by the company. (Insurance Co. *vs.* Wolff, 95 U.S., 326, 333; 24 Law. ed., 387, 390.)
>
> It cannot here be doubted that if the insurance company, or McCabe as its agent, had been informed of the fact, within the personal knowledge of Lord, that Cable was seriously ill with acute pneumonia, the policy would not have been delivered. It is difficult for us to believe that Lord, with that knowledge, could think he had a right to accept this policy; but, whether so or not, the concealment of the fact was a fraud upon the company. The statement made was deceptive and misleading, whatever were the intentions of Lord, and a court of equity ought not to permit the completion of the wrong. Courts of equity cannot sustain an insurance upon the life of a dying man when the nature of his malady and the seriousness of his illness are concealed from the insurer.

The same doctrine has been applied when there is an attempt to show that the waiver or *estoppel* arises from the payment of the premium. In the case of Nyman *vs.* Manufacturers' & Merchants' Life Assn., *supra*, the court said:

> It is further insisted by plaintiff that defendant, by accepting and retaining premiums or assessments from the insured, is estopped from denying the validity of the certificate. The first premium was paid on the day the policy was delivered, and the last one two days before the insured's death. There is no proof whatever that defendant or its agent knew, before the the death of Mrs. Nyman, that, at the time the policy was delivered and the first premium paid, she was not in good health. Receiving premiums subsequently, with knowledge that she was them ill, could have no significance, if defendant was ignorant of the fact that the insured was in bad health when the policy was delivered and the first premium paid. If Mrs. Nyman had been in good health when she received the policy and paid the the first premium, defendant would not have been justified in refusing to accept premium if she afterwards from denying liability in this case must be knowledge that the insured was not in good health when the policy was delivered.

The case presents another aspect, namely, the waiver made by the plaintiff of any and all benefits accruing from the policy, which waiver expressly appears in document Exhibit A, known as "Accord, Satisfaction and Release".

The pertinent clauses of the document read as follows:

> Whereas, the. Insular Life Assce. Co., Ltd., claims that the delivery of the said policy No. 47710 was not valid because said delivery was made while the said Arturo Sindayen was not in good health;
>
> Whereas, the undersigned, Fortunata Lucero Sindayen, widow of the said Arturo Sindayen, is named as beneficiary in the said policy of life insurance; and
>
> Whereas, it is the desire of the Insular Life Assce. Co., Ltd., and of the beneficiary, Fortunata Lucero Sindayen that all differences, controversies and disputes that may grow out of the insurance of the said policy of life insurance and out of the claims that the said beneficiary may make under the said policy of life insurance the settled and compromised; and
>
> Whereas, the said Insular Life Assce. Co., Ltd. has at the date hereof paid Fortunato Lucero Sinadyen, the beneficiary named in said policy of life insurance, the sum of Forty Pesos and Sixty Centavos (40.06), lawful money of the Philippine Islands, the receipt whereof is hereby acknowledge;
>
> Now, thereof, in consideration of the promises and the sum of Forty Pesos and Sixty Centavos (P40.06), said Fortunata Lucero Sindayen, for herself, her heirs, executors, administrators and assigns, release and forever discharge said Insular Life Assurance Co., Ltd., its successors, and assigns, of all claims, obligation or indebtedness which she, as such beneficiary over had or now has, hereafter can, shall, or may have, for, upon, or by reason of said policy of life insurance numbered 47710 upon the life of said Arturo Sindayen, the latter now deceased, or arising therefrom or connected therewith in any matter.

There is no dispute that the aforesaid document was signed by the plaintiff. There was irregularity in its execution because it was authenticated by the notary public in the absence of plaintiff. It is admitted that due to this irregularity the document is not a public instrument, but there is no doubt that it is an authentic private instrument whose evidentiary value cannot be disregarded. Its terms are binding upon the plaintiff, who understood the same notwithstanding her denial.

However, it it said that the defendant likewise waived the defense which gas hereinbefore been extensively considered, because it failed to return the first premium collected, and this alleged failure is predicated upon the statement contained in the penultimate paragraph of the instrument stating that the check for P40.06 was returned to the plaintiff in consideration of her waiver of any claim whatsoever. A careful reading of the instrument will convince the mind that what was really meant is that the delivery of the check was another consideration of the plaintiff's waiver, it being self-evident that said check constituted, in effect, a refund of the first premium paid by insured and received by the insurer. It is ridiculous to think that such a negligible amount has been the only consideration of the plaintiff's waiver of any right or benefit accurring to her from the policy. A careful perusal of the instrument will show that the real consideration of the plaintiff's waiver was the unenforceability of the policy due to her husband's illness and the mutual desire of the plaintiff of the insurer to settle amicably the cases instead of resorting to courts.

In conclusion it is my opinion: (1) That the policy has not produced any effect from which the plaintiff may derive any right, and (2) that she has expressly waived any all rights accurring from the policy; and for these reasons I dissent from the majority opinion.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-15895 November 29, 1920

RAFAEL ENRIQUEZ, as administrator of the estate of the late Joaquin Ma. Herrer, plaintiff-appellant,
vs.
SUN LIFE ASSURANCE COMPANY OF CANADA, defendant-appellee.

Jose A. Espiritu for appellant.
Cohn, Fisher and DeWitt for appellee.

MALCOLM, *J.:*

This is an action brought by the plaintiff ad administrator of the estate of the late Joaquin Ma. Herrer to recover from the defendant life insurance company the sum of pesos 6,000 paid by the deceased for a life annuity. The trial court gave judgment for the defendant. Plaintiff appeals.

The undisputed facts are these: On September 24, 1917, Joaquin Herrer made application to the Sun Life Assurance Company of Canada through its office in Manila for a life annuity. Two days later he paid the sum of P6,000 to the manager of the company's Manila office and was given a receipt reading as follows:

MANILA, I. F., *26 de septiembre, 1917*.

PROVISIONAL RECEIPT Pesos 6,000

Recibi la suma de seis mil pesos de Don Joaquin Herrer de Manila como prima dela Renta Vitalicia solicitada por dicho Don Joaquin Herrer hoy, sujeta al examen medico y aprobacion de la Oficina Central de la Compañia.

The application was immediately forwarded to the head office of the company at Montreal, Canada. On November 26, 1917, the head office gave notice of acceptance by cable to Manila. (Whether on the same day the cable was received notice was sent by the Manila office of Herrer that the application had been accepted, is a disputed point, which will be discussed later.) On December 4, 1917, the policy was issued at Montreal. On December 18, 1917, attorney Aurelio A. Torres wrote to the Manila office of the company stating that Herrer desired to withdraw his application. The following day the local office replied to Mr. Torres, stating that the policy had been issued, and called attention to the notification of November 26, 1917. This letter was received by Mr. Torres on the morning of December 21, 1917. Mr. Herrer died on December 20, 1917.

As above suggested, the issue of fact raised by the evidence is whether Herrer received notice of acceptance of his application. To resolve this question, we propose to go directly to the evidence of record.

The chief clerk of the Manila office of the Sun Life Assurance Company of Canada at the time of the trial testified that he prepared the letter introduced in evidence as Exhibit 3, of date November 26, 1917, and handed it to the local manager, Mr. E. E. White, for signature. The witness admitted on cross-examination that after preparing the letter and giving it to he manager, he new nothing of what became of it. The local manager, Mr. White, testified to having received the cablegram accepting the application of Mr. Herrer from the home office on November 26, 1917. He said that on the same day he signed a letter notifying Mr. Herrer of this acceptance. The witness further said that letters, after being signed, were sent to the chief clerk and placed on the mailing desk for transmission. The witness could not tell if the letter had every actually been placed in the mails. Mr. Tuason, who was the chief clerk, on November 26, 1917, was not called as a witness. For the defense, attorney Manuel Torres

testified to having prepared the will of Joaquin Ma. Herrer, that on this occasion, Mr. Herrer mentioned his application for a life annuity, and that he said that the only document relating to the transaction in his possession was the provisional receipt. Rafael Enriquez, the administrator of the estate, testified that he had gone through the effects of the deceased and had found no letter of notification from the insurance company to Mr. Herrer.

Our deduction from the evidence on this issue must be that the letter of November 26, 1917, notifying Mr. Herrer that his application had been accepted, was prepared and signed in the local office of the insurance company, was placed in the ordinary channels for transmission, but as far as we know, was never actually mailed and thus was never received by the applicant.

Not forgetting our conclusion of fact, it next becomes necessary to determine the law which should be applied to the facts. In order to reach our legal goal, the obvious signposts along the way must be noticed.

Until quite recently, all of the provisions concerning life insurance in the Philippines were found in the Code of Commerce and the Civil Code. In the Code of the Commerce, there formerly existed Title VIII of Book III and Section III of Title III of Book III, which dealt with insurance contracts. In the Civil Code there formerly existed and presumably still exist, Chapters II and IV, entitled insurance contracts and life annuities, respectively, of Title XII of Book IV. On the after July 1, 1915, there was, however, in force the Insurance Act. No. 2427. Chapter IV of this Act concerns life and health insurance. The Act expressly repealed Title VIII of Book II and Section III of Title III of Book III of the code of Commerce. The law of insurance is consequently now found in the Insurance Act and the Civil Code.

While, as just noticed, the Insurance Act deals with life insurance, it is silent as to the methods to be followed in order that there may be a contract of insurance. On the other hand, the Civil Code, in article 1802, not only describes a contact of life annuity markedly similar to the one we are considering, but in two other articles, gives strong clues as to the proper disposition of the case. For instance, article 16 of the Civil Code provides that "In matters which are governed by special laws, any deficiency of the latter shall be supplied by the provisions of this Code." On the supposition, therefore, which is incontestable, that the special law on the subject of insurance is deficient in enunciating the principles governing acceptance, the subject-matter of the Civil code, if there be any, would be controlling. In the Civil Code is found article 1262 providing that "Consent is shown by the concurrence of offer and acceptance with respect to the thing and the consideration which are to constitute the contract. An acceptance made by letter shall not bind the person making the offer except from the time it came to his knowledge. The contract, in such case, is presumed to have been entered into at the place where the offer was made." This latter article is in opposition to the provisions of article 54 of the Code of Commerce.

If no mistake has been made in announcing the successive steps by which we reach a conclusion, then the only duty remaining is for the court to apply the law as it is found. The legislature in its wisdom having enacted a new law on insurance, and expressly repealed the provisions in the Code of Commerce on the same subject, and having thus left a void in the commercial law, it would seem logical to make use of the only pertinent provision of law found in the Civil code, closely related to the chapter concerning life annuities.

The Civil Code rule, that an acceptance made by letter shall bind the person making the offer only from the date it came to his knowledge, may not be the best expression of modern commercial usage. Still it must be admitted that its enforcement avoids uncertainty and tends to security. Not only this, but in order that the principle may not be taken too lightly, let it be noticed that it is identical with the principles announced by a considerable number of respectable courts in the United States. The courts who take this view have expressly held that an acceptance of an offer of insurance not actually or constructively communicated to the proposer does not make a contract. Only the mailing of acceptance, it has been said, completes the contract of insurance, as the *locus poenitentiae* is ended when the acceptance has passed beyond the control of the party. (I Joyce, The Law of Insurance, pp. 235, 244.)

In *resume*, therefore, the law applicable to the case is found to be the second paragraph of article 1262 of the Civil Code providing that an acceptance made by letter shall not bind the person making the offer except from the time it came to his knowledge. The pertinent fact is, that according to the provisional receipt, three things had to be accomplished by the insurance company before there was a contract: (1) There had to be a medical examination of the applicant; (2) there had to be approval of the application by the head office of the company; and (3) this approval had in some way to be communicated by the company to the applicant. The further admitted facts are that the head office in Montreal did accept the application, did cable the Manila office to that effect, did actually issue the policy and did, through its agent in Manila, actually write the letter of notification and place it in the usual channels for transmission to the addressee. The fact as to the letter of notification thus fails to concur with the essential elements of the general rule pertaining to the mailing and delivery of mail matter as announced by the American courts, namely, when a letter or other mail matter is addressed and mailed with postage prepaid there is a rebuttable presumption of fact that it was received by the addressee as soon as it could have been transmitted to him in the ordinary course of the mails. But if any one of these elemental facts fails to appear, it is fatal to the presumption. For instance, a letter will not be presumed to have been received by the addressee unless it is shown that it was deposited in the post-office, properly addressed and stamped. (*See* 22 C.J., 96, and 49 L. R. A. [N. S.], pp. 458, et seq., notes.)

We hold that the contract for a life annuity in the case at bar was not perfected because it has not been proved satisfactorily that the acceptance of the application ever came to the knowledge of the applicant.*lawph!l.net*

Judgment is reversed, and the plaintiff shall have and recover from the defendant the sum of P6,000 with legal interest from November 20, 1918, until paid, without special finding as to costs in either instance. So ordered.

Mapa, C.J., Araullo, Avanceña and Villamor, JJ., concur.
Johnson, J., dissents.

Republic of the Philippines
SUPREME COURT
Manila

SECOND DIVISION

G.R. No. L-48563 May 25, 1979

VICENTE E. TANG, petitioner,
vs.
HON. COURT OF APPEALS and PHILIPPINE AMERICAN LIFE INSURANCE COMPANY, respondents.

Ambrosio D. Go for petitioner.

Ferry, De la Rosa, Deligero Salonga & Associates for private respondent.

ABAD SANTOS, *J.:*

This is a petition to review on certiorari of the decision of the Court of Appeals (CA-G.R. No. 55407-R, June 8, 1978) which affirmed the decision of the Court of First Instance of Manila in Civil Case No. 90062 wherein the petitioner herein was the plaintiff and Philippine American Life Insurance Co. the herein respondent was the defendant. The action was for the enforcement of two insurance policies that had been issued by the defendant company under the following circumstances.

On September 25, 1965, Lee See Guat, a widow, 61 years old, and an illiterate who spoke only Chinese, applied for an insurance on her life for P60,000 with the respondent Company. The application consisted of two parts, both in the English language. The second part of her application dealt with her state of health and because her answers indicated that she was healthy, the Company issued her Policy No. 0690397, effective October 23, 1965, with her nephew Vicente E. Tang, herein Petitioner, as her beneficiary,

On November 15, 1965, Lee See Guat again applied with the respondent Company for an additional insurance on her life for P40,000. Considering that her first application had just been approved, no further medical examination was made but she was required to accomplish and submit Part I of the application which reads: "I/WE HEREBY DECLARE AND AGREE that all questions, statements answers contained herein, as well as those made to or to be made to the Medical Examiner in Part II are full, complete and true and bind all parties in interest under the policy herein applied for; that there shall be no contract of insurance unless a policy is issued on this application and the fun first premium thereon, according to the mode of payment specified in answer to question 4D above, actually paid during the lifetime and good health of the Proposed Insured." Moreover, her answers in Part II of her previous application were used in appraising her insurability for the second insurance. On November 28, 1965, Policy No. 695632 was issued to Lee See Guat with the same Vicente E. Tang as her beneficiary.

On April 20, 1966, Lee See Guat died of lung cancer. Thereafter, the beneficiary of the two policies, Vicente E. Tang claimed for their face value in the amount of P100,000 which the insurance company refused to pay on the ground that the insured was guilty of concealment and misrepresentation at the time she applied for the two policies. Hence, the filing of Civil Case No. 90062 in the Court of First Instance of Manila which dismissed the claim because of the concealment practised by the insured in violation of the Insurance Law.

On appeal, the Court of Appeals, affirmed the decision. In its decision, the Court of Appeals stated, *inter alia*: "There is no doubt that she deliberately concealed material facts about her physical condition and history and/or conspired with whoever assisted her in relaying false information to the medical examiner, assuming that the examiner could not communicate directly with her."

The issue in this appeal is the application of Art. 1332 of the Civil Code which stipulates:

> Art. 1332. When one of the parties is unable to read, or if the contract is in a language not understood by him, and mistake or fraud is alleged, the person enforcing the contract must show that the terms thereof have been fully explained to the former.

According to the Code Commission: "This rule is especially necessary in the Philippines where unfortunately there is still a fairly large number of illiterates, and where documents are usually drawn up in English or Spanish." (Report of the Code Commission, p. 136.) Art. 1332 supplements Art. 24 of the Civil Code which provides that " In all contractual, property or other relations, when one of the parties is at a disadvantage on account of his moral dependence, ignorance, indigence, mental weakness, tender age or other handicap, the court must be vigilant for his protection.

It is the position of the petitioner that because Lee See Guat was illiterate and spoke only Chinese, she could not be held guilty of concealment of her health history because the applications for insurance were in English and the insurer has not proved that the terms thereof had been fully explained to her.

It should be noted that under Art. 1332 above quoted, the obligation to show that the terms of the contract had been fully explained to the party who is unable to read or understand the language of the contract, when fraud or mistake is alleged, devolves on the party seeking to enforce it. Here the insurance company is not seeking to enforce the contracts; on the contrary, it is seeking to avoid their performance. It is petitioner who is seeking to enforce

them even as fraud or mistake is not alleged. Accordingly, respondent company was under no obligation to prove that the terms of the insurance contracts were fully explained to the other party. Even if we were to say that the insurer is the one seeking the performance of the contracts by avoiding paying the claim, it has to be noted as above stated that there has been no imputation of mistake or fraud by the illiterate insured whose personality is represented by her beneficiary the petitioner herein. In sum, Art. 1332 is inapplicable to the case at bar. Considering the findings of both the CFI and Court of Appeals that the insured was guilty of concealment as to her state of health, we have to affirm.

WHEREFORE, the decision of the Court of Appeals is hereby affirmed. No special pronouncement as to costs.

SO ORDERED.

Concepcion, Jr., and Santos, JJ., concur.

Aquino, J., concurs in the result.

Separate Opinions

ANTONIO, *J.,* concurring:

I concur.

In a contract of insurance each party "must communicate to the other, in good faith, *all facts within his knowledge*which are *material* to the contract, and which the other has not the means of ascertaining ... (section 27, Act 2427, as amended. Emphasis supplied). As a general rule, a failure by the insured to disclose conditions affecting the risk, of which he is aware makes the contract voidable at the option of the insurer (45 C.J.S. 153). The reason for this rule is that insurance policies are traditionally contracts "*ubemae fidei*" which means most abundant good faith absolute and perfect candor or openness and honesty; the absence of any concealment or deception however slight. Here, the Court of Appeals found that the insured "deliberately concealed material facts about her physical condition and history and/or concealed with whoever assisted her in relaying false information to the medical examiner ... "

Certainly, petitioner cannot assume inconsistent positions by attempting to enforce the contract of insurance for the purpose of collecting the proceeds of the policy and at the same time nullify the contract by claiming that he executed the same thru fraud or mistake.

 # Separate Opinions

ANTONIO, *J.,* concurring:

I concur.

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SECOND DIVISION

[G.R. No. 118870. March 29, 1996]

NERISSA Z. *PEREZ, petitioner, vs.* THE COURT OF APPEALS (Ninth Division) and RAY C. PEREZ, *respondents.*

D E C I S I O N

ROMERO, *J.:*

Parties herein would have this Court duplicate the feat of King Solomon who was hailed in Biblical times for his sagacious, if, at times unorthodox, manner of resolving conflicts, the most celebrated case being that when his authority was invoked to determine the identity of the real mother as between two women claiming the same infant. Since there could only be one mother, the daunting task that confronted the king/judge was to choose the true one.

In the instant case, we are faced with the challenge of deciding, as between father and mother, who should have rightful custody of a child who bears in his person both their genes.

While there is a provision of law squarely in point, the two courts whose authority have been invoked to render a decision have arrived at diametrically opposite conclusions.

It has fallen upon us now to likewise act as judge between the trial court, on the one hand, and the appellate, on the other.

On the issue of custody over the minor Ray Perez II, respondent Court of Appeals ruled in favor of the boy's father Ray C. Perez, reversing the trial court's decision to grant custody to Nerissa Z. Perez, the child's mother.

Ray Perez, private respondent, is a doctor of medicine practicing in Cebu while Nerissa, his wife who is petitioner herein, is a registered nurse. They were married in Cebu onDecember 6, 1986. After six miscarriages, two operations and a high-risk pregnancy, petitioner finally gave birth to Ray Perez II in New York on July 20, 1992.

Petitioner who began working in the United States in October 1988, used part of her earnings to build a modest house in Mandaue City, Cebu. She also sought medical attention for her successive miscarriages in New York. She became a resident alien in February 1992.

Private respondent stayed with her in the U.S. twice and took care of her when she became pregnant. Unlike his wife, however, he had only a tourist visa and was not employed.

On January 17, 1993, the couple and their baby arrived in Cebu. After a few weeks, only Nerissa returned to the U.S. She alleged that they came home only for a five-week vacation and that they all had round-trip tickets. However, her husband stayed behind to take care of his sick mother and promised to follow her with the baby. According to Ray, they had agreed to reside permanently in the Philippines but once Nerissa was in New York, she changed her mind and continued working. She was supposed to come back immediately after winding up her affairs there.

When Nerissa came home a few days before Ray II's first birthday, the couple was no longer on good terms. That their love for each other was fading became apparent from their serious quarrels. Petitioner did not want to live near her in-laws and rely solely on her husband's meager income of P5,000.00.[1] She longed to be with her only child but he was being kept away from her by her husband. Thus, she did not want to leave RJ (Ray Junior) with her husband and in-laws. She wished for her son to grow up with his mother.

On the other hand, Ray wanted to stay here, where he could raise his son even as he practiced his profession. He maintained that it would not be difficult to live here since they have their own home and a car. They could live comfortably on his P 15,000.00 monthly income[2] as they were not burdened with having to pay any debts.

Petitioner was forced to move to her parents' home on Guizo Street in Mandaue. Despite mediation by the priest who solemnized their marriage, the couple failed to reconcile.

On July 26, 1993, Nerissa Z. Perez filed a petition for habeas corpus[3] asking respondent Ray C. Perez to surrender the custody of their son, Ray Z. Perez II, to her.

On August 27, 1993, the court a *quo* issued an Order awarding custody of the one-year old child to his mother, Nerissa Perez, citing the second paragraph of Article 213 of the Family Code which provides that no child under seven years of age shall be separated from the mother, unless the court finds compelling reasons to order otherwise. The dispositive portion of the Order reads:

"WHEREFORE, foregoing premises considered, Order is hereby issued ordering the respondent to turn over the custody of their child Ray Cortes Perez II, his passport and roundtrip ticket to herein petitioner with a warning that if he will escape together with the child for the purpose of hiding the minor child instead of complying with this Order, that warrant for his arrest will be issued.

SO ORDERED."[4]

Upon appeal by Ray Perez, the Court of Appeals, on September 27, 1994, reversed the trial court's order and awarded custody of the boy to his father.[5]

Petitioner's motion for reconsideration having been denied,[6] she filed the instant petition for review where the sole issue is the custody of Ray Perez II, now three years old.

Respondent court differed in opinion from the trial court and ruled that there were enough reasons to deny Nerissa Perez custody over Ray II even if the child is under seven years old. It held that granting custody to the boy's father would be for the child's best interest and welfare.[7]

Before us is the unedifying situation of a husband and wife in marital discord, struggling for custody of their only child. It is sad that petitioner and private respondent have not found it in their hearts to understand each other and live together once again as a family. Separated in fact, they now seek the Court's assistance in the matter of custody or parental authority over the child.

The wisdom and necessity for the exercise of joint parental authority need not be belabored. The father and the mother complement each other in giving nurture and providing that holistic care which takes into account the physical, emotional, psychological, mental, social and spiritual needs of the child. By precept and example, they mold his character during his crucial formative years.

However, the Court's intervention is sought in order that a decision may be made as to which parent shall be given custody over the young boy. The Court's duty is to determine whether Ray Perez II will be better off with petitioner or with private respondent. We are not called upon to declare which party committed the greater fault in their domestic quarrel.

When the parents of the child are separated, Article 213 of the Family Code is the applicable law. It provides:

"ART. 213. In case of *separation of the parents,* parental authority shall be exercised by the parent designated by the Court. The Court shall take into account all relevant considerations, especially the choice of the child over seven years of age, unless the parent chosen is unfit.

No child under seven years of age shall be separated from the mother, unless the court finds compelling reasons to order otherwise." (Italics supplied)

Since the Code does not qualify the word "separation" to mean "legal separation" decreed by a court, couples who are separated in fact, such as petitioner and private respondent, are covered within its terms.[8]

The Revised Rules of Court also contains a similar provision. Rule 99, Section 6 (Adoption and Custody of Minors) provides:

"SEC. 6. Proceedings as to child whose parents are separated. Appeal. - When husband and wife are divorced or living separately and apart from each other, and the questions as to the care, custody, and control of a child or children of their marriage is brought before a Court of First Instance by petition or as an incident to any other proceeding, the court, upon hearing the testimony as may be pertinent, shall award the care, custody, and control of each such child as will be for its best interest, permitting the child to choose which parent it prefers to live with if it be over ten years of age, unless the parent chosen be unfit to take charge of the child by reason of moral depravity, habitual drunkenness, incapacity, or poverty x x x. *No child under seven years of age shall be separated from its mother, unless the court finds there are compelling reasons therefor."* (Italics supplied)

The provisions of law quoted above clearly mandate that a child under seven years of age shall not be separated from his mother unless the court finds compelling reasons to order otherwise. The use of the word "shall" in Article 213 of the Family Code and Rule 99, Section 6 of the Revised Rules of Court connotes a mandatory character. In the case of*Lacson v. San Jose-Lacson,*[9] the Court declared:

"The use of the word *shall* in Article 363[10] of the Civil Code, coupled with the observations made by the Code Commission in respect to the said legal provision, underscores its mandatory character. It prohibits in no uncertain terms the separation of a mother and her child below seven years, unless such separation is grounded upon compelling reasons as determined by a court."[11]

The rationale for awarding the custody of children younger than seven years of age to their mother was explained by the Code Commission:

"The general rule is recommended in order to avoid many a tragedy where a mother has seen her baby torn away from her. No man can sound the deep sorrows of a mother who is deprived of her child of tender age. The exception allowed by the rule has to be for 'compelling reasons' for the good of the child; those cases must indeed be rare, if the mother's heart is not to be unduly hurt. If she has erred, as in cases of adultery, the penalty of imprisonment and the divorce decree (relative divorce) will ordinarily be sufficient punishment for her. Moreover, moral dereliction will not have any effect upon the baby who is as yet unable to understand her situation." (Report of the Code Commission, p. 12)[12]

The Family Code, in reverting to the provision of the Civil Code that a child below seven years old should not be separated from the mother (Article 363), has expressly repealed the earlier Article 17, paragraph three of the Child and Youth Welfare Code (Presidential Decree No. 603) which reduced the child's age to five years.[13]

The general rule that a child under seven years of age shall not be separated from his mother finds its *raison d'etre* in the basic need of a child for his mother's loving care.[14] Only the most compelling of reasons shall justify the court's awarding the custody of such a child to someone other than his mother, such as her unfitness to exercise sole parental authority. In the past the following grounds have been considered ample justification to deprive a mother of custody and parental authority: neglect, abandonment,[15] unemployment and immorality,[16] habitual drunkenness,[17] drug addiction, maltreatment of the child, insanity and being sick with a communicable disease.[18]

It has long been settled that in custody cases,[19] the foremost consideration is always the Welfare and best interest of the child. In fact, no less than an international instrument, the Convention on the Rights of the Child provides: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."[20]

Courts invariably look into all relevant factors presented by the contending parents, such as their material resources, social and moral situations.[21]

In the case at bench, financial capacity is not a determinative factor inasmuch as both parties have demonstrated that they have ample means.

Respondent court stated that petitioner has no permanent place of work in the U.S.A. and has taken this point against her. The records, however, show that she is employed in aNew York hospital[22] and was, at the time the petition was filed, still abroad.[23] She testified that she intends to apply for a job elsewhere, presumably to improve her work environment and augment her income, as well as for convenience.[24] The Court takes judicial notice of the fact that a registered nurse, such as petitioner, is still very much in demand in the United States. Unlike private respondent, a doctor who by his own admission could not find employment there, petitioner immediately got a job in New York. Considering her skill and experience, petitioner should find no difficulty in obtaining work elsewhere, should she desire to do so.

The decision under review casts doubt on petitioner's capability to take care of the child, particularly since she works on twelve-hour shifts thrice weekly, at times, even at night. There being no one to help her look after the child, it is alleged that she cannot properly attend to him. This conclusion is as unwarranted as it is unreasonable. First, her present work schedule is not so unmanageable as to deprive her of quality time for Ray II. Quite a number of working mothers who are away from home for longer periods of time

are still able to raise a family well, applying time management principles judiciously. Second, many a mother, finding herself in such a position, has invited her own mother or relative to join her abroad, providing the latter with plane tickets and liberal allowances, to look after the child until he is able to take care of himself. Others go on leave from work until such time as the child can be entrusted to day-care centers. Delegating child care temporarily to qualified persons who run day-care centers does not detract from being a good mother, as long as the latter exercises supervision, for even in our culture, children are often brought up by housemaids or "yayas" under the eagle eyes of the mother. Third, private respondent's work schedule was not presented in evidence at the trial. Although he is a general practitioner, the records merely show that he maintains a clinic, works for several companies on retainer basis and teaches part-time.[25] Hence, respondent court's conclusion that "his work schedule is flexible (and h)e can always find time for his son"[26] is not well-founded. Fourth, the fact that private respondent lives near his parents and sister is not crucial in this case. Fifth, petitioner's work schedule cited in the respondent court's decision is not necessarily permanent. Hospitals work in shifts and, given a mother's instinctive desire to lavish upon her child the utmost care, petitioner may be expected to arrange her schedule in such a way as to allocate time for him. Finally, it does not follow that petitioner values her career more than her family simply because she wants to work in the United States. There are any number of reasons for a person's seeking a job outside the country, e.g. to augment her income for the family's benefit and welfare, and for psychological fulfillment, to name a few. In the instant case, it has been shown that petitioner earned enough from her job to be able to construct a house for the family in Mandaue City. The record describes sketchily the relations between Ray and Nerissa Perez. The transcripts of the three hearings are inadequate to show that petitioner did not exert earnest efforts and make sacrifices to save her marriage.

It is not difficult to imagine how heart-rending it is for a mother whose attempts at having a baby were frustrated several times over a period of six years to finally bear one, only for the infant to be snatched from her before he has even reached his first year. The mother's role in the life of her child, such as Ray II, is well-nigh irreplaceable. In prose and poetry, the depth of a mother's love has been immortalized times without number, finding as it does, its justification, not in fantasy but in reality.

WHEREFORE, the petition for review is GRANTED. The decision of the Court of Appeals dated September 27, 1994 as well as its Resolution dated January 24, 1995 are hereby REVERSED and SET ASIDE. The Order of the trial court dated August 27, 1993 is hereby REINSTATED. Custody over the minor Ray Z. Perez II is awarded to his mother, herein petitioner Nerissa Z. Perez. This decision is immediately executory.

SO ORDERED.

Regalado (Chairman), Puno, and *Mendoza, JJ.,* concur.
Torres, Jr., J., on leave.

FIRST DIVISION

[G.R. No. 119176. March 19, 2002]

COMMISSIONER OF INTERNAL REVENUE, *petitioner, vs.* LINCOLN PHILIPPINE LIFE INSURANCE COMPANY, INC. (now JARDINE-CMA LIFE INSURANCE COMPANY, INC.) and THE COURT OF APPEALS, *respondents*.

D E C I S I O N

KAPUNAN, *J.*:

This is a petition for review on *certiorari* filed by the Commission on Internal Revenue of the decision of the Court of Appeals dated November 18, 1994 in C.A. G.R. SP No. 31224 which reversed in part the decision of the Court of Tax Appeals in C.T.A. Case No. 4583.

The facts of the case are undisputed.

Private respondent Lincoln Philippine Life Insurance Co., Inc., (now Jardine-CMA Life Insurance Company, Inc.) is a domestic corporation registered with the Securities and Exchange Commission and engaged in life insurance business. In the years prior to 1984, private respondent issued a special kind of life insurance policy known as the "Junior Estate Builder Policy," the distinguishing feature of which is 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 by petitioner only on the initial sum assured.

In 1984, private respondent also issued 50,000 shares of stock dividends with a par value of ₱100.00 per share or a total par value of ₱5,000,000.00. The actual value of said shares, represented by its book value, was ₱19,307,500.00. Documentary stamp taxes were paid based only on the par value of ₱5,000,000.00 and not on the book value.

Subsequently, petitioner issued deficiency documentary stamps tax assessment for the year 1984 in the amounts of (a) ₱464,898.75, corresponding to the amount of automatic increase of the sum assured on the policy issued by respondent, and (b) ₱78,991.25 corresponding to the book value in excess of the par value of the stock dividends. The computation of the deficiency documentary stamp taxes is as follows:

On Policies Issued:

Total policy issued during the year	₱1,360,054,000.00
Documentary stamp tax due thereon	
(P1,360,054,000.00 divided by	

P200.00 multiplied by P0.35)	₱	2,380,094.50
Less: Payment	₱	1,915,495.75
Deficiency	₱	464,598.75
Add: Compromise Penalty		300.00

TOTAL AMOUNT DUE & COLLECTIBLE	₱	464,898.75

Private respondent questioned the deficiency assessments and sought their cancellation in a petition filed in the Court of Tax Appeals, docketed as CTA Case No. 4583.

On March 30, 1993, the Court of Tax Appeals found no valid basis for the deficiency tax assessment on the stock dividends, as well as on the insurance policy. The dispositive portion of the CTA's decision reads:

WHEREFORE, the deficiency documentary stamp tax assessments in the amount of ₱464,898.76 and ₱78,991.25 or a total of ₱543,890.01 are hereby cancelled for lack of merit. Respondent Commissioner of Internal Revenue is ordered to desist from collecting said deficiency documentary stamp taxes for the same are considered withdrawn.

SO ORDERED.[1]

Petitioner appealed the CTA's decision to the Court of Appeals. On November 18, 1994, the Court of Appeals promulgated a decision affirming the CTA's decision insofar as it nullified the deficiency assessment on the insurance policy, but reversing the same with regard to the deficiency assessment on the stock dividends. The CTA ruled that the correct basis of the documentary stamp tax due on the stock dividends is the actual value or book value represented by the shares. The dispositive portion of the Court of Appeals' decision states:

IN VIEW OF ALL THE FOREGOING, the decision appealed from is hereby *REVERSED* with respect to the deficiency tax assessment on the stock dividends, but *AFFIRMED* with regards to the assessment on the Insurance Policies. Consequently, private respondent is ordered to pay the petitioner herein the sum of ₱78,991.25, representing documentary stamp tax on the stock dividends it issued. No costs pronouncement.

SO ORDERED.[2]

A motion for reconsideration of the decision having been denied,[3] both the Commissioner of Internal Revenue and private respondent appealed to this Court, docketed as G.R. No. 118043 and G.R. No. 119176, respectively. In G.R. No. 118043, private respondent appealed the decision of the Court of Appeals insofar as it upheld the validity of the deficiency tax assessment on the stock dividends. The Commissioner of Internal Revenue, on his part, filed the present petition questioning that portion of the Court of Appeals' decision which invalidated the deficiency assessment on the insurance policy, attributing the following errors:

> THE HONORABLE COURT OF APPEALS ERRED WHEN IT RULED THAT THERE IS A SINGLE AGREEMENT EMBODIED IN THE POLICY AND THAT THE AUTOMATIC INCREASE CLAUSE IS NOT A SEPARATE AGREEMENT, CONTRARY TO SECTION 49 OF THE INSURANCE CODE AND SECTION 183 OF THE REVENUE CODE THAT A RIDER, A CLAUSE IS PART OF THE POLICY.
>
> THE HONORABLE COURT OF APPEALS ERRED IN NOT COMPUTING THE AMOUNT OF TAX ON THE TOTAL VALUE OF THE INSURANCE ASSURED IN THE POLICY INCLUDING THE ADDITIONAL INCREASE ASSURED BY THE AUTOMATIC INCREASE CLAUSE DESPITE ITS RULING THAT THE ORIGINAL POLICY AND THE AUTOMATIC CLAUSE CONSTITUTED ONLY A SINGULAR TRANSACTION.[4]

Section 173 of the National Internal Revenue Code on documentary stamp taxes provides:

Sec. 173. Stamp taxes upon documents, instruments and papers. - Upon documents, instruments, loan agreements, and papers, and upon acceptances, assignments, sales, and transfers of the obligation, right or property incident thereto, there shall be levied, collected and paid for, and in respect of the transaction so had or accomplished, the corresponding documentary stamp taxes prescribed in the following section of this Title, by the person making, signing, issuing, accepting, or transferring the same wherever the document is made, signed, issued, accepted, or transferred when the obligation or right arises from Philippine sources or the property is situated in the Philippines, and at the same time such act is done or transaction had: **Provided**, That whenever one party to the taxable document enjoys exemption from the tax herein imposed, the other party thereto who is not exempt shall be the one directly liable for the tax. (As amended by PD No. 1994) The basis for the value of documentary stamp taxes to be paid on the insurance policy is Section 183 of the National Internal Revenue Code which states in part:

The basis for the value of documentary stamp taxes to be paid on the insurance policy is Section 183 of the National Internal Revenue Code which states in part:

Sec. 183. Stamp tax on life insurance policies. - On all policies of insurance or other instruments by whatever name the same may be called, whereby any insurance shall be made or renewed upon any life or lives, there shall be collected a documentary stamp tax of

thirty (now 50c) centavos on each Two hundred pesos per fractional part thereof, of the amount insured by any such policy.

Petitioner claims that the "automatic increase clause" in the subject insurance policy is separate and distinct from the main agreement and involves another transaction; and that, while no new policy was issued, the original policy was essentially re-issued when the additional obligation was assumed upon the effectivity of this "automatic increase clause" in 1984; hence, a deficiency assessment based on the additional insurance not covered in the main policy is in order.

The Court of Appeals sustained the CTA's ruling that there was only one transaction involved in the issuance of the insurance policy and that the "automatic increase clause" is an integral part of that policy.

The petition is impressed with merit.

Section 49, Title VI of the Insurance Code defines an insurance policy as the written instrument in which a contract of insurance is set forth.[5] Section 50 of the same Code provides that the policy, which is required to be in printed form, may contain any word, phrase, *clause*, mark, sign, symbol, signature, number, or word *necessary to complete the contract of insurance*.[6] It is thus clear that any rider, clause, warranty or endorsement pasted or attached to the policy is considered part of such policy or contract of insurance.

The subject insurance policy at the time it was issued contained an "automatic increase clause." Although the clause was to take effect only in 1984, it was written into the policy at the time of its issuance. The distinctive feature of the "junior estate builder policy" called the "automatic increase clause" already formed part and parcel of the insurance contract, hence, there was no need for an execution of a separate agreement for the increase in the coverage that took effect in 1984 when the assured reached a certain age.

It is clear from Section 173 that the payment of documentary stamp taxes is done at the time the act is done or transaction had and the tax base for the computation of documentary stamp taxes on life insurance policies under Section 183 is the amount fixed in policy, unless the interest of a person insured is susceptible of exact pecuniary measurement.[7] What then is the amount fixed in the policy? Logically, we believe that the amount fixed in the policy is the figure written on its face and whatever increases will take effect in the future by reason of the "automatic increase clause" embodied in the policy without the need of another contract.

Here, although the automatic increase in the amount of life insurance coverage was to take effect later on, the date of its effectivity, as well as 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 "automatic increase clause" in the policy is in the nature of a conditional obligation under Article 1181,[8] by which the increase of the insurance coverage shall depend upon the happening of the event which constitutes the obligation. In the instant case, the additional insurance that took effect in 1984 was an obligation subject to a suspensive obligation,[9] but still a part of the insurance sold to which private respondent was liable for the payment of the documentary stamp tax.

The deficiency of documentary stamp tax imposed on private respondent is definitely 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."

Finally, it should be emphasized that while tax avoidance schemes and arrangements are not prohibited,[10] tax laws cannot be circumvented in order to evade the payment of just taxes. In the case at bar, 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.

WHEREFORE, the petition is hereby given DUE COURSE. The decision of the Court of Appeals is SET ASIDE insofar as it affirmed the decision of the Court of Tax Appeals nullifying the deficiency stamp tax assessment petitioner imposed on private respondent in the amount of ₱464,898.75 corresponding to the increase in 1984 of the sum under the policy issued by respondent.

SO ORDERED.

Davide, Jr., C.J., (Chairman), and *Ynares-Santiago, J.,* concur.
Puno, J., on official leave.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-15774 November 29, 1920

PILAR C. DE LIM, plaintiff-appellant,
vs.
SUN LIFE ASSURANCE COMPANY OF CANADA, defendant-appellee.

Sanz and Luzuriaga for appellant.
Cohn and Fisher for appellee.

MALCOLM, *J.:*

This is an appeal by plaintiff from an order of the Court of First Instance of Zamboanga sustaining a demurrer to plaintiff's complaint upon the ground that it fails to state a cause of action.

As the demurrer had the effect of admitting the material facts set forth in the complaint, the facts are those alleged by the plaintiff. On July 6, 1917, Luis Lim y Garcia of Zamboanga made application to the Sun Life Assurance Company of Canada for a policy of insurance on his life in the sum of P5,000. In his application Lim designated his wife, Pilar C. de Lim, the plaintiff herein, as the beneficiary. The first premium of P433 was paid by Lim, and upon such payment the company issued what was called a "provisional policy." Luis Lim y Garcia died on August 23, 1917, after the issuance of the provisional policy but before approval of the application by the home office of the insurance company. The instant action is brought by the beneficiary, Pilar C. de Lim, to recover from the Sun Life Assurance Company of Canada the sum of P5,000, the amount named in the provisional policy.

The "provisional policy" upon which this action rests reads as follows:

> *Received* (subject to the following stipulations and agreements) the sum of four hundred and thirty-three pesos, being the amount of the first year's premium for a Life Assurance Policy on the life of Mr. Luis D. Lim y Garcia of Zamboanga for P5,000, for which an application dated the 6th day of July, 1917, has been made to the Sun Life Assurance Company of Canada.
>
> The above-mentioned life is to be assured in accordance with the terms and conditions contained or inserted by the Company in the policy which may be granted by it in this particular case for *four months only* from the date of the application, provided that the Company shall confirm this agreement by issuing a policy on said application when the same shall be submitted to the Head Office in Montreal. Should the Company not issue such a policy, then this agreement shall be null and void *ab initio*, and the Company shall be held not to have been on the risk at all, but in such case the amount herein acknowledged shall be returned.
>
> [SEAL.] (Sgd.) T. B. MACAULAY, President.
> (Sgd.) A. F. Peters, Agent.

Our duty in this case is to ascertain the correct meaning of the document above quoted. A perusal of the same many times by the writer and by other members of the court leaves a decided impression of vagueness in the mind. Apparently it is to be a provisional policy "for four months only from the date of this application." We use the term "apparently" advisedly, because immediately following the words fixing the four months period comes the word "provided" which has the meaning of "if." Otherwise stated, the policy for four months is expressly made subjected to the affirmative condition that "the company shall confirm this agreement by issuing a policy on said application when the same shall be submitted to the head office in Montreal." To reenforce the same there follows the negative condition — Should the company not issue such a policy, then this agreement shall be null and void *ab initio*, and the company shall be held not to have been on the risk." Certainly, language could hardly be used which would more clearly stipulate that the agreement should not go into effect until the home office of the company should confirm it by issuing a policy. As we read and understand the so-called provisional policy it amounts to nothing but an acknowledgment on behalf of the company, that it has received from the person named therein the sum of money agreed upon as the first year's premium upon a policy to be issued upon the application, *if* the application is accepted by the company.

It is of course a primary rule that a contract of insurance, like other contracts, must be assented to by both parties either in person or by their agents. So long as an application for insurance has not been either accepted or rejected, it is merely an offer or proposal to make a contract. 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. Our view is, that a contract of insurance was not here consummated by the parties.*lawph!l.net*

Appellant relies on Joyce on Insurance. Beginning at page 253, of Volume I, Joyce states the general rule concerning the agent's receipt pending approval or issuance of policy. The first rule which Joyce lays down is this: If the act of acceptance of the risk by the agent and the giving by him of a receipt, is within the scope of the agent's authority, and nothing remains but to issue a policy, then the receipt will bind the company. This rule does not apply, for while here nothing remained but to issue the policy, this was made an express condition to the contract. The second rule laid down by Joyce is this: Where an agreement is made between the applicant and the agent whether by signing an application containing such condition, or otherwise, that no liability shall attach until the principal approves the risk and a receipt is given buy the agent, such acceptance is merely conditional, and it subordinated to the act of the company in approving or rejecting; so in life insurance a "binding slip" or "binding receipt" does not insure of itself. This is the rule which we believe applies to the instant case. The third rule announced by Joyce is this: Where the acceptance by the agent is within the scope of his authority a receipt containing a contract for insurance for a specific time which is not absolute but conditional, upon acceptance or rejection by the principal, covers the specified period unless the risk is declined within that period. The case cited by Joyce to substantiate the last principle is that a Goodfellow *vs*. Times & Beacon Assurance Com. (17 U. C. Q. B., 411), not available.

The two cases most nearly in point come from the federal courts and the Supreme Court of Arkansas.

In the case of Steinle *vs*. New York Life Insurance Co. ([1897], 81 Fed., 489} the facts were that the amount of the first premium had been paid to an insurance agent and a receipt given therefor. The receipt, however, expressly declared that if the application was accepted by the company, the insurance shall take effect from the date of the application but that if the application was not accepted, the money shall be returned. The trite decision of the

circuit court of appeal was, "On the conceded facts of this case, there was no contract to life insurance perfected and the judgment of the circuit court must be affirmed."

In the case of Cooksey *vs*. Mutual Life Insurance Co. ([1904], 73 Ark., 117) the person applying for the life insurance paid and amount equal to the first premium, but the application and the receipt for the money paid, stipulated that the insurance was to become effective only when the application was approved and the policy issued. The court held that the transaction did not amount to an agreement for preliminary or temporary insurance. It was said:

It is not an unfamiliar custom among life insurance companies in the operation of the business, upon receipt of an application for insurance, to enter into a contract with the applicant in the shape of a so-called "binding receipt" for temporary insurance pending the consideration of the application, to last until the policy be issued or the application rejected, and such contracts are upheld and enforced when the applicant dies before the issuance of a policy or final rejection of the application. It is held, too, that such contracts may rest in parol. Counsel for appellant insists that such a preliminary contract for temporary insurance was entered into in this instance, but we do not think so. On the contrary, the clause in the application and the receipt given by the solicitor, which are to be read together, stipulate expressly that the insurance shall become effective only when the "application shall be approved and the policy duly signed by the secretary at the head office of the company and issued." It constituted no agreement at all for preliminary or temporary insurance; Mohrstadt vs. Mutual Life Ins. Co., 115 Fed., 81, 52 C. C. A., 675; Steinle vs. New York Life Ins. Co., 81 Fed., 489, 26 C. C. A., 491." (See further Weinfeld vs. Mutual Reserve Fund Life Ass'n. [1892], 53 Fed, 208' Mohrstadt vs. Mutual Life Insurance Co. [1902], 115 Fed., 81; Insurance co. vs. Young's Administrator [1875], 90 U. S., 85; Chamberlain vs. Prudential Insurance Company of America [1901], 109 Wis., 4; Shawnee Mut. Fire Ins. Co. vs. McClure [1913], 39 Okla., 509; Dorman vs. Connecticut Fire Ins. Co. [1914], 51 *contra*, Starr vs. Mutual Life Ins. Co. [1905], 41 Wash., 228.)

We are of the opinion that the trial court committed no error in sustaining the demurrer and dismissing the case. It is to be noted, however, that counsel for appellee admits the liability of the company for the return of the first premium to the estate of the deceased. It is not to be doubted but that the Sun Life Assurance Company of Canada will immediately, on the promulgation of this decision, pay to the estate of the late Luis Lim y Garcia the of P433.

The order appealed from, in the nature of a final judgment is affirmed, without special finding as to costs in this instance. So ordered.

Mapa, C.J., Johnson, Araullo, Avanceña and Villamor, JJ., concur.

SECOND DIVISION

[G.R. No. 113899. October 13, 1999]

GREAT PACIFIC LIFE ASSURANCE CORP., *petitioner vs*. COURT OF APPEALS AND MEDARDA V. LEUTERIO, *respondents.*

D E C I S I O N

QUISUMBING, *J.*:

This petition for review, under Rule 45 of the Rules of Court, assails the Decision[1] dated May 17, 1993, of the Court of Appeals and its Resolution[2] dated January 4, 1994 in CA-G.R. CV No. 18341. The appellate court affirmed in toto the judgment of the Misamis Oriental Regional Trial Court, Branch 18, in an insurance claim filed by private respondent against Great Pacific Life Assurance Co. The dispositive portion of the trial court's decision reads:

"WHEREFORE, judgment is rendered adjudging the defendant GREAT PACIFIC LIFE ASSURANCE CORPORATION as insurer under its Group policy No. G-1907, in relation to Certification B-18558 liable and ordered to pay to the DEVELOPMENT BANK OF THE PHILIPPINES as creditor of the insured Dr. Wilfredo Leuterio, the amount of EIGHTY SIX THOUSAND TWO HUNDRED PESOS (P86,200.00); dismissing the claims for damages, attorney's fees and litigation expenses in the complaint and counterclaim, with costs against the defendant and dismissing the complaint in respect to the plaintiffs, other than the widow-beneficiary, for lack of cause of action."[3]

The facts, as found by the Court of Appeals, are as follows:

A contract of group life insurance was executed between petitioner Great Pacific Life Assurance Corporation (hereinafter Grepalife) and Development Bank of the Philippines (hereinafter DBP). Grepalife agreed to insure the lives of eligible housing loan mortgagors of DBP.

On November 11, 1983, Dr. 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?

Answer: No. If so give details _____.

8. Are you now, to the best of your knowledge, in good health?

Answer: [x] Yes [ ] No."[4]

On November 15, 1983, Grepalife issued Certificate No. B-18558, as insurance coverage of Dr. Leuterio, to the extent of his DBP mortgage indebtedness amounting to eighty-six thousand, two hundred (P86,200.00) pesos.

On August 6, 1984, Dr. Leuterio died due to "massive cerebral hemorrhage." Consequently, 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 on November 15, 1983. 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.

On October 20, 1986, the widow of the late Dr. Leuterio, respondent Medarda V. Leuterio, filed a complaint with the Regional Trial Court of Misamis Oriental, Branch 18, against Grepalife for "Specific Performance with Damages."[5] During the trial, Dr. Hernando Mejia, who issued the death certificate, was called to testify. Dr. Mejia's findings, based partly from the information given by the respondent widow, stated that Dr. Leuterio complained of headaches presumably due to high blood pressure. The inference was not conclusive because Dr. Leuterio was not autopsied, hence, other causes were not ruled out.

On February 22, 1988, the trial court rendered a decision in favor of respondent widow and against Grepalife. On May 17, 1993, the Court of Appeals sustained the trial court's decision. Hence, the present petition. Petitioners interposed the following assigned errors:

"1. THE LOWER COURT ERRED IN HOLDING DEFENDANT-APPELLANT LIABLE TO THE DEVELOPMENT BANK OF THE PHILIPPINES (DBP) WHICH IS NOT A PARTY TO THE CASE FOR PAYMENT OF THE PROCEEDS OF A MORTGAGE REDEMPTION INSURANCE ON THE LIFE OF PLAINTIFF'S HUSBAND WILFREDO LEUTERIO ONE OF ITS LOAN BORROWERS, INSTEAD OF DISMISSING THE CASE AGAINST DEFENDANT-APPELLANT [Petitioner Grepalife] FOR LACK OF CAUSE OF ACTION.

2. THE LOWER COURT ERRED IN NOT DISMISSING THE CASE FOR WANT OF JURISDICTION OVER THE SUBJECT OR NATURE OF THE ACTION AND OVER THE PERSON OF THE DEFENDANT.

3. THE LOWER COURT ERRED IN ORDERING DEFENDANT-APPELLANT TO PAY TO DBP THE AMOUNT OF P86,200.00 IN THE ABSENCE OF ANY EVIDENCE TO SHOW HOW MUCH WAS THE ACTUAL AMOUNT PAYABLE TO DBP IN ACCORDANCE WITH ITS GROUP INSURANCE CONTRACT WITH DEFENDANT-APPELLANT.

4. THE LOWER COURT ERRED IN - HOLDING THAT THERE WAS NO CONCEALMENT OF MATERIAL INFORMATION ON THE PART OF WILFREDO LEUTERIO IN HIS APPLICATION FOR MEMBERSHIP IN THE GROUP LIFE INSURANCE PLAN BETWEEN DEFENDANT-APPELLANT OF THE INSURANCE CLAIM ARISING FROM THE DEATH OF WILFREDO LEUTERIO."[6]

Synthesized below are the assigned errors for our resolution:

1. Whether the Court of Appeals erred in holding petitioner liable to DBP as beneficiary in a group life insurance contract from a complaint filed by the widow of the decedent/mortgagor?

2. Whether the Court of Appeals erred in not finding that Dr. Leuterio concealed that he had hypertension, which would vitiate the insurance contract?

3. Whether the Court of Appeals erred in holding Grepalife liable in the amount of eighty six thousand, two hundred (P86,200.00) pesos without proof of the actual outstanding mortgage payable by the mortgagor to DBP.

Petitioner alleges that the complaint was instituted by the widow of Dr. Leuterio, not the real party in interest, hence the trial court acquired no jurisdiction over the case. It argues that when the Court of Appeals affirmed the trial court's judgment, Grepalife was held liable to pay the proceeds of insurance contract in favor of DBP, the indispensable party who was not joined in the suit.

To resolve the issue, we must consider the insurable interest in mortgaged properties and the parties to this type of contract. The rationale of a group insurance policy of mortgagors, otherwise known as the "mortgage redemption insurance," is a device for the protection of both the mortgagee and the mortgagor. On the part of the mortgagee, it has to enter into such form of contract so that in the event of the unexpected demise of the mortgagor during the subsistence of the mortgage contract, the proceeds from such insurance will be applied to the payment of the mortgage debt, thereby relieving the heirs of the mortgagor from paying the obligation.[7] In a similar vein, ample protection is given to the mortgagor under such a concept so that in the event of death; the mortgage obligation will be extinguished by the application of the insurance proceeds to the mortgage indebtedness.[8] Consequently, where the mortgagor pays the insurance premium under the group insurance policy, making the loss payable to the mortgagee, the insurance is on the mortgagor's interest, and the mortgagor continues to be a party to the contract. In this type of policy insurance, the mortgagee is simply an appointee of the insurance fund, such loss-payable clause does not make the mortgagee a party to the contract.[9]

Section 8 of the Insurance Code provides:

"Unless the policy provides, where a mortgagor of property effects insurance in his own name providing that the loss shall be payable to the mortgagee, or assigns a policy of insurance to a mortgagee, the insurance is deemed to be upon the interest of the mortgagor, who does not cease to be a party to the original contract, and any act of his, prior to the loss, which would otherwise avoid the insurance, will have the same effect, although the property is in the hands of the mortgagee, but any act which, under the contract of insurance, is to be performed by the mortgagor, may be performed by the mortgagee therein named, with the same effect as if it had been performed by the mortgagor."

The insured private respondent did not cede to the mortgagee all his rights or interests in the insurance, the policy stating that: "In the event of the debtor's death before his indebtedness with the Creditor [DBP] shall have been fully paid, an amount to pay the

outstanding indebtedness shall first be paid to the creditor and the balance of sum assured, if there is any, shall then be paid to the beneficiary/ies designated by the debtor."[10] When DBP submitted the insurance claim against petitioner, the latter denied payment thereof, interposing the defense of concealment committed by the insured. Thereafter, DBP collected the debt from the mortgagor and took the necessary action of foreclosure on the residential lot of private respondent.[11] In *Gonzales La O vs. Yek Tong Lin Fire & Marine Ins. Co.*[12] we held:

"Insured, being the person with whom the contract was made, is primarily the proper person to bring suit thereon. * * * Subject to some exceptions, insured may thus sue, although the policy is taken wholly or in part for the benefit of another person named or unnamed, and although it is expressly made payable to another as his interest may appear or otherwise. * * * Although a policy issued to a mortgagor is taken out for the benefit of the mortgagee and is made payable to him, yet the mortgagor may sue thereon in his own name, especially where the mortgagee's interest is less than the full amount recoverable under the policy, * * *.'

And in volume 33, page 82, of the same work, we read the following:

'Insured may be regarded as the real party in interest, although he has assigned the policy for the purpose of collection, or has assigned as collateral security any judgment he may obtain."[13]

And since a policy of insurance upon life or health may pass by transfer, will or succession to any person, whether he has an insurable interest or not, and such person may recover it whatever the insured might have recovered,[14] the widow of the decedent Dr. Leuterio may file the suit against the insurer, Grepalife.

The second assigned error refers to an alleged concealment that the petitioner interposed as its defense to annul the insurance contract. Petitioner contends that Dr. Leuterio failed to disclose that he had hypertension, which might have caused his death. 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 assured, but he designedly and intentionally withholds the same.[15]

Petitioner merely relied on the testimony of the attending physician, Dr. Hernando Mejia, as supported by the information given by the widow of the decedent. Grepalife asserts that Dr. Mejia's technical diagnosis of the cause of death of Dr. Leuterio was a duly documented hospital record, and that the widow's declaration that her husband had "possible hypertension several years ago" should not be considered as hearsay, but as part of *res gestae.*

On the contrary the medical findings were not conclusive because Dr. Mejia did not conduct an autopsy on the body of the decedent. As the attending physician, Dr. Mejia stated that he had no knowledge of Dr. Leuterio's any previous hospital confinement.[16] Dr. Leuterio's death certificate stated that hypertension was only "the possible cause of death." The private respondent's statement, as to the medical history of her husband, was due to her unreliable recollection of events. Hence, the statement of the physician was properly considered by the trial court as hearsay.

The question of whether there was concealment was aptly answered by the appellate court, thus:

"The insured, Dr. Leuterio, had answered in his insurance application that he was in good health and that he had not consulted a doctor or any of the enumerated ailments, including hypertension; when he died the attending physician had certified in the death certificate that the former died of cerebral hemorrhage, probably secondary to hypertension. From this report, the appellant insurance company refused to pay the insurance claim. Appellant alleged that the insured had concealed the fact that he had hypertension.

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...

x x x

Appellant insurance company had failed to establish that there was concealment made by the insured, hence, it cannot refuse payment of the claim."[17]

The fraudulent intent on the part of the insured must be established to entitle the insurer to rescind the contract.[18] 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.[19] In the case at bar, the petitioner failed to clearly and satisfactorily establish its defense, and is therefore liable to pay the proceeds of the insurance.

And that brings us to the last point in the review of the case at bar. Petitioner claims that there was no evidence as to the amount of Dr. Leuterio's outstanding indebtedness to DBP at the time of the mortgagor's death. Hence, for private respondent's failure to establish the same, the action for specific performance should be dismissed. Petitioner's claim is without merit. A life insurance policy is a valued policy.[20] 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.[21] The mortgagor paid the premium according to the coverage of his insurance, which states that:

"The policy states that upon receipt of due proof of the Debtor's death during the terms of this insurance, a death benefit in the amount of P86,200.00 shall be paid.

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

and the balance of the Sum Assured, if there is any shall then be paid to the beneficiary/ies designated by the debtor."[22] (Emphasis omitted)

However, we noted that the Court of Appeals' decision was promulgated on May 17, 1993. In private respondent's memorandum, she states that DBP foreclosed in 1995 their residential lot, in satisfaction of mortgagor's outstanding loan. Considering this supervening event, the insurance proceeds shall inure to the benefit of the heirs of the deceased person or his beneficiaries. Equity dictates that DBP should not unjustly enrich itself at the expense of another (*Nemo cum alterius detrimenio protest*). Hence, it cannot collect the insurance proceeds, after it already foreclosed on the mortgage. The proceeds now rightly belong to Dr. Leuterio's heirs represented by his widow, herein private respondent Medarda Leuterio.

WHEREFORE, the petition is hereby DENIED. The Decision and Resolution of the Court of Appeals in CA-G.R. CV 18341 is AFFIRMED with MODIFICATION that the petitioner is ORDERED to pay the insurance proceeds amounting to Eighty-six thousand, two hundred (P86,200.00) pesos to the heirs of the insured, Dr. Wilfredo Leuterio (deceased), upon presentation of proof of prior settlement of mortgagor's indebtedness to Development Bank of the Philippines. Costs against petitioner.

SO ORDERED.

Mendoza, Buena, and *De Leon Jr., JJ.,* concur.
Bellosillo, (Chairman), J., on official leave.

Republic of the Philippines
SUPREME COURT
Manila

FIRST DIVISION

G.R. No. L-38613 February 25, 1982

PACIFIC TIMBER EXPORT CORPORATION, petitioner,
vs.
THE HONORABLE COURT OF APPEALS and WORKMEN'S INSURANCE COMPANY, INC., respondents.

DE CASTRO, ** *J.:*

This petition seeks the review of the decision of the Court of Appeals reversing the decision of the Court of First Instance of Manila in favor of petitioner and against private respondent which ordered the latter to pay the sum of Pll,042.04 with interest at the rate of 12% interest from receipt of notice of loss on April 15, 1963 up to the complete payment, the sum of P3,000.00 as attorney's fees and the costs [1] thereby dismissing petitioner s complaint with costs. [2]

The findings of the of fact of the Court of Appeals, which are generally binding upon this Court, Except as shall be indicated in the discussion of the opinion of this Court the substantial correctness of still particular finding having been disputed, thereby raising a question of law reviewable by this Court [3] are as follows:

> March 19, l963, 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 (Exhibit A).
>
> 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 (Exhibits B and C, respectively). Policy No. 53 H0 1033 (Exhibit B) was for 542 pieces of logs equivalent to 499,950 board feet. Policy No. 53 H0 1033 was for 853 pieces of logs equivalent to 695,548 board feet (Exhibit C). 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 (Exhibit A), 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 co 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 (Exhibit F) 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 (Exhibit G).

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 (Exhibit H). 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 Pl1,042.04 (Exhibit 4).

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. 53 110 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'(Exhibit J-1). 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 (Exhibit K). 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 (Exhibit L).

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 (Exhibit M). [4]

Petitioner assigned as errors of the Court of Appeals, the following:

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THE COURT OF APPEALS ERRED IN HOLDING THAT THE COVER NOTE WAS NULL AND VOID FOR LACK OF VALUABLE CONSIDERATION BECAUSE THE COURT DISREGARDED THE PROVEN FACTS THAT PREMIUMS FOR THE COMPREHENSIVE INSURANCE COVERAGE THAT INCLUDED THE COVER NOTE WAS PAID BY PETITIONER AND THAT INCLUDED THE COVER NOTE WAS PAID BY PETITIONER AND THAT NO SEPARATE PREMIUMS ARE COLLECTED BY PRIVATE RESPONDENT ON ALL ITS COVER NOTES.

I

I

THE COURT OF APPEALS ERRED IN HOLDING THAT PRIVATE RESPONDENT WAS RELEASED FROM LIABILITY UNDER THE COVER NOTE DUE TO UNREASONABLE DELAY IN GIVING NOTICE OF LOSS BECAUSE THE COURT DISREGARDED THE PROVEN FACT THAT PRIVATE RESPONDENT DID NOT PROMPTLY AND SPECIFICALLY OBJECT TO THE CLAIM ON THE GROUND OF DELAY IN GIVING NOTICE OF LOSS AND, CONSEQUENTLY, OBJECTIONS ON THAT GROUND ARE WAIVED UNDER SECTION 84 OF THE INSURANCE ACT. [5]

1. 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 (p. 33, tsn, September 24, 1965).

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. [6]

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. [7]

2. 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.

From what has been said, We find duly substantiated petitioner's assignments of error.

ACCORDINGLY, the appealed decision is set aside and the decision of the Court of First Instance is reinstated in toto with the affirmance of this Court. No special pronouncement as to costs.

SO ORDERED.

Teehankee (Chairman), Makasiar, Fernandez Guerrero, Melencio-Herrera and Plana, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-14300 January 19, 1920

SAN MIGUEL BREWERY, ETC., plaintiff-appellee,
vs.
LAW UNION AND ROCK INSURANCE CO., (LTD.) ET AL., defendants-appellees.
HENRY HARDING, defendant-appellant.

Crossfield and O'Brien for appellant Harding.
Lawrence and Ross for appellee Law Union etc. Ins. Co.
Sanz and Luzuriaga for appellee "Filipinas, Compañia de Seguros."
No appearance for the other appellee.

STREET, *J.:*

This action was begun on October 8, 1917, in the Court of First Instance of the city of Manila by the plaintiff, the San Miguel Brewery, for the purpose of recovering upon two policies of insurance underwritten respectively by Law Union and Rock Insurance Company (Ltd.), and the "Filipinas" *Compania de Seguros*, for the sum of P7,500 each, insuring certain property which has been destroyed by fire. The plaintiff, the San Miguel Brewery, is named as the party assured in the two policies referred to, but it is alleged in the complaint that said company was in reality interested in the property which was the subject of insurance in the character of a mortgage creditor only, and that the owner of said property upon the date the policies were issued was one D. P. Dunn who was later succeeded as owner by one Henry Harding. Accordingly said Harding was made a defendant, as a person interested in the subject of the litigation.

The prayer of the complaint is that judgment be entered in favor of the plaintiff against the two companies named for the sum of P15,000, with interest and costs, and further that upon satisfaction of the balance of P4,505.30 due to the plaintiff upon the mortgage debt, and upon the cancellation of the mortgage, the plaintiff be absolved from liability to the defendants or any of them. The peculiar form of the latter part of the prayer is evidently due to the design of the plaintiff to lay a foundation for Harding to recover the difference between the plaintiff's credit and the amount for which the property was insured. Accordingly, as was to be expected, Harding answered, admitting the material allegations of the complaint and claiming for himself the right to recover the difference between the plaintiff's mortgage credit and the face value of the policies. The two insurance companies also answered, admitting in effect their liability to the San Miguel Brewery to the extent of its mortgage credit, but denying liability to Harding on the ground that under the contracts of insurance the liability of the insurance companies was limited to the insurable interest of the plaintiff therein. Soon after the action was begun the insurance companies effected a settlement with the San Miguel Brewery by paying the full amount of the credit claimed by it, with the result that the litigation as between the original plaintiff and the two insurance companies came to an end, leaving the action to be prosecuted to final judgement by the defendant Harding with respect to the balance claimed to be due to him upon the policies.

Upon hearing the evidence the trial judge came to the conclusion that Harding had no right of action whatever against the companies and absolved them from liability without special finding as to costs. From this decision the said Henry Harding has appealed.

The two insurance companies who are named as defendants do not dispute their liability to the San Miguel Brewery, to the extent already stated, and the only question here under discussion is that of the liability of the insurance companies to Harding. It is therefore necessary to take account of such facts only as bear upon this aspect of the case.

In this connection it appears that on January 12, 1916, D. P. Dunn, then the owner of the property to which the insurance relates, mortgaged the same to the San Miguel Brewery to secure a debt of P10,000. In the contract of mortgage Dunn agreed to keep the property insured at his expense to the full amount of its value in companies to be selected by the Brewery Company and authorized the latter in case of loss to receive the proceeds of the insurance and to retain such part as might be necessary to cover the mortgage debt. At the same time, in order more conveniently to accomplish the end in view, Dunn authorized and requested the Brewery Company to effect said insurance itself. Accordingly on the same date Antonio Brias, general manager of the Brewery, made a verbal application to the Law Union and Rock Insurance Company for insurance to the extent of P15,000 upon said property. In reply to a question of the company's agent as to whether the Brewery was the owner of the property, he stated that the company was interested only as a mortgagee. No information was asked as to who was the owner of the property, and no information upon this point was given.

It seems that the insurance company to whom this application was directed did not want to carry more than one-half the risk. It therefore issued its own policy for P7,500 and procured a policy in a like amount to be issued by the "Filipinas" *Compania de Seguros.* Both policies were issued in the name of the San Miguel Brewery as the assured, and contained no reference to any other interest in the property. Both policies contain the usual clause requiring assignments to be approved and noted on the policy. The premiums were paid by the Brewery and charged to Dunn. A year later the policies were renewed, without change, the renewal premiums being paid by the Brewery, supposedly for the account of the owner. In the month of March of the year 1917 Dunn sold the insured property to the defendant Henry Harding, but not assignment of the insurance, or of the insurance policies, was at any time made to him.

We agree with the trial court that no cause of action in Henry Harding against the insurance companies is show. He is not a party to the contracts of insurance and cannot directly maintain an action thereon. (Uy Tam and Uy Yet*vs.* Leonard, 30 Phil. Rep., 471.) His claim is merely of an equitable and subsidiary nature and must be made effective, if at all, through the San Miguel Brewery in whose name the contracts are written. Now the Brewery, as mortgagee of the insured property, undoubtedly had an insurable interest therein; but it could not, in any event, recover upon these policies an amount in excess of its mortgage credit. In this connection it will be remembered that Antonio Brias, upon making application for the insurance, informed the company with which the insurance was placed that the

Brewery was interested only as a mortgagee. It would, therefore, be impossible for the Brewery mortgage on the insured property.

This conclusion is not only deducible from the principles governing the operation and effect of insurance contracts in general but the point is clearly covered by the express provisions of sections 16 and 50 of the Insurance Act (Act No. 2427). In the first of the sections cited, it is declared that "the measure of an insurable interest in property is the extent to which the insured might be damnified by loss or injury thereof" (sec. 16); while in the other it is stated that "the insurance shall be applied exclusively to the proper interest of the person in whose name it is made unless otherwise specified in the policy" (sec. 50).

These provisions would have been fatal to any attempt at recovery even by D. P. Dunn, if the ownership of the property had continued in him up to the time of the loss; and as regards Harding, an additional insuperable obstacle is found in the fact that the ownership of the property had been charged, prior to the loss, without any corresponding change having been effected in the policy of insurance. In section 19 of the Insurance Act we find it stated that "a change of interest in any part of a thing insured unaccompanied by a corresponding change of interest in the insurance, suspends the insurance to an equivalent extent, until the interest in the thing and the interest in the insurance are vested in the same person." Again in section 55 it is declared that "the mere transfer of a thing insured does not transfer the policy, but suspends it until the same person becomes the owner of both the policy and the thing insured."

Undoubtedly these policies of insurance might have been so framed as to have been "payable to the Sane Miguel Brewery, mortgagee, as its interest may appear, remainder to whomsoever, during the continuance of the risk, may become the owner of the interest insured." (Sec 54, Act No. 2427.) Such a clause would have proved an intention to insure the entire interest in the property, not merely the insurable interest of the San Miguel Brewery, and would have shown exactly to whom the money, in case of loss, should be paid. But the policies are not so written.

It is easy to collect from the facts stated in the decision of the trial judge, no less than from the testimony of Brias, the manager of the San Miguel Brewery, that, as the insurance was written up, the obligation of the insurance companies was different from that contemplated by Dunn, at whose request the insurance was written, and Brias. In the contract of mortgage Dunn had agreed, at his own expense, to insure the mortgaged property for its full value and to indorse the policies in such manner as to authorize the Brewery Company to receive the proceeds in case of loss and to retain such part thereof as might be necessary to satisfy the remainder then due upon the mortgage debt. Instead, however, of effecting the insurance himself Dunn authorized and requested the Brewery Company to procure insurance on the property in the amount of P15,000 at Dunn's expense. The Brewery Company undertook to carry this mandate into effect, and it of course became its duty to procure insurance of the character contemplated, that is, to have the policies so written as to protect not only the insurable interest of the Brewery, but also the owner. Brias seems to have supposed that the policies as written had this effect, but in this he was mistaken. It was certainly a hardship on the owner to be required to pay the premiums upon P15,000 of insurance when he was receiving no benefit whatever except in protection to the extent of his indebtedness to the Brewery. The blame for the situation thus created rests, however, with the Brewery rather than with the insurance companies, and there is nothing in the record to indicate that the insurance companies were requested to write insurance upon the insurable interest of the owner or intended to make themselves liable to that extent.

If during the negotiations which resulted in the writing of this insurance, it had been agreed between the contracting parties that the insurance should be so written as to protect not only the interest of the mortgagee but also the residuary interest of the owner, and the policies had been, by inadvertence, ignorance, or mistake written in the form in which they were issued, a court would have the power to reform the contracts and give effect to them in the sense in which the parties intended to be bound. But in order to justify this, it must be made clearly to appear that the minds of the contracting parties did actually meet in agreement and that they labored under some mutual error or mistake in respect to the expression of their purpose. Thus, in *Bailey vs. American Central Insurance Co*. (13 Fed., 250), it appeared that a mortgage desiring to insure his own insurable interest only, correctly stated his interest, and asked that the same be insured. The insurance company agreed to accept the risk, but the policy was issued in the name of the owner, because of the mistaken belief of the company's agent that the law required it to be so drawn. It was held that a court of equity had the power, at the suit of the mortgage, to reform the instrument and give judgment in his favor for the loss thereunder, although it had been exactly as it was. Said the court: "If the applicant correctly states his interest and distinctly asks for an insurance thereon, and the agent of the insurer agrees to comply with his request, and assumes to decide upon the form of the policy to be written for that purpose, and by mistake of law adopts the wrong form, a court of equity will reform the instrument so as to make it insurance upon the interest named." (*See also* Fink *vs.* Queens Insurance Co., 24 Fed., 318; Esch *vs.* Home Insurance Co., 78 Iowa, 334; 16 Am. St. Rep., 443; Woodbury Savings etc., Co., *vs.*Charter Oak Insurance Co., 31 Conn., 517; Balen *vs.* Hanover Fire Insurance Co., 67 Mich., 179.)

Similarly, in cases where the mortgage is by mistake described as owner, the court may grant reformation and permit a recovery by the mortgage in his character as such. (Dalton *vs.* Milwaukee etc. Insurance Co., 126 Iowa, 377; Spare *vs.* Home Mutual Insurance Co., 17 Fed., 568.) In *Thompson vs. Phoenix Insurance Co*. (136 U.S., 287; 34 L. 3d., 408), it appeared that one Kearney made application to an insurance company for insurance on certain property in his hands as receiver and it was understood between him and the company's agent that, in case of loss, the proceeds of the policy should accrue to him and his successors as receiver and to others whom it might concern. However, the policy, as issued, was so worded as to be payable only to him as receiver. In an action brought on the policy by a successor of Kearney, it was alleged that the making of the contract in this form was due to inadvertence, accident, and mistake upon the part of both Kearney and the company.

Said the court:

> If by inadvertence, accident, or mistake the terms of the contract were not fully set forth in the policy, the plaintiff is entitled to have it reformed.

In another case the same court said:

We have before us a contract from which by mistake, material stipulations have been omitted, whereby the true intent and meaning of the parties are not fully or accurately expressed. There was a definite concluded agreement as to insurance, which, in point of time, preceded the preparation and delivery of the policy, and this is demonstrated by legal and exact evidence, which removes all doubt as to the sense and undertaking of the parties. In the agreement there has been a mutual mistake, caused chiefly by that contracting party who now seeks to limit the insurance to an interest in the property less than that agreed to be insured. The written agreement did not effect that which the parties intended. That a court of equity can afford relief in such a case, is, we think, well settled by the authorities. (Smell *vs.* Atlantic, etc., Ins. Co., 98 U.S., 85, 89; 25 L. ed., 52.)

But to justify the reformation of a contract, the proof must be of the most satisfactory character, and it must clearly appear that the contract failed to express the real agreement between the parties. (Philippine Sugar Estates Development Company *vs.* Government of the Philippine Islands, 62 L. ed., 1177, *reversing* Government of Philippine Island *vs.* Philippine Sugar Estates Development Co., 30 Phil. Rep., 27.)

In the case now before us the proof is entirely insufficient to authorize the application of the doctrine state in the foregoing cases, for it is by means clear from the testimony of Brias — and none other was offered — that the parties intended for the policy to cover the risk of the owner in addition to that of the mortgagee. It results that the defendant Harding is not entitled to relief in any aspect of the case.

The judgment is therefore affirmed, with costs against the appellant. So ordered.

Arellano, C.J., Johnson, Araullo, Malcolm and Avanceña, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-20853 May 29, 1967

BONIFACIO BROS., INC., ET AL., plaintiffs-appellants,
vs.
ENRIQUE MORA, ET AL., defendants-appellees.

G. Magsaysay for plaintiffs-appellants.
Abad Santos and Pablo for defendant-appellee H. E. Reyes, Inc.
J. P. Santilla and A. D. Hidalgo, Jr. for other defendant-appellee.

CASTRO, *J.:*

This is an appeal from the decision of the Court of First Instance of Manila, Branch XV, in civil case 48823, affirming the decision of the Municipal Court of Manila, declaring the H.S. Reyes, Inc. as having a better right than the Bonifacio Bros., Inc. and the Ayala Auto Parts Company, appellants herein, to the proceeds of motor insurance policy A-0615, in the sum of P2,002.73, issued by the State Bonding & Insurance Co. Inc., and directing payment of the said amount to the H. Reyes, Inc.

Enrique Mora, owner of Oldsmobile sedan model 1956, bearing plate No. QC- mortgaged the same to the H.S. Reyes, Inc., with the condition that the former would insure the automobile with the latter as beneficiary. The automobile was thereafter insured on June 23, 1959 with the State Bonding & Insurance Co., Inc., and motor car insurance policy A-0615 was issued to Enrique Mora, the pertinent provisions of which read:

> 1. The Company (referring to the State Bonding & Insurance Co., Inc.) will, subject to the Limits of Liability, indemnify the Insured against loss of or damages to the Motor Vehicle and its accessories and spare parts whilst thereon; (a) by accidental collision or overturning or collision or overturning consequent upon mechanical breakdown or consequent upon wear and tear,
>
> x x x x x x x x x
>
> 2. At its own option the Company may pay in cash the amount of the loss or damage or may repair, reinstate, or replace the Motor Vehicle or any part thereof or its accessories or spare parts. The liability of the Company shall not exceed the value of the parts whichever is the less. The Insured's estimate of value stated in the schedule will be the maximum amount payable by the Company in respect of any claim for loss or damage.*1äwphï1.ñët*
>
> x x x x x x x x x
>
> 4. The Insured may authorize the repair of the Motor Vehicle necessitated by damage for which the Company may be liable under this Policy provided that: — (a) The estimated cost of such repair does not exceed the Authorized Repair Limit, (b) A detailed estimate of the cost is forwarded to the Company without delay, subject to the condition that "Loss, if any is payable to H.S. Reyes, Inc.," by virtue of the fact that said Oldsmobile sedan was mortgaged in favor of the said H.S. Reyes, Inc. and that under a clause in said insurance policy, any loss was made payable to the H.S. Reyes, Inc. as Mortgagee;

x x x x x x x x x

During the effectivity of the insurance contract, the car met with an accident. The insurance company then assigned the accident to the Bayne Adjustment Co. for investigation and appraisal of the damage. Enrique Mora, without the knowledge and consent of the H.S. Reyes, Inc., authorized the Bonifacio Bros. Inc. to furnish the labor and materials, some of which were supplied by the Ayala Auto Parts Co. For the cost of labor and materials, Enrique Mora was billed at P2,102.73 through the H.H. Bayne Adjustment Co. The insurance company after claiming a franchise in the amount of P100, drew a check in the amount of P2,002.73, as proceeds of the insurance policy, payable to the order of Enrique Mora or H.S. Reyes,. Inc., and entrusted the check to the H.H. Bayne Adjustment Co. for disposition and delivery to the proper party. In the meantime, the car was delivered to Enrique Mora without the consent of the H.S. Reyes, Inc., and without payment to the Bonifacio Bros. Inc. and the Ayala Auto Parts Co. of the cost of repairs and materials.

Upon the theory that the insurance proceeds should be paid directly to them, the Bonifacio Bros. Inc. and the Ayala Auto Parts Co. filed on May 8, 1961 a complaint with the Municipal Court of Manila against Enrique Mora and the State Bonding & Insurance Co., Inc. for the collection of the sum of P2,002.73 The insurance company filed its answer with a counterclaim for interpleader, requiring the Bonifacio Bros. Inc. and the H.S. Reyes, Inc. to interplead in order to determine who has better right to the insurance proceeds in question. Enrique Mora was declared in default for failure to appear at the hearing, and evidence against him was received *ex parte*. However, the counsel for the Bonifacio Bros. Inc., Ayala Auto Parts Co. and State Bonding & Insurance Co. Inc. submitted a stipulation of facts, on the basis of which are Municipal Court rendered a decision declaring the H.S. Reyes, Inc. as having a better right to the disputed amount and ordering State Bonding & Insurance Co. Inc. to pay to the H. S. Reyes, Inc. the said sum of P2,002.73. From this decision, the appellants elevated the case to the Court of First Instance of Manila which the stipulation of facts was reproduced. On October 19, 1962 the latter court rendered a decision, affirming the decision of the Municipal Court. The Bonifacio Bros. Inc. and the Ayala Auto Parts Co. moved for reconsideration of the decision, but the trial court denied the motion. Hence, this appeal.

The main issue raised is whether there is privity of contract between the Bonifacio Bros. Inc. and the Ayala Auto Parts Co. on the one hand and the insurance company on the other. The appellants argue that the insurance company and Enrique Mora are parties to the repair of the car as well as the towage thereof performed. The authority for this assertion is to be found, it is alleged, in paragraph 4 of the insurance contract which provides that "the insured may authorize the repair of the Motor Vehicle necessitated by damage for which the company may be liable under the policy provided that (a) the estimated cost of such repair does not exceed the Authorized Repair Limit, and (b) a detailed estimate of the cost is forwarded to the company without delay." It is stressed that the H.H. Bayne Adjustment Company's recommendation of payment of the appellants' bill for materials and repairs for which the latter drew a check for P2,002.73 indicates that Mora and the H.H. Bayne Adjustment Co. acted for and in representation of the insurance company.

This argument is, in our view, beside the point, because from the undisputed facts and from the pleadings it will be seen that the appellants' alleged cause of action rests exclusively upon the terms of the insurance contract. The appellants seek to recover the insurance proceeds, and for this purpose, they rely upon paragraph 4 of the insurance contract document executed by and between the State Bonding & Insurance Company, Inc. and Enrique Mora. The appellants are not mentioned in the contract as parties thereto nor is there any clause or provision thereof from which we can infer that there is an obligation on the part of the insurance company to pay the cost of repairs directly to them. It is fundamental that contracts take effect only between the parties thereto, except in some specific instances provided by law where the contract contains some stipulation in favor of a third person.[1]Such stipulation is known as stipulation *pour autrui* or a provision in favor of a third person not a pay to the contract. Under this doctrine, a third person is allowed to avail himself of a benefit granted to him by the terms of the contract, provided that the contracting parties have clearly and deliberately conferred a favor upon such person.[2] Consequently, a third person not a party to the contract has no action against the parties thereto, and cannot generally demand the enforcement of the same.[3] The question of whether a third person has an enforcible interest in a contract, must be settled by determining whether the contracting parties intended to tender him such an interest by deliberately inserting terms in their agreement with the avowed purpose of conferring a favor upon such third person. In this connection, this Court has laid down the rule that the fairest test to determine whether the interest of a third person in a contract is a stipulation *pour autrui* or merely an incidental interest, is to rely upon the intention of the parties as disclosed by their contract.[4] In the instant case the insurance contract does not contain any words or clauses to disclose an intent to give any benefit to any repairmen or materialmen in case of repair of the car in question. The parties to the insurance contract omitted such stipulation, which is a circumstance that supports the said conclusion. On the other hand, the "loss payable" clause of the insurance policy stipulates that "Loss, if any, is payable to H.S. Reyes, Inc." indicating that it was only the H.S. Reyes, Inc. which they intended to benefit.

We likewise observe from the brief of the State Bonding & Insurance Company that it has vehemently opposed the assertion or pretension of the appellants that they are privy to the contract. If it were the intention of the insurance company to make itself liable to the repair shop or materialmen, it could have easily inserted in the contract a stipulation to that effect. To hold now that the original parties to the insurance contract intended to confer upon the appellants the benefit claimed by them would require us to ignore the indespensable requisite that a stipulation*pour autrui* must be clearly expressed by the parties, which we cannot do.

As regards paragraph 4 of the insurance contract, a perusal thereof would show that instead of establishing *privity between* the appellants and the insurance company, such stipulation merely establishes the procedure that the insured has to follow in order to be entitled to indemnity for repair. This paragraph therefore should not be construed as bringing into existence in favor of the appellants a right of action against the insurance company as such intention can never be inferred therefrom.

Another cogent reason for not recognizing a right of action by the appellants against the insurance company is that "a policy of insurance is a distinct and independent contract between the insured and insurer, and third persons have no right either in a court of equity, or in a court of law, to the proceeds of it, unless there be some contract of trust, expressed or implied between the insured and third person."[5] In this case, no contract of trust, expressed or implied exists. We, therefore, agree with the trial court that no cause of action exists in favor of the appellants in so far as the proceeds of insurance are concerned. The appellants' claim, if at all, is merely equitable in nature and must be made effective through Enrique Mora who entered into a contract with the Bonifacio Bros. Inc. This conclusion is deducible not only from the principle governing the operation and effect of insurance contracts in general, but is clearly covered by the express provisions of section 50 of the Insurance Act which read:

> The insurance shall be applied exclusively to the proper interests of the person in whose name it is made unless otherwise specified in the policy.

The policy in question has been so framed that "Loss, if any, is payable to H.S. Reyes, Inc.," which unmistakably shows the intention of the parties.

The final contention of the appellants is that the right of the H.S. Reyes, Inc. to the insurance proceeds arises only if there was loss and not where there is mere damage as in the instant case. Suffice it to say that any attempt to draw a distinction between "loss" and "damage" is uncalled for, because the word "loss" in insurance law embraces injury or damage.

> *Loss in insurance, defined*. — The injury or damage sustained by the insured in consequence of the happening of one or more of the accidents or misfortune against which the insurer, in consideration of the premium, has undertaken to indemnify the insured. (1 Bouv. Ins. No. 1215; Black's Law Dictionary; Cyclopedic Law Dictionary, cited in Martin's Phil. Commercial Laws, Vol. 1, 1961 ed. p. 608).

Indeed, according to sec. 120 of the Insurance Act, a loss may be either total or partial.

Accordingly, the judgment appealed from is hereby affirmed, at appellants' cost.

Concepcion, C.J., Reyes, J.B.L., Dizon, Regala, Makalintal, Bengzon, J.P., Zaldivar, Sanchez and Castro, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-23276 November 29, 1968

MELECIO COQUIA, MARIA ESPANUEVA and MANILA YELLOW TAXICAB CO., INC., plaintiffs-appellees,
vs.
FIELDMEN'S INSURANCE CO., INC., defendant-appellant.

Antonio de Venecia for plaintiffs-appellees.
Rufino Javier for defendant-appellant.

CONCEPCION, *C.J.:*

This is an appeal from a decision of the Court of First Instance of Manila, certified to us by the Court of Appeals, only questions of law being involved therein. Indeed, the pertinent facts have been stipulated and/or, admitted by the parties at the hearing of the case in the trial court, to dispense with the presentation of evidence therein.

It appears that on December 1, 1961, appellant Fieldmen's Insurance Company, Inc. — hereinafter referred to as the Company — issued, in favor of the Manila Yellow Taxicab Co., Inc. — hereinafter referred to as the Insured — a common carrier accident insurance policy, covering the period from December 1, 1961 to December 1, 1962. It was stipulated in said policy that:

> The Company will, subject to the Limits of Liability and under the Terms of this Policy, indemnify the Insured in the event of accident caused by or arising out of the use of Motor Vehicle against all sums which the Insured will become legally liable to pay in respect of: Death or bodily injury to any fare-paying passenger*including the Driver*, Conductor and/or Inspector who is riding in the Motor Vehicle insured at the time of accident or injury. [1]

While the policy was in force, or on February 10, 1962, a taxicab of the Insured, driven by Carlito Coquia, met a vehicular accident at Mangaldan, Pangasinan, in consequence of which Carlito died. The Insured filed therefor a claim for P5,000.00 to which the Company replied with an offer to pay P2,000.00, by way of compromise. The Insured rejected the same and made a counter-offer for P4,000.00, but the Company did not accept it. Hence, on September 18, 1962, the Insured and Carlito's parents, namely, Melecio Coquia and Maria Espanueva — hereinafter referred to as the Coquias — filed a complaint against the Company to collect the proceeds of the aforementioned policy. In its answer, the Company admitted the existence thereof, but pleaded lack of cause of action on the part of the plaintiffs.

After appropriate proceedings, the trial court rendered a decision sentencing the Company to pay to the plaintiffs the sum of P4,000.00 and the costs. Hence, this appeal by the Company, which contends that plaintiffs have no cause of action because: 1) the Coquias

have no contractual relation with the Company; and 2) the Insured has not complied with the provisions of the policy concerning arbitration.

As regards the first defense, it should be noted that, 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.[2]

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. Does the policy in question belong to such class of contracts *pour autrui*?

In this connection, said policy provides, *inter alia*:

> *Section I — Liability to Passengers*. 1. The Company will, subject to the Limits of Liability and under the Terms of this Policy, indemnify the Insured in the event of accident caused by or arising out of the use of Motor Vehicle against all sums which the Insured will become legally liable to pay in respect of: Death or bodily injury to any fare-paying passenger including the Driver ... who is riding in the Motor Vehicle insured at the time of accident or injury.
>
> *Section II — Liability to the Public*
>
> xxx xxx xxx
>
> 3. In terms of and subject to the limitations of and for the purposes of this Section, the Company will indemnify any authorized Driver who is driving the Motor Vehicle....
>
> *Conditions*
>
> xxx xxx xxx
>
> 7. In the event of death of any person entitled to indemnity under this Policy, the Company will, in respect of the liability incurred by such person, indemnify his personal representatives in terms of and subject to the limitations of this Policy, provided, that such representatives shall, as though they were the Insured, observe, fulfill and be subject to the Terms of this Policy insofar as they can apply.
>
> 8. The Company may, at its option, make indemnity payable directly to the claimants or heirs of claimants, with or without securing the consent of or prior notification to the Insured, it being the true intention of this Policy to protect, to the extent herein specified and subject always to the Terms Of this Policy, the liabilities of the Insured towards the passengers of the Motor Vehicle and the Public.

Pursuant to these stipulations, the Company "will indemnify *any authorized Driver* who is driving the Motor Vehicle" of the Insured and, in the event of death of said driver, the Company shall, likewise, "indemnify his personal representatives." In fact, the Company "may, at its option, make indemnity payable *directly* to the *claimants or heirs of claimants ... it being the true intention of this Policy to protect ... the liabilities of the Insured* towards the passengers of the Motor Vehicle and the Public" — in other words, third parties.

Thus, 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,[3] 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.[4]

The second defense set up by the Company is based upon Section 17 of the policy reading:

> If any difference or dispute shall arise with respect to the amount of the Company's liability under this Policy, the same shall be referred to the decision of a single arbitrator to be agreed upon by both parties or failing such agreement of a single arbitrator, to the decision of two arbitrators, one to be appointed in writing by each of the parties within one calendar month after having been required in writing so to do by either of the parties and in case of disagreement between the arbitrators, to the decision of an umpire who shall have been appointed in writing by the arbitrators before entering on the reference and the costs of and incident to the reference shall be dealt with in the Award. And it is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator, arbitrators or umpire of the amount of the Company's liability hereunder if disputed shall be first obtained.

The record shows, however, that none of the parties to the contract invoked this section, or made any reference to arbitration, during the negotiations preceding the institution of the present case. In fact, counsel for both parties stipulated, in the trial court, that none of them had, at any time during said negotiations, even suggested the settlement of the issue

between them by arbitration, as provided in said section. Their aforementioned acts or omissions had the effect of a waiver of their respective right to demand an arbitration. Thus, in Kahnweiler vs. Phenix Ins. Co. of Brooklyn,[5] it was held:

> Another well-settled rule for interpretation of all contracts is that the court will lean to that interpretation of a contract which will make it reasonable and just. Bish. Cont. Sec. 400. Applying these rules to the tenth clause of this policy, its proper interpretation seems quite clear. When there is a difference between the company and the insured as to the amount of the loss the policy declares: "The same shall then be submitted to competent and impartial arbitrators, one to be selected by each party ...". It will be observed that the obligation to procure or demand an arbitration is not, by this clause, in terms imposed on either party. It is not said that either the company or the insured shall take the initiative in setting the arbitration on foot. The company has no more right to say the insured must do it than the insured has to say the company must do it. The contract in this respect is neither unilateral nor self-executing. To procure a reference to arbitrators, the joint and concurrent action of both parties to the contract is indispensable. The right it gives and the obligation it creates to refer the differences between the parties to arbitrators are mutual. One party to the contract cannot bring about an arbitration. Each party is entitled to demand a reference, but neither can compel it, and neither has the right to insist that the other shall first demand it, and shall forfeit any right by not doing so. If the company demands it, and the insured refuses to arbitrate, his right of action is suspended until he consents to an arbitration; and if the insured demands an arbitration, and the company refuses to accede to the demand, the insured may maintain a suit on the policy, notwithstanding the language of the twelfth section of the policy, *and, where neither party demands an arbitration, both parties thereby waive it*.[6]

To the same effect was the decision of the Supreme Court of Minnesota in Independent School Dist. No. 35, St. Louis County vs. A. Hedenberg & Co., Inc.[7] from which we quote:

> This rule is not new in our state. In Meyer v. Berlandi, 53 Minn. 59, 54 N.W. 937, decided in 1893, this court held that the parties to a construction contract, having proceeded throughout the entire course of their dealings with each other in entire disregard of the provision of the contract regarding the mode of determining by arbitration the value of the extras, thereby waived such provision.
>
> xxx xxx xxx
>
> The test for determining whether there has been a waiver in a particular case is stated by the author of an exhaustive annotation in 117 A.L.R. p. 304, as follows: "Any conduct of the parties inconsistent with the notion that they treated the arbitration provision as in effect, or any conduct which might be reasonably construed as showing that they did not intend to avail themselves of such provision, may amount to a waiver thereof and estop the party charged with such conduct from claiming its benefits".
>
> xxx xxx xxx
>
> The decisive facts here are that both parties from the inception of their dispute proceeded in entire disregard of the provisions of the contract relating to arbitration and that neither at any stage of such dispute, either before or after commencement of the action, demanded arbitration, either by oral or written demand, pleading, or otherwise. Their conduct was as effective a rejection of the right to arbitrate as if, in the best Coolidge tradition, they had said, "We do not choose to arbitrate". As arbitration under the express provisions of article 40 was "at the choice of either party," and was chosen by neither, a waiver by both of the right to arbitration followed as a matter of law.

WHEREFORE, the decision appealed from should be as it is hereby affirmed *in toto*, with costs against the herein defendant-appellant, Fieldmen's Insurance Co., Inc. It is so ordered.

Reyes, J.B.L., Dizon, Makalintal, Zaldivar, Sanchez, Castro, Fernando and Capistrano, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-22042 August 17, 1967

DIONISIA, EULOGIO, MARINA, GUILLERMO and NORBERTO all surnamed GUINGON, plaintiffs-appellees,
vs.
ILUMINADO DEL MONTE, JULIO AGUILAR and CAPITAL INSURANCE and SURETY CO., INC., defendants.
CAPITAL INSURANCE and SURETY CO., INC., defendant-appellant.

Generoso Almario and Associates for plaintiffs-appellees.
Achacoso and Associates for defendant-appellant.

BENGZON, J.P., *J.:*

Julio Aguilar owned and operated several jeepneys in the City of Manila among which was one with plate number PUJ-206-Manila, 1961. He entered into a contract with the Capital

Insurance & Surety Co., Inc. insuring the operation of his jeepneys against accidents with third-party liability. As a consequence thereof an insurance policy was executed by the Capital Insurance & Surety Co., Inc., the pertinent provisions of which in so far as this case is concerned contains the following:

Section II —LIABILITY TO THE PUBLIC

> 1. The Company, will, subject to the limits of liability, indemnify the Insured in the event of accident caused by or arising out of the use of the Motor Vehicle/s or in connection with the loading or unloading of the Motor Vehicle/s, against all sums including claimant's costs and expenses which the Insured shall become legally liable to pay in respect of:
>
> a. death of or bodily injury to any person
>
> b. damage to property

During the effectivity of such insurance policy on February 20, 1961 Iluminado del Monte, one of the drivers of the jeepneys operated by Aguilar, while driving along the intersection of Juan Luna and Moro streets, City of Manila, bumped with the jeepney abovementioned one Gervacio Guingon who had just alighted from another jeepney and as a consequence the latter died some days thereafter.

A corresponding information for homicide thru reckless imprudence was filed against Iluminado del Monte, who pleaded guilty. A penalty of four months imprisonment was imposed on him.

As a corollary to such action, the heirs of Gervacio Guingon filed an action for damages praying that the sum of P82,771.80 be paid to them jointly and severally by the defendants, driver Iluminado del Monte, owner and operator Julio Aguilar, and the Capital Insurance & Surety Co., Inc. For failure to answer the complaint, Del Monte and Aguilar were declared in default. Capital Insurance & Surety Co., Inc. answered, alleging that the plaintiff has no cause of action against it. During the trial the following facts were stipulated:

> COURT: The Court wants to find if there is a stipulation in the policy whereby the insured is insured against liability to third persons who are not passengers of jeeps.
>
> ALMARIO: As far as I know, in my honest belief, there is no particularization as to the passengers, whether the passengers of the jeep insured or a passenger of another jeep or whether it is a pedestrian. With those, we can submit the stipulation.
>
> SIMBULAN: I admit that. (T.s.n., p. 21, Jan. 23, 1962; p. 65 Rec. on Appeal)

On August 27, 1962, the Court of First Instance of Manila rendered its judgment with the following dispositive portion:

> WHEREFORE, judgment is rendered sentencing Iluminado del Monte and Julio Aguilar jointly and severally to pay plaintiffs the sum of P8,572.95 as damages for the death of their father, plus P1,000.00 for attorney's fees plus costs.
>
> The defendant Capital Insurance and Surety Co., Inc. is hereby sentenced to pay the plaintiffs the sum of Five Thousand (P5,000.00) Pesos plus Five Hundred (P500.00) Pesos as attorney's fees and costs. These sums of P5,000.00 and P500.00 adjudged against Capital Insurance and Surety Co., Inc. shall be applied in partial satisfaction of the judgment rendered against Iluminado del Monte and Julio Aguilar in this case.
>
> SO ORDERED.

The case was appealed to the Court of Appeals which appellate court on September 30, 1963 certified the case to Us because the appeal raises purely questions of law.

The issues raised before Us in this appeal are (1) As the company agreed to indemnify the insured Julio Aguilar, is it only the insured to whom it is liable? (2) Must Julio Aguilar first show himself to be entitled to indemnity before the insurance company may be held liable for the same? (3) Plaintiffs not being parties to the insurance contract, do they have a cause of action against the company; and (4) Does the fact that the insured is liable to the plaintiffs necessarily mean that the insurer is liable to the insured?

In the discussion of the points thus raised, what is paramount is the interpretation of the insurance contract with the aim in view of attaining the objectives for which the insurance was taken. The Rules of Court provide that parties may be joined either as plaintiffs or defendants, as the right to relief in respect to or arising out of the same transactions is alleged to exist (Sec. 6, Rule 3). The policy, on the other hand, contains a clause stating:

> E. *Action Against Company*
>
> No action shall lie against the Company unless, as a condition precedent thereto, the Insured shall have fully complied with all of the terms of this Policy, nor until the amount of the Insured's obligation to pay shall have been finally determined either by judgment against the Insured after actual trial or by written agreement of the Insured, the claimant, and the Company.
>
> Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by the Policy. Nothing contained in this policy shall give any person or organization any right to join the Company as

> a co-defendant in any action against the Insured to determine the Insured's liability.
>
> Bankruptcy or insolvency of the Insured or of the Insured's estate shall not relieve the Company of any of its obligations hereunder.

Appellant contends that the "no action" clause in the policy closes the avenue to any third party which may be injured in an accident wherein the jeepney of the insured might have been the cause of the injury of third persons, alleging the freedom of contracts. Will the mere fact that such clause was agreed upon by the parties in an insurance policy prevail over the Rules of Court which authorizes the joining of parties plaintiffs or defendants?

The foregoing issues raise two principal: questions: (1) Can plaintiffs sue the insurer at all? (2) If so, can plaintiffs sue the insurer *jointly* with the insured?

The policy in the present case, as aforequoted, is one whereby the insurer agreed to indemnify the insured "against all sums . . . which the Insured shall become legally *liable* to pay in respect of: a. death of or bodily injury to any person . . . ." Clearly, therefore, it is one for indemnity against liability;[1] from the fact then that the insured is liable to the third person, such third person is entitled to sue the insurer.*1äwphï1.ñët*

The right of the person injured to sue the insurer of the party at fault (insured), depends on whether the contract of insurance is intended to benefit third persons also or only the insured. And the test applied has been this: Where the contract provides for indemnity against *liability* to third persons, then third persons to whom the insured is liable, can sue the insurer. Where the contract is for indemnity against actual loss or payment, then third persons cannot proceed against the insurer, the contract being solely to reimburse the insured for liability actually discharged by him thru payment to third persons, said third persons' recourse being thus limited to the insured alone.[2]

The next question is on the right of the third person to sue the insurer jointly with the insured. The policy requires, as afore-stated, that suit and final judgment be first obtained against the insured; that only "thereafter" can the person injured recover on the policy; it expressly disallows suing the insurer as a co-defendant of the insured in a suit to determine the latter's liability. As adverted to before, the query is which procedure to follow — that of the insurance policy or the Rules of Court.

The "no action" clause in the policy of insurance cannot prevail over the Rules of Court provision aimed at avoiding multiplicity of suits. In a case squarely on the point, *American Automobile Ins. Co. vs. Struwe*, 218 SW 534 (Texas CCA), it was held that a "no action" clause in a policy of insurance cannot override procedural rules aimed at avoidance of multiplicity of suits. We quote:

> Appellants filed a plea in abatement on the grounds that the suit had been prematurely brought against the insurance company, and that it had been improperly joined with Zunker, as said insurance company, under the terms of the policy, was only liable after judgment had been awarded against Zunker. . . .
>
> * * * That plea was properly overruled, because under the laws of Texas a dual suit will always be avoided whenever all parties can have a fair trial when joined in one suit. Appellee, had he so desired, could have prosecuted his claim to judgment as against Zunker and then have sued on that judgment against the insurance company, but the law does not make it imperative that he should do so, but would permit him to dispose of the whole matter in one suit.
>
> The rule has often been announced in Texas that when two causes of action are connected with each other, or grow out of the same transaction, they may be properly joined, and in such suit all parties against whom the plaintiff asserts a common or an alternative liability may be joined as defendants. . . . Even if appellants had presented any plea in abatement as to joinder of damages arising from a tort with those arising from a contract, it could not, under the facts of this case, be sustained, for the rule is that a suit may include an action for breach of contract and one for tort, provided they are connected with each other or grew out of the same transaction.

Similarly, in the instant suit, Sec. 5 of Rule 2 on "Joinder of causes of action" and Sec. 6 of Rule 3 on "Permissive joinder of parties" cannot be superseded, *at least with respect to third persons not a party to the contract*, as herein, by a "no action" clause in the contract of insurance.

Wherefore, the judgment appealed from is affirmed *in toto*. Costs against appellant. So ordered.

Reyes, J.B.L., Makalintal, Zaldivar, Sanchez, Castro, Angeles and Fernando, JJ., concur. Concepcion, C.J. and Dizon, J., are on leave.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-9374 February 16, 1915

FRANCISCO DEL VAL, ET AL., plaintiffs-appellants,
vs.
ANDRES DEL VAL, defendant-appellee.

Ledesma, Lim and Irureta Goyena for appellants.
O'Brien and DeWitt for appellee.

MORELAND, *J.*:

This is an appeal from a judgment of the Court of First Instance of the city of Manila dismissing the complaint with costs.

The pleadings set forth that the plaintiffs and defendant are brother and sisters; that they are the only heirs at law and next of kin of Gregorio Nacianceno del Val, who died in Manila on August 4, 1910, intestate; that an administrator was appointed for the estate of the deceased, and, after a partial administration, it was closed and the administrator discharged by order of the Court of First Instance dated December 9, 1911; that during the lifetime of the deceased he took out insurance on his life for the sum of P40,000 and made it payable to the defendant as sole beneficiary; that after his death the defendant collected the face of the policy; that of said policy he paid the sum of P18,365.20 to redeem certain real estate which the decedent had sold to third persons with a right to repurchase; that the redemption of said premises was made by the attorney of the defendant in the name of the plaintiff and the defendant as heirs of the deceased vendor; that the redemption of said premises they have had the use and benefit thereof; that during that time the plaintiffs paid no taxes and made no repairs.

It further appears from the pleadings that the defendant, on the death of the deceased, took possession of most of his personal property, which he still has in his possession, and that he has also the balance on said insurance policy amounting to P21,634.80.

Plaintiffs contend that the amount of the insurance policy belonged to the estate of the deceased and not to the defendant personally; that, therefore, they are entitled to a partition not only of the real and personal property, but also of the P40,000 life insurance. The complaint prays a partition of all the property, both real and personal, left by the deceased; that the defendant account for P21,634.80, and that that sum be divided equally among the plaintiffs and defendant along with the other property of deceased.

The defendant denies the material allegations of the complaint and sets up as special defense and counterclaim that the redemption of the real estate sold by his father was made in the name of the plaintiffs and himself instead of in his name alone without his knowledge or consent; and that it was not his intention to use the proceeds of the insurance policy for the benefit of any person but himself, he alleging that he was and is the sole owner thereof and that it is his individual property. He, therefore, asks that he be declared the owner of the real estate redeemed by the payment of the P18,365.20, the owner of the remaining P21,634.80, the balance of the insurance policy, and that the plaintiff's account for the use and occupation of the premises so redeemed since the date of the redemption.

The learned trial court refused to give relief to either party and dismissed the action. It says in its opinion: "This purports to be an action for partition, brought against an heir by his coheirs. The complaint, however, fails to comply with Code Civ., Pro. sec. 183, in that it does not 'contain an adequate description of the real property of which partition is demanded.' Because of this defect (which has not been called to our attention and was discovered only after the cause was submitted) it is more than doubtful whether any relief can be awarded under the complaint, except by agreement of all the parties."

This alleged defect of the complaint was made one of the two bases for the dismissal of the action.

We do not regard this as sufficient reason for dismissing the action. It is the doctrine of this court, set down in several decisions, Lizarraga Hermanos vs. Yap Tico, 24 Phil. Rep., 504, that, even though the complaint is defective to the extent of failing in allegations necessary to constitute a cause of action, if, on the trial of the cause, evidence is offered which establishes the cause of action which the complaint intended to allege, and such evidence is received without objection, the defect is thereby cured and cannot be made the ground of a subsequent objection. If, therefore, evidence was introduced on the trial in this case definitely and clearly describing the real estate sought to be partitioned, the defect in the complaint was cured in that regard and should not have been used to dismiss the action. We do not stop to inquire whether such evidence was or was not introduced on the trial, inasmuch as this case must be turned for a new trial with opportunity to both parties to present such evidence as is necessary to establish their respective claims.

The court in its decision further says: "It will be noticed that the provision above quoted refers exclusively to real estate. . . . It is, in other words, an exclusive real property action, and the institution thereof gives the court no jurisdiction over chattels. . . . But no relief could possibly be granted in this action as to any property except the last (real estate), for the law contemplated that all the personal property of an estate be distributed before the administration is closed. Indeed, it is only in exceptional cases that the partition of the real estate is provided for, and this too is evidently intended to be effected as a part of the administration, but here the complaint alleges that the estate was finally closed on December 9, 1911, and we find upon referring to the record in that case that subsequent motion to reopen the same were denied; so that the matter of the personal property at least must be considered *res judicata* (for the final judgment in the administration proceedings must be treated as concluding not merely what was adjudicated, but what might have been). So far, therefore, as the personal property at least is concerned, plaintiffs' only remedy was an appeal from said order."

We do not believe that the law is correctly laid down in this quotation. The courts of the Islands have jurisdiction to divide personal property between the common owners thereof and that power is as full and complete as is the power to partition real property. If an actual partition of personal property cannot be made it will be sold under the direction of the court and the proceeds divided among the owners after the necessary expenses have been deducted.

The administration of the estate of the decedent consisted simply, so far as the record shows, in the payment of the debts. No division of the property, either real or personal, seems to have been made. On the contrary, the property appears, from the record, to have been turned over to the heirs in bulk. The failure to partition the real property may have been due either to the lack of request to the court by one or more of the heirs to do so, as the court has no authority to make a partition of the real estate without such request; or it may have been due to the fact that all the real property of decedent had been sold under *pacto de retro* and that, therefore, he was not the owner of any real estate at the time of his death. As to the personal property, it does not appear that it was disposed of in the manner provided by law. (Sec. 753, Code of Civil Procedure.) So far as this action is concerned, however, it is sufficient for us to know that none of the property was actually divided among the heirs in the administration proceeding and that they remain coowners and tenants-in- common thereof at the present time. To maintain an action to partition real or personal property it is necessary to show only that it is owned in common.

The order finally closing the administration and discharging the administrator, referred to in the opinion of the trial court, has nothing to do with the division of either the real or the personal property. The heirs have the right to ask the probate court to turn over to them both the real and personal property without division; and where that request is unanimous it is the duty of the court to comply with it, and there is nothing in section 753 of the Code of Civil Procedure which prohibits it. In such case an order finally settling the estate and discharging the administrator would not bar a subsequent action to require a division of either the real or personal property. If, on the other hand, an order had been made in the administration proceedings dividing the personal or the real property, or both, among the heirs, then it is quite possible that, to a subsequent action brought by one of the heirs for a partition of the real or personal property, or both, there could have been interposed a plea of *res judicata* based on such order. As the matter now stands, however, there is no ground on which to base such a plea. Moreover, no such plea has been made and no evidence offered to support it.

With the finding of the trial court that the proceeds of the life-insurance policy belong exclusively to the defendant as his individual and separate property, we agree. That the proceeds of an insurance policy belong exclusively to the beneficiary and not to the estate of the person whose life was insured, and that such proceeds are the separate and individual property of the beneficiary, and not of the heirs of the person whose life was insured, is the doctrine in America. We believe that the same doctrine obtains in these Islands by virtue of section 428 of the Code of Commerce, which reads:

> The amount which the underwriter must deliver to the person insured, in fulfillment of the contract, shall be the property of the latter, even against the claims of the legitimate heirs or creditors of any kind whatsoever of the person who effected the insurance in favor of the former.

It is claimed by the attorney for the plaintiffs that the section just quoted is subordinate to the provisions of the Civil Code as found in article 1035. This article reads:

> An heir by force of law surviving with others of the same character to a succession must bring into the hereditary estate the property or securities he may have received from the deceased during the life of the same, by way of dowry, gift, or for any good consideration, in order to compute it in fixing the legal portions and in the account of the division.

Counsel also claim that the proceeds of the insurance policy were a donation or gift made by the father during his lifetime to the defendant and that, as such, its ultimate destination is determined by those provisions of the Civil Code which relate to donations, especially article 819. This article provides that "gifts made to children which are not betterments shall be considered as part of their legal portion."

We cannot agree with these contentions. The contract of life insurance is a special contract and the destination of the proceeds thereof is determined by special laws which deal exclusively with that subject. The Civil Code has no provisions which relate directly and specifically to life- insurance contracts or to the destination of life insurance proceeds. That subject is regulated exclusively by the Code of Commerce which provides for the terms of the contract, the relations of the parties and the destination of the proceeds of the policy.

The proceeds of the life-insurance policy being the exclusive property of the defendant and he having used a portion thereof in the repurchase of the real estate sold by the decedent prior to his death with right to repurchase, and such repurchase having been made and the conveyance taken in the names of all of the heirs instead of the defendant alone, plaintiffs claim that the property belongs to the heirs in common and not to the defendant alone.

We are not inclined to agree with this contention unless the fact appear or be shown that the defendant acted as he did with the intention that the other heirs should enjoy with him the ownership of the estate — in other words, that he proposed, in effect, to make a gift of the real estate to the other heirs. If it is established by the evidence that that was his intention and that the real estate was delivered to the plaintiffs with that understanding, then it is probable that their contention is correct and that they are entitled to share equally with the defendant therein. If, however, it appears from the evidence in the case that the conveyances were taken in the name of the plaintiffs without his knowledge or consent, or that it was not his intention to make a gift to them of the real estate, then it belongs to him. If that facts are as stated, he has two remedies. The one is to compel the plaintiffs to reconvey to him and the other is to let the title stand with them and to recover from them the sum he paid on their behalf.

For the complete and proper determination of the questions at issue in this case, we are of the opinion that the cause should be returned to the trial court with instructions to permit the parties to frame such issues as will permit the settlement of all the questions involved and to introduce such evidence as may be necessary for the full determination of the issues framed. Upon such issues and evidence taken thereunder the court will decide the questions involved according to the evidence, subordinating his conclusions of law to the rules laid down in this opinion.

We do not wish to be understood as having decided in this opinion any question of fact which will arise on the trial and be there in controversy. The trial court is left free to find the facts as the evidence requires. To the facts as so found he will apply the law as herein laid down.

The judgment appealed from is set aside and the cause returned to the Court of First Instance whence it came for the purpose hereinabove stated. So ordered.

Arellano, C.J., and Carson, J., concur.
Torres, J., concurs in the result.

Separate Opinions

ARAULLO, *J.,* concurring:

I concur in the result and with the reasoning of the foregoing decision, only in so far as concerns the return of the record to the lower court in order that it fully and correctly decide all the issues raised therein, allow the parties to raise such questions as may help to decide all those involved in the case, and to present such evidence as they may deem requisite for a complete resolution of all the issues in discussion, because it is my opinion that it is inopportune to make, and there should not be made in the said majority decision the findings therein set forth in connection with articles 428 of the Code of Commerce and 1035 of the Civil Code, in order to arrive at the conclusion that the amount of the insurance policy referred to belongs exclusively to the defendant, inasmuch a this is one of the questions which, according to the decision itself, should be decided by the lower court after an examination of the evidence introduced by the parties; it is the lower court that should make those findings, which ought afterwards to be submitted to this court, if any appeal be taken from the judgment rendered in the case by the trial court in compliance with the foregoing decision.

Republic of the Philippines
SUPREME COURT
Manila

FIRST DIVISION

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

THE INSULAR LIFE ASSURANCE COMPANY, LTD., plaintiff-appellee,
vs.
CARPONIA T. EBRADO and PASCUALA VDA. DE EBRADO, defendants-appellants.

MARTIN, *J.*:

This is a novel question in insurance law: Can a common-law wife named as beneficiary in the life insurance policy of a legally married man claim the proceeds thereof in case of death of the latter?

On September 1, 1968, Buenaventura Cristor Ebrado was issued by The Life Assurance Co., Ltd., Policy No. 009929 on a whole-life for P5,882.00 with a, rider for Accidental Death for the same amount Buenaventura C. Ebrado designated T. Ebrado as the revocable beneficiary in his policy. He to her as his wife.

On October 21, 1969, Buenaventura C. Ebrado died as a result of an t when he was hit by a failing branch of a tree. As the policy was in force, The Insular Life Assurance Co., Ltd. liable to pay the coverage in the total amount of P11,745.73, representing the face value of the policy in the amount of P5,882.00 plus the additional benefits for accidental death also in the amount of P5,882.00 and the refund of P18.00 paid for the premium due November, 1969, minus the unpaid premiums and interest thereon due for January and February, 1969, in the sum of P36.27.

Carponia T. Ebrado filed with the insurer a claim for the proceeds of the Policy as the designated beneficiary therein, although she admits that she and the insured Buenaventura C. Ebrado were merely living as husband and wife without the benefit of marriage.

Pascuala Vda. de Ebrado also filed her claim as the widow of the deceased insured. She asserts that she is the one entitled to the insurance proceeds, not the common-law wife, Carponia T. Ebrado.

In doubt as to whom the insurance proceeds shall be paid, the insurer, The Insular Life Assurance Co., Ltd. commenced an action for Interpleader before the Court of First Instance of Rizal on April 29, 1970.

After the issues have been joined, a pre-trial conference was held on July 8, 1972, after which, a pre-trial order was entered reading as follows: *ñé+.£ºwph!1*

> During the pre-trial conference, the parties manifested to the court. that there is no possibility of amicable settlement. Hence, the Court proceeded to have the parties submit their evidence for the purpose of

> the pre-trial and make admissions for the purpose of pretrial. During this conference, parties Carponia T. Ebrado and Pascuala Ebrado agreed and stipulated: 1) *that the deceased Buenaventura Ebrado was married to Pascuala Ebrado with whom she has six — (legitimate) namely; Hernando, Cresencio, Elsa, Erlinda, Felizardo and Helen, all surnamed Ebrado*; 2) that during the lifetime of the deceased, he was insured with Insular Life Assurance Co. Under Policy No. 009929 whole life plan, dated September 1, 1968 for the sum of P5,882.00 with the rider for accidental death benefit as evidenced by Exhibits A for plaintiffs and Exhibit 1 for the defendant Pascuala and Exhibit 7 for Carponia Ebrado; 3) *that during the lifetime of Buenaventura Ebrado, he was living with his common-wife, Carponia Ebrado, with whom she had 2 children although he was not legally separated from his legal wife*; 4) that Buenaventura in accident on October 21, 1969 as evidenced by the death Exhibit 3 and affidavit of the police report of his death Exhibit 5; 5) that complainant Carponia Ebrado filed claim with the Insular Life Assurance Co. which was contested by Pascuala Ebrado who also filed claim for the proceeds of said policy 6) that in view ofthe adverse claims the insurance company filed this action against the two herein claimants Carponia and Pascuala Ebrado; 7) that there is now due from the Insular Life Assurance Co. as proceeds of the policy P11,745.73; 8) that the beneficiary designated by the insured in the policy is Carponia Ebrado and the insured made reservation to change the beneficiary but although the insured made the option to change the beneficiary, same was never changed up to the time of his death and the wife did not have any opportunity to write the company that there was reservation to change the designation of the parties agreed that a decision be rendered based on and stipulation of facts as to who among the two claimants is entitled to the policy.
>
> Upon motion of the parties, they are given ten (10) days to file their simultaneous memoranda from the receipt of this order.
>
> SO ORDERED.

On September 25, 1972, the trial court rendered judgment declaring among others, Carponia T. Ebrado disqualified from becoming beneficiary of the insured Buenaventura Cristor Ebrado and directing the payment of the insurance proceeds to the estate of the deceased insured. The trial court held: *ñé+.£ºwph!1*

> It is patent from the last paragraph of Art. 739 of the Civil Code that a criminal conviction for adultery or concubinage is not essential in order to establish the disqualification mentioned therein. Neither is it also necessary that a finding of such guilt or commission of those acts be made in a separate independent action brought for the purpose. The guilt of the donee (beneficiary) may be proved by preponderance of evidence in the same proceeding (the action brought to declare the nullity of the donation).
>
> It is, however, essential that such adultery or concubinage exists at the time defendant Carponia T. Ebrado was made beneficiary in the policy in question for the disqualification and incapacity to exist and that it is only necessary that such fact be established by preponderance of evidence in the trial. Since it is agreed in their stipulation above-quoted that the deceased insured and defendant Carponia T. Ebrado were living together as husband and wife without being legally married and that the marriage of the insured with the other defendant Pascuala Vda. de Ebrado was valid and still existing at the time the insurance in question was purchased there is no question that defendant Carponia T. Ebrado is disqualified from becoming the beneficiary of the policy in question and as such she is not entitled to the proceeds of the insurance upon the death of the insured.

From this judgment, Carponia T. Ebrado appealed to the Court of Appeals, but on July 11, 1976, the Appellate Court certified the case to Us as involving only questions of law.

We affirm the judgment of the lower court.

1. It is quite unfortunate that the Insurance Act (RA 2327, as amended) or even the new Insurance Code (PD No. 612, as amended) does not contain any specific provision grossly resolutory of the prime question at hand. Section 50 of the Insurance Act which provides that "(t)he insurance shag be applied exclusively to the proper interest of the person in whose name it is made" [1] cannot be validly seized upon to hold that the mm includes the beneficiary. The word "interest" highly suggests that the provision refers only to the "insured" and not to the beneficiary, since a contract of insurance is personal in character. [2] Otherwise, the prohibitory laws against illicit relationships especially on property and descent will be rendered nugatory, as the same could easily be circumvented by modes of insurance. Rather, the general rules of civil law should be applied to resolve this void in the Insurance Law. Article 2011 of the New Civil Code states: "The contract of insurance is governed by special laws. *Matters not expressly provided for in such special laws shall be regulated by this Code*." When not otherwise specifically provided for by the Insurance Law, the contract of life insurance is governed by the general rules of the civil law regulating contracts. [3] And under Article 2012 of the same Code, "any person who is forbidden from receiving any donation under Article 739 cannot be named beneficiary of a fife insurance policy by the person who cannot make a donation to him. [4] Common-law spouses are, definitely, barred from receiving donations from each other. Article 739 of the new Civil Code provides: *ñé+.£ºwph!1*

> The following donations shall be void:

> 1. *Those made between persons who were guilty of adultery or concubinage at the time of donation;*
>
> Those made between persons found guilty of the same criminal offense, in consideration thereof;
>
> 3. Those made to a public officer or his wife, descendants or ascendants by reason of his office.
>
> In the case referred to in No. 1, the action for declaration of nullity may be brought by the spouse of the donor or donee; *and the guilt of the donee may be proved by preponderance of evidence in the same action.*

2. In essence, a life insurance policy is no different from a civil donation insofar as the beneficiary is concerned. Both are founded upon the same consideration: liberality. A beneficiary is like a donee, because from the premiums of the policy which the insured pays out of liberality, the beneficiary will receive the proceeds or profits of said insurance. As a consequence, the proscription in Article 739 of the new Civil Code should equally operate in life insurance contracts. The mandate of Article 2012 cannot be laid aside: any person who cannot receive a donation cannot be named as beneficiary in the life insurance policy of the person who cannot make the donation.[5] Under American law, a policy of life insurance is considered as a testament and in construing it, the courts will, so far as possible treat it as a will and determine the effect of a clause designating the beneficiary by rules under which wins are interpreted. [6]

3. Policy considerations and dictates of morality rightly justify the institution of a barrier between common law spouses in record to Property relations since such hip ultimately encroaches upon the nuptial and filial rights of the legitimate family There is every reason to hold that the bar in donations between legitimate spouses and those between illegitimate ones should be enforced in life insurance policies since the same are based on similar consideration As above pointed out, a beneficiary in a fife insurance policy is no different from a donee. Both are recipients of pure beneficence. So long as manage remains the threshold of family laws, reason and morality dictate that the impediments imposed upon 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. Thus, in *Matabuena v. Cervantes*, [7] this Court, through Justice Fernando, said: *ñé+.£ªwph!1*

> If the policy of the law is, in the language of the opinion of the then Justice J.B.L. Reyes of that court (Court of Appeals), 'to prohibit donations in favor of the other consort and his descendants because of and undue and improper pressure and influence upon the donor, a prejudice deeply rooted in our ancient law;" por-que no se enganen desponjandose el uno al otro por amor que han de consuno' (According to) the Partidas (Part IV, Tit. XI, LAW IV), reiterating the rationale 'No Mutuato amore invicem spoliarentur' the Pandects (Bk, 24, Titl. 1, De donat, inter virum et uxorem); then there is very reason to apply the same prohibitive policy to persons living together as husband and wife without the benefit of nuptials. For it is not to be doubted that assent to such irregular connection for thirty years bespeaks greater influence of one party over the other, so that the danger that the law seeks to avoid is correspondingly increased. Moreover, as already pointed out by Ulpian (in his lib. 32 ad Sabinum, fr. 1), 'it would not be just that such donations should subsist, lest the condition 6f those who incurred guilt should turn out to be better.' So long as marriage remains the cornerstone of our family law, reason and morality alike demand that the disabilities attached to marriage should likewise attach to concubinage.
>
> It is hardly necessary to add that even in the absence of the above pronouncement, any other conclusion cannot stand the test of scrutiny. It would be to indict the frame of the Civil Code for a failure to apply a laudable rule to a situation which in its essentials cannot be distinguished. Moreover, if it is at all to be differentiated the policy of the law which embodies a deeply rooted notion of what is just and what is right would be nullified if such irregular relationship instead of being visited with disabilities would be attended with benefits. Certainly a legal norm should not be susceptible to such a reproach. If there is every any occasion where the principle of statutory construction that what is within the spirit of the law is as much a part of it as what is written, this is it. Otherwise the basic purpose discernible in such codal provision would not be attained. Whatever omission may be apparent in an interpretation purely literal of the language used must be remedied by an adherence to its avowed objective.

4. We do not think that a conviction for adultery or concubinage is exacted before the disabilities mentioned in Article 739 may effectuate. More specifically, with record to the disability on "persons who were guilty of adultery or concubinage at the time of the donation," Article 739 itself provides: *ñé+.£ªwph!1*

> In the case referred to in No. 1, the action for declaration of nullity may be brought by the spouse of the donor or donee; *and the guilty of the donee may be proved by preponderance of evidence in the same action.*

The underscored clause neatly conveys that no criminal conviction for the offense is a condition precedent. In fact, it cannot even be from the aforequoted provision that a prosecution is needed. On the contrary, the law plainly states that the guilt of the party may be proved "in the same acting for declaration of nullity of donation. And, it would be sufficient if evidence preponderates upon the guilt of the consort for the offense indicated. The quantum of proof in criminal cases is not demanded.

In the caw before Us, the requisite proof of common-law relationship between the insured and the beneficiary has been conveniently supplied by the stipulations between the parties in the pre-trial conference of the case. It case agreed upon and stipulated therein that the deceased insured Buenaventura C. Ebrado was married to Pascuala Ebrado with whom she has six legitimate children; that during his lifetime, the deceased insured was living with his common-law wife, Carponia Ebrado, with whom he has two children. These stipulations are nothing less than*judicial admissions* which, as a consequence, no longer require proof and cannot be contradicted. [8] A *fortiori*, on the basis of these admissions, a judgment may be validly rendered without going through the rigors of a trial for the sole purpose of proving the illicit liaison between the insured and the beneficiary. In fact, in that pretrial, the parties even agreed "that a decision be rendered based on this agreement and stipulation of facts as to who among the two claimants is entitled to the policy."

ACCORDINGLY, the appealed judgment of the lower court is hereby affirmed. Carponia T. Ebrado is hereby declared disqualified to be the beneficiary of the late Buenaventura C. Ebrado in his life insurance policy. As a consequence, the proceeds of the policy are hereby held payable to the estate of the deceased insured. Costs against Carponia T. Ebrado.

SO ORDERED.

Teehankee (Chairman), Makasiar, Muñ;oz Palma, Fernandez and Guerrero, JJ., concur.1äwphï1.

SECOND DIVISION

[G.R. Nos. 128833. April 20, 1998]

RIZAL COMMERCIAL BANKING CORPORATION, UY CHUN BING AND ELI D. LAO, *petitioners*, *vs*. COURT OF APPEALS and GOYU & SONS, INC., *respondents*.

[G.R. No. 128834. April 20, 1998]

RIZAL COMMERCIAL BANKING CORPORATION, *petitioners*, *vs*. COURT OF APPEALS, ALFREDO C. SEBASTIAN, GOYU & SONS, INC., GO SONG HIAP, SPOUSES GO TENG KOK and BETTY CHIU SUK YING alias BETTY GO, *respondents*.

[G.R. No. 128866. April 20, 1998]

MALAYAN INSURANCE INC., *petitioner, vs.* GOYU & SONS, INC. *respondent*.

D EC I S I O N

MELO, *J.*:

The issues relevant to the herein three consolidated petitions revolve around the fire loss claims of respondent Goyu & Sons, Inc. (GOYU) with petitioner Malayan Insurance Company, Inc. (MICO) in connection with the mortgage contracts entered into by and between Rizal Commercial Banking Corporation (RCBC) and GOYU.

The Court of Appeals ordered MICO to pay GOYU its claims in the total amount of P74,040,518.58, plus 37% interest per annum commencing July 27, 1992. RCBC was ordered to pay actual and compensatory damages in the amount of P5,000,000.00. MICO and RCBC were held solidarily liable to pay GOYU P1,500,000.00 as exemplary damages and P1,500,000.00 for attorney's fees. GOYU's obligation to RCBC was fixed at P68,785,069.04 as of April 1992, without any interest, surcharges, and penalties. RCBC and MICO appealed separately but, in view of the common facts and issues involved, their individual petitions were consolidated.

The undisputed facts may be summarized as follows:

GOYU applied for credit facilities and accommodations with RCBC at its Binondo Branch. After due evaluation, RCBC Binondo Branch, through its key officers, petitioners Uy Chun Bing and Eli D. Lao, recommended GOYU's application for approval by RCBC's executive committee. A credit facility in the amount of P30 million was initially granted. Upon GOYU's application and Uy's and Lao's recommendation, RCBC's executive committee increased GOYU's credit facility to P50 million, then to P90 million, and finally to P117 million.

As security for its credit facilities with RCBC, GOYU executed two real estate mortgages and two chattel mortgages in favor of RCBC, which were registered with the Registry of Deeds at Valenzuela, Metro Manila. Under each of these four mortgage contracts, GOYU committed itself to insure the mortgaged property with an insurance company approved by RCBC, and subsequently, to endorse and deliver the insurance policies to RCBC.

GOYU obtained in its name a total of ten insurance policies from MICO. In February 1992, Alchester Insurance Agency, Inc., the insurance agent where GOYU obtained the Malayan insurance policies, issued nine endorsements in favor of RCBC seemingly upon instructions of GOYU (Exhibits "1-Malayan" to "9-Malayan").

On April 27, 1992, one of GOYU's factory buildings in Valenzuela was gutted by fire. Consequently, GOYU submitted its claim for indemnity on account of the loss insured against. MICO denied the claim on the ground that the insurance policies were either attached pursuant to writs of attachments/garnishments issued by various courts or that the

insurance proceeds were also claimed by other creditors of GOYU alleging better rights to the proceeds than the insured. GOYU filed a complaint for specific performance and damages which was docketed at the Regional Trial Court of the National Capital Judicial Region (Manila, Branch 3) as Civil Case No. 93-65442, now subject of the present G.R. No. 128833 and 128866.

RCBC, one of GOYU's creditors, also filed with MICO its formal claim over the proceeds of the insurance policies, but said claims were also denied for the same reasons that MICO denied GOYU's claims.

In an interlocutory order dated October 12, 1993 (Record, pp. 311-312), the Regional Trial Court of Manila (Branch 3), confirmed that GOYU's other creditors, namely, Urban Bank, Alfredo Sebastian, and Philippine Trust Company obtained their respective writs of attachments from various courts, covering an aggregate amount of P14,938,080.23, and ordered that the proceeds of the ten insurance policies be deposited with the said court minus the aforementioned P14,938,080.23. Accordingly, on January 7, 1994, MICO deposited the amount of P50,505,594.60 with Branch 3 of the Manila RTC.

In the meantime, another notice of garnishment was handed down by another Manila RTC sala (Branch 28) for the amount of P8,696,838.75 (Exhibit "22-Malayan").

After trial, Branch 3 of the Manila RTC rendered judgment in favor of GOYU, disposing:

WHEREFORE, judgment is hereby rendered in favor of the plaintiff and against the defendant, Malayan Insurance Company, Inc. and Rizal Commercial Banking Corporation, ordering the latter as follows:

1. For defendant Malayan Insurance Co., Inc.:

   a. To pay the plaintiff its fire loss claims in the total amount of P74,040,518.58 less the amount of P50,000,000.00 which is deposited with this Court;

   b. To pay the plaintiff damages by way of interest for the duration of the delay since July 27, 1992 (ninety days after defendant insurer's receipt of the required proof of loss and notice of loss) at the rate of twice the ceiling prescribed by the Monetary Board, on the following amounts:

      1) P50,000,000.00 — from July 27, 1992 up to the time said amount was deposited with this Court on January 7, 1994;

      2) P24,040,518.58 — from July 27, 1992 up to the time when the writs of attachments were received by defendant Malayan;

2. For defendant Rizal Commercial Banking Corporation:

   a. To pay the plaintiff actual and compensatory damages in the amount of P2,000,000.00;

3. For both defendants Malayan and RCBC:

a. To pay the plaintiff, jointly and severally, the following amounts:

1) P1,000,000.00 as exemplary damages;

2) P1,000,000.00 as, and for, attorney's fees;

3) Costs of suit.

and on the Counterclaim of defendant RCBC, ordering the plaintiff to pay its loan obligations with defendant RCBC in the amount of P68,785,069.04, as of April 27, 1992, with interest thereon at the rate stipulated in the respective promissory notes (without surcharges and penalties) per computation, pp. 14-A, 14-B & 14-C.

FURTHER, the Clerk of Court of the Regional Trial Court of Manila is hereby ordered to release immediately to the plaintiff the amount of P50,000,000.00 deposited with the Court by defendant Malayan, together with all the interests earned thereon.

(Record, pp. 478-479.)

From this judgment, all parties interposed their respective appeals. GOYU was unsatisfied with the amounts awarded in its favor. MICO and RCBC disputed the trial court's findings of liability on their part. The Court of Appeals partly granted GOYU's appeal, but sustained the findings of the trial court with respect to MICO and RCBC's liabilities, thusly:

WHEREFORE, the decision of the lower court dated June 29, 1994 is hereby modified as follows:

1. FOR DEFENDANT MALAYAN INSURANCE CO., INC:

a) To pay the plaintiff its fire loss claim in the total amount of P74,040,518.58 less the amount of P50,505,594.60 (per O.R. No. 3649285) plus deposited in court and damages by way of interest commencing July 27, 1992 until the time Goyu receives the said amount at the rate of thirty-seven (37%) percent per annum which is twice the ceiling prescribed by the Monetary Board.

2. FOR DEFENDANT RIZAL COMMERCIAL BANKING CORPORATION:

a) To pay the plaintiff actual and compensatory damages in the amount of P5,000,000.00.

3. FOR DEFENDANTS MALAYAN INSURANCE CO., INC., RIZAL COMMERCIAL BANKING CORPORATION, UY CHUN BING AND ELI D. LAO:

a) To pay the plaintiff jointly and severally the following amounts:

1. P1,500,000.00 as exemplary damages;

2. P1,500,000.00 as and for attorney's fees.

4. And on RCBC's Counterclaim, ordering the plaintiff Goyu & Sons, Inc. to pay its loan obligation with RCBC in the amount of P68,785,069.04 as of April 27, 1992 without any interest, surcharges and penalties.

The Clerk of the Court of the Regional Trial Court of Manila is hereby ordered to immediately release to Goyu & Sons, Inc. the amount of P50,505,594.60 (per O.R. No. 3649285) deposited with it by Malayan Insurance Co., Inc., together with all the interests thereon.

(*Roll*

o, p. 200.)

RCBC and MICO are now before us in G.R. No. 128833 and 128866, respectively, seeking review and consequent reversal of the above dispositions of the Court of Appeals.

In G.R. No. 128834, RCBC likewise appeals from the decision in C.A. G.R. No. CV-48376, which case, by virtue of the Court of Appeals' resolution dated August 7, 1996, was consolidated with C.A. G.R. No. CV-46162 (subject of herein G.R. No. 128833). At issue in said petition is RCBC's right to intervene in the action between Alfredo C. Sebastian (the creditor) and GOYU (the debtor), where the subject insurance policies were attached in favor of Sebastian.

After a careful review of the material facts as found by the two courts below in relation to the pertinent and applicable laws, we find merit in the submissions of RCBC and MICO.

The several causes of action pursued below by GOYU gave rise to several related issues which are now submitted in the petitions before us. This Court, however, discerns one primary and central issue, and this is, whether or not RCBC, as mortgagee, has any right over the insurance policies taken by GOYU, the mortgagor, in case of the occurrence of loss.

As earlier mentioned, accordant with the credit facilities extended by RCBC to GOYU, the latter executed several mortgage contracts in favor of RCBC. It was expressly stipulated in these mortgage contracts that GOYU shall insure the mortgaged property with any of the insurance companies acceptable to RCBC. GOYU indeed insured the mortgaged property with MICO, an insurance company acceptable to RCBC. Based on their stipulations in the mortgage contracts, GOYU was supposed to endorse these insurance policies in favor of, and deliver them, to RCBC. Alchester Insurance Agency, Inc., MICO's underwriter from whom GOYU obtained the subject insurance policies, prepared the nine endorsements (see Exh. "1-Malayan" to "9-Malayan"; also Exh. "51-RCBC" to "59-RCBC"), copies of which were delivered to GOYU, RCBC, and MICO. However, because these endorsements do not bear the signature of any officer of GOYU, the trial court, as well as the Court of Appeals, concluded that the endorsements are defective.

We do not quite agree.

It is settled that a mortgagor and a mortgagee have separate and distinct insurable interests in the same mortgaged property, such that each one of them may insure the same property for his own sole benefit. There is no question that GOYU could insure the mortgaged property for its own exclusive benefit. In the present case, although it appears that GOYU obtained the subject insurance policies naming itself as the sole payee, the intentions of the parties as shown by their contemporaneous acts, must be given due consideration in order to better serve the interest of justice and equity.

It is to be noted that nine endorsement documents were prepared by Alchester in favor of RCBC. The Court is in a quandary how Alchester could arrive at the idea of endorsing any specific insurance policy in favor of any particular beneficiary or payee other than the insured had not such named payee or beneficiary been specifically disclosed by the insured itself. It is also significant that GOYU voluntarily and purposely took the insurance policies from MICO, a sister company of RCBC, and not just from any other insurance company. Alchester would not have found out that the subject pieces of property were mortgaged to RCBC had not such information been voluntarily disclosed by GOYU itself. Had it not been for GOYU, Alchester would not have known of GOYU's intention of obtaining insurance coverage in compliance with its undertaking in the mortgage contracts with RCBC, and verily, Alchester would not have endorsed the policies to RCBC had it not been so directed by GOYU.

On equitable principles, particularly on the ground of estoppel, the Court is constrained to rule in favor of mortgagor RCBC. The basis and purpose of the doctrine was explained in *Philippine National Bank vs. Court of Appeals* (94 SCRA 357 [1979]), to wit:

The doctrine of estoppel is based upon the grounds of public policy, fair dealing, good faith and justice, and its purpose is to forbid one to speak against his own act, representations, or commitments to the injury of one to whom they were directed and who reasonably relied thereon. The doctrine of estoppel springs from equitable principles and the equities in the case. It is designed to aid the law in the administration of justice where without its aid injustice might result. It has been applied by this Court wherever and whenever special circumstances of a case so demand.

(

p. 368.)

Evelyn Lozada of Alchester testified that upon instructions of Mr. Go, through a certain Mr. Yam, she prepared in quadruplicate on February 11, 1992 the nine endorsement documents for GOYU's nine insurance policies in favor of RCBC. The original copies of each of these nine endorsement documents were sent to GOYU, and the others were sent to RCBC and MICO, while the fourth copies were retained for Alchester's file (tsn, February 23, pp. 7-8). GOYU has not denied having received from Alchester the originals of these endorsements.

RCBC, in good faith, relied upon the endorsement documents sent to it as this was only pursuant to the stipulation in the mortgage contracts. We find such reliance to be justified under the circumstances of the case. GOYU failed to seasonably repudiate the authority of the person or persons who prepared such endorsements. Over and above this, GOYU continued, in the meantime, to enjoy the benefits of the credit facilities extended to it by RCBC. After the occurrence of the loss insured against, it was too late for GOYU to disown the endorsements for any imagined or contrived lack of authority of Alchester to prepare and issue said endorsements. If there had not been actually an implied ratification of said endorsements by virtue of GOYU's inaction in this case, GOYU is at the very least estopped from assailing their operative effects. To permit GOYU to capitalize on its non-confirmation of these endorsements while it continued to enjoy the benefits of the credit facilities of RCBC which believed in good faith that there was due endorsement pursuant to their mortgage contracts, is to countenance grave contravention of public policy, fair dealing, good faith, and justice. Such an unjust situation, the Court cannot sanction. Under the peculiar circumstances obtaining in this case, the Court is bound to recognize RCBC's right to the proceeds of the insurance policies if not for the actual endorsement of the policies, at least on the basis of the equitable principle of estoppel.

GOYU cannot seek relief under Section 53 of the Insurance Code which provides that the proceeds of insurance shall exclusively apply to the interest of the person in whose name or for whose benefit it is made. The peculiarity of the circumstances obtaining in the instant case presents a justification to take exception to the strict application of said provision, it having been sufficiently established that it was the intention of the parties to designate RCBC as the party for whose benefit the insurance policies were taken out. Consider thus the following:

1. It is undisputed that the insured pieces of property were the subject of mortgage contracts entered into between RCBC and GOYU in consideration of and for securing GOYU's credit facilities from RCBC. The mortgage contracts contained common provisions whereby GOYU, as mortgagor, undertook to have the mortgaged property properly covered against any loss by an insurance company acceptable to RCBC.

2. GOYU voluntarily procured insurance policies to cover the mortgaged property from MICO, no less than a sister company of RCBC and definitely an acceptable insurance company to RCBC.

3. Endorsement documents were prepared by MICO's underwriter, Alchester Insurance Agency, Inc., and copies thereof were sent to GOYU, MICO, and RCBC. GOYU did not assail, until of late, the validity of said endorsements.

4. GOYU continued until the occurrence of the fire, to enjoy the benefits of the credit facilities extended by RCBC which was conditioned upon the endorsement of the insurance policies to be taken by GOYU to cover the mortgaged properties.

This Court can not over stress the fact that upon receiving its copies of the endorsement documents prepared by Alchester, GOYU, despite the absence of its written conformity thereto, obviously considered said endorsement to be sufficient compliance with its obligation under the mortgage contracts since RCBC accordingly continued to extend the benefits of its credit facilities and GOYU continued to benefit therefrom. Just as plain too is the intention of the parties to constitute RCBC as the beneficiary of the various insurance policies obtained by GOYU. The intention of the parties will have to be given full force and effect in this particular case. The insurance proceeds may, therefore, be exclusively applied to RCBC, which under the factual circumstances of the case, is truly the person or entity for whose benefit the policies were clearly intended.

Moreover, the law's evident intention to protect the interests of the mortgagee upon the mortgaged property is expressed in Article 2127 of the Civil Code which states:

ART. 2127. The mortgage extends to the natural accessions, to the improvements, growing fruits, and the rents or income not yet received when the obligation becomes due, and to the amount of the indemnity granted or owing to the proprietor from the insurers of the property mortgaged, or in virtue of expropriation for public use, with the declarations, amplifications and limitations established by law, whether the estate remains in the possession of the mortgagor, or it passes into the hands of a third person.

Significantly, the Court notes that out of the 10 insurance policies subject of this case, only 8 of them appear to have been subject of the endorsements prepared and delivered by Alchester for and upon instructions of GOYU as shown below:

	INSURANCE POLICY PARTICULARS	ENDORSEMENT
a.	Policy Number : F-114-07795	None
	Issue Date : March 18, 1992	
	Expiry Date : April 5, 1993	
	Amount : P9,646,224.92	

b. Policy Number : ACIA/F-174-07660 Exhibit *"1-Malayan"*

Issue Date : January 18, 1992

Expiry Date : February 9, 1993

Amount : P4,307,217.54

c. Policy Number : ACIA/F-114-07661 Exhibit *"2-Malayan"*

Issue Date : January 18, 1992

Expiry Date : February 15, 1993

Amount : P6,603,586.43

d. Policy Number : ACIA/F-114-07662 Exhibit *"3-Malayan"*

Issue Date : January 18, 1992

Expiry Date : (not legible)

Amount : P6,603,586.43

e. Policy Number : ACIA/F-114-07663 Exhibit *"4-Malayan"*

Issue Date : January 18, 1992

Expiry Date : February 9, 1993

Amount : P9,457,972.76

f. Policy Number : ACIA/F-114-07623 Exhibit *"7-Malayan"*

Issue Date : January 13, 1992

Expiry Date : January 13, 1993

Amount : P24,750,000.00

g. Policy Number : ACIA/F-174-07223 Exhibit *"6-Malayan"*

Issue Date : May 29, 1991

Expiry Date : June 27, 1992

Amount : P6,000,000.00

h. Policy Number : CI/F-128-03341 None

Issue Date : May 3, 1991

Expiry Date : May 3, 1992

Amount : P10,000,000.00

i. Policy Number : F-114-07402 Exhibit *"8-Malayan"*

Issue Date : September 16, 1991

Expiry Date : October 19, 1992

Amount : P32,252,125.20

j. Policy Number : F-114-07525 Exhibit *"9-Malayan"*

Issue Date : November 20, 1991

Expiry Date : December 5, 1992

Amount : P6,603,586.43

(pp. 456-457, Record; Folder of Exhibits for MICO.)

Policy Number F-114-07795 [(a) above] has not been endorsed. This fact was admitted by MICO's witness, Atty. Farolan (tsn, February 16, 1994, p. 25). Likewise, the record shows no endorsement for Policy Number CI/F-128-03341 [(h) above]. Also, one of the endorsement documents, Exhibit *"5-Malayan"*, refers to a certain insurance policy number ACIA-F-07066, which is not among the insurance policies involved in the complaint.

The proceeds of the 8 insurance policies endorsed to RCBC aggregate to P89,974,488.36. Being exclusively payable to RCBC by reason of the endorsement by Alchester to RCBC, which we already ruled to have the force and effect of an endorsement by GOYU itself, these 8 policies can not be attached by GOYU's other creditors up to the extent of the GOYU's outstanding obligation in RCBC's favor. Section 53 of the Insurance Code ordains that the insurance proceeds of the endorsed policies shall be applied exclusively to the proper interest of the person for whose benefit it was made. In this case, to the extent of GOYU's obligation with RCBC, the interest of GOYU in the subject policies had been transferred to RCBC effective as of the time of the endorsement. These policies may no longer be attached by the other creditors of GOYU, like Alfredo Sebastian in the present G.R. No. 128834, which may nonetheless forthwith be dismissed for being moot and academic in view of the results reached herein. Only the two other policies amounting to P19,646,224.92 may be validly attached, garnished, and levied upon by GOYU's other creditors. To the extent of GOYU's outstanding obligation with RCBC, all the rest of the other insurance policies above-listed which were endorsed to RCBC, are, therefore, to be released from attachment, garnishment, and levy by the other creditors of GOYU.

This brings us to the next relevant issue to be resolved, which is, the extent of GOYU's outstanding obligation with RCBC which the proceeds of the 8 insurance policies will discharge and liquidate, or put differently, the actual amount of GOYU's liability to RCBC.

The Court of Appeals simply echoed the declaration of the trial court finding that GOYU'S total obligation to RCBC was only P68,785,060.04 as of April 27, 1992, thus sanctioning the trial court's exclusion of Promissory Note No. 421-92 (renewal of Promissory Note No. 908-91) and Promissory Note No. 420-92 (renewal of Promissory Note No. 952-91) on the ground that their execution is highly questionable for not only are these dated after the fire, but also because the signatures of either GOYU or any its representative are conspicuously absent. Accordingly, the Court of Appeals speculated thusly:

…Hence, this Court is inclined to conclude that said promissory notes were pre-signed by plaintiff in blank terms, as averred by plaintiff, in contemplation of the speedy grant of future loans, for the same practice of procedure has always been adopted in its previous dealings with the bank.

(*Rollo*, pp. 181-182.)

The fact that the promissory notes bear dates posterior to the fire does not necessarily mean that the documents are spurious, for it is presumed that the ordinary course of business had been followed (*Metropolitan Bank and Trust Company vs. Quilts and All, Inc*., 222 SCRA 486 [1993]). The obligor and not the holder of the negotiable instrument has the burden of proof of showing that he no longer owes the obligee any amount (*Travel-On, Inc. vs. Court of Appeals*, 210 SCRA 351 [1992]).

Even casting aside the presumption of regularity of private transactions, receipt of the loan amounting to P121,966,058.67 (Exhibits 1-29, RCBC) was admitted by GOYU as indicated in the testimony of Go Song Hiap when he answered the queries of the trial court:

ATTY. NATIVIDAD

Q: But insofar as the amount stated in Exhibits 1 to 29-RCBC, you received all the amounts stated therein?

A: Yes, sir, I received the amount.

COURT

He is asking if he received all the amounts stated in Exhibits 1 to 29-RCBC?

WITNESS:

Yes, Your Honor, I received all the amounts.

COURT

Indicated in the Promissory Notes?

WITNESS

A. The promissory Notes they did not give to me but the amount I asked which is correct, Your Honor.

COURT

Q: You mean to say the amounts indicated in Exhibits 1 to 29-RCBC is correct?

A: Yes, Your Honor.

(tsn, Jan. 14, 1994, p. 26.)

Furthermore, aside from its judicial admission of having received all the proceeds of the 29 promissory notes as hereinabove quoted, GOYU also offered and admitted to RCBC that its obligation be fixed at P116,301,992.60 as shown in its letter dated March 9, 1993, which pertinently reads:

We wish to inform you, therefore that we are ready and willing to pay the current past due account of this company in the amount of P116,301,992.60 as of 21 January 1993, specified in pars. 15, p. 10, and 18, p. 13 of your affidavits of Third Party Claims in the Urban case at Makati, Metro Manila and in the Zamboanga case at Zamboanga city, respectively, less the total of P8,851,519.71 paid from the Seaboard and Equitable insurance companies and other legitimate deductions. We accept and confirm this amount of P116,301,992.60 as stated as true and correct.

(Exhibit BB.)

The Court of Appeals erred in placing much significance on the fact that the excluded promissory notes are dated after the fire. It failed to consider that said notes had for their origin transactions consummated *prior* to the fire. Thus, careful attention must be paid to the fact that Promissory Notes No. 420-92 and 421-92 are mere *renewals* of Promissory Notes No. 908-91 and 952-91, loans already availed of by GOYU.

The two courts below erred in failing to see that the promissory notes which they ruled should be excluded for bearing dates which are after that of the fire, are mere *renewals* of previous ones. The proceeds of the loan represented by these promissory notes were admittedly received by GOYU. There is ample factual and legal basis for giving GOYU's judicial admission of liability in the amount of P116,301,992.60 full force and effect

It should, however, be quickly added that whatever amount RCBC may have recovered from the other insurers of the mortgaged property will, nonetheless, have to be applied as payment against GOYU's obligation. But, contrary to the lower courts' findings, payments effected by GOYU prior to January 21, 1993 should no longer be deducted. Such payments had obviously been duly considered by GOYU, in its aforequoted letter dated March 9, 1993, wherein it admitted that its past due account totaled P116,301,992.60 as of January 21, 1993.

The net obligation of GOYU, after deductions, is thus reduced to P107,246,887.90 as of January 21, 1993, to wit:

Total Obligation as admitted by GOYU as of January 21, 1993: P116,301,992.60

Broken down as follows

	Principal[1]	Interest
Regular	80,535,946.32	
FDU	7,548,025.17	
Total:	108,083,971.49	8,218,021.11[2]

LESS:

1)	Proceeds from Seaboard Eastern Insurance Company:	6,095,145.81
2)	Proceeds from Equitable Insurance Company:	2,756,373.00
3)	Payment from foreign department negotiation:	203,584.89
		9,055,104.70[3]

NET AMOUNT as of January 21, 1993: **P 107,246,887.90**

The need for the payment of interest due upon the principal amount of the obligation, which is the cost of money to RCBC, the primary end and the ultimate reason for RCBC's existence and being, was duly recognized by the trial court when it ruled favorably on RCBC's counterclaim, ordering GOYU "to pay its loan obligation with RCBC in the amount of P68,785,069.04, as of April 27,1992, with interest thereon at the rate stipulated in the respective promissory notes (without surcharges and penalties) per computation, pp. 14-A, 14-B, 14-C" (Record, p. 479). Inexplicably, the Court of Appeals, without even laying down the factual or legal justification for its ruling, modified the trial court's ruling and ordered GOYU "to pay the principal amount of P68,785,069.04 without any interest, surcharges and penalties" (Rollo, p. 200).

It is to be noted in this regard that even the trial court hedgingly and with much uncertainty deleted the payment of additional interest, penalties, and charges, in this manner:

Regarding defendant RCBC's commitment not to charge additional interest, penalties and surcharges, the same does not require that it be embodied in a document or some form of writing to be binding and enforceable. The principle is well known that generally a verbal agreement or contract is no less binding and effective than a written one. And the existence of such a verbal agreement has been amply established by the evidence in this case. In any event, regardless of the existence of such verbal agreement, it would still be unjust and inequitable for defendant RCBC to charge the plaintiff with surcharges and penalties considering the latter's pitiful situation. (Emphasis supplied.)

(Record, p. 476)

The essence or rationale for the payment of interest or cost of money is separate and distinct from that of surcharges and penalties. What may justify a court in not allowing the creditor to charge surcharges and penalties despite express stipulation therefor in a valid agreement, may not equally justify non-payment of interest. The charging of interest for loans forms a very essential and fundamental element of the banking business, which may truly be considered to be at the very core of its existence or being. It is inconceivable for a bank to grant loans for which it will not charge any interest at all. We fail to find justification for the Court of Appeals' outright deletion of the payment of interest as agreed upon in the respective promissory notes. This constitutes gross error.

For the computation of the interest due to be paid to RCBC, the following rules of thumb laid down by this Court in *Eastern Shipping Lines, Inc. vs. Court of Appeals* (234 SCRA 78 [1994]), shall apply, to wit:

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 of 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 on 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 a forbearance of credit.

(pp. 95-97.)

There being written stipulations as to the rate of interest owing on each specific promissory note as summarized and tabulated by the trial court in its decision (pp.470 and 471, Record) such agreed interest rates must be followed. This is very clear from paragraph II, sub-paragraph 1 quoted above.

On the issue of payment of surcharges and penalties, we partly agree that GOYU's pitiful situation must be taken into account. We do not agree, however, that payment of any amount as surcharges and penalties should altogether be deleted. Even assuming that RCBC, through its responsible officers, herein petitioners Eli Lao and Uy Chun Bing, may have relayed its assurance for assistance to GOYU immediately after the occurrence of the fire, we cannot accept the lower courts' finding that RCBC had thereby *ipso facto* effectively waived

collection of any additional interests, surcharges, and penalties from GOYU. Assurances of assistance are one thing, but waiver of additional interests, surcharges, and penalties is another.

Surcharges and penalties agreed to be paid by the debtor in case of default partake of the nature of liquidated damages, covered by Section 4, Chapter 3, Title XVIII of the Civil Code. Article 2227 thereof provides:

ART. 2227. Liquidated damages, whether intended as a indemnity or penalty, shall be equitably reduced if they are iniquitous and unconscionable.

In exercising this vested power to determine what is iniquitous and unconscionable, the Court must consider the circumstances of each case. It should be stressed that the Court will not make any sweeping ruling that surcharges and penalties imposed by banks for non-payment of the loans extended by them are generally iniquitous and unconscionable. What may be iniquitous and unconscionable in one case, may be totally just and equitable in another. This provision of law will have to be applied to the established facts of any given case. Given the circumstances under which GOYU found itself after the occurrence of the fire, the Court rules the surcharges rates ranging anywhere from 9% to 27%, plus the penalty charges of 36%, to be definitely iniquitous and unconscionable. The Court tempers these rates to 2% and 3%, respectively. Furthermore, in the light of GOYU's offer to pay the amount of P116,301,992.60 to RCBC as March 1993 (See: Exhibit "BB"), which RCBC refused, we find it more in keeping with justice and equity for RCBC not to charge additional interest, surcharges, and penalties from that time onward.

Given the factual milieu spread hereover, we rule that it was error to hold MICO liable in damages for denying or withholding the proceeds of the insurance claim to GOYU.

Firstly, by virtue of the mortgage contracts as well as the endorsements of the insurance policies, RCBC has the right to claim the insurance proceeds, in substitution of the property lost in the fire. Having assigned its rights, GOYU lost its standing as the beneficiary of the said insurance policies.

Secondly, for an insurance company to be held liable for unreasonably delaying and withholding payment of insurance proceeds, the delay must be wanton, oppressive, or malevolent (*Zenith Insurance Corporation vs. CA*, 185 SCRA 403 [1990]). It is generally agreed, however, that an insurer may in good faith and honesty entertain a difference of opinion as to its liability. Accordingly, the statutory penalty for vexatious refusal of an insurer to pay a claim should not be inflicted unless the evidence and circumstances show that such refusal was willful and without reasonable cause as the facts appear to a reasonable and prudent man (*Buffalo Ins. Co. vs. Bommarito* [CCA 8th] 42 F [2d] 53, 70 ALR 1211;*Phoenix Ins. Co. vs. Clay*, 101 Ga. 331, 28 SE 853, 65 Am St Rep 307; *Kusnetsky vs. Security Ins. Co*., 313 Mo. 143, 281 SW 47, 45 ALR 189). The case at bar does not show that MICO wantonly and in bad faith delayed the release of the proceeds. The problem in the determination of who is the actual beneficiary of the insurance policies, aggravated by the claim of various creditors who wanted to partake of the insurance proceeds, not to mention the importance of the endorsement to RCBC, to our mind, and as now borne out by the outcome herein, justified MICO in withholding payment to GOYU.

In adjudging RCBC liable in damages to GOYU, the Court of Appeals said that RCBC cannot avail itself of two simultaneous remedies in enforcing the claim of an unpaid creditor, one for specific performance and the other for foreclosure. In doing so, said the appellate court, the second action is deemed barred, RCBC having split a single cause of action (Rollo, pp. 195-199). The Court of Appeals was too accommodating in giving due consideration to this argument of GOYU, for the foreclosure suit is still pending appeal before the same Court of Appeals in CA G.R CV No. 46247, the case having been elevated by RCBC.

In finding that the foreclosure suit cannot prosper, the Fifteenth Division of the Court of Appeals pre-empted the resolution of said foreclosure case which is not before it. This is plain reversible error if not grave abuse of discretion.

As held in *Peña vs. Court of Appeals* (245 SCRA 691[1995]):

It should have been enough, nonetheless, for the appellate court to merely set aside the questioned orders of the trial court for having been issued by the latter with grave abuse of discretion. In likewise enjoining permanently herein petitioner "from entering in and interfering with the use or occupation and enjoyment of petitioner's (now private respondent) residential house and compound," the appellate court in effect, precipitately resolved with finality the case for injunction that was yet to be heard on the merits by the lower court. Elevated to the appellate court, it might be stressed, were mere incidents of the principal case still pending with the trial court. In *Municipality of Biñan, Laguna vs. Court of Appeals*, 219 SCRA 69, we ruled that the Court of Appeals would have "no jurisdiction in a *certiorari* proceeding involving an incident in a case to rule on the merits of the main case itself which was not on appeal before it."

(

pp. 701-702.)

Anent the right of RCBC to intervene in Civil Case No. 1073, before the Zamboanga Regional Trial Court, since it has been determined that RCBC has the right to the insurance proceeds, the subject matter of intervention is rendered moot and academic. Respondent Sebastian must, however, yield to the preferential right of RCBC over the MICO insurance policies. It is basic and fundamental that the first mortgagee has superior rights over junior mortgagees or attaching creditors (*Alpha Insurance & Surety Co. vs. Reyes*, 106 SCRA 274 [1981]; *Sun Life Assurance Co. of Canada vs. Gonzales Diaz*, 52 Phil. 271 [1928]).

WHEREFORE, the petitions are hereby GRANTED and the decision and resolution of December 16, 1996 and April 3, 1997 in CA-G.R. CV No. 46162 are hereby REVERSED and SET ASIDE, and a new one entered:

1. Dismissing the Complaint of private respondent GOYU in Civil Case No. 93-65442 before Branch 3 of the Manila Regional Trial Court for lack of merit;

2. Ordering Malayan Insurance Company, Inc. to deliver to Rizal Commercial Banking Corporation the proceeds of the insurance policies in the amount of P51,862,390.94 (per report of adjuster Toplis & Harding (Far East), Inc., Exhibits "2" and "2-1"), less the amount of P50,505,594.60 (per O.R. No. 3649285);

3. Ordering the Clerk of Court to release the amount of P50,505,594.60 including the interests earned to Rizal Commercial Banking Corporation;

4. Ordering Goyu & Sons, Inc. to pay its loan obligation with Rizal Commercial Banking Corporation in the principal amount of P107,246,887.90, with interest at the respective rates stipulated in each promissory note from January 21, 1993 until finality of this judgment, and surcharges at 2% and penalties at 3% from January 21, 1993 to March 9, 1993, minus payments made by Malayan Insurance Company, Inc. and the proceeds of the amount deposited with the trial court and its earned interest. The total amount due RCBC at the time of the finality of this judgment shall earn interest at the legal rate of 12% in lieu of all other stipulated interests and charges until fully paid.

The petition of Rizal Commercial Banking Corporation against the respondent Court in CA-GR CV 48376 is DISMISSED for being moot and academic in view of the results herein arrived at. Respondent Sebastian's right as attaching creditor must yield to the preferential rights of Rizal Commercial Banking Corporation over the Malayan insurance policies as first mortgagee.

SO ORDERED.

Regalado, (Chairman), Puno, Mendoza, and *Martinez, JJ.,* concur.

Republic of the Philippines
SUPREME COURT
Manila

FIRST DIVISION

G.R. No. 71360 July 16, 1986

DEVELOPMENT INSURANCE CORPORATION, petitioner,
vs.
INTERMEDIATE APPELLATE COURT, and PHILIPPINE UNION REALTY DEVELOPMENT CORPORATION,respondents.

Balgos & Perez Law Offices for petitioner.

Agustin M. Sundiam for private respondent.

CRUZ, *J.:*

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*. The petitioner is now before us, hoping presumably that it will fare better here than before the trial court and the Intermediate Appellate Court. We shall see.

On the question of default, the record argues mightily against it. It is indisputable that summons was served on it, through its senior vice-president, on June 19,1980. On July 14, 1980, ten days after the expiration of the original 15-day period to answer (excluding July 4), its counsel filed an ex parte motion for an extension of five days within which to file its answer. On July 18, 1980, the last day of the requested extension-which at the time had not yet been granted-the same counsel filed a second motion for another 5-day extension, fourteen days after the expiry of the original period to file its answer. The trial court nevertheless gave it five days from July 14, 1980, or until July 19, 1980, within which to file its answer. But it did not. It did so only on July 26, 1980, after the expiry of the original and extended periods, or twenty-one days after the July 5, deadline. As a consequence, the trial court, on motion of the private respondent filed on July 28, 1980, declared the petitioner in default. This was done almost one month later, on August 25, 1980. Even so, the petitioner made no move at all for two months thereafter. It was only on October 27, 1980, more than one month after the judgment of default was rendered by the trial court on September 26, 1980, that it filed a motion to lift the order of default and vacate the judgment by default. [1]

The pattern of inexcusable neglect, if not deliberate delay, is all too clear. The petitioner has slumbered on its right and awakened too late. While it is true that in *Trajano v. Cruz,* [2] which it cites, this Court declared "that judgments by default are generally looked upon with disfavor," the default judgment in that case was set aside precisely because there was excusable neglect, Summons in that case was served through "an employee in petitioners' office and not the person in-charge," whereas in the present case summons was served on the vice-president of the petitioner who however refused to accept it. Furthermore, as Justice Guerrero noted, there was no evidence showing that the petitioners in Trajano intended to unduly delay the case.

Besides, the petitioners in Trajano had a valid defense against the complaint filed against them, and this justified a relaxation of the procedural rules to allow full hearing on the substantive issues raised. In the instant case, by contrast, the petitioner must just the same fail on the merits even if the default orders were to be lifted. As the respondent Court

observed, "Nothing would be gained by having the order of default set aside considering the appellant has no valid defense in its favor." [3]

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. [4] 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 INP [5] and, indeed, its own expressed admission in its answer [6] 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." [7]

There is no reason to disturb the factual findings of the lower court, as affirmed by the Intermediate Appellate Court, that 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.[8]

The petitioner argues that since at the time of the fire the building insured was worth P5,800,000.00, the private respondent should be considered its own insurer for the difference between that amount and the face value of the policy and should share *pro rata* in the loss sustained. Accordingly, the private respondent is entitled to an indemnity of only P67,629.31, the rest of the loss to be shouldered by it alone. In support of this contention, the petitioner cites Condition 17 of the policy, which provides:

> If the property hereby insured shall, at the breaking out of any fire, be collectively of greater value than the sum insured thereon then the insured shall be considered as being his own insurer for the difference, and shall bear a ratable proportion of the loss accordingly. Every item, if more than one, of the policy shall be separately subject to this condition.

However, there is no evidence on record that the building was worth P5,800,000.00 at the time of the loss; only the petitioner says so and it does not back up its self-serving estimate with any independent corroboration. On the contrary, the building was insured at P2,500,000.00, and this must be considered, by agreement of the insurer and the insured, the actual value of the property insured on the day the fire occurred. This valuation becomes even more believable if it is remembered that at the time the building was burned it was still under construction and not yet completed.

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 aforestated 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.

The refusal of its vice-president to receive the private respondent's complaint, as reported in the sheriff's return, was the first indication of the petitioner's intention to prolong this case and postpone the discharge of its obligation to the private respondent under this agreement. That intention was revealed further in its subsequent acts-or inaction-which indeed enabled it to avoid payment for more than five years from the filing of the claim against it in 1980. The petitioner has temporized long enough to avoid its legitimate responsibility; the delay must and does end now.

WHEREFORE, the appealed decision is affirmed in full, with costs against the petitioner.

SO ORDERED.

Yap (Chairman), Narvasa, Melencio-Herrera and Paras, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-24566 July 29, 1968

AGRICULTURAL CREDIT & COOPERATIVE FINANCING ADMINISTRATION (ACCFA), plaintiff-appellant,
vs.
ALPHA INSURANCE & SURETY CO., INC., defendant-appellee,
RICARDO A. LADINES, ET AL., third party-defendants-appellees.

Deogracias E. Lerma and Esmeraldo U. Guloy for plaintiff-appellant.
L. L. Reyes for defendant-appellee.
Geronimo F. Abellera for third party defendants-appellees.

REYES, J.B.L., *J.:*

Appeal, on points of law, against a decision of the Court of First Instance of Manila, in its Case No. 43372, upholding a motion to dismiss.

At issue is the question whether or not the provision of a fidelity bond that no action shall be had or maintained thereon unless commenced within one year from the making of a claim for the loss upon which the action is based, is valid or void, in view of Section 61-A of the Insurance Act invalidating stipulations limiting the time for commencing an action thereon to less than one year from the time the cause of action accrues.

Material to this decision are the following facts: *1äwphï1.ñët*

According to the allegations of the complaint, in order to guarantee the Asingan Farmers' Cooperative Marketing Association, Inc. (FACOMA) against loss on account of "personal dishonesty, amounting to larceny or estafa of its Secretary-Treasurer, Ricardo A. Ladines, the appellee, Alpha Insurance & Surety Company had issued, on 14 February 1958, its bond, No. P-FID-15-58, for the sum of Five Thousand Pesos (P5,000.00) with said Ricardo Ladines as principal and the appellee as solidary surety. On the same date, the Asingan FACOMA assigned its rights to the appellant, Agricultural Credit Cooperative and Financing Administration (ACCFA for short), with approval of the principal and the surety.

During the effectivity of the bond, Ricardo Ladines converted and misappropriated, to his personal benefit, some P11,513.22 of the FACOMA funds, of which P6,307.33 belonged to the ACCFA. Upon discovery of the loss, ACCFA immediately notified in writing the survey company on 10 October 1958, and presented the proof of loss within the period fixed in the bond; but despite repeated demands the surety company refused and failed to pay. Whereupon, ACCFA filed suit against appellee on 30 May 1960.

Defendant Alpha Insurance & Surety Co., Inc., (now appellee) moved to dismiss the complaint for failure to state a cause of action, giving as reason that (1) the same was filed more than one year after plaintiff made claim for loss, contrary to the eighth condition of the bond, providing as follows: .

> EIGHT LIMITATION OF ACTION
>
> No action, suit or proceeding shall be had or maintained upon this Bond unless the same be commenced within one year from the time of making claim for the loss upon which such action, suit or proceeding, is based, in accordance with the fourth section hereof.

(2) the complaint failed to show that plaintiff had filed civil or criminal action against Ladines, as required by conditions 4 and 11 of the bond; and (3) that Ladines was a necessary and indispensable party but had not been joined as such.

At first, the Court of First Instance denied dismissal; but, upon reconsideration, the court reversed its original stand, and dismissed the complaint on the ground that the action was filed beyond the contractual limitation period (Record on Appeal, pages 56-59).

Hence, this appeal.

We find the appeal meritorious.

A fidelity bond is, in effect, in the nature of a contract of insurance against loss from misconduct, and is governed by the same principles of interpretation: Mechanics Savings Bank & Trust Co. vs. Guarantee Company, 68 Fed. 459; Pao Chan Wei vs. Nemorosa, 103 Phil. 57. Consequently, the condition of the bond in question, limiting the period for bringing action thereon, is subject to the provisions of Section 61-A of the Insurance Act (No. 2427), as amended by Act 4101 of the pre-Commonwealth Philippine Legislature, prescribing that —

> SEC. 61-A — A condition, stipulation or agreement in any policy of insurance, limiting the time for commencing an action thereunder to a period of less than one year from the time when the cause of action accrues is void.

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" (Maao Sugar Central vs. Barrios, 79 Phil. 666), the cause of action does not accrue until the party obligated refuses, expressly or impliedly, to comply with its duty (in this case, to pay the amount of the bond). The year for instituting action in court must be reckoned, therefore, from the time of appellee's refusal to comply with its bond; it can not be counted from the creditor's filing of the claim of loss, for that does not import that the surety company will refuse to pay. In so far, therefore, as condition eight of the bond requires action to be filed within one year from the filing of the claim for loss, such stipulation contradicts the public policy expressed in Section 61-A of the Philippine Insurance Act. Condition eight of the bond, therefore, is null and void, and the appellant is not bound to comply with its provisions.

In *Eagle Star Insurance Co. vs. Chia Yu*, 96 Phil. 696, 701, this Court ruled: *.1äwphï1.ñët*

> It may perhaps be suggested that the policy clause relied on by the insurer for defeating plaintiff's action should be given the construction that would harmonize it with section 61-A of the Insurance Act by taking it to mean that the time given the insured for bringing his suit is twelve months after the cause of action accrues. But the question then would be: When did the cause of action accrue? On that question we agree with the court below that 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. As the policy provides that the insured should file his claim, first, with the carrier and then with the insurer, he had a right to wait for his claim to be finally decided before going to court. The law does not encourage unnecessary litigation.

The discouraging of unnecessary litigation must be deemed a rule of public policy, considering the unrelieved congestion in the courts.

As a consequence of the foregoing, condition eight of the Alpha bond is null and void, and action may be brought within the statutory period of limitation for written contracts (New Civil Code, Article 1144). The case of Ang vs. Fulton Fire Insurance Co., 2 S.C.R.A. 945 (31 July 1961), relied upon by the Court a quo, is no authority against the views herein expressed, since the effect of Section 61-A of the Insurance Law on the terms of the Policy or contract was not there considered.

The condition of previous conviction (paragraph b, clause 4, of the contract) having been deleted by express agreement and the surety having assumed solidary liability, the other grounds of the motion to dismiss are equally untenable. A creditor may proceed against any one of the solidary debtors, or some or all of them simultaneously (Article 1216, New Civil Code).

WHEREFORE, the appealed order granting the motion to dismiss is reversed and set aside, and the records are remanded to the Court of First Instance, with instructions to require defendant to answer and thereafter proceed in conformity with the law and the Rules of Court. Costs against appellee. So ordered.

Concepcion, C.J., Dizon, Makalintal, Zaldivar, Sanchez, Castro, Angeles and Fernando, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-15862 July 31, 1961

PAULO ANG and SALLY C. ANG, plaintiffs-appellees,
vs.
FULTON FIRE INSURANCE CO., ET AL., defendants.
FULTON FIRE INSURANCE CO., defendant-appellant.

Santiago Ranada for plaintiffs-appellees.
Benjamin S. Valte for defendant-appellant.

LABRADOR, *J.*:

The present action was instituted by the spouses Paulo Ang and Sally C. Ang against the Fulton Fire Insurance Company and the Paramount Surety and Insurance Company, Inc. to recover from them the face value of a fire insurance policy issued in plaintiffs' favor covering a store owned and operated by them in Laoag, Ilocos Norte. From a judgment of the court ordering the defendant Fulton Fire Insurance Co. to pay the plaintiffs the sum of P10,000.00, with interest, and an additional sum of P2,000.00 as attorney's fees, and costs, the defendants have appealed directly to this Court.

On September 9, 1953, defendant Fulton Fire Insurance Company issued a policy No. F-4730340, in favor of P. & S Department Store (Sally C. Ang) over stocks of general merchandise, consisting principally of dry goods, contained in a building occupied by the plaintiffs at Laoag, Ilocos Norte. The premium is P500.00 annually. The insurance was issued for one year, but the same was renewed for another year on September 31, 1954. On December 17, 1954, the store containing the goods insured was destroyed by fire. On December 30, following, plaintiffs executed the first claim form. The claim together with all the necessary papers relating thereto, were forwarded to he Manila Adjustment Company, the defendants' adjusters and received by the latter on Jane 8, 1955. On January 12, 1955, the Manila Adjustment Company accepted receipt of the claim and requested the submission of the books of accounts of the insured for the year 1953-1954 and a clearance from the Philippine Constabulary and the police. On April 6, 1956, the Fulton Fire Insurance Company wrote the plaintiffs that their claim was denied. This denial of the claim was received by the plaintiffs on April 19, 1956. On January 13, 1955, plaintiff Paulo Ang and ten others were charged for arson in Criminal Case No. 1429 in the Justice of the Peace Court of Laoag, Ilocos

Norte. The case was remanded for trial to the Court of First Instance of Ilocos Norte and there docketed as Criminal Case No. 2017. The said court in a decision dated December 9, 1957, acquitted plaintiff Paulo Ang of the crime of arson.

The present action was instituted on May 5, 1958. The action was originally instituted against both the Fulton Fire Insurance Company and the Paramount Surety and Insurance Company, Inc., but on June 16, 1958, upon motion of the Paramount Surety, the latter was dropped from the complaint.

On May 26, 1958, the defendant Fulton Fire Insurance Company filed an answer to the complaint, admitting the existence of the contract of insurance, its renewal and the loss by fire of the department store and the merchandise contained therein, but denying that the loss by the fire was accidental, alleging that it was occasioned by the willful act of the plaintiff Paulo Ang himself. It claims that under paragraph 13 of the policy, if the loss or damage is occasioned by the willful act of the insured, *or if the claim is made and rejected but no action is commenced within 12 months after such rejection*, all benefits under the policy would be forfeited, and that since the claim of the plaintiffs was denied and plaintiffs received notice of denial on April 18, 1956, and they brought the action only on May 5, 1958, all the benefits under the policy have been forfeited.

On February 12, 1959, plaintiffs filed a reply to the above answer of the Fulton Fire Insurance, alleging that on May 11, 1956, plaintiffs had instituted Civil Case No. 2949 in the Court of First Instance of Manila, to assert the claim; that this case was dismissed without prejudice on September 3, 1957 and that deducting the period within which said action was pending, the present action was still within the 12 month period from April 12, 1956. The court below held that the bringing of the action in the Court of First Instance of Manila on May 11, 1956, tolled the running of the 12 month period within which the action must be filed. Said the court on this point:

> True, indeed, plaintiffs committed a procedural mistake in first suing the agent instead of its principal, the herein defendant, as correctly pointed out by counsel for the defendant, for 'Un agente residente de una compania de seguros extranjera que comercia en las Islas Filipinos no es responsable como mandante ni como mandatario, en virtud de contratas de seguro expendidos a nombre de la compania', (Macias & Co. vs. Warner, Barnes & Co., 43 Phil. 161). But the mistake being merely procedural, and the defendant not having been misled by the error, 'There is nothing sacred about process or pleadings, their forms or contents. Their sole purpose is to facilitate the application of justice to the rival claims of contending parties. They were created not to hinder and delay, but to facilitate and promote the administration of justice (Alonso vs. Villamor, 16 Phil 578.)
>
> The complaint, Exh. 'C', was dismissed by the Court without prejudice (Exh. 'H-1') on September 3, 1957, and motion for reconsideration dated September 21, 1957. The instant complaint was filed on May 8, 1958. The Rules of Court (See 132 thereof) is applicable in the computation of time. Now, as correctly pointed out by the plaintiffs' counsel, by simple mathematical computation, the present action was filed leas thin nine (9) months after the notice of rejection received by plaintiffs on April 19, 1956, because the filing of the original complaint stopped the running of the period." (Decision, pp. 42-43, R.O.A.)

In view of the reasons thus above quoted, the court rendered decision in favor of the plaintiffs.

On the appeal before this Court, defendant-appellant argues that the court below erred in holding that the filing of the previous suit tolled or suspended the running of the prescriptive period.

The clause subject of the issue is paragraph 13 of the policy, which reads as follows:

> 13. If the claim be in any respect fraudulent, or if any false declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured or any one acting on his behalf to obtain any benefit under this Policy, or, if the loss or damage be occasioned by the willful act or with connivance of the Insured, or, if the claim be made and rejected and an action or suit be not commenced within twelve months after such rejection or (in case of arbitration place in pursuance of the 18th condition of this Policy) within twelve months after the arbitrator or arbitrators or umpire shall have made their award, all benefits under this Policy shall be forfeited. (Emphasis supplied). (Decision. p. 10, R.O.A.).

The appellant cites in support of its contention the cases of *E. Macias & Co. vs. Warner, Barnes & Co., Ltd*., 43 Phil 155; *E. Macias & Co. vs. China Fire Insurance Co*., 46 Phil. 345 and *Castillo etc. vs. Metropolitan Insurance Co*., 47 O.G. (September, 1951).

In answer to appellant's contention, counsel for appellees contend that the action of the plaintiffs against the defendant had not yet prescribed at the time of the bringing of the action, because the period of prescription was interrupted by the filing of the first action against the Paramount Surety & Insurance Co., in accordance with Article 1155 of the Civil Code. Counsel further argues that the basis of prescription of an action is the abandonment by a person of his right of action or claim, so that any act of said person tending to show his intention not to abandon his right of action or claim, as the filing of the previous action in the case at bar, interrupts the period of prescription. Furthermore, counsel argues, the dismissal of the previous action is without prejudice, which means that plaintiffs have the right to file another complaint against the principal.

The basic error committed by the trial court is its view that the filing of the action against the agent of the defendant company was "merely a procedural mistake of no significance or consequence, which may be overlooked." The condition contained in the insurance policy that claims must be presented within one year after rejection is not merely a procedural requirement. The condition is an important matter, essential to a prompt settlement of

claims against insurance companies, as it demands that insurance suits be brought by the insured while the evidence as to the origin and cause of destruction have not yet disappeared. It is in the nature of a condition precedent to the liability of the insurer, or in other terms, a resolutory cause, the purpose of which is to terminate all liabilities in case the action is not filed by the insured within the period stipulated.

The bringing of the action against the Paramount Surety & Insurance Company, the agent of the defendant Company cannot have any legal effect except that of notifying the agent of the claim. Beyond such notification, the filing of the action can serve no other purpose. There is no law giving any effect to such action upon the principal. Besides, there is no condition in the policy that the action must be filed against the agent, and this Court can not by interpretation, extend the clear scope of the agreement beyond what is agreed upon by the parties.

The case of *E. Macias & Co. vs. China Fire Insurance Co*. has settled the issue presented by the appellees in the case at bar definitely against their claim. In that case, We declared that the contractual station in an insurance policy prevails over the statutory limitation, as well as over the exceptions to the statutory limitations that the contract necessarily supersedes the statute (of limitations) and the limitation is in all phases governed by the former. (E. Macias & Co. vs. China Fire Insurance & Co., 46 Phil. pp. 345-353). As stated in said case and in accordance with the decision of the Supreme Court of the United States in Riddlesbarger vs. Hartford Fire Insurance Co. (7 Wall., 386), the rights of the parties flow from the contract of insurance, hence they are not bound by the statute of limitations nor by exemptions thereto. In the words of our own law, their contract is the law between the parties, and their agreement that an action on a claim denied by the insurer must be brought within one year from the denial, governs, not the rules on the prescription of actions.

The judgment appealed from is hereby set aside and the case dismissed, with costs against the plaintiffs-appellees.

Bengzon, C.J., Padilla, Concepcion, Reyes, J.B.L., Barrera, Paredes, Dizon, De Leon and Natividad, JJ., concur.

Republic of the Philippines
SUPREME COURT
Manila

SECOND DIVISION

G.R. No. 94071 March 31, 1992

NEW LIFE ENTERPRISES and JULIAN SY, petitioners,
vs.
HON. COURT OF APPEALS, EQUITABLE INSURANCE CORPORATION, RELIANCE SURETY AND INSURANCE CO., INC. and WESTERN GUARANTY CORPORATION, respondents.

REGALADO, *J.:*

This appeal by *certiorari* seeks the nullification of the decision [1] of respondent Court of Appeals in CA-G.R. CV No. 13866 which reversed the decision of the Regional Trial Court, Branch LVII at Lucena City, jointly deciding Civil Cases Nos. 6-84, 7-84 and 8-84 thereof and consequently ordered the dismissal of the aforesaid actions filed by herein petitioners.

The undisputed background of this case as found by the court *a quo* and adopted by respondent court, being sustained by the evidence on record, we hereby reproduce the same with approval. [2]

> The antecedents of this case show that 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 Enterpriseswith 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 inthe amount of P300,000.00 (Renewed under Renewal Certificate No. 41997) An additional insurancewas 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'clockin 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 innature. According to the plaintiffs, the building and the stocks inside were burned. After the fire, JulianSy went to the agent of Reliance Insurance whom he asked to accompany him to the office of thecompany so that he can file his claim. He averred that in support of his claim, he submitted the fireclearance, 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 saidcompany agrees to pay, they would also pay. The same treatment was given him by the otherinsurance companies. Ultimately, the three insurance companies denied plaintiffs' claim for payment.

In its letter of denial dated March 9, 1983, (Exhibit "C" No. 8-84) Western Guaranty Corporationthrough Claims Manager Bernard S. Razon told the plaintiff that his claim "is denied for breach ofpolicy conditions." Reliance Insurance purveyed the same message in its letter dated November 23, 1982 and signed by Executive Vice-President Mary Dee Co (Exhibit ″C" No. 7-84) which said that "plaintiff's claim is denied for breach of policy conditions." The letter of denial received by the plaintifffrom Equitable Insurance Corporation (Exhibit ″C" No. 6-84) 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 (Exhibit "G-l" No 7-84) toExecutive 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-PresidentMary Dee Co informed Atty. Dator that Julian Sy violated Policy Condition No. "3" which requires theinsured

> to give notice of any insurance or insurances already effected covering the stocks in trade. [3]

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, which cases were consolidated for trial, and thereafter the court below rendered its decision on December 19, l986 with the following disposition:

> WHEREFORE, judgment in the above-entitled cases is rendered in the following manner, viz:
>
> 1. In Civil Case No. 6-84, judgment is rendered for the plaintiff New Life Enterprises and against the defendant Equitable Insurance Corporation ordering the latter to pay the former the sum of TwoHundred Thousand (P200,000.00) Pesos and considering that payment of the claim of the insuredhas been unreasonably denied, pursuant to Sec. 244 of the Insurance Code, defendant is furtherordered to pay the plaintiff attorney's fees in the amount of Twenty Thousand (P20,000.00) Pesos. Allsums of money to be paid by virtue hereof shall bear interest at 12% *per annum* (pursuant to Sec.244 of the Insurance Code) from February 14, 1983, (91st day from November 16, 1982, when SwornStatement of Fire Claim was received from the insured) until they are fully paid;
>
> 2. In Civil Case No. 7-84, judgment is rendered for the plaintiff Julian Sy and against the defendantReliance Surety and Insurance Co., Inc., ordering the latter to pay the former the sum ofP1,000,000.00 (P300,000.00 under Policy No. 69135 and P700,000.00 under Policy No. 71547) andconsidering that payment of the claim of the insured has been unreasonably denied, pursuant to Sec.244 of the Insurance Code, defendant is further ordered to pay the plaintiff the amount of P100,000.00 as attorney's fees.
>
> All sums of money to be paid by virtue hereof shall bear interest at 12% *per annum* (pursuant to Sec. 244 of the Insurance Code) from February 14, 1983, (91st day from November 16, 1982 when SwornStatement of Fire Claim was received from the insured) until they are fully paid;

> 3. In Civil Case No. 8-84, judgment is rendered for the plaintiff New Life Enterprises and against thedefendant Western Guaranty Corporation ordering the latter to pay the sum of P350,000.00 to theConsolidated Bank and Trust Corporation, Lucena Branch, Lucena City, as stipulated on the face ofPolicy No. 37201, and considering that payment of the aforementioned sum of money has been unreasonably denied, pursuant to Sec. 244 of the Insurance Code, defendant is further ordered topay the plaintiff attorney's fees in the amount of P35,000.00.
>
> All sums of money to be paid by virtue hereof shall bear interest at 12% *per annum* (pursuant to Sec. 244 of the Insurance Code) from February 5, 1982, (91st day from 1st week of November 1983 when insured filed formal claim for full indemnity according to adjuster Vetremar Dela Merced) until they are fully paid. [4]

As aforestated, respondent Court of Appeals reversed said judgment of the trial court, hence this petition the cruxwherein is whether or not Conditions Nos. 3 and 27 of the insurance contracts were violated by petitioners thereby resulting in their forfeiture of all the benefits thereunder.

Condition No. 3 of said insurance policies, otherwise known as the "Other Insurance Clause," is uniformlycontained in all the aforestated insurance contracts of herein petitioners, as follows:

> 3. The insured shall give notice to the Company of any insurance or insurances already effected, orwhich may subsequently be effected, covering any of the property or properties consisting of stocksin trade, goods in process and/or inventories only hereby insured, and unless such notice be givenand the particulars of such insurance or insurances be stated therein or endorsed on this policy pursuant to Section 50 of the Insurance Code, by or on behalf of the Company before the occurrenceof 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 loss ordamage not more than P200,000.00. [5]

Petitioners admit that the respective insurance policies issued by private respondents did not state or endorse thereon the other insurance coverage obtained or subsequently effected on the same stocks in trade for the loss of which compensation is claimed by petitioners. [6] The policy issued by respondent Western Guaranty Corporation(Western) did not declare respondent Reliance Surety and Insurance Co., Inc. (Reliance) and respondent Equitable Insurance Corporation (Equitable) as co-insurers on the same stocks, while Reliance's Policies covering the same stocks didnot likewise declare Western and Equitable as such co-insurers. It is further admitted by petitioners that Equitable's policy stated "nil" in the space thereon requiring indication of any co-insurance although there were three (3) policies subsisting on the same stocks in trade at the time of the loss, namely, that of Western in the amount of P350,000.00 and two (2) policies of Reliance in the total amount of P1,000,000.00. [7]

In other words, the coverage by other insurance or co-insurance effected or subsequently arranged by petitioners were neither stated nor endorsed in the policies of the three (3) private respondents, warranting forfeiture of all benefits thereunder if we are to follow the express stipulation in the aforequoted Policy Condition No. 3.

Petitioners contend that they are not to be blamed for the omissions, alleging that insurance agent Leon 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 even read policies. [8] These contentions cannot pass judicial muster.

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. Theknowledge of such insurance by the insurer's agents, even assuming the acquisition thereof by the former, is notthe "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 applicabilityhere has likewise been roundly refuted by respondent court whose factual findings we find acceptable.

Thus, it points out that while petitioner Julian Sy claimed that he had informed insurance agent Alvarez regarding the co-insurance on the property, he contradicted himself by inexplicably claiming that he had not read the termsof the policies; that Yap Dam Chuan could not likewise have obtained such knowledge for the same reason, asidefrom the fact that the insurance with Western was obtained before those of Reliance and Equitable; and that theconclusion of the trial court that Reliance and Equitable are "sister companies" is an unfounded conjecture drawnfrom the mere fact that Yap Kam Chuan was an agent for both companies which also had the same insuranceclaims adjuster. Availment of the services of the same agents and adjusters by different companies is a

commonpractice in the insurance business and such facts
do not warrant the speculative conclusion of the trial court.

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. [9] 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. [10] The parties must abide by the
terms of the contract because such terms constitute the
measureof the insurer's liability and compliance therewith is a
condition precedent to the insured's right of recovery from the insurer.[11]

While it is a cardinal principle of insurance law that a policy or contract
of insurance is to be construed liberally infavor 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 suchterms
are clear and unambiguous, they must be taken and understood in their plain, ordinary and
popular sense.[12] Moreover, obligations arising from contracts have the force of law between
the contracting parties and should be compliedwith in good faith. [13]

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. [14] It may be true that themajority rule, as cited
by petitioners, is that injured persons may accept policies without reading them, and
that this is not negligence *per se.* **15** 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 [16] and the contract
concerns indemnity in case ofloss in his money-making trade of which important
consideration he could not have been unaware as it was pre-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.

We reiterate our pronouncement in *Pioneer Insurance and Surety Corporation vs. Yap:* [17]

> . . .
> And considering the terms of the policy which required the insured to dec
> lare other insurances,the statement in question must be deemed to be a
> statement (warranty) binding on both insurer and insured, that there
> were no other insurance on the property. . . .
>
> The annotation then, must be deemed
> to be a warranty that the property was not insured by any other policy.
> Violation thereof entitled the insurer to rescind (Sec. 69, Insurance
> Act). Suchmisrepresentation is fatal in the light of our views in *Santa Ana*
> *vs. Commercial Union Assurance Company, Ltd.*, 55 Phil. 329.
> The materiality of non-disclosure of other insurance policies is not open
> to doubt.
>
> xxx xxx xxx
>
> The obvious purpose of the aforesaid requirement in the policy
> is to prevent over-insurance and thus avert the perpetration of
> fraud. The public, as well as the insurer, is interested in preventing the
> situation in which a fire would be profitable to the insured. According to
> Justice Story: "The insured has no right to complain, for he assents to
> comply with all the stipulations on
> his side, in order toentitle himself to the
> benefit of the contract, which, upon reason or principle, he
> has no right to askthe court to dispense with the
> performance of his own part of the agreement, and yet to
> bind the otherparty to obligations, which, but for those stipulations,
> would not have been entered into."

Subsequently, in the case of *Pacific Banking Corporation vs. Court of Appeals, et al*., [18] we held:

> It is not disputed that the insured failed to reveal before the
> loss three other insurances. As found by the Court
> of Appeals, by reason of said unrevealed insurances, the
> insured had been guilty of a
> falsedeclaration; a clear misrepresentation and a vital one because where
> the insured had been asked to reveal
> but did not, that was deception. Otherwise stated, had the
> insurer known that there were many co-insurances, it could
> have hesitated or plainly desisted from entering into such contract.
> Hence, theinsured was guilty of clear fraud (*Rollo*, p. 25).
>
> Petitioner's contention that the allegation of fraud is but
> a mere inference or suspicion is untenable. In fact,
> concrete evidence of fraud or false declaration by
> the insured was furnished by the petitioner itself when the facts
> alleged in the policy under clauses ″Co-Insurances Declared" and
> "OtherInsurance Clause" are materially different from the actual number
> of co-insurances taken over
> thesubject property. Consequently, ″the whole foundation of the
> contract fails, the
> risk does not attachand the policy never becomes a contract between the
> parties." Representations of facts are the foundation of the contract and
> if the foundation does not exist, the superstructure does

> not arise.Falsehood in such representations is not shown to vary or add to the contract, or to terminate a contract which has once been made, but to show that no contract has ever existed (Tolentino,Commercial Laws of the Philippines, p. 991, Vol. II, 8th Ed.,) A void or inexistent contract is one which has no force and effect from the very beginning, as if it had never been entered into, and which cannot be validated either by time or by ratification (Tongoy vs. C.A., 123 SCRA 99 (1983); Avila v. C.A., 145 SCRA, 1986).
>
> As the insurance policy against fire expressly required that notice should be given by the insured ofother insurance upon the same property, the total absence of such notice nullifies the policy.

To further warrant and justify the forfeiture of the benefits under the insurance contracts involved, we need merelyto turn to Policy Condition No. 15 thereof, which reads in part:

> 15. . . . if any false declaration be made or used in support thereof, . . . all benefits under this Policy shall be forfeited . . . . [19]

Additionally, insofar as the liability of respondent Reliance is concerned, it is not denied that the complaint for recovery was filed in court by petitioners only on January 31, 1984, or after more than one (1) year had elapsedfrom petitioners' receipt of the insurers' letter of denial on November 29, 1982. Policy Condition No. 27 of their insurance contract with Reliance provides:

> 27. *Action or suit clause.* —
> If a claim be made and rejected and an action or suit be not commenced either in the Insurance Commission or any court of competent jurisdiction of notice of such rejection,or in case of arbitration taking place as *provided* herein, within twelve (12) months after due notice ofthe award made by the arbitrator or arbitrators or umpire, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder. [20]

On this point, the trial court ruled:

> . . . However, because of the peculiar circumstances of this case, we hesitate in concluding thatplaintiff's right to ventilate his claim in court has been barred by reason of the time constraint *provided*in the insurance contract. It is evident that after the plaintiff had received the letter of denial, he stillfound it necessary to be informed of the specific causes or reasons for the denial of his claim, reasonfor which his lawyer, Atty. Dator deemed it wise to send a letter of inquiry to the defendant which wasanswered by defendant's Executive Vice-President in a letter dated March 30, 1983, . . . Assuming,gratuitously, that the letter of Executive Vice-President Mary Dee Co dated March 30, 1983, was received by plaintiff on the same date, the period of limitation should start to run only from said date in the spirit of fair play and equity. . . . [21]

We have perforce to reject this theory of the court below for being contrary to what we have heretofore declared:

> It is important to note the principle laid down by this Court in the case of *Ang vs. Fulton Fire Insurance Co.* (2 SCRA 945 [1961]) to wit:
>
> > The condition contained in an insurance policy that claims must be presented within one year after rejection is not merely a procedural requirement but an important matter essential to a prompt settlement of claims against insurance companies as it demandsthat insurance suits be brought by the insured while the evidence as to the origin andcause of destruction have not yet disappeared.
>
> In enunciating the above-cited principle, this Court had definitely settled the rationale for the necessity of bringing suits against the Insurer within one year from the rejection of the claim. The contention of the respondents that the one-year prescriptive period does not start to run until thepetition 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 anddefeat the very principle which this Court had laid down. Moreover, it can easily be used by insured persons as a scheme or device to waste time until any evidence which may be considered againstthem is destroyed.
>
> xxx xxx xxx

> While in the Eagle Star case (96 Phil. 701),
> this Court uses the phrase "final rejection", the
> samecannot be taken to mean the rejection of a petition
> for reconsideration as insisted by respondents.
> Such was clearly not the meaning contemplated by this Court. The insura nce policy in said caseprovides that the insured should file his claim first, with the carrier and then with the insurer.
> The "finalrejection" being referred to in said case is the rejection by the insurance company. [22]

Furthermore, assuming *arguendo* that petitioners felt the
legitimate need to be clarified as to the policy condition violated, there was a considerable lapse of time from their receipt of the insurer's clarificatory letter dated March 30, 1983, up to the time the complaint was filed in court on January 31, 1984. The one-year prescriptive periodwas yet to expire on November 29, 1983, or about eight (8) months from the receipt of the clarificatory letter, butpetitioners let the
period lapse without bringing their action in court.
We accordingly find no "peculiarcircumstances" sufficient to
relax the enforcement of the one-year prescriptive period and
we, therefore, hold thatpetitioners' claim was definitely filed out of time.

WHEREFORE, finding no cogent reason to disturb the judgment
of respondent Court of Appeals, the same ishereby AFFIRMED.

SO ORDERED.

Melencio-Hererra and Nocon, JJ., concur.

Paras, J., took no part.

Padilla, J., took no part.

Republic of the Philippines
SUPREME COURT
Manila

EN BANC

G.R. No. L-15184 May 31, 1963

SAURA IMPORT & EXPORT CO., INC., plaintiff-appellant,
vs.
PHILIPPINE INTERNATIONAL SURETY CO., INC., and PHILIPPINE NATIONAL BANK, defendants-appellees.

Saura, Magno & Associates for plaintiff-appellant.
Tolentino, Garcia and D. R. Cruz for defendant-appellee Philippine International Surety Co., Inc.
Ramon B. de los Reyes and Antonio P. Cruz for defendant-appellee Philippine National Bank.

PAREDES, *J.:*

Instant case was certified by the Court of Appeals to Us, it appearing that the issues involved are purely of law.

On December 26, 1952, the Saura Import & Export Co Inc., mortgaged to the Phil. National Bank, a parcel of land covered by T.C.T. No. 40445 of the Registry of Deeds of Davao, issued in its name, to secure the payment of promissory note of P27,000.00 (Exhs. P, B-2). On April 30, 1953, the mortgage was amended to guarantee an increased amount, bringing the total mortgaged debt to P37,000.00 (Exhs. P-2, B-3). The provisions of the mortgaged contact, pertinent to the resolution of the present case, provide as follows —

> 2. . . . he shall insure the mortgaged property at all times against fire and earthquake for an amount and with such company satisfactory to the Mortgagee, indorsing to the latter the corresponding policies; he shall keep the mortgaged property in good condition, making repairs and protecting walls that may be necessary; . . .
>
> x x x x x x x x x

Erected on the land mortgaged, was a building of strong materials owned by the mortgagor Saura Import & Export Co., Inc., which had always been covered by insurance, many years prior to the mortgage contract. Pursuant to the requirement, Saura insured the building and its contents with the Philippine International Surety, an insurance firm acceptable to mortgagee Bank, for P29,000.00 against fire for the period of one year from October 2, 1954. As required therefor, the insurance policy was endorsed to the mortgagee PNB, in a Memo which states —

> Loss if any, payable to the Philippine National Bank as their interest may appear, subject to the terms, conditions and warranties of this policy (Exh. A).

The policy was delivered to the mortgagee Bank by Saura. On October 15, 1954, barely thirteen (13) days after the issuance of the fire insurance policy (October 2, 1954), the insurer cancelled the same, effective as of the date of issue (Exh. A-2). Notice of the cancellation was given to appellee bank in writing, sent by Registered Mail and personally addressed to Fortunato Domingo, Branch Manager of the appellee Bank's Davao Branch, and

was received by the Bank on November 8, 1954. On April 6, 1955, the building and its contents, worth P40,685.69 were burned. On April 11, 1955, Saura filed a claim with the Insurer and mortgagee Bank. Upon the presentation of notice of loss with the PNB, Saura learned for the first time that the policy had previously been cancelled on October 2, 1954, by the insurer, when Saura's folder in the Bank's filed was opened and the notice of cancellation (original and duplicate) sent by the Insurer to the Bank, was found. Upon refusal of the Insurer Philippine International Surety to pay the amount of the insurance, Civil Case No. 26847 was filed with the Manila CFI against the Insurer, and the PNB was later included as party defendant, after it had refused to prosecute the case jointly with Saura Import & Export Co., Inc.

At the trial, it was established that neither the Insurer nor the mortgagee Bank informed the plaintiff Saura of the cancellation of the policy. On April 30, 1957, the court *a quo* rendered the following judgment —

> . . . IN VIEW WHEREOF, complaint dismissed; costs against the plaintiff; but as there is no proof on the counterclaim of the Philippines International Surety, the same is also dismissed.
>
> Wherefore, the parties respectfully pray that the foregoing stipulation of facts be admitted and approved by this Honorable Court, without prejudice to the parties adducing other evidence to prove their case not covered by this stipulation of facts. *1äwphï1.ñët*

A motion to reconsider the above judgment, seasonably presented on May 14, 1957, was subsequently denied. The decision rendered and the resolution denying the motion for reconsideration constitute the subject of the instant appeal by plaintiff Saura on the three alleged errors, which converge on the correctness of the ruling, wholly dismissing the complaint absolving both the insurance company and the bank from liability.

In the determination of liabilities of the parties herein, let us look into the general principles of insurance, in matters of cancellations of policy by the insurer. Fire insurance policies and other contracts of insurance upon property, in addition to the common provision for cancellation of the policy upon request of the insured, generally provide for cancellation by the insurer by notice to the insured for a prescribed period, which is usually 5 days, and the return of the unearned portion of the premium paid by the insured, such provision for cancellation upon notice being authorized by statutes in some jurisdiction, either specifically or as a provision of an adopted standard form of policy. The purpose of provisions or stipulations for notice to the insured, is to prevent the cancellation of the policy, without allowing the insured ample opportunity to negotiate for other insurance in its stead. The form and sufficiency of a notice of cancellation is determined by policy provisions. In order to form the basis for the cancellation of a policy, notice to the insured n not be in any particular form, in the absence of a statute or policy provision prescribing such form, and it is sufficient, so long as it positively and unequivocally indicates to the insured, that it is the intention of the company that the policy shall cease to be binding. Where the policy contains no provisions that a certain number of days notice shall be given, a reasonable notice and opportunity to obtain other insurance must be given. Actual personal notice to the insured is essential to a cancellation under a provision for cancellation by notice. The actual receipt by the insured of a notice of cancellation is universally recognized as a condition precedent to a cancellation of the policy by the insurer, and consequently a letter containing notice of cancellation which is mailed by the insurer but not received by the insured, is ineffective as cancellation (29 Am. Jur. pp. 732-741).

The policy in question (Exh. A), does not provide for the notice, its form or period. The Insurance Law, Act No. 2427, does not likewise provide for such notice. This being the case, it devolves upon the Court to apply the generally accepted principles of insurance, regarding cancellation of the insurance policy by the insurer. From what has been heretofore stated, actual notice of cancellation in a clear and unequivocal manner, preferably in writing, in view of the importance of an insurance contract, should be given by the insurer to the insured, so that the latter might be given an opportunity to obtain other insurance for his own protection. The notice should be personal to the insured and not to and/or through any unauthorized person by the policy. In the case at bar, the defendant insurance company, must have realized the paramount importance of sending a notice of cancellation, when it sent the notice of cancellation of the policy to the defendant bank (as mortgagee), but not to the insured with which it (insurance company) had direct dealing. It was the primary duty of the defendant-appellee insurance company to notify the insured, but it did not. It should be stated that the house and its contents were burned on April 6, 1955, at the time when the policy was enforced (October 2, 1954 to October 2, 1955); and that under the facts, as found by the trial court, to which We are bound, it is evident that both the insurance company and the appellee bank failed, wittingly or unwittingly, to notify the insured appellant Saura of the cancellation made.

Of course, the defendant insurance company contends that it gave notice to the defendant-appellee bank as mortgagee of the property, and that was already a substantial compliance with its duty to notify the insured of the cancellation of the policy. But notice to the bank, as far appellant herein is concerned, is not effective notice.

> If a mortgage or lien exists against the property insured, and the policy contains a clause stating that loss, if any, shall be payable to such mortgagee or the holder of such lien as interest may appear, notice of cancellation to the mortgagee or lienholder alone is ineffective as a cancellation of the policy to the owner of the property. (Connecticut Ins. Co. v. Caumisar, 218 Ky. 378, 391 SW 776, cited in 29 Am. Jur. p. 743).

Upon authority of the above case, therefore, the liability of the insurance company becomes a fact.

It may be argued that in the appeal brief of appellant, no error has been assigned against the insurance company and no prayer is found therein asking that it be made liable. It must be noted, however, that the case was dismissed the lower court and the main object of the

appeal is to secure a reversal of the said judgment. This Court is clothed with ample authority to review matters, even if they are not assigned as errors in the appeal, if it finds that their consideration is necessary in arriving at a just decision of the case. Thus it was held:

> While an assignment of error which is required by law or rule of court has been held essential to appellate review, only those assigned will be considered, there are a number of cases which appear to accord to the appellate court a broad discretionary power to waive the lack of proper assignment of errors and consider errors not assigned. And an unassigned error closely related to an error properly assigned, or upon which the determination of the question raised by the error properly assigned is dependent, will be considered by the appellate court notwithstanding the failure to assign it as error. (Hernandez v. Andal, 78 Phil. 198-199).

Although assigned errors apparently appear to be directed against the appellee bank alone, they in essence, seek a reversal of the decision on dismissal, entered by the lower court, which in the main has for its purpose the finding of liability on the policy. In the course of our examination of the records of the case, the decision and the errors assigned, We found that liability attached principally the insurance company, for its failure to give notice of the cancellation of the policy to herein appellant itself.

Because of the conclusions reached, We find it unnecessary to discuss the errors assigned against appellee bank.

WHEREFORE, the decision appealed from is hereby reversed, and another is entered, condemning the defendant-appellee Philippine International Surety Co., Inc., to pay Saura Import & Export Co., Inc., appellant herein, the sum of P29,000.00, the amount involved in Policy No. 429, subject-matter of the instant case. Without costs.

Bengzon, C.J., Padilla, Bautista Angelo, Concepcion, Reyes, J.B.L., Barrera, Dizon, Regala and Makalintal, JJ., concur.
Labrador, J., took no part.

Republic of the Philippines
SUPREME COURT
Manila

FIRST DIVISION

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

MALAYAN INSURANCE CO., INC. (MICO), petitioner,
vs.
GREGORIA CRUZ ARNALDO, in her capacity as the INSURANCE COMMISSIONER, and CORONACION PINCA, respondents.

CRUZ, *J.:*

When a person's house is razed, the fire usually burns down the efforts of a lifetime and forecloses hope for the suddenly somber future. The vanished abode becomes a charred and painful memory. Where once stood a home, there is now, in the sighing wisps of smoke, only a gray desolation. The dying embers leave ashes in the heart.

For peace of mind and as a hedge against possible loss, many people now secure fire insurance. This is an aleatory contract. By such insurance, the insured in effect wagers that his house will be burned, with the insurer assuring him against the loss, for a fee. If the house does burn, the insured, while losing his house, wins the wagers. The prize is the recompense to be given by the insurer to make good the loss the insured has sustained.

It would be a pity then if, having lost his house, the insured were also to lose the payment he expects to recover for such loss. Sometimes it is his fault that he cannot collect, as where there is a defect imputable to him in the insurance contract. Conversely, the reason may be an unjust refusal of the insurer to acknowledge a just obligation, as has happened many times.

In the instant case the private respondent has been sustained by the Insurance Commission in her claim for compensation for her burned property. The petitioner is now before us to dispute the decision, **1** on the ground that there was no valid insurance contract at the time of the loss.

The chronology of the relevant antecedent facts is as follows:

On June 7, 1981, the petitioner (hereinafter called (MICO) issued to the private respondent, Coronacion Pinca, Fire Insurance Policy No. F-001-17212 on her property for the amount of P14,000.00 effective July 22, 1981, until July 22, 1982. [2]

On October 15,1981, MICO allegedly cancelled the policy for non-payment, of the premium and sent the corresponding notice to Pinca. [3]

On December 24, 1981, payment of the premium for Pinca was received by DomingoAdora, agent of MICO. [4]

On January 15, 1982, Adora remitted this payment to MICO,together with other payments. [5]

On January 18, 1982, Pinca's property was completely burned. [6]

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. [7]

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.

From the procedural viewpoint alone, the petition must be rejected. It is stillborn.

The records show that notice of the decision of the public respondent dated April 5, 1982, was received by MICO on April 10, 1982. [8] On April 25, 1982, it filed a motion for reconsideration, which was denied on June 4, 1982. [9] Notice of this denial was received by MICO on June 13, 1982, as evidenced by Annex "1" duly authenticated by the Insurance Commission. **10** The instant petition was filed with this Court on July 2, 1982. **11**

The position of the petition is that the petition is governed by Section 416 0f the Insurance Code giving it thirty days wthin which to appeal by certiorari to this Court. Alternatively, it also invokes Rule 45 of the Rules of Court. For their part, the public and private respondents insist that the applicable law is B.P. 129, which they say governs not only courts of justice but also quasi-judicial bodies like the Insurance Commission. The period for appeal under this law is also fifteen days, as under Rule 45.

The pivotal date is the date the notice of the denial of the motion for reconsideration was received by MICO.

MICO avers this was June 18, 1982, and offers in evidence its Annex "B," **12** which is a copy of the Order of June 14, 1982, with a signed rubber-stamped notation on the upper left-hand corner that it was received on June 18, 1982, by its legal department. It does not indicate from whom. At the bottom, significantly, there is another signature under which are the ciphers "6-13-82," for which no explanation has been given.

Against this document, the private respodent points in her Annex "1," **13** the authenticated copy of the same Order with a rubber-stamped notation at the bottom thereof indicating that it was received for the Malayan Insurance Co., Inc. by J. Gotladera on "6-13-82." The signature may or may not habe been written by the same person who signed at the bottom of the petitioner's Annex "B."

Between the two dates, the court chooses to believe June 13, 1982, not only because the numbers "6-13-82" appear on both annexes but also because it is the date authenticated by the administrative division of the Insurance Commission. Annex "B" is at worst self-serving; at best, it might only indicate that it was received on June 18, 1982, by the legal department of MICO, after it had been received earlier by some other of its personnel on June 13, 1982. Whatever the reason for the delay in transmitting it to the legal department need not detain us here.

Under Section 416 of the Insurance Code, the period for appeal is thirty days from notice of the decision of the Insurance Commission. The petitioner filed its motion for reconsideration on April 25, 1981, or fifteen days such notice, and the reglementary period began to run again after June 13, 1981, date of its receipt of notice of the denial of the said motion for reconsideration. As the herein petition was filed on July 2, 1981, or nineteen days later, there is no question that it is *tardy by four days.*

Counted from June 13, the fifteen-day period prescribed under Rule 45, assuming it is applicable, would end on June 28, 1982, or also *four days* from July 2, when the petition was filed.

If it was filed under B.P. 129, then, considering that the motion for reconsideration was filed on the fifteenth day after MICO received notice of the decision, only one more day would have remained for it to appeal, to wit, June 14, 1982. That would make the petition *eighteen days* late by July 2.

Indeed, even if the applicable law were still R.A. 5434, governing appeals from administrative bodies, the petition would still be tardy. The law provides for a fixed period of ten days from notice of the denial of a seasonable motion for reconsideration within which to appeal from the decision. Accordingly, that ten-day period, counted from June 13, 1982, would have ended on June 23, 1982, making the petition filed on July 2, 1982, *nine days* late.

Whichever law is applicable, therefore, the petition can and should be dismissed for late filing.

On the merits, it must also fail. MICO's arguments that there was no payment of premium and that the policy had been cancelled before the occurence of the loss are not acceptable. Its contention that the claim was allowed without proof of loss is also untenable.

The petitioner relies heavily on Section 77 of the Insurance Code providing that:

> SEC. 77. An insurer is entitled to payment of the premium as soon as the thing 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.

The above provision is not applicable because payment of the premium was in fact eventually made in this case. Notably, the premium invoice issued to Pinca at the time of the delivery of the policy on June 7, 1981 was stamped "Payment Received" of the amoung of

P930.60 on "12-24-81" by Domingo Adora. **14** This is important because it suggests an understanding between MICO and the insured that such payment could be made later, as agent Adora had assured Pinca. In any event, it is not denied that this payment was actually made by Pinca to Adora, who remitted the same to MICO.

The payment was made on December 24, 1981, and the fire occured on January 18, 1982. One wonders: suppose the payment had been made and accepted in, say, August 1981, would the commencement date of the policy have been changed to the date of the payment, or would the payment have retroacted to July 22, 1981? If MICO accepted the payment in December 1981 and the insured property had not been burned, would that policy not have expired just the same on July 22, 1982, pursuant to its original terms, and not on December 24, 1982?

It would seem from MICO's own theory, that the policy would have become effective only upon payment, if accepted and so would have been valid only from December 24, 1981m but only up to July 22, 1981, according to the original terms. In others words, the policy would have run for only eight months although the premium paid was for one whole year.

It is not disputed that the preium was actually paid by Pinca to Adora on December 24, 1981, who received it on behalf of MICO, to which it was remitted on January 15, 1982. What is questioned is the validity of Pinca's payment and of Adora's authority to receive it.

MICO's acknowledgment of Adora as its agent defeats its contention that he was not authorized to receive the premium payment on its behalf. It is clearly provided in Section 306 of the Insurance Code that:

> SEC. 306. xxx xxx xxx
>
> Any insurance company which delivers to an insurance agant or insurance broker a policy or contract of insurance shall be demmed 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.

And it is a well-known principle under the law of agency that:

> Payment to an agent having authority to receive or collect payment is equivalent to payment to the principal himself; such payment is complete when the money delivered is into the agent's hands and is a discharge of the indebtedness owing to the principal. **15**

There is the petitioner's argument, however, that Adora was not authorized to accept the premium payment because six months had elapsed since the issuance by the policy itself. It is argued that this prohibition was binding upon Pinca, who made the payment to Adora at her own riskl as she was bound to first check his authority to receive it. **16**

MICO is taking an inconsistent stand. While contending that acceptance of the premium payment was prohibited by the policy, it at the same time insists that the policy never came into force because the premium had not been paid. One surely, cannot have his cake and eat it too.

We do not share MICO's view that there was no existing insurance at the time of the loss sustained by Pinca because her policy never became effective for non-payment of premium. Payment was in fact made, rendering the policy operative as of June 22, 1981, and removing it from the provisions of Article 77, Thereafter, the policy could be cancelled on any of the supervening grounds enumerated in Article 64 (except "nonpayment of premium") provided the cancellation was made in accordance therewith and with Article 65.

Section 64 reads as follows:

> 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; **17**

(2) The notice must be based on the occurrence, after the effective date of the policy, of one or more of the grounds mentioned;**18**

(3) The notice must be (a) in writing, (b) mailed, or delivered to the named insured, (c) at the address shown in the policy; **19**

(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. [20]

MICO's claims it cancelled the policy in question on October 15, 1981, for non-payment 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 the assured by mail through our mailing section" [21] 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's 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 petitioner then says that its "stand is enervated (sic) by the legal presumption of regularity and due performance of duty." [22](not realizing perhaps that "enervated" means "debilitated" not "strengthened").

On the other hand, there is the flat denial of Pinca, who says she never received the claimed cancellation and who, of course, did not have to prove such denial Considering the strict language of Section 64 that no insurance policy shall be cancelled except upon prior notice, it behooved MICO's to make sure that the cancellation was actually sent to and received by the insured. The presumption cited is unavailing against the positive duty enjoined by Section 64 upon MICO and the flat denial made by the private respondent that she had received notice of the claimed cancellation.

It stands to reason that if Pinca had really received the said notice, she would not have made payment on the original policy on December 24, 1981. Instead, she would have asked for a new insurance, effective on that date and until one year later, and so taken advantage of the extended period. The Court finds that if she did pay on that date, it was because she honestly believed that the policy issued on June 7, 1981, was still in effect and she was willing to make her payment retroact to July 22, 1981, its stipulated commencement date. After all, agent Adora was very accomodating and had earlier told her "to call him up any time" she was ready with her payment on the policy earlier issued. She was obviously only reciprocating in kind when she paid her premium for the period beginning July 22, 1981, and not December 24, 1981.

MICO's suggests that Pinca knew the policy had already been cancelled and that when she paid the premium on December 24, 1981, her purpose was "to renew it." As this could not be done by the agent alone under the terms of the original policy, the renewal thereof did not legally bind MICO. which had not ratified it. To support this argument, MICO's cites the following exchange:

> Q: Now, Madam Witness, on December 25th you made the alleged payment. Now, my question is that, did it not come to your mind that after the lapse of six (6) months, your policy was cancelled?
>
> A: I have thought of that but the agent told me to call him up at anytime.
>
> Q: So if you thought that your policy was already intended to revive cancelled policy?
>
> A: Misleading, Your Honor.
>
> Hearing Officer: The testimony of witness is that, she thought of that.
>
> Q: I will revise the question. Now, Mrs. Witness, you stated that you thought the policy was cancelled. Now, when you made the payment of December 24, 1981, your intention was to revive the policy if it was already cancelled?
>
> A: Yes, to renew it. [23]

A close study of the above transcript will show that Pinca meant to renew the policy *if* it had really been already cancelled but not if it was stffl effective. It was all conditional. As it has not been shown that there was a valid cancellation of the policy, there was consequently no need to renew it but to pay the premium thereon. Payment was thus legally made on the *original* transaction and it could be, and was, validly received on behalf of the insurer by its agent Adora. Adora. incidentally, had not been informed of the cancellation either and saw no reason not to accept the said payment.

The last point raised by the petitioner should not pose much difficulty. The valuation fixed in fire insurance policy is conclusive in case of total loss in the absence of fraud, [24] 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. [25] 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 [26] issued by the Integrated National Police, Lao-ang, Samar, 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 bumed in the fire that razed the commercial district of Lao-ang, Samar, on January 18, 1982. [27]

There is nothing in the Insurance Code that makes the participation of an adjuster in the assessment of the loss imperative or indespensable, as MICO suggests. Section 325, which it cites, simply speaks of the licensing and duties of adjusters.

We see in this cases 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's 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 its candor and bona fides.

WHEREFORE, the petition is DENIED. The decision of the Insurance Commission dated April 10, 1981, and its Order of June 4, 1981, are AFFIRMED in full, with costs against the petitioner. This decision is immediately executory.

SO ORDERED.

Teehankee, C.J., Narvasa and Paras, JJ., concur.

Gancayco, J, is on leave.