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AHMEDABAD

OFFICE OF THE INSURANCE OMBUDSMAN (GUJARAT)

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Case No. 21-001-0080-10

Smt.Parvatiben D.Patel V/s.

Life Insurance Corporation of India

Award Dated 21-07-2009

Repudiation of Death claim under Life Insurance Policy:

The Assured died within 1 year and 7 months from the inception of the policy. Claim was repudiated alleging that the assured was suffering from pain in both the legs and unable to walk and progressive weakness upper and lower limbs (Syringo Myelia) Reliance was placed on claim for 'B' wherein Doctor Dinesh H. Tandel stated that DLA was suffering from this disease for 2 years from the date of death i.e. 23-5-07 and claim form B1 wherein it was stated that DLA was admitted at Mahavir Hospital on 04-01-06 and discharged on 12-1-06 where history given by the DLA was "pain in both the legs, unable to walk", paraparesis both the legs progressive from last 2 to 3 months.

In the instant case, the Respondent failed to produce the case papers of the treatment of the disease from which the DLA suffered prior to the date of the proposal. Actual cause of death was cardio respiratory arrest which had no nexus with the so called diseases said to be not discharged by the DLA.

The Investigating officer had opined that the DLA was in good health and death was genuine hence claim may be admitted.

The Respondent fails to prove by giving satisfactory compliance to the three conditions of the part II of sections 45 of Insurance Act, 1938.

The decision of the Respondent to repudiate the claim was set aside.

Ahmedabad Ombudsman Centre

Case No. 21-001-0002-10

Mrs. K.V. Khemka V/s.

Life Insurance Corporation of India

Award Dated 30-06-2009

Repudiation of Death claim under life policy.

The Assured died on 21-02-08 within 1 year and 11 months from the inception of the policy due to heart attack. Claim was repudiated alleging that the Assured was suffering from Hansen's disease (leprosy) and was under treatment for the said disease when he signed the proposal form on 31-3-2006. Reliance was placed on the certificate of Doctor Sunil Pradhan who treated the Assured from July, 2005 to July, 2006 and Doctor R.K.Posale of Baroda Clinic Laboratory. Both the doctors had confirmed that the Assured was suffering from the Hansen's disease. Non disclosure of this fact denied the opportunity to decline grant of insurance. Misstatement in this regard sniped Utmost Good faith which forms the corner stone of Insurance Contract. Though the ennobling provision of section 45 of Insurance Act, 1938 was not operating in favour of the Respondent Insurance, the documents adduced could prove that with a fraudulent intention insurance was taken.

As such, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre

Case No. 21-001-0080-10

Smt.Parvatiben D.Patel V/s.

Life Insurance Corporation of India

Award Dated 21-07-2009

Repudiation of Death claim under Life Insurance Policy:

The Assured died within 1 year and 7 months from the inception of the policy. Claim was repudiated alleging that the assured was suffering from pain in both

the legs and unable to walk and progressive weakness upper and lower limbs (Syringo Myelia) Reliance was placed on claim for 'B' wherein Doctor Dinesh H. Tandel stated that DLA was suffering from this disease for 2 years from the date of death i.e. 23-5-07 and claim form B1 wherein it was stated that DLA was admitted at Mahavir Hospital on 04-01-06 and discharged on 12-1-06 where history given by the DLA was "pain in both the legs, unable to walk", paraparesis both the legs progressive from last 2 to 3 months.

In the instant case, the Respondent failed to produce the case papers of the treatment of the disease from which the DLA suffered prior to the date of the proposal. Actual cause of death was cardio respiratory arrest which had no nexus with the so called diseases said to be not discharged by the DLA.

The Investigating officer had opined that the DLA was in good health and death was genuine hence claim may be admitted.

The Respondent fails to prove by giving satisfactory compliance to the three conditions of the part II of sections 45 of Insurance Act, 1938.

The decision of the Respondent to repudiate the claim was set aside.

Ahmedabad Ombudsman Centre

Case No. 21-001-0002-10

Mrs. K.V. Khemka V/s.

Life Insurance Corporation of India

Award Dated 30-06-2009

Repudiation of Death claim under life policy.

The Assured died on 21-02-08 within 1 year and 11 months from the inception of the policy due to heart attack. Claim was repudiated alleging that the Assured was suffering from Hansen's disease (leprosy) and was under treatment for the said disease when he signed the proposal form on 31-3-2006. Reliance was placed on the certificate of Doctor Sunil Pradhan who treated the Assured from July, 2005 to July, 2006 and Doctor R.K.Posale of Baroda Clinic Laboratory. Both the doctors had confirmed that the Assured was suffering from the Hansen's disease. Non disclosure of this fact denied the opportunity to

decline grant of insurance. Misstatement in this regard sniped Utmost Good faith which forms the corner stone of Insurance Contract. Though the ennobling provision of section 45 of Insurance Act, 1938 was not operating in favour of the Respondent Insurance, the documents adduced could prove that with a fraudulent intention insurance was taken.

As such, the decision of the Respondent to repudiate the claim was upheld.

Ahmedabad Ombudsman Centre

Case No. 21-004-0126-10

Mr. M.B.Shah Vs.

ICICI Prudential Life Insurance Co.Ltd.

Award Dated 24-08-2009.

Repudiation of Death Claim under Life Ins. Policy.

While proposing for insurance, the deceased Life Assured had not disclosed the fact of his suffering from cancer (Spurious Carcinoma) prior to his filling the proposal form, The Respondent could produce certificate of treatment by Cancer Hospital. Had he disclosed the facts in the proposal form, the Respondent would have declined to allot the risk. The Assured died within 1 year 11 months from taking the policy due to Cardio Respiratory arrest and cancer of buccal mucosa.

The evidence being foolproof beyond doubt, though the provision of Section 45 of Insurance Act, 1938 was operating against the insurer, all the three conditions of Part II of the said section was proved. Hence, the decision of the Respondent to repudiate the claim was upheld.

Award dated 29-06-2009

Case No.21-007-0006-10

Mrs. Madhuben Ishwarlal Purani Vs.

Max Newyork Life Insurance Co

The death claim under the subject policy was repudiated by the Respondent alleging incorrect statement and withholdment of material information with regard to his health at the time of affecting the assurance with the Respondent under the subject policy

The DLA aged 34 years old male was treated on OPD basis for 4-5 days before his death by Dr. Girjesh Agrawal. He had short history (4-5 days) of high grade fever, vomiting and headache. He died on 20.12.08 cause of death was septicemia and Meningeal fever.

Claim form "C" proforma for last attending doctor for death claim dated 29.1.2009 has shows that DLA had no addiction and history of any disease such as hypertension, liver disease etc. and cause of death was Infected fever.

In the claim form "C" in reply to questions 2 (C) How long you had known the deceased? Doctor has replied one or two months. And in reply to Question 6 were you deceased's usual doctor he has replied. I don't know, same reply is repeated for the question on details of treatment in the past.

There are also on record statements obtained by investigator of the Respondent Rothshield Health Care (TPA) Services Ltd. from claimant, DLA's relative and neighbor. These statements confirm that DLA was suffering from fever since 4-5 days and he had no history of any kind of addiction, major illness and medical treatment.

The certificate obtained by the Respondent from Dr. Girjesh Agrawal dated 2.1.2009 states that DLA was declared dead on 20.12.2008 at 10.30 pm. He was under his treatment since 17.12.08 to 20.12.08. He was suffering from cirrhosis of liver. He was alcohol last four years H/O cause of death was alcoholic cirrhosis with high grade fever. However the information given in this certificate is at variance from the statement of Dr. Girjesh Agarwal dated 2.4.2009 and information recorded by him in claim form "C"

The sole evidence on record on the basis of which the claim has been repudiated is a certificate Date 29.1.2009 from Dr. Girjesh Agrawal who is a DHMS most probably having a Diploma in Homeopathy. However the contents of this certificate have been retracted by a written statement dated 2.4.2009 and are not corroborated by claim form "C" attending physician's statement for death claim obtained by the Respondent and Questionnaire for last attending Doctor/Hospital obtained by Respondent's claim investigator.

This certificate is very vague as it simply states about DLA as "He was alcohol last four years" and gives cause of death as Cirrhosis of liver with high grade fever and was under the treatment of Dr. Agrawal from 17.12.08 to 20.12.08. It is also pertinent that Dr. Girjesh Agrawal was not the usual doctor of the DLA and he knew him for past one –two months.

Information given in form "C" obtained from Dr. Girjesh Agrawal by the Respondent corroborates that the Doctor has known the DLA for last one or two months and he is not the deceased's usual doctor. Cause of death has been given as infectious fever. This raises doubts as to his statements that DLA was alcohol last four years.

Questionnaire obtained by the Respondent's investigator from last attending Doctor/Hospital is negative so far as consumption of alcohol by DLA is concerned. In reply to Question 6 Do you know about the personal habits of alcohol/Gutkha/betel nut & tobacco chewing / any particular addiction? The doctor has replied "No".

Claim form "C" does not confirm history of cirrhosis or consumption of alcohol. There is no evidence on record to prove that

DLA was consuming alcohol for last four years, or he was suffering from cirrhosis of liver. This form does not corroborate information given in certificate dated 2.1.09 from the same doctor.

All the evidences collected by the investigator of the respondent in the form of questioner from relatives and neighbors also rule out history of any kind of addiction or history of any major illness and medical treatment for alcoholic cirrhosis of liver.

There is no evidence on record to confirm or corroborate that DLA was in the habit of consuming alcohol for the last 4 years and cause of his death was due to alcoholic cirrhosis of liver. Respondent has failed to produce any concrete evidence to show that DLA was suffering from Alcoholic cirrhosis of liver and had taken treatment for the same prior to the date of signing the proposal form

Thus the Respondent fails to justify repudiation of claim on the grounds of suppression of material facts.

Complaint succeeds and forum directed to the Respondent to settle the claim.

Award dated 30-06-2009

Case No.21-007-0023-10

Ms. Samjotaben Kalpeshbhai Bhudrekar Vs.

Max Newyork Life Insurance Co

The policy resulted into claim by death of the DLA on 28-08-2008 within four months from the date of proposal. The complainant (sister of the Life Assured and nominee under the policy) lodged the claim with the respondent along with Original policy document and copy of death certificate of DLA. The cause of death was accidental head injury.

The respondent vide their letter dated 3.10.2008 and 19.11.008 called for the following requirements to process the claim

The complainant however submitted claim form "A" and claim form "C" to the Respondent and submitted FIR, Post mortem report and Punchnama.

The complainant submitted that after the requirements called for by the Respondent were submitted by her the Respondent has not informed her about the status of claim since last 7 months.

The respondent produced their investigator's report dated 20.1.2008 and pleaded that the complainant has not submitted the required documents to process the claim. They further submitted that the claim is pending for the want of required documents to ascertain the identity of DLA and the cause of death of DLA and the requisite documents are crucial for claim evaluation since it is very early claim

The Respondent raised following issues:

1. The Complainant is not submitting requisites documents called for on 3.10.2008 and 19.10.2008.
2. The DLA withheld correct Information regarding his occupation and residence while effecting the subject Insurance, when he signed the Proposal Form on 16-05-2008
3. The identity of the DLA and nominee and cause of death of DLA are not confirmed.
4. Further investigation report is awaited to find out the veracity of the claim.

As per Insurance Regulatory and development Authority (Protection of Policy holder's Interest) Regulation, 2002.

A life Insurance policy shall clearly state:

(n) Documents that are normally required to be submitted by a claimant in support of a claim under the policy.

As per clause 10 of the policy the company must receive satisfactory proof of the happening of the insured event and its cause and further receive the claim application form, attending registered medical practitioner statement in pre specified format, all hospitalization records pertaining to the illness/injury/surgery including but not limited to the discharge summary, investigation test reports, medical prescriptions, all hospitalization bill and receipts. FIR and police reports (if applicable), copy of driving license (if applicable)

The Complainant has submitted to the respondent original policy document, death certificate, claimant's statement and Form "A" and Attending physicians statements – "Form C". She cannot submit hospital treatment record, Post mortem report (PMR), FIR, Panchanama and Final police investigation report because DLA was not admitted to any hospital after the accident and was declared dead by Dr. K B Sonara, as no FIR was lodged by the complainant question of submitting copies of FIR, PMR, Panchnama and Final police investigation report does not arise.

Since the Death certificate of DLA was obtained by filing affidavit which raises doubts about of cause of death of DLA and the decision under the case depends upon the verification of the truth as to the cause of death of DLA and occupation of DLA, and when the death certificate itself has been obtained on the strength of an affidavit and legal procedure for lodgment of FIR not followed, proper legal procedure will be required which is beyond the jurisdiction of this forum.

Hence without getting into merits of the case and passing any quantitative award for the same, the complainant is deemed as beyond jurisdiction for this Forum, leaving it for the complaint to other means to resolve the grievance either within the framework of Government Rules under reference or taking recourse to any other forum as may be considered appropriate.

BHOPAL

Category - Death claim

Sub Category:

Non settlement of death claim

Shri Anil Kumar Srivastava……..Complainant

LIC of India ……..…Respondent

Order No.BPL/LI 09-10/ 30

Case No. LI-62-23/05-09/ BPL

Brief Background

Shri Anil Kumar Srivastava (complainant) lodged the complaint that his son Late Shri Arjun Srivastava was insured under policy no.352403707 under Bima Gold Plan for SA of Rs. 1.00 lakh on 25.01.2006. At the time of proposal he was told by the Agent that policy is with accident benefit and in case of death double the Sum Assured will be payable. His son died on 16.10.2008 by accident, the claim was paid for basic Sum Assured.

Aggrieved from the decision of the respondent he lodged the complaint on 25.05.2009 seeking the direction for payment of accident benefit.

For the sake of natural justice hearing was fixed on 18-08-09 at Bhopal.

The Complainant presents himself and submitted that the policy was with accident benefit and the death has occurred due to accident hence, he should be paid accident benefit. It was the respondent's duty to advise the policyholder to opt for accident benefit after being a major. That they did not; hence, it is the deficiency of service of the respondent for which he should not be suffered.

The Respondent represented by Shri S.C. Sithole, Manager, (CRM) submitted the policy was issued without accident benefit being a minor at the time of proposal. After the next policy year the policy holder should opt for the accident benefit if he desired, but they did not opt for accident benefit. The policy was without accident benefit on the date of accident. Hence, payment was made for basic sum assured only. The application should be rejected as there was no accident benefit covered under the policy.

FINDINGS & CONCLUSIONS:-I have gone through the materials on records and submission made during the hearing. My observations are as under.

There is no doubt that the above policy no.352403707 was issued to the DLA without accident benefit. Subsequently, the same was also not opted for accident benefit. The death has occurred due to accident. Since, the policy was without accident benefit the respondent's action to pay basic sum assured is just & fair and requires no intervention.

The complaint is dismissed without any relief.

Dated at BHOPAL, on 21st day of AUGUST 2009

----------END----------

Sub.Category

Non Payment of death claim

Non Payment of Death Claim

Shri S.S. Sharma ……..Complainant

L.I.C .Of India, Bhopal…….…Respondent

Order No.BPL/LI 09-10/ 08

Case No.LI/329-20/03-09/ BPL

Brief Background

Shri. S.S Sharma, Resident of Rajgarh, Biora, and [M.P] complained that he & his wife was Insured under joint life policy.no.351117987, on 28-03-94 for S.A. Of Rs.100000/ under salary saving scheme. Subsequently changed to Qly .mode of payment. Due to some financial problem he could pay the premium till 30-11-02, and policy was in lapse condition from Dec.2002.On 09-03-05 Mrs. Krishna Sharma died. The claim lodged by the complainant, paid initially by Respondent for Rs. 17636/. .Dissatisfying with claim amount complainant served legal notice through his Advocate on dt.18-02-07.In response of which further payment of Rs.53019/ on dt.18-05-2007, but did not return the policy document. Aggrieved from the action of the Respondent lodged the complaint that since Respondent has not served revival notice he should be given a chance to revive the policy.

For the sake of natural justice hearing was held on 12-05-2009. The complainant presents himself and submitted that due to failure of the Respondent to serve revival notice under the policy he should be given a chance to revive the policy, so he can avail full benefit of the policy.

The respondent presented by Mrs. Peshwe, submitted that on the date of Death i.e. on 09-03-05 the policy was in lapsed condition due to nonpayment of premium due from Dec.2002. Policy loan was availed by the complainant and the interest due thereon was also not paid, we took foreclosure action

surrendering the policy after deducting outstanding loan and loan interest and the balance amount kept with us. Due to technical reason the foreclosure action could not be completed. Mean while on receipt of death intimation Branch has processed the claim and paid Rs. 17636/. On receipt Advocate notice the matter was referred to Divisional office, who has advised to pay further amt. of Rs.53019/ and paid accordingly on 18-05-2007.

Since the above policy was issued covering risk of husband and wife can be revive during survival of both the life assured. Now the wife of the complainant who is also insured under the policy has died and the policy is in lapse condition on 09-03-05, cannot be revived as per the terms and condition of policy. The premium notice are being sent to the policy holder as matter of courtesy, .While issuing the policy in the policy schedule itself it is clearly mentioned that when premium is due for payment.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on record and submission made during the hearing and my observations are summarized as under.

There is no doubt that policy no. 351117987 was issued to the complaint. The policy was in lapse condition as on the date of death of Mrs. Krishna. The claim has also been paid by the Respondent to the complainant. Now revival of the policy after the death of one of the life assured is not permissible. In view of the above Respondent action seems to correct and requires no intervention. Hence the complainant is dismissed without any relief.

Dated at BHOPAL on 14th day of May, 2009

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Non Settlement of Death claim

Shri Ahsan Bag ..... Complainant

LIC of India.....Respondent

Order no BPL/LI/07-09/22

CASE NO. LI/267-20/12-08/SDL

Brief Background

Shri Ahsan Bag s/o Late Shri Ayub Bag ,resident of Jethari Distt. Anuppur M.P. has lodged the complaint that his father was insured under Policy No. 377681406 for Rs. 1.00 lakh on 28.01.1999 and paid the premium regularly up to 2004 due to

some financial problem he could not paid the premium due on January 2005 and submitted his application for loan cum revival on 10.01.2006 and submitted all the requirements. The same was approved by divisional office on 06.02.2006, but policy revived on 13.12.2007. Meanwhile, DLA dies on 17.01.2007. The claim preferred by the claimant settled for Rs. 42200/- being a paid up value rejected by the complainant and asked for full SA under the plea that all the requirements are complied with for the revival of the policy, on 10.01.2006.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.18-12-08 to the Hon'ble ombudsman seeking direction to the respondent to make the payment of full Sum Assured.

For the sake of natural justice hearing was fixed on 14/07/2009 at Bhopal.

The complainant present himself and submitted that the requirements for revival of the above policy was submitted on 10.01.2006 and it could not be revived due to carelessness of the respondent for which he should not suffered a loss and claimed full SA along with interest for delay in payment.

The respondent represented by Shri Basudev Patra, Manager (Claims) confirmed that the revival requirements were received on 10.01.2006, the decision was also taken to revive the policy on 16.02.2006 as evident from personal statement regarding health form No. 680. Approved by Administrative Officer (PS/SSS) on the basis of the letter dated 06.02.2006 of Divisional Office but thereafter procedure could not be completed for the revival and policy was revived on 13.12.2007 after the death of DLA on 17.01.2007.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that the revival requirements were submitted on 10.01.2006 and the same was also approved by the competent authority on 06.02.2006, but the Policy was revived on 13.12.2007 after the death of the LA proves gross negligence of the respondent.

In view of the above I am of the considered opinion that the decision taken by the respondent is not justified and directed to pay full sum assured along with the interest @ 9% from the date of intimation of death to till the payment, within 15 days from the date of receipt of this order.

Dated at BHOPAL, on 16th July, 2009

Sub Category: Repudiation of death claim

Order No.BPL/LI 09-10/ 39

Case No. LI-84-21/06-09/SDL

Smt. Darshan Kaur……..Complainant

LIC of India ……..…Respondent

Brief Background

Smt. Darshan Kaur, resident of Jayant Collary Distt. Singroli (MP) lodged the complaint that her husband Late Shri Gurdayal Singh Saini was insured under the Policy No. 378427466, 378430853 and 379096356 under Plan & Term 174-12, 179-12 and 180-20 for SA of Rs. 2.00 lakh each plan with date of commencement 28.03.2006, 27.03.2007 and 30.03.2007 respectively and he died on 17.06.2007 due to Heart Attack.

Claim preferred by her **repudiated** by the respondent under the plea of non disclosure of material fact.

Aggrieved from the action of the respondent the complainant lodged the complaint on 11.06.2009 seeking the direction for full payment.

For the sake of natural justice hearing was fixed on 09-09-09 at Bhopal.

The Complainant did not present herself. However, ex-party hearing was conducted.

The Respondent represented by Shri B.Patra, Manager CRM, LIC, DO, Shahdol submitted that the death has occurred within 1 year from the commencement of the policy hence investigation was conducted which reveals that DLA has availed the treatment at AIIMS, NEW DELHI for a systematic Oclerosis-ild in September 2004 which he did not disclosed at the time of filling in the proposal form for the above insurance. Had he mentioned the same, underwriting decision would have been altered. Further he has also availed the sick leave for the period from 15.04.2003 to 23.04.2003 (09 days), 16.09.2003 to 24.09.2003 (09 days) 16.10.2003 to 26.10.2003 (11 days) ,11.02.2004 to 20.03.2004 (28 days) , 01.04.2005 to 10.04.2005 ,24.07.2006 to 01.08.2006 (09days) and 23.02.2007 to 08.03.2007 (16 days), the same have also not been disclosed in the proposal form.

The respondent submitted claim form B and B1, certificate of employers and medical card from Jayant Health Center, Sidhi, which reveals that DLA was under the treatment

prior to the date of insurance. Under the circumstances, the decision of repudiating the death claim is justified.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submission made during the hearing. My observations are as under.

There is no doubt that the above policies were issued to the DLA. DLA died on 17.06.2007 due to Heart Attack. While verifying the claim form B and B-1 completed by the Medical Examiner of Jayant Colliery clearly states that the DLA has availed the treatment at AIIMS, NEW DELHI for a systematic Oclerosis-ild in September 2004. The Hospital records also reveal the same thing. The sick leave records of the employer also supporting the same thing.

Insurance is a contract of utmost good faith; both the parties to the contract are expected to reveal all the truth regarding health and terms & conditions of the contract. Failure of which will vitiate the contract ab-initio.

Decision held that under the above circumstances, the decision taken by the respondent is just & fair for the first two policies requires no intervention, but under Policy No.379096356 under table no. 180-20 fund value is refundable, which the respondent has not refunded till date.

The respondent is directed to pay fund value as per the rules with panel interest within 15 days from the date of receipt of this order, failing to which further interest @ 9% will be payable.

Dated at BHOPAL, on 10th day of SEPTEMBER 2009**.**

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Repudiation of Death claim

Order No.BPL/LI 09-10/ 38

Case No. LI-277-20/01-09/SDL

Smt. Uma Devi ……..Complainant

LIC of India ……Respondent

Brief Background

Smt. Uma Devi, resident of Bijuri Colory Distt. Anuppur (MP) lodged the complaint that her husband Late Shri Ramadhar Tiwari was insured under Policy No. 378295936, 378298381 and 378396124 under Endowment Plan for SA of 1.00 lakh, 20,000 and 58000.00 respectively with date of commencement 15.10.2002, 15.01.2003 and 28.07.2003 and he died on 09.10.2004 due to stomach pain.

Claim preferred by her repudiated by the respondent under the plea of non disclosure of material fact.

Aggrieved from the action of the respondent the complainant lodged the complaint on 28.12.2008 seeking the direction for full payment.

For the sake of natural justice hearing was fixed on 09-09-09 at Bhopal.

The Complainant did not present herself. However, ex-party hearing was conducted.

The Respondent represented by Shri B.Patra, Manager CRM, LIC, DO, Shahdol submitted that the death has occurred within 2 years from the commencement of the policy hence investigation was conducted which reveals that DLA has availed sick leave during the period 11.03.2002 to 10.04.2002 for 25 days and from 11.8.2003 to 25.8.2003 for 13 days has no reveal at the time of filling in the proposal form if had he mentioned in the proposal form the underwriting decision have been deferred. Moreover as per the hospital's treatment records reveals that the DLA was chronic alcoholic which he did not disclosed in the proposal form, on the basis of which the claim is rightly repudiated.

FINDINGS & CONCLUSIONS:-

There is no doubt that the above policies were issued to the DLA. The hospital records reveal that DLA died on 09.10.2004 due to left hemi-plegia with Hyper Tension. The hospital record of South Eastern Coalfield Ltd., Central Hospital, Manendragarh C.G. has also revealed about his past history wherein it was mentioned that **chronic alcoholic has left for last 2 years.** Moreover, the claim intimation was given on 20.01.2005 whereas, the Repudiation letter was issued on 16.08.2007 after 2 ½ years.

Hon'ble Ombudsman asked to produce the certificate of medical examiner on the basis of which the DLA has availed sick leave. But respondent failed to produce the same and to prove the materiality of the fact. The date of commencement of

the policy is 15.10.2002, 15.01.2003 and 28.07.2003 respectively and the claim is repudiated by the Divisional Office, Shahdol on 16.08.2007 after 4 ½ years approx. on the ground of non-disclosure of material facts without having sufficient proof is absolutely unjustified. Hence, I am of the considered opinion that there is a **too much delay** in taking the decision after 2 ½ years.

Therefore, the respondent is directed to pay full Sum Assured under of all the three policies i.e. Rs.1.78 lakhs with panel interest within 15 days from the receipt of this order failing to which 9% interest will be payable.

Dated at BHOPAL, on 10th day of SEPTEMBER 2009**.**

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Repudiation of Death claim

Order No.BPL/LI 09-10/ 37

Case No. LI 146-24/07-09/BPL

Smt. Megha Jha……..Complainant

LIC of India ……..…Respondent

Brief Background

Smt. Megha Jha, resident of Bhopal (MP) lodged the complaint that she and her husband Late Shri Saroj Kumar Jha were insured under Jeevan Sathi Policy (Plan & Term 89/17) for Rs. 50,000/- on 15.10.2001. After 3 years w.e.f. 10.2.2004 premium could not be paid and revived on 15-10-2006 by submitting declaration of good health and premiums due from oct.2004 to oct.2005.On 12-02-2008 Late Shri Saroj kumar died on 12-02-2008 due to heart attack. Claim preferred by Mrs. Megha Jha for full sum assured rejected by the Respondent on the ground that at the time of revival of the policy on 15-02-06 the DLA has not shown his treatment of head injury taken by him during the period 01-05-2004 to 24-05-2005 due to accident; and cancel the effect of revival and paid RS.18023/- towards paid up value and bonus up to 15-10-2004.

Aggrieved from the action of the respondent the complainant lodged the complaint on 28.07.2009 seeking the direction for full payment.

For the sake of natural justice hearing was fixed on 08-09-09 at Bhopal.

The Complainant present herself and submitted that after running the policy for 7 years the death claim is rejected on the ground of the head injury not shown at the time of revival is totally unjustified. Actually it was a minor injury he had in May 2005 and for which he was also not treated by a Neurosurgeon, he was totally fit for the duty in the police department.

The death has occurred due to heart attack and not due to head injury or consequence thereof. Hence, the repudiation of claim on the ground of non disclosure of head injury at the time of revival is a meager excuse to search from the responsibility of the respondent.

The Respondent represented by Smt. Peshwe, AO Claims, LIC, DO, Bhopal submitted that as per the employer certificate dated 08.09.2008 along with zerox copy of the Medical Officer Certificate the DLA was treated during the period from 05.04.2005 to 24.05.2005 for head injury which he fails to disclose in the declaration of good health submitted for revival on 20.04.2006. Had he mentioned the same the special reports would have been called for and revival decision may also be altered. Hence, the claim was rightly paid for Rs. 18023//- towards SA & Bonus.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submission made during the hearing. My observations are as under.

There is no doubt that the above policy were issued to the complainant on 15.10.2001. It was also revived on 15.02.2006. The declaration of good health completed by DLA does not reveal the head injury. The cause of death is due to heart attack has no nexus with head injury. The claim was repudiated by the respondent on 26.11.2008 due to non disclosure of head injury canceling the revival but did not refund the premium amount collected on revival of the policy and thereafter. The DLA was in the employment of Police Department having a tough nature of work requires good health. Even after the head injury he was quite fit to discharge his duties and the policy also run for 07 years from the date of commencement and 02 years after revival. I am therefore of the considered opinion that the claimant should be paid for Sum Assured of Rs. 50,000/- on compensatory ground as exgratia after deducting the payment of Rs. 18023/- made to her.

The respondent is directed to pay Rs.31977.00 within 15 days from the receipt of this order failing to which 9% interest will be payable.

Dated at BHOPAL, on 08th day of SEPTEMBER 2009**.**

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Repudiation of Death claim

Order No.BPL/LI 09-10/ 34

Case No. ICICI 63-23/05-09/mum

Islam Ahmed ……..Complainant

ICICI Prudential Life Ins.……..…Respondent

Brief Background

Smt.Kulsum Begum Khan (complainant), resident of Amlai Distt. Shahdol (MP) lodged the complaint that her husband Late Shri Islam Ahmed Khan was insured under policy no.06927628 and 0692663 from ICICI Prudential Life Ins.company on 06.12.2007 for SA of Rs. 3.75 lakhs and 1.125 lakhs under life stage RP and Smartkid New Unit Linked RP and paid Rs. 50000/- and 15000/- respectively towards the yearly premium died on 29.11.2008 due to Heart Attack. Prior to that he was enjoying good health and died suddenly before he treated by Doctors. Claim preferred by her was not settled by the respondent despite several follow ups. She has lodged the complaint on 19.05.2009 seeking the direction to pay the claim amount.

For the sake of natural justice hearing was fixed on 02-09-09 at Bhopal.

The Complainant did not present herself and submitted that on the basis of the papers submitted by her proceeding may be done and the decision taken by the Hon'ble Ombudsman will be binding to her.

The Respondent represented by Smt. Kalpana Sampat,Chief Underwriting Claims & Group Operations, Mumbai submitted that being a early death claim investigation were conducted and found that the DLA was suffering from ailments and taken a treatment on 12.09.2004 for backache for 05 days and on 3.3.2005 he was suffering from fever and chest pain and took the treatment for 10 days again on 7.10.2007 he has taken a

treatment for 7 days for Dysentery by Dr. Sudhakar Singh and produced the copies of prescriptions. While filling in the proposal form on 29.11.2007, DLA has not revealed the above facts of his ailments. The cause of death was heart attack which is relevant to chest pain hence it is a clear case of non disclosure of material fact and liable to repudiate the claim.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submission made during the hearing. My observations are as under.

There is no doubt that the DLA was insured under the policy no.06927628 and 0692663 from ICICI Prudential Life Ins.company on 06.12.2007 for SA of Rs. 3.75 lakhs and 1.125 lakhs under life stage RP and Smartkid New Unit Linked RP and paid Rs. 50000/- and 15000/- by the respondent.

The proposal form dated 29.11.2007 does not reveal the treatment taken by the DLA for chest pain, dysentery and backache. Whereas, as per the Doctor's prescription, DLA was under his treatment for the above disease proves non disclosure of material fact.

The DLA has paid Rs. 65000/- premium towards first year premium on 29.11.2007. However, looking to the family conditions of the DLA having 5 children & no one is bread winner in the family the respondent is directed to pay Rs.1.50 lakh on ex-gratia basis on humanitarian ground within 15 days from the date of receipt of this order.

Dated at BHOPAL, on 03rd day of SEPTEMBER 2009

----------END----------

Repudiation of Death claim

Smt. Jeevan Bala Vohra ……..Complainant

LIC of India ……..…Respondent

Order No.BPL/LI 09-10/ 31

Case No. LI-246-21/12-08/ BPL

Brief Background

Smt. Jeevan Bala Vohra (complainant) lodged the complaint that her husband Late Shri Dharamchand Jain (DLA) was insured under policy no.352362985 for S.A. of Rs.85000/- under plan and term 106/15 (12) on 28.03.2005. He died on 26.06.2007 due to Mouth Cancer. Claim preferred by her repudiated by the respondent on the ground of non disclosure of material fact.

Aggrieved from the decision of the respondent she lodged the complaint on 01.12.2008 seeking the direction for payment of death claim.

For the sake of natural justice hearing was fixed on 18-08-09 at Bhopal.

The Complainant presents herself and submitted that her husband was enjoying good health at the time of taking the insurance and up to October 2006. The repudiation of claim made on the ground of cancer treatment taken in 2004 is totally wrong. If, they were aware of it they would have taken the policy for big sum assured.

The Respondent represented by Shri S.C. Sithole, Manager, (CRM) submitted the DLA was suffering from mouth cancer and he has availed the treatment at Indore in 2004, as per the case papers of Jawahar Lal Nehru Cancer Hospital and Research Center, Bhopal wherein, they have mentioned in the column of clinical history that he has taken the treatment in 2004 in Indore for tongue flap. Whereas, the DLA has not revealed the above facts while filling in the proposal form for the insurance on 28.03.2005. It is a clear case of non disclosure of material fact. Hence, the action of the respondent to repudiate the liability under the policy is justifiable.

On inquiry from the ombudsman that whether they have obtained any certificate from the hospital of Indore where he has taken the treatment in 2004 to prove that DLA was suffering from mouth cancer prior to the date of proposal, the respondent's representative could not produced the same.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submission made during the hearing. My observations are as under.

There is no doubt that the above policy no. 352362985 for S.A. of Rs.85000/- under plan and term 106/15 (12) on 28.03.2005 was issued to the DLA. The death has occurred due to mouth cancer on 26.06.2007.

The policy was issued after medical examination by the Medical Examiner which reveals no adverse at the time of taking the policy.

The proposal form also does not reveal any adverse features in personal history.

The respondent failed to submit the **indisputable proof** proving that the DLA was suffering from mouth cancer and operated in 2004.

In view of the above I am of the considered opinion to pay Rs. 50,000/- on ex-gratia basis on humanitarian ground.

Therefore, the respondent is directed to pay Rs.50000/- within 15 days from the date of the receipt of the order failing to which interest @ 9% would be payable.

Dated at BHOPAL, on 21st day of AUGUST 2009

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Repudiation of Death claim

Smt. Laxmi Devi Agarwal..... Complainant

LIC of India.....Respondent

Order noBPL/LI/07-09/21

CASE NO. LI/332-24/03-09/SDL

Brief Background

Smt. Laxmi Devi Agarwal w/o Late Shri Vishwanath Agarwal, resident of Manindargarh Distt. Korea C.G. has lodged the complaint that her husband was insured under Policy No. 377864560 for Rs. 10.00 lakhs on 28.07.2004 died on 12.04.2005 due to Cancer. Death Claim preferred by her repudiated by the respondent on the ground of suppression of material fact.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.03-03-09 to the Hon'ble ombudsman seeking direction to the respondent to make the payment of full Sum Assured.

For the sake of natural justice hearing was fixed on 14/07/2009 at Bhopal.

The complainant did not present herself despite conveyed to her on telephone twice and sent the hearing letter dated 19.06.2009.

The respondent represented by Shri Basudev Patra, Manager (Claims) submitted that the policy was proposed on 02.08.2004 and DLA died on 12.04.205 being a early death claim investigation was conducted which reveals that the DLA was suffering from ailments i.e. chest pain for one year, wait lost of 28 kg. in one year, C.T. scan was done on 26.06.2004 and DLA was put on ATT in April 2004 at Jaslok Hospital, Mumbai and submitted the hospital records of Jaslok Hospital, which proves that the DLA was under treatment before the taking the insurance policy and he suppressed his ailments while filling in the proposal form.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

The Proposal form dated 02.08.04 has not disclosed any ailments of DLA. The hospital record of Jaslok Hospital proves that DLA was suffering from the cancer prior to the date of proposal.

The insurance is a contract of utmost good faith both the parties are expected to reveal all the material facts.

In view of the above I am of the considered opinion that the decision taken by the respondent is just & fair and does not require any intervention.

The complaint is dismissed without any relief.

Dated at BHOPAL, on 16th July, 2009

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Miscellaneous – cheated by Agent

Parvati Devi ..... Complainant

Bajaj allianz life Ins.Co.ltd.....Respondent

Order no BPL/LI/04-09/18

CASE No. BA/274-22/05-09/Pune

Brief Background

Parvati Devi, resident of Jamkunda Camp Distt. Chhindwara, M.P. complained that her husband died during his service in Colliery. The death benefit amounting Rs. 9.00 lakh was received by her was deposited in State Bank of India. Shri Munnalal Bharati and Shri Sunil Rai, agent of the Bajaj allianz contacted her and convinced to invest the amount in Bajaj Allianz, for 3 years under single premium to get double amount within 3 years. Accordingly, she invested the amount in different policies for herself and her daughter and son as detailed below:-

Name of the Insured	Policy No.	Premium Amt.
Parvati Devi -	79293984	Rs.1.00 lakh
Parvati Devi	79294706	Rs. 1.00 lakh
Saroj Bharati	79294326	Rs. 1.00 lakh
Saroj Bharati -	82114115	Rs. 75000
Jitendra Kumar	79292296	Rs. 1.00 lakh
Jitendra Kumar	79292714	Rs. 1.00 lakh
Manju Bharati	79293491	Rs. 1.00 lakh
Manju Bharati	79293678	Rs. 1.00 lakh
Manju Bharati	82199992	Rs. 50000
Manju Bharati	83377545	Rs. 25000

Total Amount Rs.		Rs. 8.5 lakh

She is an illiterate widow having a pension income of Rs. 1800/- per month. The agent has mis-guided her and issued the policies under annual premium for 10 years. After completion of one year she received intimation for subsequent premium, she came to know that premium is payable for every years for 10 years, which is beyond his capacity, as she is a illiterate widow having source of income of Rs. 1800 per month from pension only. Hence, wrote to the company on 28.12.2008 to cancel the policy and refund the amount. Company has refused to refund of full amount.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.05-01-09 to the Hon'ble ombudsman seeking direction to the respondent to refund the premium with interest.

For the sake of natural justice hearing was fixed on 07/07/2009 at Bhopal.

The complainant presents herself and submitted that she has no source of income except pension. The agent has misguided her by issuing a policy under annual mode instead of single premium for 10 years. She requested to refund the full amount with interest.

The respondent represented by Shri Nitendra Singh Bais, Astt. Branch Supervisor, submitted that the company has decided to cancel the policies under free-look

period as a special case and refund the fund value, for which they requested to the complainant to submit the policy documents.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that the above policies were issued to the complainant for Rs. 8.5 lakh for the term 10 years. It is a known fact that proposal form are being filled in by the agents only, only signature are being obtained by the policy holder.

The Q. No. 5, premium frequency column is also misguiding. The annual income of the proposer shown is Rs. 5.00 lakh p.a., it is difficult to convince that the person having no source of income except pension of Rs. 1800/- per month can pay annual premium Rs.8.5 lakh which proves that it is a mis-presentation of facts for the personal interest.

The insurance is a contract of utmost good faith. Both the parties are expected to reveal the facts only. Any mis-presentation of facts on either side vitiates the contract ab-initio.

In view of the above for the sake of equity and justice the respondent is directed to cancel the policy and refund full amount of premium i.e. Rs. 8.5 lakh with interest @ 9% p.a. from the date of receipt to till the date of payment within 15 days to the receipt of this order.

Dated at BHOPAL, on 07th of July 2009.

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Repudiation of Death Claim

Sh. Kailash Chandra Pande..... Complainant

HDFC Standard Life Insurance .....Respondent

Order no BPL/LI/06-09/12

CASE No. HDFC/368-24/03-09/Mum

Brief Background

Shri Kailash Chandra Pande, resident of Bichiya, Rewa, M.P. complained that his wife Smt. Manorama K. Pande was insured under policy no. 11777779, a unit linked pension plan on 31.03.2008 with half yearly premium of Rs. 49950.00. She died on 20.10.2008 due to cancer. The claim preferred by the complainant rejected by the respondent on 05.12.2008 due to nonpayment of half yearly premium due on 30.09.2008.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.25-03-2009 to the Hon'ble ombudsman seeking direction to the respondent to pay the claim.

For the sake of natural justice hearing was fixed on 17/06/2009 at Bhopal.

The complainant represented himself with his daughter and submitted that the DLA was died due to cancer on 20.10.2008. The premium was due on 30.09.2008 was not paid due to hospitalization of his wife Smt. Manorama, suffering from cancer. The respondent is failed to remind us to deposit the premium in time, because we were busy in hospital for the treatment of DLA. If had they remind us, we would have made the payment of premium. At least company should refund us the premium amount on a compensatory ground.

The respondent represented by Shri Thomas, Legal Manager of HDFC, Bhopal, submitted that while issuing the policy, it is clearly mentioned in the policy schedule when the premium is due for payment. However, as a matter of courtesy we are sending reminders through SMS for premium. Under the above policy only one half yearly premium was deposited. IInd half premium was due on 30.09.2008 was not paid even after 15 days grace period. The above policy was under unit linked pension plan and no risk is covered. As per the policy condition nothing is payable.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that policy no. 11777779, a unit linked pension plan was purchased on 31.03.2008 with half yearly premium of Rs. 49950.00. The policy was in lapsed condition on the date of death of DLA.

Under the circumstances, the respondent's action to reject the claim is just & fair requires no intervention.

The complaint is dismissed without any relief.

Dated at BHOPAL, on 19th June, 2009

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Repudiation of Death Claim

Smt. Sushma Agarwal ..... Complainant

Bajaj Allianz .....Respondent

Order no BPL/LI/06-09/11

CASE No. BA/364-23/03-09/pune

Brief Background

Smt. Sushma Agarwal w/o Late Shri Arun Agarwal (DLA), resident of Rewa,M.P. complained that her husband was insured under unit gain plus gold policy no. 70361013 for Rs. 250000 and paid Rs 50,000/- towards first premium and Rs. 1.00 lakh as top up premium. He died on 12.11.2007 due to liver cirrhosis. The claim preferred by her, rejected by the respondent on 18.09.2008 on the ground of non disclosure of material fact.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.22-03-2009 to the Hon'ble ombudsman seeking direction to the respondent to pay the death claim.

For the sake of natural justice hearing was fixed on 17/06/2009 at Bhopal.

The complainant authorized her brother in law Dr. Arvind Agarwal submitted that the DLA was died due to liver cirrhosis, but DLA and we were not aware of the disease till the date of his admission in the hospital. Hence, it is not a non-disclosure of material fact. Moreover, the premium was paid for Rs. 1.50 lakh even if the claim is rejected for the SA but we are entitled for the refund of fund value. Respondent has also not care to refund the same amount, which we are entitled.

The respondent represented by Shri Pradeep Mahor, Asstt. Manager of Bajaj Allianz, Bhopal, submitted that there were two policies under which the DLA was covered. Out of which under pol. No. 24416433 the SA amount has been paid to the claimant, whereas, the second policy was completed on 16.10.2007 and DLA died on 12.11.2007, being a early death claim, investigation were conducted, which reveals that the DLA was suffering liver cirrhosis since last one year as revealed from the medical attendant certificate, submitted by the claimant, which proves that the DLA was suffering from liver cirrhosis since one year. Hence, the rejection of claim is justified. However, fund value is payable to the claimant.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that unit gain plus gold policy no. 70361013 for Rs. 250000 was taken by the DLA and paid Rs 50,000/- towards first premium and Rs. 1.00 lakh as top up premium. He died on 12.11.2007 due to liver cirrhosis. As per the hospital records it is also proves that DLA was suffering from liver cirrhosis since last one year.

Insurance is a contract of utmost good faith; both the parties are expected to reveal all the correct information.

Under the circumstances, the respondent's action to reject the liability of full Sum Assured is just & fair. But, they have failed to refund the fund value.

Respondent is directed to pay the fund value under the above policy along with the interest @ 9% from the date of intimation to till date of payment.

Dated at BHOPAL, on 19th June, 2009

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Repudiation of Death Claim

Smt. Pushpa Bai Rai..... Complainant

LICI, DO, Jabalpur.....Respondent

Order no BPL/LI/06-09/10

CASE No. LI/264-24/12-08/JBP

Brief Background

Smt. Pushpa Bai Rai w/o Late Shri Bansilal Rai (DLA), resident of Thanwari Badi Tah. Dhansaur Distt. Seoni complained that her husband was insured under policy nos. 301155996 and 373221692 for Rs. 50000 each under Plan & Term 14/10 on 21.06.2007 and 14/19 on 28.05.2004 respectively. He died on 10.07.2007 due to chest pain and fever. The claim preferred by her, rejected by the respondent on 10.11.2008 on the ground of understatement of age.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.21-12-08 to the Hon'ble ombudsman seeking direction to the respondent to pay the death claim.

For the sake of natural justice hearing was fixed on 17/06/2009 at Bhopal.

The complainant presents herself and submitted that the DLA was died due to heart attack immediately within one day prior to that he was enjoying good health. As he was illiterate he has submitted self declaration of age, while taking the insurance as per the advice of the agent and the same was also certified by the "Sarpanch" of the Village and by Medical Examiner. As per my knowledge the age of my husband was correct.

The respondent represented by Shri Sudhakar Mehta, Manager (Claims) of LIC DO, Jabalpur, submitted that as per the declaration of age the date of birth of the DLA was 15.06.1958 and he was of 46 years while taking the first insurance. Subsequently revived on 17.4.2007 and DLA died on 10.7.2007, within 3 months from the date of revival. Being an early death claim investigation was conducted which reveals that the DLA was of 55 years old at the time of taking the life insurance policy and not 46 years as declared by him. On further inquiry he submitted the school certificate of his eldest son Shri Bhagwati Lal, wherein the date of birth was of his son was 20.01.1973. If we take the same as correct the age of his father at the time of birth of his son comes to 14.5 years which is not possible. The copy of Ration Card also shows the age of DLA as 55 which prove that the DLA has obtained the insurance by misstating his correct age. Had he mention the correct age, the underwriting decision would have been deferred and special medical reports would have been called for.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that policy nos. 301155996 and 373221692 were issued to DLA. It is proved that he has submitted declaration of age stating his date of birth as 15.06.1958 and he was of 46 years while taking the first insurance. From the school certificate of his eldest son Shri Bhagwati Lal, wherein the date of birth of his son is 20.01.1973, which derives that the age of the DLA at the time of his son's birth was only 14.5 years old, proves misstatement of correct age.

The insurance is a contract of utmost good faith both the parties are expected to reveal all the material facts.

Under the circumstances, respondent's action is just & fair, requires no interference.

The complaint is dismissed without any relief.

Dated at BHOPAL, on 19th June, 2009

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Repudiation of Death Claim

Smt. Santosh bai ……..Complainant

L.I.C .Of India, Indore……..Respondent

Order No.BPL/LI 09-10/ 09

Case No.LI/78-20/06-08/ IND

Brief Background

Smt.Santosh bai w/o Balmukund Patidar , [DLA] Resident of Babulda,Teh. Bhanpur, Dist. Mandsaur, [M.P] complained that her husband was insured under pol.no. 344482922 for s.a of rs. 100000/ under plan no.149 -25 on 13-10-04,died on 02-06-07, due to cancer .Claim preferred by her rejected by the respondent on the ground of non disclosure of material fact on 28-02-2008. Aggrieved from the action of the Respondent, Complainant lodged the complaint seeking direction for payment of claim under the policy. The complaint was registered on 12-06-2008 and issued P II, P III, issued to the complainant and self contained note called from the Respondent, which was received on 31-07-2008.But complainant did submit the above forms despite frequent reminders on 22-08-2008, 17-10-2008 and01-01-09. For the sake of natural justice hearing was fixed on 15-01-2009, and informed the complainant on 06-01-2009, but the complainant did not presents herself Hence hearing again fixed on 16-02-09 and send letter on 23-01-09 but Complaint failed to present herself .Again hearing fixed on 12-05-09 and informed to complaint by Registered post on 30-04-2009. The Respondent did not present, hence hearing was held ex party.

The Respondent submitted that since the above policy was issued covering risk of husband and wife can be revive during survival of both the life assured. Now the wife of the complaint who is also insured under the policy has died and the policy is in lapse condition on 09-03-05 it cannot be revived as per the terms and condition of policy. The premium notice are being sent to the policy holder as matter of courtesy, .While issuing the policy in the policy schedule itself it is clearly mentioned that when premium is due for payment.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on record and submission made during the hearing and my observations are summarized as under.

There is no doubt that policy no. 351117987 was issued to the complaint. The policy was in lapse condition as on the date of death of Mrs. Krishna. The claim has also been paid by the Respondent to the complainant. Now revival of the policy after the death of one of the life assured is not permissible. In view of the above Respondent action seems to correct and requires no intervention. Hence the complainant is dismissed without any relief.

Dated at BHOPAL on 14th day of May, 2009

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Repudiation of Death Claim

Smt. Kavita Dhanotia …… ……..Complainant

Aviva Life Insurance……..…Respondent

Order No. BPL/LI/ 09-10/07

Case No.Aviva/292/01-09/GUR

Brief Background

Smt. Kavita Dhanotia, W/O Suresh Kumar Dhanotiya [DLA] Residence of Indore [M.P] complaint that her husband was insured with the Respondent under Pol.no. AFL 1951732 on 30-03-2008 and for Rs.937500/, and paid premium Rs. 25000/, died on 12-08-2008 due cardio respiratory arrest. The claim preferred by her repudiated by the company due non disclosure of material fact. Aggrieved from the action of the respondent, complainant lodged complaint to this office seeking direction for payment to the Respondent.

For the sake of natural justice hearing was held on 11-05-2009. The complainant presents herself and submitted that her husband was for Rs. One lac sum assured on 30-03-2008 was enjoying good health at the time of proposal, died all of a sudden due to cardio respiratory arrest. He had leukemia in the year 2004 for which he was treated and cured. The other insurance companies i.e. ING AND S.B.I.LIFE, with whom the DLA was insured had repudiated the claim but refunded fund value Rs. 77441/ and Rs.9834/ . Similarly the respondent should be directed to refund fund value.

The respondent submitted that as per last medical attendant certificate issued by Choithram hospital, Indore , Annexure F- reveals that secondary cause of death was AC. Leukemia ,and duration of illness leading to death " K/C/O ALL [acute lymphoblast leukemia], since 2004. Whereas while filling in the proposal form the DLA has failed to provide correct information regarding health, which was material to disclose at the time of proposal.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on record and submission made during the hearing and my observations are summarized as under.

There is no doubt that policy no. AFL 1951732 was issued to the DLA. The proposal form completed by DLA, for insurance does not reveals any adverse regarding his health. Hospital records and the complaint also confirm that DLA had leukemia since 2004.

Insurance is a contract of UTMOST GOOD FAITH. Both parties are expected to reveals all material facts. In view of the above the Respondent action of repudiating liability is justified. However he should refund the fund value as on the date of notification of death as per policy condition no. 3 [a], page 14.

The Respondent is directed to refund fund value on ex-gratia basis.

Dated at BHOPAL on 13th day of May, 2009

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Repudiation of Death Claim

Smt. Ram Dehi Kushwaha ..... Complainant

LICI, DO, Gwalior.....Respondent

Order no BPL/LI/04-09/05

CASE No. LI/250-21/12-08/GWL

Brief Background

Smt. Ramdehi w/o Late Shri Jagdish Prasad Kushwaha (DLA), resident of Murar, Gwalior, complained that her husband was insured under policy nos. 202070436 and 202071732 for Rs. 25000 and 1.00 lakh on 22.01.1997 and 28.03.99 respectively. He died on 20.11.2001 due to fever. The claim preferred by her, rejected by the respondent on 19.12.2008 on the ground of non disclosure of material fact.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.03-12-08 to the Hon'ble ombudsman seeking direction to the respondent to pay the accident benefit.

For the sake of natural justice hearing was fixed on 22/04/2009 at Bhopal.

The complainant presents herself and submitted that the DLA was employee of MPSEB and he was insured with the respondent for 5 policies, out of which, 03 policies claim payment has been made whereas claim under two policies were rejected on the ground of non disclosure of material fact, which is totally unjustified. DLA was enjoying good health but due to emergency services leaves are not easily available except medical ground, hence, he has taken leaves on medical ground by producing false medical certificates.

The respondent represented by Shri R.S. Barman, A.O. (Claims) of LIC DO, Gwalior, submitted that above two policies were issued on 22.01.97 and 28.03.1999 whereas the DLA died on 20.11.2001. Due to early death claim, the investigation was conducted which reveals that the DLA has taken medical leave from his employer on medical grounds which he has not mentioned in his proposal form. Both the policies were issued under non-medical scheme.

Under the circumstances, the statement made by the DLA regarding his health is more important. The employer certificate regarding leave particulars shows that DLA has availed leave on medical ground from 16.09.1996 to 02.10.1996 (17 days), 31.10.96 to 05.11.96 (06 days), 20.10.96 to 23.11.1996 (33 days), 16.01.97 to 24.01.1997 (9 days) 18.04.1997 to 31.05.1997 (44 days). Had he mentioned the same, medical reports and other special reports would have been called for which might have alter underwriting decision. Moreover, the certificate CR No. 919531 dated 20.11.2001 issued by medical college and J.A.H. group of Hospital, shows that the DLA was a known case of Pulmonary T.B. since four years, which proves that the DLA was suffering Pulmonary T.B. before the date of proposal, which he fails to disclose in the proposal form.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that policy no. 202070436 and 202071732 Rs. 25000 and 1.00 lakh were issued on 22.01.1997 and 28.03.99.

It is proved that he has taken medical leave from his employer before taking the above two insurance policies. It is also proved that he was suffering from Pulmonary T.B. since last 4 years which he did not disclosed in the proposal form, which is a suppression of material fact.

The insurance is a contract of utmost good faith both the parties are expected to reveal all the material facts.

Under the circumstances, respondent’s action is just & fair, requires no interference.

The complaint is dismissed without any relief.

Dated at BHOPAL, on 30th April, 2009

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Repudiation of Death Claim

Smt. Prabha Koshtha ..... Complainant

Bajaj Allianz life Ins.Co.Ltd.Respondent

Order no BPL/LI/04-09/04

CASE No. BA/327-24/02-09/pune

Brief Background

Smt Prabha Koshtha w/o Late Shri Anand Kumar Koshtha (DLA), resident of Jabalpur, M.P. complained that her husband was insured under policy no. 62465270 for Rs. 2.00 lakhs with accidental rider of Rs. 2.00 lakhs on 30.08.07 with the respondent. He died on 25.10.2007 due to accident. The accidental claim preferred by her rejected by the respondent on the ground of breach of law.

Aggrieved from the action of respondent Complainant has lodged the complaint on dt.27-02-09 to the Hon'ble ombudsman seeking direction to the respondent to pay the accident benefit.

For the sake of natural justice hearing was fixed on 22/04/2009 at Bhopal.

The complainant presents herself and submitted that the policy was issued with accidental benefit cover, however, the respondent has paid only basic sum assured i.e. Rs. 2.00 lakhs and rejected the claim for accident benefit even though the death has occurred due to road accident only. The FIR and other police reports also confirm that death has occurred due to accident only and hence, she should be paid the accidental benefit also i.e. Rs. 2.00 lakh with interest.

The respondent represented by Shri Pradeep Mahore, Representative of Bajaj Allianz, submitted that as per the exclusion clause (a) of policy condition if, death has occurs as a result of the insured person committing any breach of law; accident benefit shall not be paid. He has also submitted that copy of FIR and other

investigations reports in support of his submission, wherein the DLA was charged under section 279, 337 and 304 (A) IPC. As per the statement of his brother in law traveling with DLA on the date of accident reported in his FIR report that he was driving car speedily and negligently.

FINDINGS & CONCLUSIONS:-

I have gone through the materials on records and submissions made during hearing and my observations are summarized as follow.

There is no doubt that policy no. 62465270 for Rs. 2.00 lakhs with accidental rider was issued on 30.08.07. The death has also occurred due to accident. It is also proved that accident has occurred due to breach of law committed by insured person. Under the circumstance, as per the terms & conditions of the policy, respondent's action is just & fair, requires no interference.

The complaint is dismissed without any relief.

Dated at BHOPAL, on 30th April, 2009

----------**END**----------

BHUBANESWAR

(01)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-003-0732

Sri Bansidhar Sahu Vrs Tata AIG Life Ins. Co. Ltd.

Award dated 06th April, 2009

FACT:-

The father of the complainant had taken one policy for Rs.1.5 lacs from Tata AIG Life Insurance Co. Ltd. (insurer). The claim was repudiated by the insurer on the ground of suppression of material facts. It was further alleged that one official of the insurer took Rs.20,000/- for

settlement of the claim. As per the submission of the insurer, the policyholder was suffering from diabetes before the proposal and the same was not disclosed. The complainant on the other hand submitted that the cause of death being otherwise the insurer should not have taken such view.

AWARD:-

The Hon'ble Ombudsman observed that cause of death was cerebral malaria fever. Both insurer and the complainant agreed to this view. Secondly, if the insurer's observation that the DLA was suffering from diabetes prior to proposal is considered as correct, whether it amounts to material suppression of facts or not. The judgment under petition no.1935 of 2004 before NCDRC, New Delhi as submitted by the insurer was not applicable to this case. As regards to the test report of the DLA for diabetes done in the year 1999, it is observed that it was seven year before to the proposal date. The Insurer had not produced any documents to establish that DLA was treated for diabetes within few years before taking the policy. So, omission in not stating the same in the proposal can be ignored. So, the hon'ble Ombudsman directed to pay to settle the death claim with full benefit within one month from the date receipt of the consent letter.

(02)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-003-0736

Sri Sibaram Kar Vrs Tata AIG Life Ins. Co. Ltd.

Award dated 03rd April, 2009

FACT:-

The brother of the complainant had taken one policy for Rs.4 lacs from Tata AIG Life Insurance Co. Ltd. (insurer). The claim was repudiated by the insurer on the ground of suppression of material facts. The cause of death was cerebral malaria. As per the submission of the insurer, the policyholder was suffering from fever before the proposal and the same was not disclosed. The insurer relied on the certificate issued by one doctor issue after the date of death wherein it was stated the DLA was suffering from fever since last 6 months prior to his death.

AWARD:-

The Hon'ble Ombudsman observed that word "6" has been over written. It appears to the naked eye that it was "5". The overwritten part was not authenticated by the doctor through his initial. The same doctor had issued another certificate where it was stated that DLA was completely well four days before death and suddenly suffered from viral fever. So, it appears there was no previous suffering. Moreover, the insurer had not produced any document to establish that DLA was treated prior to the proposal. So, the hon'ble Ombudsman directed to settle the death claim with full benefit within one month from the date receipt of the consent letter.

(03)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-009-0737

Smt. Pramodini Sahu Vrs Bajaj Allianz Life Ins. Co. Ltd.

Award dated 03rd April, 2009

FACT:-

The husband of the complainant had taken two policies of Rs.2.20 lacs from Bajaj Allianz Life Insurance Co. Ltd. (insurer). The claim was repudiated by the insurer on the ground of suppression of material facts. As per the submission of the insurer, the DLA had fractured of his right hand arm and was suffering from diabetes before the proposal and the same was not disclosed. He took admission for operation of his said fracture and after operation he died. On the other hand, the complainant submitted that her husband told about the fractured to the agent who told that it was not necessary. Secondly, proposal was completed by the agent and her husband was asked to sign only.

AWARD:-

The Hon'ble Ombudsman observed that the pleas taken by the complainant that this fact of fractured hand was not mentioned as per the instruction of the agent cannot be accepted. Once, the deceased insured has signed the proposal and the contract is concluded on that basis, the facts stated in the proposal should be considered as final. In this case, the material fact was left concealed and so repudiation by the insurer is valid. The complaint stands dismissed.

(04)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-003-0743

Sri Shyam Sundar Prusty Vrs TATA AIG Life Insurance Co. Ltd.

Award dated 09th April, 2009

FACT:-

The wife of the complainant had taken one policy for Rs.42,010=00 on 258.05.2007 from TATA AIG Life Insurance Co. Ltd. (insurer). She expired on 21.09.2007. The complainant lodged the claim. The insurer repudiated the death claim on the ground of suppression of material facts. As per insurer, the deceased life assured (DLA) was suffering from breathlessness prior to the date of proposal and was under treatment of doctor. Further, he was suffering from asthma. The fact was not disclosed on the proposal.

AWARD:-

The Hon'ble Ombudsman based on the documents submitted observed that the Life Assured was under treatment before the Proposal. The same was not disclosed in question No- 1 (a) of the proposal. The DLA was advised for ECG and X-ray. The complainant had given the statement that his wife suffering from cold, fever, chest pain etc. The owner of the medicine shop also gave the statement that the DLA was suffering from asthma for last 08 years. So, repudiation was done correctly. But, one thing was lacking as to whether the suppression was made fraudulently to induce the insurer to issue the policy. There was no evidence or material in this regard. Sum assured taken was only Rs.42,000=00. Considering this aspect, the Hon 'ble Ombudsman invoke the discretion to grant ex-gratia. The insurer is directed to pay Rs.15,000/- as ex-gratia on receipt of the consent letter from the complainant.

(05)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0744

Sri Bipin Bihari Mohanty Vrs Life Insurance Corporation of India

(Khurda BO, Bhubaneswar DO)

Award dated 13th April, 2009

FACT :-

The father of the complainant had taken one policy for Rs.1,00,000=00 under endowment plan for 20 years with commencement date 28.03.2003 from LIC of India (insurer). Since the policy was in lapsed condition it was revived on 25.04.2005 with one Declaration of Good Health. The DLA expired 15.07.2006. The claim was repudiated on the ground of suppression of material facts. As per insurer, prior to revival of the policy the DLA was hospitalized from 07.08.2004 to 12.08.2004 but was not disclosed the same in the DGH submitted.

AWARD:-

The Hon'ble Ombudsman observed that the discharge certificate dated 12.08.2004 was very clear on the treatment taken by the DLA, but the same was not disclosed in question – 2 of the DGH. So, the repudiation considered as proper and justified. The complaint stands dismissed.

(06)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0748

Smt.Jyostna Majhi Vrs Life Insurance Corporation of India

(Bhubaneswar BO-II, Bhubaneswar DO)

Award dated 13th April, 2009

FACT:-

The husband of the complainant had taken one policy from LIC of India (insurer). The DLA being an agent of the insurer premiums are deducted from the commission of the DLA. On his death, the complainant lodged the claim before the insurer. The insurer instead of paying the sum assured refunded the premium paid under the policy. The stand taken by the insurer is that the policy was under Bima Kiran Plan wherein there is no concession as it is high risk plan. There were 08 gaps dues for which insurer had not received the premium. So, as per rules deposited premium amount was refunded by insurer.

AWARD:-

The Hon'ble Ombudsman observed that the deceased insured had given undertaking that when commission would not be sufficient; it is his responsibility to pay the premium. The premium amount is Rs.244.00 per month only. Admittedly no intimation has been given to the deceased insured that he had not earned any commission for which he is required to pay the premium directly. A person who had worked for the insurer for 18 years should not have been treated in this manner. It is not the case that the premium amount is beyond his reach or control. Had he been intimated, he could have paid those two premiums. The complaint is allowed. The insurer is directed to settle the full claim less the amount refunded within one month from the receipt of the consent letter from the complainant.

(07)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 23-001-0755

Smt.Pramila Biswal Vrs Life Insurance Corporation of India

(Berhampur BO-I, Berhampur DO)

Award dated 30th April, 2009

FACT:-

The husband of the complainant had taken a policy from Life Insurance Corporation of India (insurer) for Rs.40,000/- sum assured. He died on 17.03.2006. The insurer settled the basic assured but refused to pay double accident benefit as the cause of death was due to accident but for consumption of liquor. The complainant submitted that there is no material that the DLA was under the influence of liquor.

AWARD:-

The Hon'ble Ombudsman observed that from the available records like P.M. report, Police final report nowhere it has been mentioned that the DLA was under influence of liquor. Rather, the documents confirm that cause was accidental. The insurer perhaps drawn the conclusion on the basis of report of the constable to OIC that a person lying on the road taking liquor. This statement is based on hearsay. The P.M. report and final report does not reveal anything. So, the hon'ble ombudsman accepted the complaint and directed the insurer to pay the accident benefit within one month from the order.

(08)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-007-0765

Smt.K.Brundabati Reddy Vrs Max New York Life Ins.Co. Ltd.

Award dated 08th April, 2009

FACT:-

The husband of the complainant had taken one policy for Rs.50,000/- from Max New York Life Insurance Co. Ltd. (insurer). The death claim was repudiated on the ground of suppression of material facts. As per the insurer, the policy was revived with health declaration. On claim investigation it was revealed that the policyholder was suffering from cirrhosis of liver at the time of revival, but it was not disclosed in the health declaration form. The insurer made the reference of Supreme Court Judgment under P.C. Chakoo Vrs. LICI.

AWARD:-

The Hon'ble Ombudsman observed that the document collected by the insurer establishes that at the time of reviving the policy the policy holder was suffering and was under treatment. So, in the health declaration there was suppression of material facts. So, the repudiation is justified and proper. The complaint stands dismissed.

(09)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0780

Sri Manas Ranjan Behera Vrs Life Insurance Corporation of India

(BBSER_II BO, Bhubaneswar DO

Award dated 29th April, 2009

Fact –

The mother of the complainant had taken one policy for Rs.40,000/- from LIC of India (insurer). There was delay in settlement of the death claim. As per the insurer, the delay was due to non-submission of requirement for consideration of the claim. The complainant was absent. So, his view point could not be ascertained.

AWARD –

The Hon'ble Ombudsman observed that since no relevant documents are available before the forum it is not possible to pass any opinion on merit of the case. So, he directed the insurer to take immediate step to settle the claim within one month of the order if documents have been received from the complainant. If the documents have not been received yet, the insurer is directed to make the correspondences with the complainant specifying the date for production of documents and settle the claim within one month of the receipt of the document.

(10)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0783

Smt. Puspalata Behuria Vrs Life Insurance of Corporation of India

(Cuttack-II BO, Cuttack DO)

Award dated 28th April, 2009

FACT:-

The husband of the complainant had taken one policy for Rs.40,000/- from LIC of India (insurer). There was delay in settlement of the death claim. As per the insurer, the delay was due to non-submission of requirement for consideration of the claim. The complainant was unable to provide any information on the matter.

AWARD:-

The Hon'ble Ombudsman observed that since the documents were not submitted to the insurer it is not possible to pass any opinion on merit of the case. So, he directed the insurer to send the necessary forms within 7 days of receipt of the order and inform the forum within 7 days of receipt of the requirements about the status of the claim.

(11)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0784

Smt. Banalata Mohanty Vrs Life Insurance of Corporation of India

(BBSR-I, BBSR DO)

Award dated 28th April, 2009

FACT:-

The husband of the complainant had taken one policy for Rs.50,000/- from LIC of India (insurer). There was delay in settlement of claim. As per the insurer, the father of the deceased policy holder was the nominee. Since, wife of the DLA submitted the Death Certificate of the nominee, as per rule, policy became open title one. So, they require succession certificate/formalities of waiver of succession certificate. But, the wife of the DLA had not submitted those requirements. As per the complainant, she being the wife and nominee died already the claim amount need to be paid to her. She had produced one legal heir certificate wherein her mother-in-law, she herself and her minor daughter is shown as legal heirs.

AWARD:- The Hon'ble Ombudsman observed that the mother-n-law of the complainant who is one of the legal heirs had not submitted any complaint or claim before L.I.C. for getting the claim amount. Moreover, the application for change of nomination by the DLA in favour of his wife was

submitted much earlier to his death, but, same was registered after his death, which amounts to negligence of the insurer. So, the hon'ble Ombudsman directed to settle the death claim with full benefit within one month from the date receipt of the consent letter in favour of the complainant.

(12)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0767

Smt. Sureswari Sahu Vrs Life Insurance Corporation of India

(Sundargarh BO of Sambalpur DO)

Award dated 01st May, 2009

FACT:-

The husband of the complainant had taken one policy viz: BIMA KIRAN for Rs.1,00,000=00 (One lacs) under Salary Savings Scheme from Life Insurance Corporation of India (insurer) with Date of commencement as 28.03.200. The deceased life assured expired on 27.09.2002. The claim was denied on the plea that the policy in question was in lapsed condition. As per insurer, there were 08 initial monthly unpaid dues. The premium for the said period not deducted in spite of sending the letter of authority to the employer. The DLA had not deposited the gap dues during his life time. So, the policy became a lapsed one. The policy being one high risk plan no concession is available. The plan is for refund of premium amount only on maturity. But, in case of death full sum assured is payable. The complainant had submitted that the insurer had not intimated about non-receipt of the premium, rather they accepted the subsequent premium.

AWARD:-

The Hon'ble Ombudsman observed that the complainant had not produced any materials to show that initial 08 premiums were deducted from the salary of her husband. The reason of non-deduction was best known to the DLA who is no more. Ordinarily, the responsibility to pay the premium lies with the insured, but in case of salary savings policy it is responsibilities of the paying authority to deduct and remit. In case deduction is beyond the control of the Paying Authority, the insured has to deposit the same. In this case, when 08 premiums were not received neither insurer intimated the same to the life-assured nor life assured took the step to deposit the unpaid premium. So, the policy becomes lapsed for negligence of both the parties. So, the Hon'ble Ombudsman directed the insurer to pay Rs.50,000=00 as ex-gratia within one month.

(13)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0769

Sri Ramesh Ch. Majhi Vrs Life Insurance Corporation of India

(Bhawanipatna BO of Berhampur DO)

Award dated 08th May, 2009

FACT:-

The father of the complainant had taken one policy for Rs.50,000=00 sum assured from Life Insurance Corporation of India (insurer) with Date of commencement as 14.09.2006. The deceased life assured expired on 02.10.2006. The claim was repudiated on the ground of suppression of material facts as regards to health. As per insurer, the DLA was treated for fever, cold and was found to be a bronchitis patient. The fact was not disclosed in the proposal papers. On other hand, the complainant submitted that his father was never treated for any disease prior to taking the policy.

AWARD:-

The Hon'ble Ombudsman observed that exact cause of death is not known as PM examination not done. As per villagers certificate death is due to cold fever and cough. Insurer does not dispute on cause of death. As per medical certificate of the Govt. T.B. Hospital, the DLA attended OPD on 12.10.2005 with complaint of fever and cough for 15 days. With face of these documents it cannot be said the DLA was not treated prior to proposal. But, considering the status of the policyholder and the sum assured taken, it cannot be said that he fraudulently taken the policy and intentionally suppressed the material facts. So, the Hon'ble Ombudsman set aside the repudiation and directed the insurer to pay the sum assured and other benefits to the complainant within one month.

(14)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0778

Smt.Pournamasi Rout Vrs Life Insurance Corporation of India

(Uditnagar BO of Sambalpur DO)

Award dated 14th May, 2009

FACT:-

The husband of the complainant had taken one policy for Rs.50,000=00 sum assured under Salary Saving Scheme from Life Insurance Corporation of India (insurer). The life assured left home on 08.11.1996. One civil suit was filed in the competent court of law to declare him as dead. The suite was disposed on 30.03.2006 declaring the life assured as dead w.e.f. the date of filing the suite i.e; 23.04.2004. Thereafter the claim was lodged before the insurer who settles only paid-up value. As per the insurer, the premium was deducted up to November, 1996. No intimation was given about the missing of the life assured. By the time court declared him as dead policy was in lapse condition. The complainant submitted that lapse intimation was not sent by the insurer and the payment of premium was also beyond her control.

AWARD:-

The Hon'ble Ombudsman observed that the insurer was not informed about the missing of the policy holder. Similarly, non-payment of premium by the legal heirs after missing cannot also be concluded as their negligence as they have no idea about rules related to insurance policies. So, he felt the case was fit for granting ex-gratia. So, the insurer was directed to pay the differential balance of sum assured (without consequential benefit, if any) less paid-up value and premium due under the policy up to the date of filing the plaint before the civil judge without charging any interest on ex-gratia basis within one from the date of receipt of the consent letter from the complainant.

(15)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0788

Smt.Saraswati Hembram Vrs Life Insurance Corporation of India

(Paradeep BO of Cuttack DO)

Award dated 29th May, 2009

FACT:-

The husband of the complainant had taken four policies under Salary Saving Scheme from Life Insurance Corporation of India (insurer). On his death full claim under two of those policies was paid. But, two other policies paid-up value was paid. As per insurer, there were gap dues under those two policies for which paid-up value was paid. But, with the same gap for other two policies full claims were paid by application of claim concession. The complainant on the other hand submitted that there was no intimation in regards to gap due by the insurer.

AWARD:-

The Hon'ble Ombudsman observed that the complainant was admitting the fact that there were intermittent gaps for non-deduction of premium from salary. During life time, the policy holder could have deposited the gap premium with the insurer which was not done by him. In spite of gaps for two policies the insurer settled full claim by deducting the gap dues as per the concession provision. But, for other two policies, it was not applicable. So, paid-up value was paid. No irregularities have been conducted by the insurer. So, the complaint stands dismissed.

(16)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0811

Sri Bijay Kumar Behera Vrs L.I.C. of India

(Sundargarh BO of Sambalpur DO)

Award dated 03rd June, 2009

FACT:

The complainant's brother had taken one policy from Life Insurance Corporation of India (insurer) for Rs.50,000/-. On the death of the Life Assured, the insurer settled only basic sum assured though the death was by accident, but accident benefit was denied on the plea that death occurred while DLA was on police duty. The insurer submitted that extra premium was not paid by the life assured for covering accident benefit while on duty.

AWARD:-

The hon'ble ombudsman observed that from the copy of the proposal it is revealed that the DLA correctly disclosed his occupation as Police Personnel and he also opted for Accident Benefit. It is the duty of the insurer to fix the premium based on the facts provided on the proposal. It is not the case that the insurer charged extra premium but the deceased insured had refused to pay. So, for negligence of the insurer at the time of fixing the premium, the deceased insured should not suffer. When he has opted for Accident Benefit and death is due to accident, the insurer should pay the accident benefit amount. In view of this, insurer is directed to pay accident benefit after deducting the extra premium which could have been paid by the DLA, but not paid, to the complainant.

(17)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0801

Smt.Jamuna Ray Vrs L.I.C of India

(Pattamundai BO of Cuttack DO)

Award dated 04th June, 2009

FACT:

The complainant's husband had taken one policy from LICI (insurer). There was delay in settlement of death claim. The insurer had submitted that two death certificates have been produced on behalf of the complainant reflecting death at two different dates, which requires thorough investigation and so delay is caused.

AWARD:-

The hon'ble ombudsman observed that out of the two death certificate one was issued by the authority of Mumbai Municipal Corporation where the policy holder died. The date of death mention is 23.05.2006. The other one issued by authority in Orissa mentioning date of death as 23.06.2006. The fact required proper investigation. On the date of order, the insurer reported that their investigation reveals that the DLA died at Mumbai and the certificate issued by Mumbai Municipal Corporation is genuine. So, the insurer is directed to settle the claim within one month from receipt of affidavit from the complainant explaining the reason of issuance of two different death certificates.

(18)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0812

Smt. Sabitri Behera Vrs. L.I.C. of India

(Sundargarh BO of Sambalpur DO)

Award dated 03rd June, 2009

FACT:

The complainant's brother had taken one policy from Life Insurance Corporation of India (insurer) for Rs.50, 000/-. On the death of the Life Assured, the insurer settled only basic sum assured though the death was by accident, but accident benefit was denied on the plea that death occurred while DLA was on police duty. The insurer submitted that extra premium was not paid by the life assured for covering accident benefit while on duty.

AWARD:-

The hon'ble ombudsman observed that from the copy of the proposal it is revealed that the DLA correctly disclosed his occupation as Police Personnel and he also opted for Accident Benefit. It is the duty of the insurer to fix the premium based on the facts provided on the proposal. It is not the case that the insurer charged extra premium but the deceased insured had refused to pay. So, for negligence of the insurer at the time of fixing the premium, the deceased insured should not suffer. When he has opted for Accident Benefit and death is due to accident, the insurer should pay the accident benefit amount. In view of this, insurer is directed to pay accident benefit after deducting the extra premium which could have been paid by the DLA, but not paid, to the complainant.

(19)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0790

Smt. Kshirodini Nayak Vrs L.I.C of India

(Angul B.O of Cuttack D.O)

Award dated 09th June, 2009

FACT:

The complainant was the widow of deceased insured who had taken three polices from L.I.C of India. The deceased insurer died on 09.07.2007. The insurer repudiated the claim on the ground of suppression of material facts as regards to health of the DLA. According to the insurer, the DLA had undergone treatment for chronic Ethanol Abuse, consuming alcohol since five years. The insurer also stated that the DLA had taken leave from his office on health ground frequently. But it was not disclosed in the proposal form.

AWARD:-

The Hon'ble Ombudsman observed that it is the common practice for the Govt. service holder to avail leave on health ground. So, non-disclosure in the proposal cannot be taken that importance. Secondly, the Medical Treatment Book of the employer reveals that the DLA was treated for chronic alcoholic prior to proposal. It amounts to suppression of material facts.

The deceased life assured had three policies with Sum Assured of Rs.1,80,000=00. Considering the nature of the case, status of the DLA, the Hon'ble Ombudsman consider fit invoke the forums jurisdiction to grant ex-gratia. So, the insurer is directed to pay Rs.50,000=00 as ex-gratia to the complainant within one month from the date of receipt of the consent letter.

(20)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 22-001-0826

Smt. Dukhi Pradhan Vrs LIC of India

(Bolangir B.O of Sambalpur D.O)

Award dated 22nd June, 2009

FACT:-

The complainant's husband was having an insurance policy bearing no-590152518 from the LIC of India. The death claim was not settled after the death of her husband. The insurer stated that due to non –submission of some documents the claim was pending.

AWARD:-

The honourable Ombudsman observed that no documents are available before this forum except copy of death certificate at the time of hearing.

So, the insurer is directed to settle the claim within one month from the date of receipt of this award (if not done till date). If the complainant has not produced any documents, she be asked to produce the documents within 15 days of receipt of this award and that the insurer is directed to settle the claim within 15 days from the date of receipt of documents from the complainant.

(21)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0834

Smt. Purnamati Sahoo ***Vrs*** ***L.I.C* of India**

(Bolangir B.O of SambalpurD.O)

Award dated 22nd June, 2009

FACT:

The complainant was the widow of one deceased insured who had taken two polices from L.I.C of India. The deceased insurer died on 01-11-1994. The complainant lodged the claim. As there has been delay the complainant has approached this forum.

AWARD:-

The copy of the letter dated on 25-08-88 of the insurer written to the deceased insured reveals that in respect of the policy which matured on 28-01-88, the policy bond was not received and so the deceased life assured was asked to send the original policy bond. This communication was made when the deceased insured was alive. So it is not possible on the part of the complainant to know whether the deceased insured has received the claim or not. So no further payment can be made by the insurer in respect of first policy which matured on 28-01-88.More over the original policy, is not with the complainant.

Coming to the second policy, by the time the policy matured, the deceased insurer had expired. The maturity date was 28-12-2001 where as the deceased insurer died on the year 1994. In that case the insurer is to explain the position. It is not the case that the deceased insurer had taken the maturity value because by that time, he had expired. It is also very different in part of the complainant to provide information or proof in support of payment of premium, unless the insurer proves that the payment has not been made and he has to pay.

No doubt there has been delay in lodging the claim. Considering the nature the case, status of the complainant and the sum assured; the Hon'ble Ombudsman awarded that the delay is not intentional. Hence it can be condoned and so directed to pay the sum assured in respect of the second policy to the complainant within one month from the date of receipt of consent letter.

(22)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0862

Smt.P. Purnabasi Bairtya Vrs Life Insurance Corporation of India

(Chhatrapur BO of Berhampur DO)

Award dated 27th July, 2009

FACT:-

The mother of the complainant had taken two policies from L.I.C. of India (insurer). The deceased insured died on 31.05.2005. After death of the Life Assured, the complainant lodged the claim. The insurer settled the claim under one policy but repudiated the claim under other policy on the ground of suppression of material facts. As per insurer, the fact on previous policy was not mentioned in the proposal which amounts to the suppression of material facts and is a valid ground for repudiation. They had accepted the previous policy with Non-Standard Age proof and so subsequent policy with Non-Standard Age Proof was not acceptable.

AWARD:-

The Hon'ble Ombudsman observed that non-disclosure of previous policy was undoubtedly suppression of material facts. But, the ground taken by the insurer is not correct. The column meant for proof of age in the proposal form has been left blank. No explanation from the insurer was given how the proposal was accepted without age proof. So, the Hon'ble Ombudsman allowed the complaint and directed the insurer to settle full claim within one month.

(23)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0860

Sri Ambica Prasad Bhoi Vrs Life Insurance Corporation of India

(Nawarangpur BO of Berhampur DO)

Award dated 28th July, 2009

FACT:-

The father of the complainant had taken three policies from L.I.C. of India (insurer). After death of the D.L.A, the complainant lodged the claim. The insurer settled the claim for two policies, but, repudiated the claim for the third policies on the plea of suppression of material facts in regards to the previous policy. As per insurer, non-disclosure of previous policy in the last proposal was intentional. Had it been disclosed, they should have called for medical examination.

AWARD:-

The Hon'ble Ombudsman observed that the DLA was a teacher. The circumstances suggest that deliberately the deceased policy holder did not disclose about two other policies. So, there is no compelling ground to take a different view. Hence, the complaint stands dismissed.

(24)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-002-0858

Sri Surya Narayan Mahapatra Vrs S.B.I. Life Ins. Co. Ltd.

Award dated 30th July, 2009

FACT:-

The complainant was the appointee under one policy where one minor was the nominee. On death of the life assured appointee lodged the claim. The claim was repudiated on the ground of suppression of material facts. Only the N.A.V. value of the invested amount was paid. As per insurer, the DLA was suffering from T.B. and was treated for the same before the proposal.

AWARD:-

The Hon'ble Ombudsman observed that the document produced by the insurer was clear evidence that the DLA was treated for T.B. before the proposal. But, there was no specific question in the proposal about the treatment of T.B. and secondly the cause of death is for different reason. Considering the both the aspects, the Hon'ble Ombudsman thought proper to grant ex-gratia. Hence, the insurer was directed to pay Rs.15,000/- as ex-gratia within one month from receipt of the consent letter.

(25)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-002-0870

Smt. Pramila Bhoi Vrs. SBI Life Ins. Co.Ltd.

Award dated 06th August, 2009

FACT:-

The complainant is the wife of the deceased policyholder who was one member of Group Insurance Policy of the insurer. On the death of the life assured the claim was lodged by the complainant, but, same was repudiated by the insurer. As per insurer, there was one 45 days exclusion clause mentioned in Section-5 of the master policy. Since, the life assured expired within 45 days of the risk, the claim was denial. The insurer in support of their stand cited the case decided by NCDRC, New Delhi under the case of Kabita Dauka Vs. SBI Life Ins. Co. Ltd.

AWARD:-

The Hon'ble Ombudsman examined the Section-5 of the policy which categorically excluded any death except by accident within 45 days. So, he concluded that the action of the insurer cannot be said as arbitrary and unjust. Hence, the complaint stands dismissed.

(26)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0893

Smt. Amulya Gauda Vrs. Life Insurance Corporation of India

(Aska BO Berhampur DO)

Award dated 03rd September, 2009

FACT:-

The husband of the complainant had taken one policy from Life Insurance Corporation of India (insurer). On his death, the complainant lodged the claim. The claim was denied on the ground that the policy was in lapsed condition. According to the insurer, only one initial premium was deposited. The subsequent premium was not deposited during the grace period. But, on the date of death, after the time of death said premium was deposited. When it was revealed that subsequent premium was deposited after death, the amount was refunded and the policy was treated as lapsed. The complainant on the other hand submitted that the premium amount was given to the concerned agent before death.

AWARD:-

The Hon'ble Ombudsman observed that the agent is not authorized to collect the premium. For negligence of the agent, the insurer cannot be penalized. But, on the other hand, there is a ring of truth that the premium might have been handed to the agent earlier because it does not appear probably that on the date of death of the policy holder, the wife could able to know about non-payment of premium and would rush to the office of the insurer to deposit the amount at the close of the office hours. It is further observed that the premium was paid part by cheque and part in cash. It is not clear who had issued the cheque. Thirdly, the insurer took more than a year to refund the deposited amount without showing any good reason for delay. In the fact of the position, considering the nature of the case and status of the complainant, the Hon'ble Ombudsman invokes the jurisdiction to grant ex-gratia. So, the insurer was directed to pay Rs.10,000/- as ex-gratia and interest on refunded amount at the prevailing rate for the delayed period.

(27)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 24-001-0903

Sri Prafulla Ku. Paikray Vrs. Life Insurance Corporation of India

(Balugaon BO of BBSR DO)

Award dated 18th September, 2009

FACT:-

The wife complainant had taken one policy from Life Insurance Corporation of India (insurer). There was delay in settlement of the claim. So, he approached this forum. Subsequently, the claim was repudiated by the insurer. According to insurer, the DLA was housewife, but, in the proposal it was stated she was having business. So, he was granted two lacs sum assured policy though the husband was not having any insurance policy. Secondly, there was delay in lodging the claim. The complainant submitted that his wife was having independent source of income. On that basis the policy was issued by the insurer.

AWARD:-

The Hon'ble Ombudsman observed that issuance of policy solely depends on income of the proposer. For lady proposer having no income insurance is dependent on insurance on the life of the husband. On the other hand, the insurer, if now says that the lady was not having any income; they should have investigated the matter before accepting high sum assured. Secondly, the reason of delay in intimation to the insurer (after two years) is not satisfactory to this forum. This casts doubts. It is not the case that he was not aware about the insurance policy of his wife. Ordinarily, the delay has got dangerous effect. So, it cannot be said insurer has acted arbitrarily.

However, considering the nature of the case, status of the DLA and the role played by the insurer while accepting the proposal, the Hon'ble Ombudsman opined that in the interest of justice, the forum can invoke its jurisdiction for ex-gratia grant as a special case. So, the insurer was directed to pay Rs.50,000/-.

(28)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No- 21-001-0878

Smt.Soubhagya Laxmi Das Vrs. Life Insurance Corporation of India

Award dated 29th September, 2009

FACT:-

The husband of the complainant had taken two policies from Life Insurance Corporation of India (insurer). On his death, the complainant lodged the claim. The claim was denied on the ground that the policy was in lapsed condition. According to the insurer, only one initial premium was deposited. The subsequent premium was not deposited during the grace period. But, on the date of death, after the time of death said premium was deposited. When it was revealed that subsequent premium was deposited after death, the amount was refunded and the policy was treated as lapsed. The complainant on the other hand submitted that the premium amount was given to the concerned agent before death.

AWARD:-

The Hon'ble Ombudsman observed that the agent is not authorized to collect the premium. For negligence of the agent, the insurer cannot be penalized. But, on the other hand, there is a ring of truth that the premium might have been handed to the agent earlier because it does not appear probably that on the date of death of the policy holder, the wife could able to know about non-payment of premium and would rush to the office of the insurer to deposit the amount at the close of the office hours. It is further observed that the premium was paid part by cheque and part in cash. It is not clear who had issued the cheque. Thirdly, the insurer took more than a year to refund the deposited amount without showing any good reason for delay. In the fact of the position, considering the nature of the case and status of the complainant, the Hon'ble Ombudsman invokes the jurisdiction to grant ex-gratia. So, the insurer was directed to pay Rs.10,000/- as ex-gratia and interest on refunded amount at the prevailing rate for the delayed period.

CHANDIGARH

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. Aviva/508/Gurgaon/Phagwara/21/09
Amarjit Kaur Vs Aviva Life Insurance Co.Ltd.

ORDER DATED: 17th APRIL, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Amarjit Kaur had stated that her husband late Sh. Paramjit Singh had purchased a policy bearing no. LLG-1233618. After his death the claim was preferred to the insurer but the same was repudiated on grounds that facts related to alcohol and high blood pressure were not disclosed. She stated that before and at time of purchasing the policy, her husband had never consumed alcohol and was 'Normal' in regard to high blood pressure. Hence there was no concealment of material facts.

FINDINGS: The insurer clarified the position by stating that in the last medical attendant report it has been mentioned that the DLA was consuming alcohol for the last five years. Hence this was considered as concealment of material facts and the claim was repudiated. On a query, as to what was the date of commencement of the policy and the date of death of the DLA the insurer replied that the date of commencement was 09.05.06 and the date of death is 30.08.08.

DECISION: Held that the policy had run for more than two years after commencement. Accordingly second part of Section 45 of the insurance Act became relevant. The policy could not be called in question after having run for two years unless the concealment of fact was material, in the knowledge of the insured that it was material, and the concealment was fraudulently done. In the present case the insurer was relying on one statement of the

attending doctor which if read carefully states that the period of 5 years was estimation and the number of years could be less. Thus it could not be said that the insurer had conclusively proved that there was a pre existing disease which was not intimated at the time of filling up of the proposal form. Giving the benefit of doubt to the complainant it was decided that the claim was payable and repudiation of the claim was not in order. The insurer was ordered to make the payment of the claim amount to the complainant.

CHANDIGARH OMBUDSMAN CEDNTRE

CASE NO. Kotak Mahindra/502/Mumbai/Ludhiana/24/09
Sh. Kulwant Singh Vs Kotak Mahindra Life Ins Co. Ltd.

ORDER DATED: 16th APRIL. 2009 **DEATH CLAIM**

FACTS: The complainant Sh. Kulwant Singh was allured in purchasing a policy. As he was handicapped the policy could not be issued in his name. So he purchased a policy in the name of his mother Smt. Jaswinder Kaur and issued a cheque of Rs. 70,000/- dated 15.02.08. He was told that his mother would get a cover of Rs. 7,40,000/- for a term of 10 years and premium of Rs. 70,000/- It took 7 months for the company to issue the policy bond. But before that his mother expired on 14.08.08. He received the policy bond on 12.09.08. When he contacted the insurer, he was told that the policy was not in effect as on the date of death. He had completed all the claim formalities but till date he had not received any reply from the company.

FINDINGS: The insurer clarified the position by stating that the policy was a pension plan policy without risk cover. On a query if written consent for transfer of Rs. 70,000/- from the complainant to his mother was obtained, the insurer replied in the negative. On a query, whether proposal form signed by the complainant's mother was available, the insurer replied in the affirmative and showed a copy of the proposal form. The complainant stated that it was not signed by his mother. On a query as to when the premium was received, the insurer replied that it was on 20.02.08 in the name of the complainant but in July-08 in the name of his mother. On a query as to why it took more than one month to issue the policy, the insurer replied that they were checking up some details which needed clarifications.

DECISION: Held that the insurer had erred in not providing proper service to the complainant. The following were the findings:-

1. Money was deposited on 20.02.08 by the complainant but no policy was issued to him.
2. Money was diverted to the DLA's account (mother of the complainant) without written consent of the complainant in July-08.

3. No proposal form signed by the complainant's mother was available (The one available was allegedly not signed by her).

Since the policy was wrongly issued without the application by the DLA, there was no valid contract. The claim was, therefore not payable. However the insurer was ordered to pay interest @8% pa w.e.f 20.02.08 till 16.02.09 on the premium paid by the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. ICICI/484/Mumbai/Rohtak/21/09
Manisha Ghai Vs ICICI Prudential Life Insurance Co.

ORDER DATED: 17th APRIL, 2009 **DEATH CLAIM**

FACTS: The complainant Ms. Manisha Ghai had stated that her husband late Sh. Bharat Bhushan Ghai had purchased a policy bearing no. 02869910 for an amount of Rs. 1,50,000. He had paid four half yearly installments of Rs. 15,000/- each. After his death on 11.04.08 the claim was preferred to the insurer. However after about six months the company repudiated the claim vide letter dated 03.11.08 on the grounds of suppression of material information. She stated that her husband was not suffering from any disease at the time of taking the policy. Hence she requested the company to reconsider her case which was also turned down.

FINDINGS: The insurer clarified the position by stating that the date of commencement of the policy was 30.05.06. The DLA expired on 11.04.08. Since the death took place within two years of the commencement of the policy, it was treated as an early death claim and investigations were carried out which revealed that the DLA was suffering from Chronic Liver disease for the last three years. Accordingly it was treated as preexisting disease and the claim was repudiated. On a query, as to what was the date of repudiation of the claim the insurer stated that it was 03.11.08.

DECISION: Held that there was a time lag of two and half years between the date of commencement of the policy and the date of repudiation. Since more than two years had elapsed till the date of repudiation, Part-II of Section 45 of Insurance Act becomes relevant. The insurer had to establish that there was a concealment of material fact, it was in the knowledge of the insured and that this concealment was fraudulently made. But the insurer had not been able to establish any of the above three conditions with documentary evidence. The insurer was advised to pay the claim.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/584/Chandigarh/Unit-II/24/09
Saroj Bala vs. LIC of India

ORDER DATED: 4th May, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Saroj Bala stated that her husband late Sh. Murari Lal had a policy bearing no. 161842009. After his death, claim was preferred to the insurer. She visited the insurance office several times, but the insurer had failed to make the payment or give any reply. Then she asked for the claim to be paid with interest @18%.

FINDINGS: The insurer clarified the position by stating that the policy was revived on 11.10.07 and the DLA expired on 17.12.2007. This was considered as an early death claim and hence investigations are being carried out.

DECISION: Held that once the policy had been revived, the policy is valid from the date of commencement viz 01.01.2000. This is clearly brought out in a prominent judgment by Hon'ble Supreme Court in case of Mithoo Lal Nayak Vs LIC of India in which the Supreme Court observes as follows:

"It is clear from the wording of the operative part of Section 45 that the period of two years for the purpose of the Section has to be calculated from the date on which the policy was originally affected. From that date a period of two years had clearly expired when the death took place".

In view of the above it cannot be treated as an early death claim. The claim is payable without any further investigations. The admissible amount of claim should be paid by the insurer to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. HDFC/555/Mumbai/Panchkula/24/09
Rohit Garg Vs HDFC Standard Life Insurance Co. Ltd.

ORDER DATED: 20th May, 2009 **DEATH CLAIM**

FACTS: The wife of the complainant Sh. Rohit Garg, Late Smt. Neena Rani had a policy bearing no. 12327501 on 06.11.2008. She was admitted in Alchemist Hospital from 04.01.09 to 10.01.09 for treatment of Pneumonia and then referred to PGI where she expired on 11.01.09. During the treatment he had informed the company about the treatment and sought reimbursement of expenditure being incurred during the treatment. He approached the company for death claim but no reply was received.

FINDINGS: The insurer clarified the position by stating that on receipt of the proposal form they had requested the complainant for getting the medical done up from their authorized diagnostic centre while letter dated 11.11.08. This was not received till the date of expiry of the life assured. Hence the policy could not be prepared and issued to the policy holder. Thus on the date of expiry the LA was not having a valid regular insurance policy. The insurer was asked for the clarification regarding the delivery of the letter dated 11.11.08 to the complainant and also about the unconcluded contract liabilities. The insurer told that the letter was issued to the policyholder for her medical examination soon after the proposal form was received. However no medical examination was done and the policy document was not issued nor any policy number given.

DECISION: Held that the policy bond was not issued because all the documents were not completed was justified. Mere receipt of premium could not be treated as completion of an insurance contract.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. HDFC/492/Mumbai/Panchkula/21/09
Lt. Col Inder Vir Singh Kang(Retd) Vs HDFC Standard Life Insurance Co. Ltd.

ORDER DATED: 20th May, 2009 **DEATH CLAIM**

FACTS: The complainant Lt. Col Inder Vir Singh (Retd) that his wife late Smt. Sukhjit Kaur Kang had a policy bearing no. 11142631. After her death on 29.03.08, the claim was preferred to the insurer which was repudiated vide letter dated 15.10.08, reason being that DLA was diagnosed with "Carcinoma-Breast" prior to the issuance of the policy. He stated that his wife was subjected to medical examination by the company's nominated doctor. The fact of her having been gone through the mastectomy of right breast could not have been hidden. Moreover she had disclosed to the doctor about the treatment she was undergoing. He requested this forum that medical examination report be called from the doctor and examined.

FINDINGS: The insurer clarified the position by stating that the fact about the carcinoma breast disease was not revealed at the time of filling up of the proposal form. The date of commencement being Aug-07, this was an early death claim and hence investigations were carried out which revealed that the DLA was suffering from pre-existing disease. On a query, whether medical report at the time of issuance of the policy was available, the insurer stated that it was available but needed time to furnish the same. In next hearing when the insurer was asked to produce records if any regarding medical treatment undertaken by the DLA before the commencement of the policy. They furnished a report from Military Hospital Chandimandir in which it has been mentioned that in 2005 she had undergone "Carcinoma Therapy and surgery for breast mastectomy. Unfortunately these facts were not mentioned in the proposal form or

medical examiner questionnaire. Hence the claim was repudiated on the grounds of concealment of material facts.

DECISION: Held that there was concealment of material fact relating to the breast mastectomy of the DLA was justified. The repudiation of the claim was therefore in order. The complaint was dismissed.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. Aviva/003/Gurgaon/Mohali/24/09
Balwinder Kaur Vs Aviva Life Insurance Co. Ltd.

ORDER DATED: 29th MAY, 2009 **DEATH CLAIM**

FACTS: As per the complainant Smt. Balwinder Kaur her husband late Sh. Karamjit Singh had purchased two policies bearing no. LSS1933764 and LSP164177. After his death claim was preferred to the insurer. However the same was repudiated on the grounds of concealment of pre-existing material information related to LA's health.

FINDINGS: The insurer clarified the position by stating that one policy was taken in Aug 07 and the other in March-08. Both the policies were less than one year old when the death took place in Aug 08. Investigations were conducted and it was revealed by Fortis hospital that the DLA was a non chronic case of alcoholism for the last 20 years and hypertension for 2 years. Hence the case was repudiated on the ground of concealment of material facts since the patient died of Chronic Pancreas Titis which is caused by chronic alcoholism.

DECISION: Held that the main complaint for which the patient had gone to the hospital was chest pain for seven days. Although one of the causes of chronic pancreas titis was chronic alcoholism, this was not the only cause. There was no record to show that the DLA was under treatment for chronic pancrea titis before the commencement of the policy. Moreover the second policy was issued after medical examination was done on the DLA. In the medical examination report it was clearly stated that there was no risk associated identified in insuring the examinee on the basis of the medical examination tests conducted. In the case of LIC Vs GM Channabasamma it had been clearly mentioned by the apex court that doctors of LIC would have examined the DLA before his proposal was accepted. Nothing had been alleged that those doctors were either incompetent lot or won by the complainant and accordingly the appeal by LIC was dismissed. This was because the Supreme Court observed that there was evidence of doctors of the LIC who had certified good health of the insured at the time of taking out the insurance policy. The Supreme Court observed that it had not been suggested that these doctors either were won over by the insured or were negligent in performing their duty. They had submitted confidential report about the health of the insured and were of the opinion that

he was in good health. This was a similar case where in the examinee Doctor Dr. BD Gupta appointed by the insurer had declared the DLA fit for being insured and accordingly the underwriting decision was accepted and the proposal was taken by the insurer. The insurer was ordered to pay sum assured of Rs. 12.50 lakhs in respect of both the policies (Rs. 5.00 lakhs and Rs. 7.50 lakhs) along with the fund value under both these policies as on date of death.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. Aviva/028/Gurgaon/Patiala/21/10
Jagpal Singh Vs Aviva Life Insurance Co.Ltd.

ORDER DATED: 11th JUNE, 2009 **DEATH CLAIM**

FACTS: The wife of the complainant Sh. Jagpal Singh, Late Smt. Mohinder Kaur had purchased a ULIP policy bearing no. LSU1857294 in the month of Feb-08 for a sum assured of Rs. 1.00 lakh by paying a premium of Rs. 20,000/-. Unfortunately she expired on 29.04.09. The claim was preferred to the insurer. However the same has been repudiated on the grounds of non disclosure of material facts. He stated that his wife had not filled any proposal form nor undergone any medical examination nor any questions regarding illness were asked by the agent. So no question of non disclosure of any facts arises. He had again requested the insurer to release the claim amount. No claim was paid.

FINDINGS: The insurer clarified the position by stating that the DOC of the policy was 21.02.08 and the DLA expired on 29.04.08. Since it was an early death claim investigations were carried out under the provisions of Section 45 of the Insurance Act 1938. Investigations revealed that the DLA had been detected for breast cancer in March-2006 and a surgery was performed in respect of the same. This was a material fact which was not disclosed in the proposal form although it was in the knowledge of the DLA.

DECISION: Held that treatment taken for breast cancer was a material fact which was in the knowledge of the insured. Non disclosure of this information was concealment of material fact in the knowledge of the complainant. The repudiation of the claim, therefore, was in order.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/563/Karnal/Narwana/24/09
Sudesh Devi Vs LIC of India

ORDER DATED: 12TH JUNE 2009 **DEATH CLAIM**

FACTS: The husband of the complainant Smt. Sudesh Devi, late Sh. Subhash Chander had purchased a policy bearing no. 171757559 from Narwana branch office. The DLA expired due to road accident on 24.11.2004. She had submitted all the death claim papers in the branch office and received the sum assured payment but the DAB payment not received so far. She had requested many times to the insurer for the DAB payment but she had not received any response from the insurer.

FINDINGS: The insurer clarified the position by stating that the claim had been admitted by the competent authority.

DECISION: Held that the death took place on 24.11.04. But the payment for DAB had not been made. This was a very serious deficiency of service and shows the lackadaisical and indifferent attitude of the insurer towards the claimant. The FIR/PMR was received on Feb 05 by the insurer and the claim must be settled within the six month of period i.e. by 31.08.05. The insurer was ordered that the double accident benefit on both the policies would be paid by the insurer to the complainant along with interest @8% pa w.e.f 01.09.05 till the date of payment.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/052/Karnal/Panipat/24/10
Krishanpal Tyagi Vs Life Insurance Co. Ltd.

ORDER DATED: 12th JUNE, 2009 **DEATH CLAIM**

FACTS: The son of the complaint Sh. Krishanpal Tyagi, late Sh. Varinder Tyagi had purchased a policy bearing no. 175935672 from branch office, Panipat on 28.03.2008. The DLA expired on 29.07.2008. He submitted all the death claim papers in the branch office but he had not received any response from the insurer.

FINDINGS: The insurer clarified the position by stating that this was an early death claim. Investigations were required under Section 45 of the Insurance Act 1938. During investigations it was revealed by the sarpanch of the village that the DLA had been admitted in Dr. Prem Hospital one year before his death. A clarification was required from Dr. Prem Hospital who stated in their letter on 24.12.08 that no patient by the name of Sh. Virender Kumar was admitted in that hospital.

DECISION: Held that the case was inordinately delayed without any sufficient reasons. The claim must have been settled after receipt of clarification from Dr. Prem Hospital on 24.12.08. Delay in settlement of the claim tantamount to harassment. There was no insurance on the life of father, the complainant, although it should be a pre requisite for such a heavy assured amount. Moreover the medical report had cleared that the DLA was fit for taking a policy. These were serious underwriting lapses for which the insurer was liable. The insurer was

ordered to pay amount of Rs. 5.00 lakhs to the complainant without any further documentary requirement or investigations

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. Birla Sun Life/575/Mumbai/Hansi/21/09
Sunita Kakkar Vs Birla Sun Life Insurance Co. Ltd.

ORDER DATED: 18th JUNE, 2009 **DEATH CLAIM**

FACTS: The husband of the complainant Smt. Sunita Kakkar, late Sh. Satish Kakkar had purchased a policy bearing no. 00665253. He expired on 03.10.08 in Sir Ganga Ram Hospital, New Delhi. He was diagnosed as a case of CLD (Cirrhosis Lever Disease) on 07.08.08 and was since then under treatment. The claim was preferred to the insurer, however the same was repudiated.

FINDINGS: The insurer clarified the position by stating that the basic claim of Rs. 5.5 lakhs had been paid. The DLA had taken critical illness rider. Under the critical illness rider, end stage liver disease was covered. The DLA was suffering from, CLD accompanied by cirrhosis of liver which was not covered under the terms and conditions of the policy. To find out whether cirrhosis of liver was covered under end stage liver disease clarification from a medical practitioner was got that whether CLD accompanied by cirrhosis of liver covers (and is a consequence of the CLD with cirrhosis) of the following:-

a) Permanent jaundice

b) Ascites and

c) Hepatic Encephalopathy.

The medical report from Principal Medical Officer, Hissar stated that it had nexus. The insurer stated that the medical officer had stated that there was ESLD should satisfy Permanent Jaundice, Ascites and Hepatic Encephalopathy.

DECISION: Held that at one place in the record shown by the insurer it had been clearly stated that ESLD was a degree of CLD. Giving the benefit of doubt to the complainant the insurer was ordered to pay the claim.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/066/Rohtak/Tohana/24/10
Angoori Devi Vs LIC of India

ORDER DATED: 18th JUNE, 2009 **DEATH CLAIM**

FACTS: The husband of the complainant Smt. Angoori Devi, Late Shri Prem Kumar purchased a policy bearing No. 175598964. The DLA expired on 09.06.2008 due to rail accident. She has submitted all the death claim papers in the branch office but she had not received any response from the insurer.

FINDINGS: The insurer stated that as per Newspaper report the person was mentally deranged and hence he committed suicide. Since it was a suicide case, the case had been repudiated.

DECISION: Held that there was no witness to state that the person had committed suicide. The newspaper is a reported version. The investigator in his investigation report had stated that there was no documentary proof of suicide and claim was payable. Giving the benefit of doubt to the complainant, the insurer was ordered that the claim must be paid.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/072/Chandigarh/Patiala/21/10
Manjit Kaur Vs LIC of India

ORDER DATED: 24th JUNE, 2009 **DEATH CLAIM**

FACTS: The husband of the complainant Smt. Manjit Kaur, Late Sh. Arab Singh was working as Head Constable at Sangrur Railway Police Station expired while on duty on 16.06.07. The basic claim under his four policies bearing no. 163272306, 161864482, 161534760 and 162170768 were settled by the company. However DAB had not been released inspite of submitting all the required documents. He stated that the immediate cause of death was drowning in a water tank near his residence. There were external damage marks on his forehead and at the back of his head when the body was recovered.

FINDINGS: The insurer clarified the position by stating that while it is a fact that the cause of death was drowning, there was a chemical analysis report which states that the DLA was under the influence of Aluminum phosphate insecticide at the time of his death.

DECISION: Held After hearing both the parties and going through the records carefully, I find that there is a certificate given by Medical Officer, Civil Hospital, Sangrur who conducted the postmortem on the basis of chemical examiner report. The officer had stated that the cause of death was due to drowning which was ante mortem in nature and was sufficient to cause death in the ordinary course, although he was under the influence of Aluminum phosphate insecticide

poisoning at the time of drowning. The probable time lapse between drowning and death, in the case was immediate. Taking the above into consideration, it was decided that proximate cause of death was drowning and not the presence of insecticide poisoning. Treating it as an accidental death double accident benefit was payable. The insurer was ordered to pay the double accident benefit payable under all the policies which were in force at the time of death to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/119/Ludhiana/Ludhiana/24/10
Balbir Singh Vs Life Insurance Co. Ltd.

ORDER DATED: 30th JUNE, 2009. **DEATH CLAIM**

FACTS: The complainant Sh. Balbir Singh stated that his son late Sh. Manmeet Singh purchased two policies bearing nos. 300066561 and 160766001 from branch office Ludhiana. His son expired due to accident in USA on 14.11.2004. He has submitted all the death claim papers in the branch office and the insurer has paid Rs. 1,73,400 against policy no. 16076600/- on 06.12.2008. But the claim under policy no. 300066561 had not been paid by the insurer. He had requested the insurer many times but had not received any response.

FINDINGS: The insurer clarified the position by stating that there was no document to prove that the DLA expired outside India. Hence supporting documentary proof was required to establish the date of departure from India so that inference could be made that the DLA was present in India at the time of making the proposal. On a query whether any documentary proof was available to show that the DLA was present in India in Aug 02 when the proposal form was filled up, the complainant showed a copy of the bank draft dated Nov 02 in favour of California State University

DECISION: Held that the insurance cover was taken when the complainant was in India as was evidenced by the Bank Draft dated Nov -02. Since claim against one policy had been paid, the insurer was ordered to pay the admissible amount of claim under the second policy also.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/109/Ludhiana/Ludhiana/24/10
Sunita Rani Vs Life Insurance Co. Ltd.

ORDER DATED: 15TH JULY, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Sunita Rani stated on that the her husband late

Sh. Inderjit purchased a policy bearing nos. 300302616 from branch office, Ludhiana on 22.02.2005. Her husband expired on 15.12.2007 due to Diabetes and Hypertension. She had submitted all the death claim papers in the branch office but the insurer rejected the death claim on 31.03.2009.

FINDINGS: The insurer clarified the position by stating that as per information given in Form 3816 by Apollo Hospital authority, the patient was suffering from DM-II from the last 8-9 years. Since this was material fact which was not disclosed the claim was repudiated on the grounds of concealment of material facts. On a query whether it was a medical or non medical policy, the insurer replied that it was medical.

DECISION: On going through Form 3816 filled by Apollo Hospital it was found that there are two contradictory statements by Apollo Hospital in Form 3816 filled in Feb 07 and Dec 07. While it was stated that the patient was suffering from DMII/Hypertension in the form filled up in Feb 2007, the same was not mentioned in the form filled up in Dec 07. There was no record of treatment of DMII from the last 8-9 years. Moreover, the DLA was medically examined before taking the policy and he had been cleared by the medical officer who conducted the medical examination. No fraudulent intent was established as required under Sec-45 of Insurance Act. Taking the above factors into consideration, it was held that the repudiation of the claim on the basis of form 3816 filled in Feb 07, alone was not in order. The complainant and the insurer were advised to get the Discharge summary from Apollo Hospital both for Feb 07 and Dec 07. In none of these documents it was mentioned that the DLA was suffering from diabetes/hypertension from the last 8-9 years. In the absence of any corroborative proof of treatment taken prior to the date of commencement of the policy the repudiation of the claim by the insurer was not justified and it was ordered that the admissible amount of claim would be paid by the insurer to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/150/Chandigarh/Chandigarh-II/24/10
Shakuntla Vs LIC of India

ORDER DATED: 30TH JULY, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Shakuntla that her husband late Sh. Vijay Singh purchased a policy bearing no. 162699583 from branch office, Chandigarh-II and the premium was deducted from his PF account (Regional Provident Fund Rohtak). He expired on 29.03.2008. She had submitted all the death claim papers in the branch office but she had not received any response from the insurer.

FINDINGS: The insurer stated that this was a case of Salary Saving Scheme and the premium was being financed through provident fund. The policy was assigned in favour of Regional Provident Fund Commissioner, Rohtak. The policy bond was with the Regional Provident Fund Commissioner, Rohtak. They had requested to deliver the policy bond to them. Unfortunately the same was not been received by them.

DECISION: Held that while the request of the insurer to Regional Provident Fund Commissioner, Rohtak to deliver the policy bond was in order. It would be appropriate if a senior officer of the insurer could visit the office of Regional Provident Fund Commissioner, Rohtak and collect the policy and forward the same to BO Unit -II, Chandigarh which was the servicing office so the claim could be paid to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/188/Chandigarh/Chandigarh/24/10
Manjeet Kaur Vs LIC of India

ORDER DATED: 7TH AUGUST, 2009 **DEATH CLAIM**

FACTS: The husband of the complainant Smt. Manjeet Kaur had purchased a policy bearing no. 163438582 under table and term 14-15 for Rs. 50,000/- on 10.07.2007. Her husband expired on 17.12.2008 due to Heart Attack in Amar Hospital Sector 70, Mohali. She submitted all the death claim papers but the insurer had repudiated the death claim on 17.06.2009 on health ground.

FINDINGS: The insurer clarified the position by stating that the DLA was hospitalized once in 2005 and twice in 2008. Since there was hospitalization in 2005 which was before the commencement of the policy, the case was treated as being one of pre-existing disease which was in the knowledge of the DLA at the time of taking the policy. The claim was accordingly repudiated.

DECISION: Held that the treatment in 2005 was for ASPARTATE which was related to bacterial malfunctioning within the body and the cause of death which was cardio pulmonary arrest was not directly related to the treatment taken in 2005. Hence it could not be considered as a concealment of vital information. Section -45 of the insurance Act 1938 clearly mentions that three conditions must be satisfied before the claim on account of concealment of material fact could be denied. While the concealment of fact of hospitalization in 2005 was not disputable it was doubtful if this was a material fact and whether the concealment was fraudulently done since the amount of insurance to Rs. 50,000. Giving the benefit of doubt to the complainant it was held that repudiation of the claim on the ground of pre-existing disease was not in order. It was ordered that admissible amount of claim would be paid by the insurer to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/263/Shimla/Shimla/24/10
Neelam Rani Vs Life Insurance Co. Ltd.

ORDER DATED: 31ST AUGUST, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Neelam Rani purchased two policies bearing nos. 152444928 and 152446627 under Salary Saving Scheme. Her husband late Sh. Raj Kumar Gill expired on 07.06.2008 due to accident. She had submitted all the death claim papers in the branch office but the insurer had repudiated the death claim. The insurer informed that the policy was in lapsed condition at the time of death.

FINDINGS: The insurer stated that the complainant purchased two policies bearing nos. 152444928 and 152446627 under Salary Saving Scheme in the name of her husband late Sh. Raj Kumar Gill who expired on 07.06.2008 due to accident. Both the policies were in a lapsed condition on the date of death of DLA. Since the premium were not received from the employer of the DLA viz Education Department Government of Himachal Pradesh, both the policies were in a lapsed condition and hence the claims were repudiated. On a query whether the insured was intimated directly or through his employer that the premium had not been received and the policies were in a lapsed condition, the insurer could not give a satisfactory reply in this regard. On a query whether any intimation was received through the employer that the DLA had requested for stopping the deduction from his salary the insurer replied in the negative.

DECISION: Held that on going through the case of Delhi Electric Supply Undertaking Vs Basanti Devi (AIR 2000 SC43) decided by Supreme Court, it was decided that the repudiation of the claim on the ground of premium having not been received from the employer of the DLA is not in agreement with the decision of the supreme Court in Delhi Electric Supply Undertaking Vs Basanti Devi (AIR 2000 SC43) where it is clearly stated that the principle is liable for the action of the agent. In this case LIC is the principle and the education department is the agent for collecting the premium from the salary of the insured and to remit the same to the insurer. The insured cannot be held liable for the lapse on the part of the employer who is an agent of the insurer. The insurer is liable to pay the claim even if the premium had not been received by them. Taking the above into consideration it was ordered that the admissible amount of claims would be paid by the insurer to the complainant after deducting the premium due and any other charges.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/296/Rohtak/Bhiwani/24/10
Roshani Devi Vs Life Insurance Co. Ltd.

ORDER DATED: 8TH SEPTEMBER, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Roshani Devi stated that her husband late Sh. Surajmal Sahran expired on 14.05.2008. She has submitted all the death claim papers in the branch office but she had not received any response from the insurer.

FINDINGS: The insurer stated that liability had been booked and Form no. 3790 was sent to her to fill up and that on the receipt of the form the claim would be paid.

DECISION: Held that the action of the insurer in booking the liability was appreciable. However since the claim was inordinately delayed, the need for form 3790 is hereby waived off. The insurer was ordered to pay the claim along with interest @8% pa w.e.f 01.11.08 up to the date of payment.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/222/Rohtak/Bahadurgarh/24/10
Smt. Shalu Verma Vs Life Insurance Co. Ltd.

ORDER DATED: 8TH SEPTEMBER, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Shalu Verma stated that her mother late Smt. Savitri purchased two policies bearing nos. 174438849 and 175712517. The DLA expired due to illness on 12.02.2008. After the death of her mother she had submitted all the death claim papers in the branch office and she had received the death claim payment under policy no. 174438849. But the insurer had repudiated the claim against policy no. 175712517 on 31.08.2008.

FINDINGS: The insurer stated that the date of commencement was 12.07.07 and date of death was 12.02.08. Since it was an early death claim investigations were carried out which revealed that she was a known case of pancreatits. Hence the claim was repudiated on account of pre existing disease.

DECISION: Held that the death certificate did not mention as to since when the DLA was suffering from pancreatitis. Hence the case could not be established for pre existing disease. Giving the benefit of doubts to the DLA, the claim was payable. The insurer was ordered to pay the claim for the policy No. 175712517.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. LIC/320/Amritsar/Amritsar/24/10
Baljeet Kaur Vs LIC of India

ORDER DATED: 23RD SEPTEMBER, 2009 **DEATH CLAIM**

FACTS: The complainant Smt. Baljeet Kaur stated that her husband late Sh. Kirpal Singh purchased a policy bearing No. 47087385. After the death of her husband she had submitted all the death claim papers in the branch office but the insurer had repudiated the death claim payment on flimsy grounds.

FINDINGS: The insurer clarified the position by stating that the DLA was mentally unsound and because of mental derangement he committed suicide in December 2003. The policy was taken in March 2002 and it was revived in March 2003 when a medical examination of DLA was conducted. On a query as to whether any adverse report was given in the medical examination of the DLA at the time of revival, the insurer replied in the negative.

DECISION: Held that the contention of the insurer that the DLA was mentally unsound was not substantiated by any medical report. The medical report conducted by the medical officer appointed by the insurer had cleared him in March-2003 of any adverse feature in health or habit or disease of any nervous system. Even in the FIR which was made the basis of repudiation, it had been stated that the DLA was mentally upset due to financial crisis. But there was no mention of mental derangement. Taking the above into consideration, it was found that the repudiation of the claim by the insurer on the ground of the DLA suffering from mental derangement/unsoundness was not in order. The claim was payable. The insurer was ordered that admissible amount of claim would be paid to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. Birla Sun Life/157/Mumbai/Chandigarh/24/10
Sh. Ranjit Kumar Toor Vs Birla Sun Life Insurance Co. Ltd.

ORDER DATED: 4TH SEPTEMBER, 2009 DEATH CLAIM

FACTS: Sh. Ranjit Kumar Toor, husband of late Sunita Toor, holder of policy no. 1210509 with Birla sun Life Co. has complained that she was approached for taking a second policy. The policy was not issued on medical ground. Rather the earlier policy was also cancelled on the ground that she was suffering from Malignancy and diabetes. On this basis, insurer cancelled her previous policy with the plea that she was suffering since 2006 i.e prior to taking previous policy and sent a refund cheque of Rs. 60,000/-. The claimant had demand full death claim of Rs. 250,000 instead of refund of Rs. 60,000/- which the insurer had denied. .

FINDINGS: The insurer clarified the position by stating that investigations were on to establish whether the DLA was suffering from cancer/diabetes before the commencement of the first policy. They wanted time to complete the investigation. The insurer was asked to clarify whether any investigations were carried out. He stated that no investigations were required as there was a declaration given by the DLA in September 08 that she was suffering from diabetes since 2006. The policy no. 1210509 which was cancelled commenced in March 2007. Hence it was considered as concealment of material fact and accordingly the policy was cancelled. As far as the second proposal was concerned which was for 7.00 lakhs this was not considered in view of the detailed questionnaire on diabetes and the proposal was declined and the premium was refunded.

After going through the documents furnished both by the insurer and the complainant, the following are the findings:

a) Proposal form in respect of the second proposal for Rs. 7.00 lakhs which was not accepted was not complete.

b) The basis on which special questionnaire on diabetes in respect of proposal from for Rs. 7.00 lakhs insurance cover was filled up was not clear.

c) Declaration regarding diabetes was made by the DLA in Sept. 2008.

d) Despite the declaration of diabetes the policy was revived on 12.01.09.

e) The policy was cancelled on 27.01.09 without any apparent new input or fact coming to light. The basis of this cancellation was not clear.

f) The first policy was not cancelled in September 08 along with the second proposal when the declaration of diabetes in 2006 was received.

Although the policy was cancelled before the death of the DLA , the very fact that the policy was revived without medical examination shows that the insurer was prepared to take the risk of insuring the patient especially when the revival was done after four months. Although it was a fact that the two proposals were made within one year of each other and the second proposal which was for Rs. 7.00 lakhs was made after the DLA was diagnosed with cancer, there was nothing substantial to support the fact of diabetes in 2006. In fact the medical records furnished by the complainant all point to the fact that the patient was diagnosed with cancer in 2008 and there was no record to show that she was a known case of diabetes prior to 2007. The insurer stated that in case of false representation of facts, Section 45 of Insurance Act becomes applicable by which the contact becomes void. However, he was not in a position to clarify as to why the policy was cancelled unilaterally in January 2009. There is no clause which shows that the policy can be terminated by the insurer unilaterally on any happening other than these.

(a) the date we confirm your surrender request;
(b) the date on which the two-year period ends after your policy has lapsed, unless the policy is revived as per the premium discontinuance provision;
(c) the date the life assured dies; or
(d) the policy maturity date.

These conditions do not refer to the provision of Section 45 of Insurance Act, 1938.

DECISION: Held that the cancellation of the policy No. 1210509 in respect of Mrs. Sunita Rani was not based on any provisions in the terms and conditions of the policy. The policy got terminated on the date of death on 21.02.09 . The policy would be treated as being in force on the date of death and the death claim settled on merits after proper investigation under Section 45 of Insurance Act 1938, since it was an early death claim.

CHENNAI

OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO(CHN) 21.01.2692/2008-09

S.Vijayalakshmi Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-001/2009-10 dated 30.04.09.

The complainant's husband had taken two Bima Gold Policies for sum assured of Rs.50000 each commencing from 28.03.06. He died on 25.08.06 within 5 months of taking the policy due to CRA, Alcoholism, Chronic

Liver disease, Hepatic Encephalopathy, UGI Bleed, and Intra-cerebral Hemorrhage.

The Insurer repudiated the claim on the grounds of suppression of material facts stating that the Life assured at the time of proposing for Insurance had failed to disclose that he was chronic alcoholic having chronic jaundice for the past one year and had availed treatment.

The complainant contended that her husband used to get cough, cold or fever and was not suffering from any other disease. When questioned whether her husband was suffering from jaundice she admitted that he was suffering from jaundice but the same was cured after taking native medicine. She produced a test report dated 12.07.06 to prove that her husband was not suffering from jaundice. This certificate pertains to post proposal period. She contended that her husband was only a social drinker and not an alcoholic and he had not availed any leave in the last one year of service.

The Insurer contended that their investigation revealed that the deceased life assured was an alcoholic and suspected to be suffering from jaundice and taking native medicine. He was admitted to Government hospital in Chennai where he died on 25th August'06. Dr.R.Parimala of Government Hospital, Chennai certified that the Insured died of CRA, Alcoholism, Chronic Liver disease and Hepatic Encephalopathy. The case records from the Government hospital revealed that the assured was a chronic alcoholic for 10 years, a smoker and was having chronic jaundice for the past one year. It has also been recorded that he was on native medicine for jaundice and yet continued to take alcohol daily for the past 6 months. There is nexus between the disease suppressed and the cause of death. The assured was an educated man working for primary agricultural co-operative bank who was well aware of his physical condition and status of health. It was evident from the hospital record that the assured was suffering from jaundice before submitting the proposal for the policy.

The Pre-proposal illness and suppression of material facts having been established by the Insurer the Ombudsman felt that there is no need to interfere with the decision of the Insurer of repudiating the claim. The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO(CHN) 21.03.2698/2008-09

N.Kalaiarasi Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-002/2009-10 dated 30.04.09.

The complainant had taken an Asha Deep policy for sum assured Rs One lakh commencing from 15.03.03. She underwent surgery for Aortic Valve replacement on 28.09.06 and preferred her claim for 50% of the sum assured under benefit B of 11(b) of policy conditions. The Insurer rejected the claim stating that the contingency referred to was not covered as per policy condition.

Asha Deep policy provides for additional benefits on the happening of any one of the contingencies referred to in para-11(b) of policy conditions. One of the contingency referred to is "Life Assured undergoes open heart surgery performed on significantly narrowed/occluded coronary arteries to restore adequate blood supply to the heart. All other operations are excluded".

The complainant underwent operation for Aortic Valve replacement which was an open heart surgery and she contended that she was entitled for benefits under 11(b) of policy conditions. She contended that she had coronary surgery performed and was diagnosed as a case of bicuspid aortic valve with severe aortic stenosis. She said that stenosis is a condition in which the aortic valve narrows and this narrowing prevents the valve from opening fully which obstructs blood flow from the heart to Aorta and onwards to the rest of the body. She said that this condition fully satisfies the terms quoted under 11(b).

The insurer argued that the contingency occurred was not covered under policy condition. They confirmed that the decision was taken after consulting their Divisional medical referee who opined that there was no

bye-pass surgery performed on coronary arteries as envisaged under condition 11(b)

The policy condition clearly stipulates that there should be an open heart bye-pass surgery performed on significantly narrow/occluded coronary arteries. Whereas the aortic valve is pertaining to aorta, the arteries are vessels through which the blood passes away from the heart to various parts of the body. The Divisional medical referee in his opinion clearly stated that the patient had normal coronary and underwent aortic valve replacement which is not covered under benefit (b). As per the discharge summary the diagnosis was Calcific Aortic stenosis-bicuspid aortic valve and the procedure done was aortic valve replacement. The coronary Angiogram revealed normal coronaries. It was proved beyond doubt that the surgery underwent by the assured does not fall under condition 11(b) of Asha Deep Plan and the assured is not eligible for the benefits there under.

The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.06.2700/2008-09

S.Sekar Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-003/2009-10 dated 30.04.09.

The complainant's wife Thenmozhi had taken an endowment policy for sum assured of Rs.50000 with date commencement 20.12.05. She died on 03.01.06 reportedly due to heart attack within 12 days of taking the policy. The Insurer repudiated the claim on the grounds that the life assured had committed suicide and as the death was by suicide within one year from the date of commencement nothing is payable under the policy.

During the hearing the complainant said that when his wife complained of un-easiness he rushed to seek assistance from the neighbours and by the

time he returned home his wife was found dead. When he was questioned whether he called any doctor to confirm the death he replied in the negative. When asked about the in-ordinate delay in preferring the claim he replied that he came to know his wife had taken the policy only when he received a letter from Mannargudi Branch of LIC intimating that the policy was transferred to Kumbakonam branch. He stated that there was no bottle of poison or medicine by the side of the body and he believed his wife had died due to heart attack.

The Insurer contended that the death of the life assured was by suicide. As per the findings of the investigating officer the neighbours of the deceased life assured reported that the Insured had committed suicide. The insurer said that the following points had been taken into consideration when they repudiated the claim; a) the death was not reported to the nearby police station and therefore no FIR/PIR was available. b) Claim forms were submitted after a period of 16 months probably with a motive to suppress the fact. c) The life assured was not taken to any clinic to give her necessary medical assistance. The Insurer submitted that the circumstances indicate that death was by suicide.

Normally under the above circumstances the affected person would have been taken to a doctor who only would have declared the death of the person. In this case the life assured was not taken to any doctor at least to confirm the death. The reasons quoted by the complainant for in-ordinate delay in submission of claim forms were not convincing. If the complainant had no misunderstanding with his wife as stated by him it can be expected that his wife would have informed him about the policy taken by her. It is seen that insured had named her husband as the nominee under the policy though she had two children. This dispels the theory of suicidal intent or misunderstanding with her husband as claimed by the Insurer.

In the present case the Insurer was not able to prove that the Life assured committed suicide by any clinching evidence but for the two letters from neighbours who declared to this effect. The complainant also was not able to satisfactorily narrate the details of the sequence that led to the death of the Insured and was unable to justify the in-ordinate delay in submitting

the claim forms and all this cast a cloud of suspicion on the cause of the death.

Considering all the above facts to ensure justice is not denied to either of the parties the Ombudsman awarded 50% of the Sum Assured (Rs.25000/-) as Ex-gratia under the policy. The complaint was partly allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.08.2730/2008-09

SR.SRIRAMAN Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-004/2009-10 dated 20.05.09.

The wife of the complainant had taken four policies under Money Plus plan in the year 2007. The Annual premium payable under all these policies were Rs.10000/- each and the life risk cover under each of these policies was Rs.50000/-. The Life assured died on 11.10.07 in a road traffic accident. The complainant who was the nominee preferred the claim with the Insurer. The Insurer settled the claim under first two policies and rejected the claim under two subsequent policies on the grounds that the Insured had withheld material information regarding previous policies taken by her at the time of effecting insurance under the policies in dispute.

The issue involved in this case is non-disclosure of previous policies and it had to be decided whether this can be treated as a suppression of material fact. The criteria in such cases would be whether the disclosure of information regarding previous policies would have adversely influenced the insurer's decision to accept subsequent proposal having regard to insurer's underwriting practices.

During the hearing the complainant contended that his wife had not taken all policies through the same agent and while filling the proposal forms the agent had not explained anything to her in this regard and she simply signed the forms. It is to be noted that the life assured had signed the declaration that she has understood all questions in Tamil and had given her answers and then only signed the proposals.

The insurer submitted that they had settled the claim under policies 734278719 and 734278720 with Double Accident benefit though the insured had not opted for the Accident benefit while submitting the proposals. For rejecting the claim under the policies734461092 and 734468873 they contend that the life assured was eligible for a maximum cover of Rs100000/-only for the given age and type of age proof submitted as per their underwriting practices. They would have declined the life cover over and above 1 lakh had the insured promptly disclosed the information about her previous policies. The insurer also contended that they could not match the previous insurance data while completing the above proposals as the life assured had quoted different date of birth in the previous policies.

From the records it was observed that the insured had declared her date of birth as 14.10.57 under the first two policies and as 05.01.58 under the subsequent two policies. The complainant submitted a copy of the record sheet issued by Aided Middle school where the insured studied as per which the date of birth was 05.03.55. The insurer contended that the admitted age of the Insured being 49 years she could not be insured for more than One Lakh sum assured as she belonged to Category-3 self-employed women group as per their underwriting norms. Had the insured disclosed the correct information they would not have accepted the life cover under the two subsequent policies which are in dispute.

Considering the above facts the Ombudsman felt that repudiation of the Life cover for suppression of material information was justifiable. However, he felt the total repudiation of the claim was not justifiable as the policies were Unit-Linked Insurance policies having a determined fund value under them, the risk of investment being borne by the Insured. The Insurance Company was directed to settle the bid value of Rs.8788 under

policy no.734461092 and Rs.8927 under policy no. 734468873. The complaint was partly allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.01.2722/2008-09

Dhanapal K Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-005/2009-10 dated 20.05.09.

The complainant's wife D.Amudhavalli had taken a New Bima Gold Policy for a sum assured of Rs.100000/- commencing from 28.12.06. She died on 30.05.07 due to Dermatofibrosarcoma.

The Insurer repudiated the claim on the grounds that the Insured had not disclosed in her proposal the fact of her suffering from Dermato fibro sarcoma of left arm for which she underwent chemotherapy on 24.07.06 and had earlier undergone operation for the same during 2005.

During the hearing the complainant admitted that his wife had got tumour in left arm operated in the year 2005 in Stanley hospital Chennai. He also admitted the fact that she had undergone test and treatment during 2006. He expressed that he had not suppressed any information intentionally and pleaded for sympathetic consideration of the claim.

The Insurer submitted that the insured was suffering from illness prior to the date of the proposal i.e 28.12.06. In support of their contention they filed claim form-B completed by Dr.R.R.Roy as per which the Insured was treated in Dr.Roy Memorial Medical center from 01.07.06 to 20.12.06 . The discharge summary from Dr. Roy Memorial Medical center where the Insured was hospitalized during the period 24.07.06 to 28.07.06 reveal that the Insured was diagnosed for Demato fibro sarcoma left arm and underwent chemotherapy.

The Non-disclosure of material facts having been established beyond doubt it was felt that the Insurer was justified in rejecting the claim. The complainant was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.08.2699/2008-09

Venkatesan R Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-006/2009-10 dated 25.05.09.

The complainant's uncle had taken an Endowment policy for sum assured of Rs.100000/- with date of commencement 28.07.03. He died on 20.08.03 due to Heart attack within 22 days of taking the policy.

The Insurer repudiated the claim on the grounds of suppression of material information stating the Insured was suffering from Tuberculosis for which he was under treatment which fact he had not disclosed in the proposal submitted by him.

During the hearing the complaint said that he received the claim forms only after a lapse of 22 months and he received the letter from the Insurer repudiating the claim after a period of more than one year on submission of claim form. He stated that the Insurer had taken an in-ordinate time for settlement of the claim which made him to move a writ petition in the High court of Madras and the court directed the Insurer to dispose of the representation within a period of Eight weeks.

The Insurer contended that the deceased life assured was suffering from Tuberculosis for which he had taken treatment from Dr.Srinivasan, Dr.Balajee and Dr. Kesavalu of Tiruthani. Further they stated that the Insured was an inpatient for Tuberculosis at Government hospital Chennai.

The Insurer based his inference mainly on the report of the Investigating officer and was unable to collect any letters/certificate of treatment from the above doctor/hospital confirming the treatment given to the Insured.

On the contrary Dr.Sreenivasan confirmed that out of the copies of the prescriptions sent by the Insurer for reference in this regard, four prescriptions were given by him to the patients suffering from common cold, and the name of the patient was filled by someone else as Sundaravaradulu. The superintendent of Government hospital of Thoracic medicine confirmed in his letter that the Insured was not admitted to their hospital during the years 2003-05. It was also observed that there was considerable delay from the complainant's side in intimating the death and submitting the claim forms. The Insurer also took more than 15 months to inform repudiation of the claim and took the decision only on intervention from the court.

The absence of need for insurance as there are no dependants, taking insurance policy for the first time at the age of 48 years, death of the insured within 20 days of taking the policy, delay in intimating the death and submitting the claim forms by the nominee (during which period evidences are likely to be destroyed), death in doubtful circumstances in which even cause of death could not be medically established all create an element of doubt about the genuineness of the claim. At the same time insurer was also not in a position to prove the pre-proposal illness with any clinching evidence. The insurer had also delayed considerably in communicating the decision to deny the claim. Considering the above facts, to ensure justice is not denied to either of the parties Ombudsman awarded an Ex-gratia of Rs.50000/- to be paid to the nominee.

The complaint was partly allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.009.2725/2008-09

Smt. Jambagalakshmi Vs Bajaj Allianz Life Insurance Company Ltd.,

AWARD No: IO (CHN) L-007/2009-10 dated 27.05.09.

The complainant's husband had taken a Unit Gain policy with life cover for Rs.150000 with date of commencement 29.03.06. He died on 09.02.08 within a period of 1 year 10 months 11 days of taking the policy. The Insurer repudiated the claim quoting suppression of material facts by the Insured that he had not disclosed the fact of undergoing CABG during 2005.

The cause of death of insured as per medical attendant's certificate was Heart attack/post myocardial infarction. The secondary cause was mentioned as anterior myocardial infarction in 2005 and coronary artery bypass grafting done on 29.04.05.

The complainant also admitted that her husband had heart problem and had undergone CABG. She contended that her husband had mentioned the name of Dr.Cherian in reply to Q.No.10 of the proposal and since Dr.Cherian is a renowned Cardiac surgeon, the insurer should have deduced from that, that her husband should have contacted the doctor for cardiac problem. She also contended that they had disclosed all the facts to the representative of the super agent through whom they took the policy. The insured who is an educated person had answered "NO" to specific questions on diseases and disorders of Cardio Vascular system, tests undergone and operations underwent. The contention of the complainant that they had mentioned the name of Dr.Cherian in the proposal and that the Insurer should have made further enquiry while underwriting the proposal does not convey much meaning.

The Insurer could get adequate evidence of pre-proposal illness and though his action in repudiating the life cover was justifiable they should not have forfeited the amount left in the Fund account as the policy was a Unit Linked Policy. The Ombudsman awarded an Ex-gratia of Rs.10000. Complaint was partly allowed

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.06.2742/2008-09

William Ragavaiah Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-008/2009-10 dated 29.05.09.

The complainant's wife an employee of Tamil Nadu Electricity Board had taken a Jeevan Shree Policy for sum assured Rs.500000/- with date of commencement 28.02.02. The policy had lapsed for non-payment of premium and the same was revived on 04.09.04 on the basis of declaration of good health. Subsequent to the revival she died due to leukemia within a period of 3 months and 5 days from the date of revival.

The Insurer repudiated the claim on the grounds of suppression of pre-revival illness stating that the Insured was suffering from leukemia and cellulites of leg before the date of revival which fact she had not disclosed in the personal statement of health submitted at the time of revival.

During the hearing the complainant admitted that his wife was suffering from cellulites in leg and was taking treatment for the same and she was not aware that she was suffering from leukemia as she was not told about this. Hence she did not deliberately hide anything about leukemia at the time of revival.

The Insurer submitted number of documents to prove the pre-revival illness of the Insured. The Insured had been admitted to Dr.V.V.R Hospital, Thanjavur from 11.11.03 to 28.11.03 where she was diagnosed for lymphodema arm left with hypocartical function with general debility and diabetes. She was also put on Anti TB Drugs. The Insured had been admitted to KTM hospital, Pattukkottai where her CT scan showed acute Pancreatitis. The discharge form from CMC Vellore confirmed that the insured had been admitted for treatment of leukemia from 13.08.04 to 23.08.04.

It was proved beyond doubt by the Insurer that the Insured had suppressed the information of her ailment knowingly in the personal statement health submitted by her for revival of the policy. The decision of the Insurer in treating the revival as Null and Void was justifiable. However it was noted that the Insurer himself had taken a decision to revise the conditions stipulated for payment of paid up value under the Jeevan Shree plan vide their circular dated 06.04.04 which was prior to the date of revival. As per this circular the policy had acquired paid up value

which should have been paid on the death of the Life assured. Hence the Ombudsman directed the Insurer to pay the paid up value along with accrued guaranteed addition which amounted to Rs. 137500.

The complaint was partly allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN) 21.01.2760/2008-09

M.Yesodha Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-009/2009-10 dated 05.06.09.

The complainant's husband had taken a Endowment policy for a sum assured of Rs.30000/- commencing from 28.02.04. The policy had lapsed for non-payment of premium due August'05 onwards and the same was revived on 12.05.06 and the life assured died on 26.01.07 due to left ventricular failure within 2 years 10 months 28 days of taking the policy and within 8 months 14 days of reviving the policy. The Insurer repudiated the claim on the ground that the life assured had history of diabetes mellitus and hypertension of 10 years duration and was a known case of alcoholic and smoker which facts he had not disclosed in the proposal and personal statement of health submitted by him.

During the hearing the complainant was represented by her son. He said that his father was aged 64 years at the time of death and accepted that all the statements stated in the repudiation letter were true. The Insurer submitted that the life assured had wrongly declared his age as 50 years while taking the policy. The discharge summary from Kamakshi memorial hospital where the assured was admitted for terminal illness clearly reveal that the life assured was a known case of Diabetes mellitus and Hypertension for the past 10 years and known alcoholic and smoker and was not under treatment for the past 6 months. The claim form B1 certified

by J.S.B hospital authorities also clearly mentions that the Insured had Hypertension since 6 years. It was also observed that the age of the life assured was wrongly shown as 50 years as against 57 years in the proposal form. It was evident that the policy was obtained not only by suppressing information of ill health but also by suppressing the correct age of the life assured. The complaint was dismissed by Ombudsman.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.04.2770/2008-09

LakshmanBeevi Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-010/2009-10 dated 15.06.09.

The complainant's daughter had taken a Bima gold Policy for sum assured Rs. 2 lakhs commencing from 28.03.06. He died on 02.09.06 due to myocardial infarction within 5 months and 4 days of taking the policy. The Insurer repudiated the claim on the grounds that the Life assured had withheld correct information regarding her qualification in the proposal form submitted by her. The Insurer stated that the life assured had mentioned her qualification as 10th Std. whereas she had not attended any school.

During the hearing the complainant admitted that her daughter took the policy on the advice given by the agent and that her daughter was un-educated and un-employed. She was engaged in embroidery work earning around Rs.2000 to Rs.4000 per month. The complainant said that her daughter was in the school only for a short period and had not attended the same regularly. She said that her daughter only signed the proposal form and was not aware of anything about the policy and they totally relied on the agent.

The Insurer contended that they repudiated the claim since the insured had given incorrect information regarding her qualification though she had not attended the school and had declared her qualification as 10th Standard in

the proposal. The Insurer stated that as per the underwriting norms applicable female category III - Single women self-employed the maximum sum assured allowed was Rs. One lakh only and had the life assured mentioned her correct qualification they would not have entertained the proposal for Rs. Two lakhs.

The Life assured died due to heart attack and the Insurer had not contested the cause of death and had not repudiated the claim on the ground of pre-proposal illness. Though the misrepresentation of the fact of qualification could be attributed to the life assured the agent who mentioned her qualification in his report ought to have verified this fact before submitting the proposal. When the insurer considers qualification as a material factor to underwrite the proposal for sum assured above one lakh on female life belonging to category-III Self employed, they should have called for qualification proof to confirm the qualification before underwriting the proposal rather than calling for the same while repudiating the claim on that ground. It was felt that had the insurer called for qualification proof and ascertained the facts at the time of underwriting they could have covered the life assured for Rs. One lakh sum assured instead of Rs. 2 lakh as proposed.

Considering all the above facts the Ombudsman directed the Insurer to pay a sum of Rs One lakh on Ex-gratia basis. The complaint was partly allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.05.2018/2009-10

N.Madheswari Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-013/2009-10 dated 16.06.09.

The complainant's husband had taken a Money Back Policy for sum assured Rs.50000/-commencing from 14.02.2004. He died on 31.07.07 due

to HIV within 3 months and 1 day of reviving his lapsed policy on 30.04.2007. The Insurer repudiated the claim on the grounds that the Life assured had withheld correct information regarding his health and had not disclosed the fact of his suffering from HIV/CCF for which he was taking treatment at Sanatorium hospital in Tambaram while reviving the policy.

The Insurer submitted evidence to prove that the Insured was admitted in the Government hospital for Thoracic medicine, Chennai from 13/12/2005 to 20/12/2005 for treatment of HIV and Pulmonary Tuberculosis. It was also proved that the insured had taken treatment in the same hospital during Feb 2006 to Sept 2006 and from 16.04.2007 to 01.05.2007 for treatment of HIV during which time he had revived the policy on 30.04.2007. He had not disclosed his illness in the personal statement of health dated 30.04.2007 while reviving the policy. The complainant also admitted that her husband was suffering from Aids and was hospitalized intermittently since Dec 2005. She said she was also under treatment for HIV and pleaded for sympathetic consideration of the case.

Except for the claim form B, B1 completed by Assistant Medical officer of Tambaram hospital which refers to the pre-revival illness of the deceased life assured, insurer has not submitted any other evidence. The outpatient registration sheet and details of treatment taken was submitted by the complainant during the hearing. Pre-revival illness of deceased life assured having been established the action of the Insurer in treating the revival as Null and Void was justified. The Insurer said since the policy had not acquired paid up value before revival nothing was payable under the policy. However, taking into account the extraordinary circumstances under which the nominee is placed who is also afflicted by HIV and has children to look after, an Ex-gratia payment of Rs.15,000 (Rupees Fifteen Thousand only) was awarded under Rule-18 of RPG rules 1998.

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P.Palanichamy Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-014 /2009-10 dated /16.06.09.

The complainant's daughter Smt. G.Poongodi a weaver by profession had taken a New Janaraksha policy for Sum assured of Rs.55000/- with date of commencement 25.08.2006. The Life assured had nominated her two daughters G.Yageswari (4 years) and G.Parameswari (2 years) as nominees and she had appointed her father G.Palanichamy as the appointee for the minor nominees to receive any claim if it arises under the policy.

The life assured died on 1st June 2008 during the second year of the policy while the policy was in force .The cause of death was reported as suicide. It was reported that the Insured consumed some poison as she was very much dejected since her husband had eloped with some other girl. The appointee under the policy Palanichamy preferred the claim with the insurer. Contrary to his expectations the complainant received a letter dated 07.10.2008 from the Insurer stating that the claim was admitted for a sum of Rs.5324/- being the refund of premiums paid.

Since the full sum assured of Rs.55,000/- under the policy was not offered, the complainant appealed to the Zonal Manager of the Insurer vide letter dated 29.09.2008 to consider his case sympathetically and settle the maximum amount. In reply he received a letter dated 19.03.2009 informing him that the Zonal office has upheld the decision of their division in this regard.

During the hearing the complainant submitted that his daughter committed suicide by consuming poison as she was very much upset by the fact that her husband had some illicit contact and ran away from the village. It was reported that at the time of taking the policy the complainant and her husband were living together. The Life assured had taken the policy with the object of saving money for the benefit of her daughters who had been nominated under the policy. The complainant submitted that since his daughter died, her minor children are staying with him as there is no one to look after them. The complainant also

affirmed that his daughter's death was not due to dowry harassment and she committed suicide as she was upset that her husband ran away with some other lady. He expressed that Poongodi's husband will not claim the proceeds of the policy and if the claim is settled for full sum assured it will be very helpful to take care of the minor children.

The Insurer contended that the claim was not repudiated but was admitted for refund of premium since clause 4-b was imposed and operative for 3 years from the date of commencement of the policy. They stated that the proposal was accepted at OR+cl.4b+cl.56. It was reported that cl.56 is in respect of Minor Nomination with Appointee. The clause4-b is a special clause imposed on female lives and reads as under:

> "Not withstanding anything within mentioned to the contrary, it is hereby declared and agreed that in the event of death of the life assured occurring as a result of intentional self injury, suicide or attempted suicide, insanity, accident other than an accident in a public place or murder at any time on or after the date on which the risk under the policy has commenced but before the expiry of Three years from the date of this policy Corporation's liability shall be limited to the sum equal to the total amount of premium (exclusive of Extra premium if any) paid under this policy without interest. Provided that in case the life assured shall commit suicide before the expiry of one year reckoned from the date of this policy the provisions of the clause under the heading "SUICIDE" printed on the back of the policy shall apply."

Though the underwriting decision of the Insurer is not the concern of the forum, the forum wanted to know the rationale behind imposing clause 4-b. To this the Insurer replied that it was a special clause imposed to ensure that the beneficiary (generally husband of the life insured) is not benefited if the lady whose life is covered is murdered or made to commit to suicide by harassment meted out to her in cases like demand for dowry.

It is a known fact that female lives in India experience a higher mortality than male at least up to a certain age and in certain sections of the society female experience more risk to their lives as they are prone to dowry

deaths. The genuine need for insurance in certain cases needs to be looked into to ensure that the beneficiary is not benefited out of his crime. The forum was also given to understand that though this clause 4-b is imposed in respect of proposals received on married women below 30 years where the premiums are financed by the husband of the insured; the same is not imposed for proposals received from self-employed women who have a genuine need for insurance.

In the present case the insured was a self-employed woman who was a weaver by profession and had an annual income Rs.24000/- as disclosed in the proposal. She had insured for a nominal sum assured of Rs.55000/- and had nominated her minor daughters as beneficiaries under the policy in case of her death during the term of the policy. The life assured died during the second year of the policy and regular suicide clause is not applicable. The life assured committed suicide in a moment of desperation when she came to know that her husband had eloped with some other lady. The father of the Insured also confirmed that the death was not due to dowry harassment and the beneficiaries under the policy are poor minor children who have now become orphan having lost their mother and not being looked after by their father also.

It was felt that the insurer's decision to deny the full sum assured under the policy quoting clause-4(b) was not appreciable. Hence the Insurer was directed to settle the FULL SUM ASSURED along with VESTED BONUS under the policy to the nominees as per rules. The complaint was allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.01.2028 /2009-10

R.Gunavathy Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-015 /2009-10 dated /17.06.09.

The complainant's husband PR.Ravichdnadran died on 24.10.2005 within a short span of 1year 2 months and 26 days of taking the Janaraksha policy No.717489308 which commenced from 28.07.2004. The Insurer has repudiated the Death claim for non-disclosure of material facts in the proposal submitted by the insured while taking the policy. The Insurer contended in his repudiation letter dated 31.03.08 that Life assured had history of long standing Hypertension and Chronic kidney disease prior to taking insurance.

During the hearing the complainant contended that her husband was diagnosed for Kidney failure after 20.08.2004 and had Naturopathy treatment initially and was subsequently treated at Army hospital in Delhi where he underwent Kidney Transplantation on 20.07.2005.She submitted that her husband was on sick leave during 2002 and 2003 for building a house and since August 2004 only he could not attend the office. She also admitted that her husband was operated for removal of cyst in kidney during 1992.

The insurer contended that the insured had previous history of Hypertension and chronic Kidney disease which he had not disclosed in the proposal. Hence the claim was repudiated. The insurer could prove that the insured was suffering from Hypertension since 2000 and had past history of Surgery for Hydrated Cyst of Liver in 1992 and these facts were not disclosed by the insured in the proposal dated 28/07/2004 submitted by him. He was diagnosed for chronic renal failure in August 2004.

As per the certificate by Employer (Form-E) the insured was on Medical leave for 34 days from 11/2002 to 03/2003 and 25 days from 04/2003 to 03/24 and was on Loss of Pay for 125 days from 04/03 to 03/04 and for 215 days from 04/04 to 03/05 and 214 days from 04/05 to 10/05.

As the life assured was diagnosed for chronic renal failure in 2004, he must have had this problem prior to the date of proposal i.e. 28.07.2004, as strengthened by the fact that he was on Medical leave for long durations in 2003 and 2004 as stated above. He had not disclosed

in his proposal any illness he had suffered in the last 5 years under Q.11 (a) and had answered in negative all questions from 11(b) to 11(h) though he had availed Medical leave for long durations.

Considering the above facts the Ombudsman felt that the decision of the Insurer in repudiating the claim was justifiable and desires no interference at the hands of the Ombudsman. The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.009.2034 /2009-10

S.Balasubramaniam Vs Bajaj Allianz Life Insurance Company ltd

AWARD No: IO (CHN) L-016 /2009-10 dated /17.06.09.

Smt M.Meenachi aged 55 years an agriculturist had taken a New Unit Gain policy from Bajaj Allianz Life Insurance Company. The sum assured under the policy was Rs.50000/- and the date of commencement of the policy was 27.02.2007 and the policy was issued on 06.03.2007. The Life assured under the policy died on 09.03.2007 within 3 days from the date of issue of the policy.

The complainant who is the son of the Life assured and the nominee preferred the claim with the insurer which was repudiated by the Insurer on the grounds of suppression of material facts. The complainant's appeal for re-consideration also was not successful.

In the Claim form – Claimant's statement cause of death of the Life assured was reported as Heart attack and she was reported to have died at her residence. In the Certificate from usual /family doctor issued by Dr.V.Dinesh Kumar of the Coonoor Diabetic centre, Coonoor, the doctor certified that the Insured M.Meenachi was first time examined by him during August 2005 when she was diagnosed for Hyper Tension and was put on anti hypertensive drugs. He further certified that in January 2006 she was diagnosed for cervical Spondylosis and put under treatment of

NSAIDS and physiotherapy. At that time she had undergone tests viz. Blood biochemical analysis, X-ray cervical spine and urine analysis. Since the proposal was submitted on 21.02.2007 the life assured ought to have disclosed the above illness in the proposal. During the hearing when the complainant was asked about his observations on the report of their usual/family Doctor, he said he had no knowledge about these ailments and expressed she may have been taking medicines and he was not aware of the same.

Considering the above facts the Ombudsman was of the opinion that the Life assured had knowingly suppressed the information about her illness and had not disclosed the details in the proposal. Suppression of material facts having been established the action of the Insurer in repudiating the claim was justified. The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.011.2029 /2009-10

C.Rajamanickam Vs ING Vysya Life Insurance company

AWARD No: IO (CHN) L-017/2009-10 dated /17.06.09

Sri A.Chinnaih had taken a policy bearing no. 00644892 under New Freedom Plan from ING Vysya Life Insurance Co.Ltd which commenced on 23.07.07. The Sum assured under the policy was Rs.300000/-. The Life assured died on 15.02.08 on a street while walking reportedly due to heart attack. The complainant who is the designated nominee under the policy preferred the claim with Insurer. The Insurer has repudiated the claim on the grounds of misrepresentation of Age which was material to cover the risk under this policy.

The repudiation of the claim in the present case was due to wrong declaration of age by the proposer at the time of taking the policy. The Life

assured died on15.02.08 within a short span of 6 months and 22 days of taking the policy which prompted the Insurer to investigate into the claim which revealed that the proposer had falsely declared his age as 65 years and had submitted a fake driving license as Age proof to corroborate his Date of birth and had thus influenced the Insurer to accept the risk on his life, though he was not insurable as per his correct age. The Insurer contended that since the life assured made an incorrect statement about his age and further submitted a fake driving license in support thereof they were misled to accept the proposal and issue the policy.

On going through the different documents submitted in this regard it was observed that Age of the life assured as on the date of death was shown in the police records and Death certificate as 67 years. Age of the insured at death was declared by the claimant himself as 67 years. As per the Identity card issued by the Election Commission age of the insured on the date of issue of the policy would be 66 years. Age of the insured as per the Ration card issued in January 2005 was 67 years. All these documents indicate that the life assured was past 66 years as on the date of issue of the policy.

Age of the life assured in the proposal was admitted as 65 years based on Date of birth declared as 25.04.1942 in support of which a driving license was submitted. The same was proved to be a fake driving license while investigating the early claim. The Assistant Licensing authority concerned confirmed that the original license was issued to one Mr. Seshu karthik and the said license number was issued on a different date. It was also observed that the license submitted had been issued for 20 years whereas the Transport authorities issue license only for a period of 5 years where applicant's age was above 45 years. The insurer was able to establish that the age proof submitted was a fake one.

It was relevant to note that the maximum age at entry under the policy was 65 years and the insured was not eligible for insurance under that plan. The repudiation of the claim therefore was justifiable and the insurer had come forward to refund the premium of Rs15000/- collected under the policy.

While filling the proposal form on behalf of the proposer, Agent introducing the proposal acts as an Agent of the proposer and therefore the proponent/claimant cannot take the stand that since the proposal was

filled by the agent they do not take responsibility for its contents. When the proposer signs the proposal which is the basis of the contract, it is his duty to ensure that the data has been correctly filled in the proposal before affixing his signature. Therefore, the complainant's contention that his father was an illiterate, the proposal form was filled by the agent; the manipulations if any should have been done by the agent cannot be accepted. The fact remains that the date of birth was mentioned as 25.04.1942 in the proposal and the age proof submitted was a driving license and the proposer is bound by this declaration when he signed the proposal.

The Insurer should have exercised more caution while admitting Age of the proposer at the entry age. In the present case a closer scrutiny of the Driving license would have revealed that the same was not a genuine one as the license was issued for 20 years to a person aged 58 years.

Considering all the above facts, the Ombudsman was of the opinion that the repudiation of the claim by the Insurer was justified. Though the insurer is not bound to pay any amount under the policy as per the Terms and conditions, they had come forward to refund the premium of Rs.15, 000/- collected under the proposal which is fair and the Insurer was directed to refund the premium subject to satisfactory discharge by the complainant in this regard.

The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.06.2040 /2009-10

Kulandhai Theresa Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-018 /2009-10 dated /17.06.09.

Sri A.Arputhasamy had taken a New Janaraksha Policy for Sum assured 30000 commencing from 21.03.05 and had nominated his wife Kulanthai

Therasa as the Nominee under the policy. He died on 26.09.06 reportedly due to AIDS. The nominee preferred the claim before the Insurer who repudiated the claim on the grounds of suppression material fact stating that the Life assured was suffering from AIDS for which he had taken treatment even before submission of the proposal and he had not disclosed the same in the proposal. The nominee had further appealed to the Zonal Manager of the Insurer and the same was turned down.

The cause of death as reported in the Claim form A was Jaundice. The life assured died within a short period of 1 year 6 months 5 days from the date of taking the policy and the Insurer caused investigation into the claim. The claim investigating officer reported that the Insured was suffering from AIDS since one year and was taking treatment in Government Hospital for Three months and died at his residence. He was not able to find out the exact date of onset of AIDS.

The Insurer repudiated the claim on the basis of a copy of First Information report filed by the complainant before the Women's police station Lalgudi and a copy of the petition filed by her before the District Munsiff cum Judicial Magistrate, Trichy District wherein it was stated that the petitioner had married Arputhaswamy(life assured)on 14.02.2003 and had a child. In the petition, the petitioner (Kuzhanthai Therasa) had stated that the parents of Arputhaswamy, knowing well that their son was suffering from AIDS, had arranged her marriage with Arputhaswamy and had cheated her intentionally. Taking this as the basis the Insurer has come to the conclusion that the Insured was suffering from AIDS before 14.02.03 which fact he had not disclosed in the proposal dated 19.03.2005.

During the hearing the complainant stated that her husband was suffering from Appendicitis and was admitted to Government Hospital, Trichy where he was diagnosed for AIDS. Subsequently he died in the house due to Jaundice. After the death of her husband her in-laws had thrown her out of the house and had detained her child and had snatched away her jewels, LIC policy, death certificate of her husband, birth certificate of her son. When asked during the hearing whether she confirms what is stated in her petition before the court, she did not answer, but submitted a medical report to confirm that her husband was suffering from AIDS. As per the

document submitted her husband was found to be HIV positive on 23.05.06 which was subsequent to the date of proposal.

The Insurer had repudiated the claim after two years from the date of commencement of policy. Sec 45 of the Insurance Act was applicable in this case as per which the Insurer should prove that the Insured had suppressed the material fact of his ill health before the date of proposal and also prove that the Insured was in the knowledge of it and knowingly and fraudulently he had suppressed the information. The Insurer had not filed before the forum any medical document to prove that the deceased life assured was suffering from AIDS before the date of proposal. The Insurer relied only on the petition filed by the complainant before the court which evidently was drafted by her advocate to safeguard his client and to get justice from her in-laws.

It was felt that the Insurer's defense of rejecting the claim based on the evidences other than medical treatment was not in order. The Insurer was not able to prove convincingly that the life assured was suffering from AIDS prior to the date of the proposal and he had the knowledge of it.

Considering the above facts the Ombudsman was of the opinion that the Insurer is not justified in rejecting the claim. The Insurer was directed to settle the full sum assured with accrued bonus under the policy. The complaint was allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.016.2057/2009-10

S.Meenakshi Vs Shriram Life Insurance Company

AWARD No: IO (CHN) L-019 /2009-10 dated /17.06.09.

The complainant's son S.Neelakantan, aged 21 years who was a Musician had taken a policy for a Sum assured of Rs.5 lakhs from Shriram Life Insurance Company. He died on 29.06.2007 due to cardiac failure. The complainant who was the nominee had preferred the Death claim which the Insurer has repudiated.

The death claim under the policy was repudiated by the Insurer on the grounds of suppression of material facts by the proposer contending that the life assured had Mitral regurgitation and underwent cataract surgery for the left eye in July 2006 around the same time his proposal for the Insurance was submitted. He had not furnished correct information about his health condition in the proposal though he was suffering from pre-existing health problem.

To substantiate their action of repudiation the Insurer had collected relevant medical records as per which the life assured was having retarded physical growth, had Mitral regurgitation and had loss of vision since his childhood. He underwent cataract surgery in the left eye during July 2006. The Insured who was well aware of his above problem had not disclosed this in the proposal submitted by him and had thus suppressed material information essential to underwrite the risk under the policy. The policy was accepted under the Non-Medical scheme of the Insurer. The Insurer argued had they known the above facts they would have rejected the application for insurance or called for additional medical evidences to satisfy themselves about the acceptability of the risk on the life proposed. Hence the claim was repudiated.

A study of various medical reports submitted revealed that the insured had retarded physical growth, secondary sexual character not present and loss of vision since child hood. The report from Dr.J.S.N Murthy revealed that the Insured had Mild MR and had L.Catract surgery done in July 2006.

The Life assured underwent left eye cataract operation on 14.07.06 in Rajan Eye care Hospital and before that he underwent Ultra sound of both eyes at Adayar Scan and Imaging centre on 26.06.06 which revealed retinal detachment right eye, partial retinal detachment left eye and dense echogenic thickening visualized retrolentally . He had consulted

Dr.A.G.Ramesh on 04.07.06 and underwent fitness test for surgery on 06.07.06 at Sri Ramachandra Medical College and Research Institute.

The Life assured submitted his proposal on 01.07.06. In the proposal to the questions 25 – on Personal Medical history of the Life assured – The Insured had replied "NO" for all the questions, some of which specifically asked – Whether he had physical deformity / handicap, whether he was suffering from ailments relating to heart, digestive system, stomach, lungs, kidney, brain or nervous system and disorders of the Eye, Ear, Nose or Throat, though he was having eye disorders for which he had undergone tests and was consulting doctors.

The proposal in the present case was signed on 01.07.06 and the proposal was accepted and First Premium Receipt issued on 08.07.06. It is pertinent to note that the Life assured had undergone ultra sound of both eyes on 26.06.06 and had consulted Dr.A.G.Ramesh 04.07.06 and underwent various tests on 06.07.06 in connection with the surgery proposed. The proposer was duty bound to disclose all this information to the Insurer before the Insurer issued the policy on 08.07.06

The above proposal for Rs.5 lakhs was accepted under the non-medical scheme of the Insurer as per the underwriting practice of the Insurer. The contention of the complainant that her son was medically examined and found fit for surgery on 06.07.06 had no relevance to the Insurer accepting this proposal as the Insurer had not arranged for the medical examination of the Life assured as per their procedures.

It was evident that the Life assured had suppressed the material facts concerning his health and had not disclosed the same in the proposal submitted by him. The Insurer could get clinching and clear evidence to prove the existence of Pre-Proposal illness of the deceased life assured. The Ombudsman was of the opinion that the action of the Insurer in repudiating the claim is in order.

The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.016.2057 /2009-10

S.Meenakshi Vs Shriram Life Insurance Company

AWARD No: IO (CHN) L-020/2009-10 dated 18.06.09.

V.Suresh, aged 26 had taken a new Bimakiran Policy for sum assured one lakh, risk commencing from 28.03.01. He died on 23.10.07. He had nominated his mother Smt.V.Renuka as the nominee under the policy. The Insurer repudiated the claim vide his letter 31.03.08 on the grounds of suppression material fact in the personal statement of health submitted by the Life assured at the time of reviving the policy.

The policy had lapsed from premium due Half-yearly September 2005 and the life assured got his policy revived on 15.12.06 by submitting a personal statement regarding health dated 09.09.06&15.12.06 and a medical report dated 09.09.06. As on the date of death the last premium paid under the policy was due September'07 paid on 16.10.07 and the policy was in force.

The primary cause of death as mentioned in Claim Form-B was Hepatic encephalopathy and secondary cause was noted as chronic liver disease. The insurer repudiated the claim stating that the life assured was a chronic consumer of alcohol and was suffering from chronic liver disease and he had not disclosed these facts in his declaration of good health submitted at the time of reviving the policy. The Insurer relied on the Last Medical Attendant's certificate issued by Dr.Ramya of CMC hospital, Vellore in which answer to Q.no.5 (b) she had replied that the insured was an alcohol consumer which resulted in chronic liver disease. The same doctor in claim form B1 in reply to the question what was the diagnosis arrived at in the hospital replied as chronic liver disease. The death summary issued by CMC hospital, Vellore also quoted that the insured was a chronic consumer of alcohol..

The life assured was admitted for his terminal illness to CMC hospital, Vellore on 16.10.07 with complaints of abdominal distension of 10 days and intermittent fever of 3 days. He was diagnosed for chronic liver disease and the cause of death as mentioned in the death summary was chronic liver disease, Hepato Renal syndrome, acute febrile illness resolved.

All the above reports while stating that the insured was a chronic consumer of alcohol did not say since when he was alcoholic. The officer who conducted the claim investigation reported that the life assured was taking alcohol from March 2006 which had no proof. The complainant argued that his son was not alcoholic on the date of revival of the policy and therefore the suppression of material fact does not arise.

The life assured was medically examined on 9th September'06 in connection with revival of his policy and the doctor who examined him has answered in negative to the question -Are there any adverse features in habit or health, past or present which you consider relevant and in reply to question no.15 the Medical examiner says the insured was healthy. The life assured has submitted personal statement regarding health on 09.09.06 and again on 15.12.06. It is pertinent to note that there is no specific question in the personal statement of health on the habits of the life assured; more so about one's drinking habit. The life assured was diagnosed for chronic liver disease only at the time of his admission to CMC hospital Vellore i.e. on 16.10.07 which is post revival date. Therefore, we cannot say that the Insured had knowledge of his liver disease and he had suppressed the same in the personal statement of health. As regards suppression of drinking habit, since there is no question asking about his drinking habit in the personal statement, the insured could not be faulted for suppression of this information.

The repudiation of the claim has been made by the Insurer after seven years from the date of issue of the policy and therefore, attracts provisions of Sec.45. In the present case the insurer has not been able to prove convincingly that there was suppression of facts alleged and that it was made knowingly and fraudulently. The Insurer, except for reference to the drinking habits of the Insured in claim form-B and Death summary, could not prove the chronic nature of the drinking habit and that the insured had this habit before the date of revival. Further no opportunity was given to

the Life assured to disclose his habit in the personal statement regarding health.

Considering the above facts the Ombudsman was of the opinion that the Insurer was not justified in repudiating the claim and directed the insurer to settle the Full Sum Assured under the policy.

The complaint was allowed.

OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO(CHN) 21.009.2074/2009-10

Smt A.Shakila VsBajaj Allianz Life Insurance Company Limited

AWARD No: IO (CHN) L-021/2009-10 dated 18.06.09.

The Complainant's husband deceased R.Akram Khan had taken a Bajaji Allianz Unit Gain policy with accident cover from Bajaj Life Insurance Company for a sum assured of Three Lakhs along with accident cover. The assured died on 09.10.07 due to multiple fractures suffered in a Road accident on 30.09.07.Subsequent to the death of the insured, A.Sakila w/o R.Akram Khan the nominee under the policy and the complainant in the present case preferred the death claim with the Insurer. The insurer while admitting the claim for basic sum assured had denied the claim for accident benefit under the policy stating that the life assured was driving the vehicle in a rash and negligent manner which resulted in the accident.

During the hearing the Insurer stated that a study of the police inquest report clearly establishes that the life assured drove the vehicle recklessly and in a negligent manner and dashed against the lorry by applying sudden brakes. The police authorities have registered a case u/s 279 of IPC (rash driving) and u/s 304(a) of IPC (causing death by negligence). Hence they denied the accident benefit as per the terms and conditions which read "No benefit is payable in case where death occurs as a result of insured person committing the breach of law". The insurer stated that the

inquest report proved beyond doubt that the life assured was totally responsible for the accident and had committed breach of law.

The representative of the complainant narrated that the life assured while driving the car had to apply brakes when a dog suddenly crossed the road. It was raining at that time and as the road was slippery on applying the brakes the car turned round and was hit by lorry. Immediately after the accident the life assured with severe injuries was rushed to CMC hospital and was admitted there on the same date. The life assured was given all medical aid in spite of which he breathed his lost on 09.10.07.

The police inquest was held on 10.10.07 at CMC hospital Vellore on the death of the R.AkramKhan who died on 09.10.07.The inquest was held in the presence of Panchayathaars. The Panchayathaars jointly and severely formed the opinion that the accident occurred due to careless driving by Sri AkramKhan.

It was observed from the copy of the FIR No.328/07 filed before us that the case was registered under section 279 and 338 of IPC and under the column-known/suspected/un-known accused with full particulars it is mentioned as Lorry driver of vehicle number KA-09-4431. It is evident from the above that the case was booked against the driver of the lorry and not the insured.

From the study of the inquest report it was observed as follows:

(i). It is mentioned that the insured was driving the car with his family members whereas it was reported by complainant that the vehicle was being driven by her husband alone and no other person was there and nobody was affected in the accident. If the insured was driving the vehicle with his family members as a result of the accident, it is very likely that the family members also would have been injured in the accident. But the inquest report does not mention any injury to the others who were in the vehicle.

(ii) It is pertinent to note that the Inquest was carried out after Nine days from the date of accident as the life assured died subsequently. In the Inquest report there is no mention as to on what basis the Panchayathaars formed the opinion stating that the accident occurred due to careless

driving by Akram khan. It is not known whether the Panchayathaars had visited the Accident spot and any enquiries were made to ascertain the facts from persons who witnessed the accident. It is to be noted that Inquest had to be held in the CMC hospital Vellore where the insured died and not at the Accident spot.

(iii) As per the FIR the lorry dashed against is shown as lorry number KA-09-4431 whereas in the Inquest report the lorry number is mentioned as KA-09-4481.

(iv) As per the FIR, the case was booked against the lorry driver u/s 279 and 338. Whereas in the Inquest report it is mentioned that the case is registered u/s 279 and 304(a) and there is no mention as to against whom the case was booked.

It was raining and it was natural for the driver to apply brakes when a dog suddenly came in front of the running car. It is likely that the accident would have taken place when the car was going at a normal speed as the road was slippery due to rain.

It appears no case has been booked against the lorry driver who was driving the heavy vehicle involved in the accident. The Insurer was asked whether they investigated the case and whether their investigation revealed as to any case had been booked against the lorry driver for third party liability and damages to the car. During the hearing it was reported by the complainant that they could not prefer any claim for the vehicle from the Insurance Company or have not filed any complaint against the lorry owner. They said the lorry driver had immediately run away from the spot and the complaint was lodged in the Virinichipuram police station at Vellore. They reported that the car belonged to a finance company and they lifted the damaged car. The police authorities did not evince any interest when they wanted to file a case against the lorry owner.

Section 279 of IPC states whoever drives any vehicle or rides on any public way in a manner so rash or negligent as to endanger human life, or to be likely to cause hurt or injury to any other person shall be punishable with imprisonment…….

In the present case the insured did not cause any hurt or injury to any other person but succumbed to injuries suffered by him. Evidently the above sections were invoked against the lorry driver who was the suspected accused as per the FIR and not against the insured.

We have not been informed whether any proceedings were held in any court after the FIR was registered to establish that the deceased life assured drove the vehicle rashly and negligently and was solely responsible for the accident. Just because the Inquest report opines that the Insured was driving the vehicle carelessly, it cannot be construed that the insured was convicted by a court of law and was found guilty of having committed breach of law.

The Post mortem report clearly states the insured died of complications of multiple injuries due to RTA and the Insurer has not submitted any document to prove that the Insured was found guilty of committing breach of law.

The decision of the Insurer in rejecting the claim for accident benefit was not in order. There was enough evidence to show that the Life assured died out of an accident. The Insurer was directed to settle the Full Accident Claim as per policy conditions. The complaint was allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI.
Case No: IO(CHN)21.005.2073/2008-09.

Md.Ayaz vs. HDFC Standard Life Insurance Company Ltd.

AWARD No: IO (CHN) L-022/2009-10 dated 18.06.09.

The Complainant's mother Smt. Nasreen had taken a policy bearing no.11647822 under the plan HDFC Unit Linked Endowment plus from HDFC Standard Life Insurance Company with date of commencement 22.02.08. The sum assured under the policy was Rs.125000. The life assured

had nominated her son Md.Ayaz as the nominee under the policy. The life assured died on 13.07.08 due to cardiac arrest at her residence. On the death of the life assured her son preferred the claim from the Insurer and the same was repudiated.

The Insurer repudiated the claim vide their letter dated 15.12.08 on the grounds of suppression of material facts stating that the Life assured was suffering from Anemia and congestive cardiac failure even before the submission of the proposal and this fact she had not disclosed in the proposal submitted by her on 19.02.08.

The complainant argued that his mother had no pre-proposal illness and that she was diagnosed for Nephrotic syndrome during 2008 after taking the policy. In proof of the same he submitted a copy of the prescription dated 28.05.08 given by Dr.E.Surender who diagnosed the insured for LVH and Hypo tension. He also submitted a copy of the Echocardiogram report dated 28.05.08 of the Insured which indicates that the Insured had "Marked left ventricular hypertrophy due to systemic hypertension." He also submitted a certificate dated 19.03.09 issued by Dr.E.Surender certifying that Nasreen begum was suffering from Nephrotic syndrome which was first diagnosed on 28.05.08 and prior to this date she was in good health.

The Insurer in support of their contention submitted various documents.

As per certificate issued by Dr.AnwarullahHajee the cause of death was Cardiac arrest. The Doctor confirms that the Insured consulted him on 12.07.08 a day prior to her death and that she was suffering from severe anemia and congestive cardiac failure for the past one year (i.e.July 2007-Pre proposal).

In the certificate issued by Dr.Zahida Parveen of Ikram Hospital,Vaniyambadi dated 11.10.07 it is stated that the Insured was suffering from complaints of giddiness and breathlessness for the past one year. It is also mentioned that she had anemia with congestive cardiac failure of one year duration.(pre proposal). It is also reported that tests, ECG and blood investigation were carried out and the Insured was treated for anemia and CCF.

The Insurer has filed a copy of the lab report from Kumran Hospital Pvt. Ltd., Chennai which indicates that Ms.Nasreen Begum underwent test for Hemoglobin on 20th January'07. The report indicates that the Hemoglobin content of the patient was 7.8 gms % as against of normal count of 12 to 14 gms % which indicates that she was suffering from Anemia.(preproposal).

Dr. T.S.Sridhar of Kumaran hospital Pvt. Ltd. has confirmed that Ms.Nasreenbegum came to the hospital as an outpatient and had undergone ECG and lab tests on 20.01.07. The complainant also confirmed during the hearing that their mother visited Kumaran Hospital during January'07 for taking ECG.(pre proposal)

These reports clearly suggest that the life assured was not enjoying good health prior to the date of proposal and was under treatment.

The certificate dated 19.03.09 of Dr.E.Surender certifies that the Insured was first diagnosed for Nephrotic Syndrome on 28.05.08. But the fact remains that she was also diagnosed to have left ventricular hypertrophy due to systemic hypertension and she had undergone ECG and blood test on 20.01.07 in Kumaran Hospital which was also confirmed by the complainant.

In the present case the Insurer had proved with records that the deceased Life assured had pre-proposal illness which she had not disclosed in the proposal. The Ombudsman felt that the action of the Insurer in repudiating the claim is in order. However, since the policy under question was a Unit linked Insurance policy the Insurer should have considered refunding the fund value of the Units under the Unit Account as on the date of Intimation of Death. While dismissing the complaint the Ombudsman directed the Insurer to refund the fund value under the policy as on the date of intimation of death.

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Case No: IO(CHN)21.009.2115/2009-10.

K.Ramesh Vinod Kumar vs. Bajaj Allianz Life Insurance Company Ltd.

AWARD No: IO (CHN) L-023/2009-10 dated 19.06.09.

The complainant's wife Mrs. Caroline Sharmila had taken Two Capital Gains policies from Bajaj Allianz life Insurance Co.Ltd with Life Cover for Rs125000/- under each commencing from 14.12.06. She died on 09.07.08 due to Carcinoma of left Breast. Her husband being the Nominee preferred the claim. The Insurer has repudiated the claim stating the life assured was suffering from Malignancy from 06.12.06 much before the submission of the proposal and had not disclosed this fact in the proposal dated 11.12.06 due to which they had repudiated the claim.

The Insurer filed number of documents in support of their contention. The X Ray Mammography of both the Breasts of Life assured taken on 06.12.06 revealed Multifocal Malignancy in the upper inner and upper outer quadrants of the left breasts. She was admitted to CMC Hospital,Vellore from 26.02.07 to 06.03.07 where she underwent biopsy of the lump which was reported as infiltrating Carcinoma. Having undergone X-ray and Mammography of both the Breasts on 06.12.06 the LA had clear knowledge of her illness which she had suppressed in her proposal submitted on 14.12.06. The contention of the complainant that they were not aware of pre proposal illness till 20.12.06 and they had orally brought to the notice of the Insurer the illness of the life assured did not stand. The repudiation decision of the insurer was upheld. However as the policies under dispute were Unit Linked Insurance policies the insurer was directed to settle the Fund Value under both the policies as on the date of death. The complaint was partly allowed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Case No: IO(CHN)21.04.2088 /2009-10

V.Vasuki Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-024 /2009-10 dated /22.06.09.

The complainant's husband had taken a New Janaraksha policy for SA 1Lakh commencing on 28.07.05. The policy had lapsed for nonpayment of premium due since June 2006 and the policy was got revived on 10.08.2007. The life assured died on 22.08.2007 due to Heart attack within 12 days of reviving the policy. The Insurer repudiated the claim on the grounds of suppression of material facts in the personal statement of health form submitted for the revival of the policy. They contended that the life assured was taking treatment in Syed Satya Hospital on the date of revival i.e. 10.08.2007 which fact he had not disclosed in the personal statement of health submitted for revival of the policy. Hence they had declared the revival as null and void and forfeited all monies paid under the policy. Since the policy had not acquired any value as on the date of revival no amount was payable under the policy.

The Insurer argued that the Life assured was not keeping good health before the date of revival of the policy and he revived the policy while he was being treated by Dr.JayaVeer of Syed Sathya Hospital. In proof of the same the Insurer has filed before the forum the prescriptions dated 05.07.07, 15.07.07, 25.07.07 issued by Doctor A.R.Jayaveer. The Insurer has also filed a copy of the ECG report dated 26.07.07 taken by the life assured at Syed Sathya Hospital which reveals Sinus Tachycardia. From these documents it was clear that the life assured was suffering from heart problem etc. and was under treatment for the same. Since the policy was revived on 10.08.2007, the life assured was very much aware of the fact that he was not enjoying good health and not disclosing the facts amounts to willful suppression of facts

The Ombudsman felt that the action of the Insurer in the case was justified and the complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.02.2097/2009-10

B.Malarkodi Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-025/2009-10 dated /22.06.09.

The complainant's husband Sri K.C.Balasundaram, aged 57 years had taken an Endowment Policy for Sum assured Rs.55000 from LIC of India with date of commencement 28.08.04. The Life assured died on 4th December 06 due to acute pulmonary oedema and end stage renal disease. The claim under the policy was repudiated by the Insurer on the grounds of non-disclosure of pre-proposal illness.

The Primary cause of death was acute Pulmonary Oedema and end stage renal disease. The secondary cause was Diabetes Mellitus. The life assured had been admitted to Apollo hospital, Chennai on 15.09.04 within a month of proposing for the policy. In the hospital he was diagnosed for acute renal failure for septicemic shock, acute pulmonary oedema, DM for HT/IHD. The main complaint of the insured was cough with chest pain. The report also mentions that the Insured had history of DM on regular treatment and history of Hyper Tension on regular treatment. The Life assured had been admitted to Apollo First Med Hospital on 03.11.04 and discharged on 06.11.04. He was diagnosed for Diabetic Nephropathy, Distal Renal Tubular Acidosis (Hyporeninaemic, Hypoaldosteronism), Hyperkalemia and fluid overload. The report mentions that the patient was a known diabetic and hypertensive on regular treatment.

The claim investigating officer who investigated the claim reports that the Life assured was a known Diabetic and chain smoker and had severe respiratory problems. He reported that the Insured had taken treatment in MK Nursing home, Tondayarpet for a long time. He reported that the Insured was Diabetic for the last 15 years and that the Insured had taken

treatment at Apollo hospital during September'04 and was suffering from Hypertension during the last Five years.

During the hearing the complainant said that her husband had difficulty in breathing during September 04 and visited Apollo Med Hospitals. She confirmed that the Insured was a diabetic patient for the past 10 years and was taking tablet Dionil. She also submitted before the forum the copies of the tests undergone by her husband and the treatment taken by him from MK Nursing home. The various reports of Rajam x-ray clinic revealed that the Post Prondial blood sugar of the insured was around 250 and was also as High as 366. The various prescriptions given by MK Nursing Home referred above revealed that the life assured was advised to take drugs such as Dionil, Glysiphage, Envas, Aten to keep under control his diabetes and Hypertension. It is to be noted that all these reports were dated in the year 2002, 2003 which clearly indicate that the Insured had Diabetes and Hypertension before submitting the proposal.

The Insurer argued that the Life assured had not disclosed the material facts and therefore they had repudiated the claim as per the terms and conditions of the policy. Pre proposal illness was established. Non disclosure of material facts having been established the repudiation of claim was considered as justified and the complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI
Case No: IO(CHN)21.01.2134/2009-10

M.Chandra Vs Life Insurance Corporation of India

AWARD No: IO (CHN) L-026/2009-10 dated /22.06.09.

The complainant's husband Sri C.Mathiallagan had taken 12 policies each for sum assured 50,000/- for various terms under Endowment Plan from LIC of India. The date of commencement under all the policies was

28.03.05. He died on 06.05.07. Under all the policies he had nominated his wife Smt M.Chandra as the nominee. On the death of the Life assured the nominee preferred the Death claim with the Insurer. The Insurer has repudiated the claim, vide letter dated 31.03.08, under all the 12 policies referred above on the grounds of suppression of material facts that the Life assured had not disclosed his previous illness in the proposal form submitted by him.

The life assured died within a period of 2 years 1 month and 6 days from the date of issue of the policy. The primary cause of death was severe respiratory distress syndrome. The secondary cause was Chronic Obstructive Pulmonary Disease (COPD) and Diabetes mellitus.

The Medical attendant's certificate issued by Dr.S.Muthulakshmi of MIOT hospital indicates that the Insured was suffering from COPD and Diabetes Mellitus for the past two years and he had also history of breathing difficulty for the past Two years.

The Insurer was able to prove with the Various Hospital reports that the life assured was not keeping good health and was suffering from TB, abdominal disorders, breathing problem etc. even before submission of proposals.

The complainant argued that the Life assured was thoroughly examined by the panel doctor of LIC of India, and then only the policies were issued and as on the date of the proposal her husband was in good health. It is to be noted that unless the proponent discloses all the facts about his health, the cursory Medical examination conducted while issuing the policy will not reveal the true health of the Insured. The Insurer argued that it is a clear case of pre-proposal illness and the case study of Med India hospital and the past history mentioned in the report of MIOT hospital clearly reveal that the Insured was not keeping good health at the time of proposing for the policies.

Since the Insurer was able to prove the pre Proposal illness of the life assured with adequate evidence the repudiation decision of the Insurer was held justified.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Complaint no21.05.2174 dated 10.06.2009.

Smt.G.Sarasu vs. LIC

AWARD No: IO (CHN) L-027/2009-10 dated /09.09.09.

The LA Mr.Gopi had taken a policy on 24.01.07 for Rs1 lakh and died on 06.02.08 due to heart attack. The insurer denied the claim on the ground that the deceased had not disclosed the previous policy no 702467327 in the proposal form and the SA for this policy was Rs2lakhs.The insurer has contended that had he disclosed this policy they would have subjected him for medical examination and also in fulfilling other requirements before accepting the proposal.

Award dated-09.09.2009.

The risk under the present policy was accepted under non medical scheme and at that time insured had not disclosed his previous policy with LIC and had he disclosed the insurer would not have issued the policy under non medical scheme. LIC had settled the claim under the previous policy for an amount of Rs214217/- and repudiated the claim under the present policy. Further it was also noticed that in the first proposal dated 31.08.06 he has mentioned the age as 30 years and in the subsequent proposal dated 22.01.07 he has mentioned the age as 27 years. Some anomalies were also noticed in his annual income and all these show that the LA was not truthful in answering the questions in the proposal form. Taking all these factors it was opined that repudiation of claim by the insurer is in order and hence the complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Complaint no-21.02.2179 dated 11.06.09.

Smt.Usha.S vs. LIC.

AWARD No: IO (CHN) L-028/2009-10 dated /10.09.09.

The assured was a fitter Gr-I in S.Rly and had taken a Jeevan Surabhi policy under NMS for Rs 1 lakh from 20.03.2000. He died on 25.10.2002 and as per the claim form A the cause of death was heart attack. It was found during the claim investigation that the assured was suffering from aspiration pneumonia, alcoholic fatty liver in 1998, and had availed sick leave during March 1998 for 36 days. These facts were not disclosed in the proposal form and hence the claim was repudiated by LIC. The assured had taken treatment at S.Rly hospital for the above during April 1998 and Dec 1998.It was also noticed that the assured had paid premium at Rs1045/-p.m for 32 months amounting to Rs33440/-. It appears that four monthly instalments premium was paid after the death of LA.

Award dated-10.09.2009.

The medical records submitted by the insurer clearly show that the insured had undergone Surgery for Hydrocele and was also treated for Pneumonia and Alcoholic fatty liver, Hyper tension in 1998.He must be in the knowledge of the above diseases which he has not disclosed in the proposal submitted by him on 20.03.2000.From the drug card issued by the railway hospital it is seen that the insured had taken treatment during 1998/2002.The complainant had also admitted the sickness of her husband.

It has also been noted that the policy has run for a longtime of 32 months and the insured had paid a total premium of Rs 33,400/- till his death. The award was given for an amount of Rs 25,000/-on ex-gratia basis taking into account the economic condition of the family members.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

Complaint no-21.05.2186 dated 16.06.2009.

Smt.R.Gowri vs. LIC

AWARD No: IO (CHN) L-029/2009-10 dated /15.09.09.

The LA had taken a Money plus policy for Rs50000/- from 27.3.2007 and died due to Cancer on 14.08 07. According to the complainant the LA had given all information in the proposal and he was not having any symptom at the time of taking the proposal. It occurred suddenly and LA was taking treatment.

The insurer had denied the claim on the ground that the assured had withheld information regarding his health at the time of taking the policy. Before the date of proposal LA was suffering from Gall bladder Polyp in May 2006 as per hospital records. This was not disclosed in the proposal form.

Award dated-15.09.2009.

The Investigating officer of the insurer had mentioned that the life assured was suffering from Lung Cancer and had undergone various tests prior to the date of proposal.

As per Apollo master health checkup dated 13.04.2002 he was diagnosed for acid peptic ulcer and peripheral neuritis.

The ultra sound abdomen scan report dated 24.05.06 of the insured reveals Gallbladder polyp.

The discharge summary dated 23.05.07 from the hospital reveals history of pain in abdomen mostly on the right side for the past one year which dates back prior to proposal period. Based on all the papers the pre-proposal illness of the life assured has been established. The Lotus hospital in their letter dated 14.02.2008 has confirmed that the insured consulted their hospital on his own on 13.04.02 when he was diagnosed for Acid peptic disease

The complainant had also confirmed that she has received around Rs3 lakhs from the insurer in respect of other policies on the life of her husband. In the case of policy under dispute insurer is justified in repudiating the claim since pre proposal illness of the LA was clearly established. The complaint was dismissed.

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OFFICE OF THE INSURANCE OMBUDSMAN, CHENNAI

AWARD No: IO (CHN) L-030/2009-10 dated /22.06.09.

Complaint no-21.08.2208 Dated 25.09.09

Smt.R.Sabitha vs. LIC

The LA Mrs S.Kanagu had taken an Endowment Policy for Rs40000/- on 28.03 .92 with Double Accident benefit. The LA fell down on 9.8.05 while descending the staircase at Salem and she took treatment immediately at the same place. She was subsequently operated for Hipbone fracture due to the fall at Cuddalore. She died on 12.10.05 which is within 120 days from the date of Accident. She received the basic SA and Bonus amount but AB claim was rejected by the insurer.

The insurer denied the claim on the ground that the conditions for eligibility of DAB were not satisfied. The insured had a fall in the house and accident was not due to violent, visible and external cause and hence does not come under the purview of accident. Further the proximate cause of death was sudden cardiac arrest and there appears to be no direct nexus between the proximate cause and the fall. As per the report the LA died due to Diabetes and bedsore.

Award dated-25.09.2009

It was contended by the insurer during the hearing that they had taken opinion from Divisional Medical Referee and he opined that death is due to complications of Septicaemia/Diabetes Mellitus rather than Hipbone fracture. Further clause 10(b) of the policy terms and conditions which provides for Accident benefit on the death of the life assured reads as under;

To pay an additional sum equal to sum assured under the policy if the life assured shall sustain any bodily injury resulting solely and directly from the accident caused by outward ,violent ,visible means and such injury shall within 120 days of its occurrence solely, directly and independently of all other causes result in the death of the life assured.

In the present case the life assured slipped and fell while descending the staircase and this can be considered as accident. However the fall cannot be construed as violent and no external force was involved. Further the accidental injury should solely, directly and independently result in the death and in the present case the primary cause of death was sudden cardiac arrest as certified by the Doctor in the claim form B. The insured was also suffering from Diabetes. Taking all the factors it was opined that death of the LA cannot be attributed to the accidental injury and hence rejection of accidental benefit by the insurer is in order. The complaint was dismissed.

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DELHI

Case No. LI/DL-III/35/09

In the matter of Shri Dwarka Prasad Chaurasia Vs

Life Insurance Corporation of India

_ DEATH

AWARD dated 14.05.2009

The policy holder Smt. Raj Kumari Chaurasia who had taken this policy in February 2002, left for her heavenly abode on 10.04.2007. The cause of death is mentioned as Heart Problem in the repudiation letter. LIC of India has repudiated the claim on the ground that at the time of proposal for the policy in response to question No.13(a), she had given a wrong answer. The question and answers are as under:

13(a)	Have you had any abortion or miscarriage or caesarian section? If so, give details.	NO

It was found by LIC of India that in the year 1963 and 1965, she was hospitalized for caesarian operations and there were also miscarriages which were not mentioned in the proposal form for the policy No.330867116. But in another policy No.330700617 taken about a year earlier, that is, in the year 2001, she herself had disclosed in the proposal form the fact of caesarian operations and miscarriages in the year 1963 and 1965. LIC of India concluded that for the policy under consideration, she had deliberately withheld material information from LIC of India. Accordingly, the claim on the death of Smt.Chourasia was refused.

2. Before me it is submitted that the insurance agent had got the blank form signed by Smt. Chourasia assuring her that she will collect necessary details from earlier policy taken in 2001 and fill up the form accordingly.

There was a mistake committed by the agent for which she should not be held responsible. It was further argued that she had no intention of making any false statement as it would be evident from the fact that she had herself disclosed caesarian operations and miscarriages in the policy taken in 2001 with the LIC of India in the same Branch and through the same Agent. In any case, it was argued that miscarriages and

caesarian operations in nineteen sixties had no connection with the cause of death which was caused due to heart problem.

3. The Officer representing LIC of India however argued that any insurance policy is based on utmost good faith and facts disclosed in a bonafied manner. If the facts with regard to caesarian operations and miscarriages would have been disclosed, LIC of India might have exercised the option of not entering into the policy contract with Mrs Chaurasia or might have insisted upon higher quantum of premium in the policy.

4. I have considered the submissions made by the complainant as well as LIC of India. Apparently, LIC of India had lost sight of distinction between an incorrect or wrong statement and a false statement. In the latter there is an element of deliberateness whereas in case of a wrong and incorrect statement, element of deliberateness might not be embedded. Where a false statement is all the time a wrong statement, a wrong statement is not necessarily a false statement. Falsity and incorrectness have different shades of connotations.

5. Coming to the facts of the instant case, in the earlier policy taken with the LIC of India, at the same Branch through the same Agent, she had disclosed the fact of caesarian operations and miscarriages. Therefore, ordinary prudence suggests that she is unlikely to make a deliberate wrong statement with regard to same facts in a policy taken subsequently within a short span of time of one year without any apprehension of being caught on wrong foot. Therefore, I am not inclined to agree with the LIC of India that it is a deliberate mis-statement. Further, I find that while taking subsequent policy, a doctor appointed by LIC of India had also examined her.

6. Next relevant point which calls for an answer to determine the issue is as to whether this incorrect statement by the policy holder has any connection with the cause of death. Caesarian operations or miscarriages were in the distant past, that is, in 1963 and 1965 whereas the policy under consideration has been taken in February, 2002. Caesarian operation is not a lingering disease. It is merely a surgical procedure to bring the baby out from the mothers' womb in certain physical situations. It does not affect the general health of the patient in any significant manner. Especially when the caesarian operations or miscarriage were in 1963 and in 1965, that is, 37 years before taking the policy. I do not see what relevance it would have had even if same was correctly mentioned in the proposal form.

7. Smt.Chourasia had died because of heart problem. It has nothing to do with any gynaecological problem or problem relating to child birth. As such, reference to caesarian operations or miscarriages in the matter of deciding the claim of death caused because of heart problem is absolutely irrelevant.

8. In view of the above, it is directed that claim should be allowed. The payment should be effected by 15.06.2009. The compliance of the Award shall be intimated to my office for information and record.

9. Copies of the Award to both the parties.

P.S. Caesarian Operations are unsafe,

If not for health, for insurance.

Case No. LI/DL-III/85/08

In the matter of Smt. Anshu Saxena Vs

Life Insurance Corporation of India

AWARD dated 14.05.2009 **DEATH**

1. Policy holder Dr.Bimal Chandra was a serving medical officer in BSES. He was admitted in Metro Hospital on 12.06.2007 because of Dengu fever. As his condition deteriorated, he was shifted to Delhi Heart and Lung Institute. He died on 28.06.2007 while in the hospital. He had taken an insurance policy dated 07.06.2005 with risk date running from 01.11.2004. On the date of death, half yearly premium due 01.05.2007 remained unpaid and as such, the policy had lapsed. Sum assured for this policy was Rs.1, 50,000/-. Death claim has been rejected by LIC of India on the ground that Dr.Bimal Chandra was suffering from pre-existing diseases, that is, chronic liver disease, Diabetic Mellitus (DM) and Hypertension (HT) which were not disclosed while taking the policy. Further, in the opinion of LIC of India, primary cause of death was chronic liver disease, HT, DM and COPD and secondary cause of death was complications of Dengue fever, though these facts are not mentioned in the repudiation letter dated 10.09.2008, these are stated in the letter dated 24.10.2008 addressed to the Ombudsman by LIC of India.

2. Before me it is stated that the repudiation letter was a three line letter in Hindi stating that Competent Authority had rejected the claim. No reasons were mentioned at all. The remarks in the discharge summary report to the effect that Dr.Chandra was a chronic smoker, alcoholic and drug abuser was vehemently contested on the ground that there was no basis for maligning a dead man. It was stated that Dr.Chandra used to drink occasionally and that too in a very small quantity. He certainly could not have been called an alcoholic. Further, it is submitted that in the discharge summary the remark that he was bed ridden for the last 5 to 6 months after trauma in hip was absolutely incorrect and baseless. It was argued that all these facts are being mentioned in the report just to divert the attention from the real cause of death, that is, Dengu fever. Since Dengu fever could not be a pre-existing disease, it was submitted that claim could not have been rejected.

3. On the other hand, Shri C.M.Kapoor, representing LIC of India referred to Form No.3784 which is medical attendant's certificate obtained by LIC of India which mentions that primary cause of death is chronic liver disease, Hypertension (HT), Diabetic Mellitus (DM) and COPD. In the column, secondary cause, it was mentioned: Right side psychosis with septic shock with multi Dysfunctions syndrome in Dengue fever. With reference to the same, the representative argued that primary cause of death being chronic liver disease, the claim has rightly been rejected. Further, it is submitted that in the proposal form, the policy holder is supposed to mention all the correct facts. Here the policy holder had not disclosed the correct facts thereby losing his right to any claim. Shri Kapoor emphasized that since policy had lapsed due to nonpayment of last premium, policy holder had no enforceable right. It was only a case of ex-gratia claim which has been rightly rejected.

4. I have considered the submissions made by both the sides. Even if it is considered to be an ex-gratia claim, ex-gratia is not merely the compassion of the officer dealing with the case. It is a judicious process regulated by established guidelines for the purpose. In this case apparently this comes within guideline 4(a) of the LIC manual which reads as under:

> "4. Relaxation in the matter of settlement of Death Claim Policies where premiums were paid for full two years:
>
> 1. The following relaxations are now made in respect of Death claims arising by the Death of the Life Assured on or after 01.10.1987:
>
> After at least two full years premiums have been paid under a policy,
>
> a) If the death of the Life Assured were to occur after expiry of Days of Grace but within three months of the due date of the first unpaid premium, consideration of claim to the extent of the full sum assured together with the declared bonuses subject to recovery of the unpaid premiums."

Since risk date was 01.11.2004, I feel claim deserved to be considered under this clause. (In fact LIC of India has considered the claim as ex-gratia but has rejected it) Merely because it was a case of ex-gratia, the claim cannot be summarily rejected by mentioning the term ex-gratia.

5. I had called for the copy of the order of the Competent Authority, that is, Zonal Committee, dated 08.04.2009 rejecting the claim but the same is not made available to me in spite of telephonic reminders from my office. As such, I dispose of this case on the facts available with me on my records.

6. Though it is argued that there was pre-existing disease or chronic liver disease, Diabetic Mellitus/Hypertension and COPD, in the death summary (no date is mentioned) issued

by Delhi Heart and Lung Institute, there is no specific mention from which date he had these diseases. All that is mentioned therein is, "USG abdomen was **suggestive** of chronic liver disease with portal hypertension with splenomegaly with mild Ascitis with grade I BPH." As such one cannot conclusively tell how long the disease was there with him, whether prior to taking the policy or subsequent to it. Further the term "suggestive" used in the report may be only a synonym for "indicative". Diagnosis may not be emphatically conclusive. (My effort to procure a copy of USG report has failed)

7. In any case, he was not admitted to the hospital for any treatment of liver disease nor the focus of treatment was on liver disease, HT/DM. It was for Dengu fever and ultimately he died of right sided pneumonitis and multi organ failure which are caused because of Dengu fever.

8. It is significant to point out that in the case history and in the death summary, nowhere it is stated what was primary cause and what was secondary cause, though in the printed format No.3784 (printed by LIC of India) report dated 12.10.2007, there are columns for primary cause and the secondary cause. Obviously the format has to be based on death summary and the facts discovered during the course of treatment. As pointed out in the death summary, no such distinction is made. On the other hand, in the death summary the immediate cause of death is mentioned as under:

   "Dengue fever with Right Sided Pneumonitis with Septic Shock with Multi-organ dysfunction Syndrome."

9. Whenever there is an apparent contradiction or variation between the death summary and the Form No.3784 of LIC in my opinion death summary should be attributed greater evidentiary value for the reason it is more contemporaneous, nearer to the time and place of happening. On the other hand Form No.3784 is only a printed format filled up much after the event. In the instant case, it has been signed nearly 3-1/2 months after death. Let me hasten to add that this is not to suggest that Form No.3784 is altogether irrelevant. But this is only an **approach** to evaluating relative importance between death summary and Form No.3784 to resolve an apparent contradiction, between the two.

10. Juxtaposing death summary with Form No.3784, one gets the impression that the Dengue fever was the immediate cause of death whereas liver disease, HT,DM etc. could be pre-existing. When we try to determine the real cause of death always it is the immediate cause of death which is relevant rather than existence or non-existence of the next proximate cause. In this case, therefore, I am inclined to take immediate cause of death as mentioned in the death summary as the cause of death for the purpose of insurance claim.

11. Probably in the modern times, no one above the age of 40 can claim that he is free from any disease. Sometimes the disease is known to the person. Sometimes it is not known

but silently exists. Diabetic Mellitus and Hypertension are almost in epidemic form caused by stress level of modern life. If someone dies from Typhoid or an accident, one cannot disallow the insurance claim merely on the ground that he was suffering from Diabetes or hypertension even if such diseases may be pre-existing.

12. Dengue fever hangs likes Sword of Damocles over Delhi in summer. It is caused by the bite of a particular type of mosquito. It follows the law of equality. It does not distinguish between rich and poor. It follows the Shakespearian epithet:

"Golden lads and girls all must,

As chimney-sweepers, come to dust."

It does not distinguish between healthy and unhealthy, between those who had taken insurance policy from LIC and those who had not.

13. In such circumstances while determining the insurance claim question to ask is **not** whether he had a pre-existing disease. Question to ask is would the gentleman have survived Dengue, if he did not have pre-existing diseases? Answer to this question in the instant case is an emphatic NO. That settles the issue in favour of late Dr. Bimal Chandra, more correctly, in favour of Smt. Anshu Saxena, his wife.

14. However considering that it was considered as a case of ex-gratia by LIC of India, it is directed that nominee should be paid 90% of sum assured by 30.06.2009. The compliance of Award shall be intimated to my office for information and record.

15.. Copies of the Award to both the parties.

P.S. Smoking is injurious to health,

Drinking is injurious to insurance policy.

Case No.LI/JD/96/08

In the matter of Shri Arjun Kumar

Vs

Life Insurance Corporation of India

ORDER dated 18.05.2009 DEATH

1. This death claim is in relation to above mentioned policy taken by Late Smt. Soni Devi Kumhar on 28.03.2006 with sum assured amounting to Rs.1 Lakh.

2. The Insurance Company has repudiated the claim vide their letter dated 29.09.2007 on the ground that in the proposal form certain very core facts stated were e.g. In column 10 husband's age was mentioned as 45 whereas he had died already by that time on 11.03.2004. Similarly with regard to husband's profession and annual income it was stated that his source of income was agriculture and animal husbandry and annual income was stated to be Rs.50,000/-.

3. Before me it is submitted by Shri Bharat Kumar son of the deceased policy holder that she had made no deliberate false statement. He invited my attention to the photocopy of the proposal form to show that in column 10 though originally against the column age it was mentioned as 45 but it was also mentioned dead. Later on someone had interpolated the alphabet G so as to read it as Gead. It was not her fault in any case. Mr. Bharat Kumar also pointed out that in column no. 13 (b) she had mentioned the term "dead" but someone had struck it off. To this the officer representing the Insurance Company pointed out that in Question No. 10 there were two separate columns to give the details regarding family. One column was meant for those who were alive and other column was meant for the deceased. In the proposal form in the column meant for the alive these facts were mentioned by the policy holder showing husband's present age at 45. If she really wanted to indicate that her husband was no more it would have been mentioned in the other column meant for the deceased.

4. The official representative of the Insurance Company pointed out that for widows the Company applied stricter conditions for giving policy. Literate widows, having only minor children were permitted to have policies. In the instant case these conditions were not satisfied since all the children were major and she was not literate.

5. I have considered the submissions made on behalf of both the sides. Whether there is a deliberate wrong statement in the proposal form or not fact remains that she was a widow on the date of taking the policy on 28.03.2006. Therefore the conditionalties as related to widows with reference to minority of children or literacy would squarely apply. Since these conditionalities were not satisfied in this case, she was not entitled to have this policy. As such benefits under this policy should not accrue.

6. However, considering the circumstances of the case the Insurance Company should refund the premiums paid.

7. The complaint is disposed off accordingly.

Case No .LI/Birla Sun/113/08

In the matter of Shri Sunil Yadav

Vs

Birla Sun Life Insurance Company Limited

AWARD dated 21.05.2009 DEATH

1. The policyholder Late Shri Mam Chand Yadav met with an accident on 17.10.2007 and was admitted in the hospital with head injury. He passed away on 20.10.2007. The Insurance Company has repudiated the claim on the ground that the pre-existing diseases i.e. CVA and diabetes were not disclosed by the policyholder in the proposal form.

2. In the written submissions made before, references made to the Hon'ble Supreme Court decision in the case of LIC of India Vs. Smt. Asha Goel and Another (AIR 2001 Supreme Court 549) which held that life insurance are contract of uberrima fides and other all the material facts should have been disclosed.

3. The representative of the Insurance Company who appeared before me argued that material facts with regard to state of health were suppressed and therefore contract itself could be regarded as void. They invited my attention to the death summary issued by Saroj Hospital & Heart Institute for the policyholder which refers to CVA which was existed for last 3 years.

4. On the other hand on behalf of complainant (policy holder's son) it is argued that the policyholder did not suffer from any such disease. The reference made in the death summary which was not clearly legible considering its handwriting could not have been taken as the basis for refusing the claim. They submitted a copy of format report of the last attending physician Dr. A.K. Rawat who had not made any reference to diabetes or CVA. In this report there is also reference to Dr. Rekha Subramaniam the consulting Physician who had mentioned routine fever, cold and cough under the column "nature of complaint". In any case they argued that as it would be clear from the report that death occurred because of head injury and leg injury. The policy holder was in comma on account of the accident, when his car driven by himself dashed against a transport vehicle.

5. I have considered the submission made on behalf of Insurance Company as well as the complainant. In this connection a reference may be made to the publication of Insurance Institute of India namely Personal Accident Sickness and Miscellaneous

Insurance, page 30, where an attempt is made to put the concept of "proximate cause" of the death in the right prospective. I may quote the observation which run as under:

> "The doctrine of proximate cause is also relevant to processing of claims. The following are illustration based on case law.
>
> An Accident and a disease may be in operation both at the same time and it has to be decided whether the result is caused by disease. If the disease is present before the accident and the accident caused a condition which is in no way contributed to by the disease, then the condition is proximately caused by the accident, e.g. if a sufferer from asthma is able to travel to and from his business and in the course of a journey falls into a street excavation and breaks his legs, this is an accidental injury."

6. Coming to the instant case, the facts and the medical report suggest the cause of death is due to head injury leading to comma and ultimate death. It has nothing to do with existence or absence of any pre-existing disease. A healthy man without any disease would have met the same fate in the same circumstances. As such existence or absence of pre- existing disease was not a material fact with reference to which the claim could have been repudiated.

7. It is directed that the claim should be allowed. The same should be intimated to this office by 30th June 2009.

Case No. LI/HDFC/106/08

In the matter of Shri Sunil Kumar Yadav Vs

HDFC Standard Life Insurance Company Limited

AWARD dated 03.06.2009 DEATH

1. While driving his own car, the policy holder Shri Mam Chand Yadav met with an accident on 17.10.2007 when his car collided against another vehicle. He was hospitalized on 17.10.2007 for head injury and leg injury caused because of the accident. He passed away in hospital on 20.10.2007. The Insurance Company has repudiated the claim on the ground that there was a pre-existing disease CVA which was not disclosed by the policy holder at the time of taking the policy.

2. At the time of hearing, it is argued that insurance policy is based on the principle of utmost good faith, that is, Uberrima Fides and because of the suppression of pre-existing disease this principle stood violated in this case in terms of Section 45 of the Insurance Act. Accordingly, the claim was not allowable, it is submitted.

3. On the other hand, on behalf of the policy holder, it was vehemently contested that no such pre-existing disease was with the policy holder. Further, it is argued that cause of death had nothing to do with any disease whatsoever. It was because of accident which led to head injury and leg injury leading to his death. As such, it is submitted that the claim should have been allowed.

4. On behalf of the Insurance Company the same contentions were reiterated that there was suppression of material facts and policy was fraudulently made suppressing these facts.

5. I have considered the submissions made by both the sides. In the death summary, no doubt, there is a mention of CVA 3 years back. The Insurance Company interprets this abbreviation as Cerebro Vascular Accident. One is not sure if this meaning of this abbreviation is correct. CVA generally denotes Cardio Vascular Artery disease. Whatever it may be, the real issue in this case is whether any disease has any relationship with the accident at all.

6. Section 45 of the Insurance Act speaks of suppression of material facts with fraudulent intention. The facts suppressed should be material to the issue and such suppression should have been with a fraudulent motive.

7. In the instant case, except for a remark "CVA 3 years back", there is no other evidence to show that there was indeed a pre-existing disease. Further, even if it is existed, it has not been shown by adducing evidence that such disease was the cause of accident. Accident is an accident. It may be due to a driver's error, it may be due to other upcoming driver's error or it may be due to any natural event like land slide or any other reason. Sometimes it may have something to do with a disease, for example, if a diabetic suffers hypoglycemia while driving the car and his vision gets blurred mind disoriented leading to the accident; one could say that there is a connection between a pre-existing or existing disease and the cause of accident. But that again is a matter of fact.

8. In the instant case, there is no full proof evidence indeed based on any documents directly evidencing a pre-existing disease except for the remark in death summary. Even if we assume that there was a pre-existing disease, it has not been shown the same caused the accident. As such, I do not consider any disease pre-existing or otherwise as a material fact in relation to this accident in the context of Section 45 of the Insurance Act.

   Further no element of fraud has been established by the Insurance Company. A mere wrong statement or unintended omission cannot be considered as fraud. Fraud inherently pre-supposes a deliberate attempt. In the instant case, no such fraud is proved. Therefore, I feel the conditionalties for application of Section 45 of the Insurance Act do not exist. As such, the Insurance Company cannot take recourse of Section 45 so as to repudiate the claim.

9. The claim should be allowed and shall be confirmed to my office for information and record by 30.06.2009

10. Copies of the Award to both the parties.

Case No. LI/HDFC/106/08

In the matter of Shri Sunil Kumar Yadav Vs

HDFC Standard Life Insurance Company Limited

AWARD dated 03.06.2009 DEATH

1. While driving his own car, the policy holder Shri Mam Chand Yadav met with an accident on 17.10.2007 when his car collided against another vehicle. He was hospitalized on 17.10.2007 for head injury and leg injury caused because of the accident. He passed away in hospital on 20.10.2007. The Insurance Company has repudiated the claim on the ground that there was a pre-existing disease CVA which was not disclosed by the policy holder at the time of taking the policy.

2. At the time of hearing, it is argued that insurance policy is based on the principle of utmost good faith, that is, Uberrima Fides and because of the suppression of pre-existing disease this principle stood violated in this case in terms of Section 45 of the Insurance Act. Accordingly, the claim was not allowable, it is submitted.

3. On the other hand, on behalf of the policy holder, it was vehemently contested that no such pre-existing disease was with the policy holder. Further, it is argued that cause of death had nothing to do with any disease whatsoever. It was because of accident which led to head injury and leg injury leading to his death. As such, it is submitted that the claim should have been allowed.

4. On behalf of the Insurance Company the same contentions were reiterated that there was suppression of material facts and policy was fraudulently made suppressing these facts.

5. I have considered the submissions made by both the sides. In the death summary, no doubt, there is a mention of CVA 3 years back. The Insurance Company interprets this abbreviation as Cerebro Vascular Accident. One is not sure if this meaning of this abbreviation is correct. CVA generally denotes Cardio Vascular Artery disease.

Whatever it may be, the real issue in this case is whether any disease has any relationship with the accident at all.

6. Section 45 of the Insurance Act speaks of suppression of material facts with fraudulent intention. The facts suppressed should be material to the issue and such suppression should have been with a fraudulent motive.

7. In the instant case, except for a remark "CVA 3 years back", there is no other evidence to show that there was indeed a pre-existing disease. Further, even if it is existed, it has not been shown by adducing evidence that such disease was the cause of accident. Accident is an accident. It may be due to a driver's error, it may be due to other upcoming driver's error or it may be due to any natural event like land slide or any other reason. Sometimes it may have something to do with a disease, for example, if a diabetic suffers hypoglycemia while driving the car and his vision gets blurred mind disoriented leading to the accident; one could say that there is a connection between a pre-existing or existing disease and the cause of accident. But that again is a matter of fact.

8. In the instant case, there is no full proof evidence indeed based on any documents directly evidencing a pre-existing disease except for the remark in death summary. Even if we assume that there was a pre-existing disease, it has not been shown the same caused the accident. As such, I do not consider any disease pre-existing or otherwise as a material fact in relation to this accident in the context of Section 45 of the Insurance Act.

   Further no element of fraud has been established by the Insurance Company. A mere wrong statement or unintended omission cannot be considered as fraud. Fraud inherently pre-supposes a deliberate attempt. In the instant case, no such fraud is proved. Therefore, I feel the conditionalties for application of Section 45 of the Insurance Act do not exist. As such, the Insurance Company cannot take recourse of Section 45 so as to repudiate the claim.

9. The claim should be allowed and shall be confirmed to my office for information and record by 30.06.2009

10. Copies of the Award to both the parties.

Case No.LI/DL-I/36/09

In the matter of Smt. Prem Lata

Vs

Life Insurance Corporation of India

AWARD dated 04.06.2009 **DEATH**

1. This grievance relates to repudiation of claim by LIC of India with regard to above mentioned policy number by Mr. Gulshan Kr. Makkar vide their letter dated 18.03.2008. Mr. Gulshan Kr. Makkar passed away on 16.12.2006 at AIIMS, Delhi, after a brief illness. The claim is made by his wife Mrs. Prem Lata.

2. Repudiation is based on the reasoning that Mr. Makkar was suffering from chronic liver disease and at the time of taking the policy on 10.03.2004 he had suppressed this material information with regard to his health.

3. In the letter under reference i.e. dated 18.03.2008, it is mentioned that LIC has evidence and reason to believe that before submitting the proposal for the policy, Mr. Makkar was suffering from the above disease.

4. Before me it is submitted that by Mrs. Prem Lata that the LIC had not identified any evidence to reject the claim, even though they are mentioning the term evidence in their letter dated 18.03.2008. She argued that it is merely on the basis of suspicion and not reason to believe that the claim was repudiated. On the other hand, the representative of the Insurance Company Mr. Pandey invited my attention to the medical attendant's certificate in form no. 3784 where the cause of death was mentioned in para '4' as "Alcoholic Lever disease, Resp tract infection with renal failure". He also refers to Para 4 (c) where it is mentioned that Mr. Makkar was suffering from this disease for last 2 years.

5. He also further submits copies of some notings spanning over 3 pages on LIC Stationery (LIC pad) by one Mr. Vijay Rawal officer of LIC, jotting down certain matters. It looks like the prescription diagnostic details by a doctor with all the medical terminology and abbreviations. It is stated that since hospitals refuse to allow photocopy of their prescriptions and diagnosis, LIC official Mr. Goyal was deputed to visit ESI Hospitals on 26.02.2008. In these jottings which are not very clearly legible considering the handwriting, it is mentioned that there was CLD (Chronic Liver Disease) problem for 5 years.

6. With reference to these materials, it is submitted that the claim has been rightly repudiated by the Insurance Company.

7. I have carefully considered the submissions made on behalf of the complainant as well as the Insurance Company. At the time of hearing, I specifically asked for the death summary which would have been more reliable contempaneous evidence so as to identify the cause of death. The Insurance Company has not been able to produce the

same. The copy form no. 3784 i.e. medical attendant report which is available is dated 02.06.2007. It is not a contempaneous document. In this form no. 3784 it is mentioned that he was suffering from this disease before his death for 2 years. Going 2 years backwards from the date of death, it is clear that on the date of policy i.e. 10.03.2004, he was not suffering from this disease or at least there is no evidence for it.

8. As regards the jottings by LIC official Mr. Goyal, I cannot treat it as reliable evidence for the reason this does not bear any doctor's signature. How authentic the copying is particularly of medical terms used is highly doubtful. There is no confirmation of a doctor on these notings by Mr. Goyal to impart any evidentiary value to it. Besides if I have to choose between form no. 3784 duly signed by the medical attendant and these unauthenticated jottings by Mr. Rawal obviously I have to choose form no. 3784. When there is a conflict between the two I have to necessarily rely on more dependable evidence i.e. form no. 3784.

9. Clearly the burden was on the Insurance Company as to adduce necessary evidence with regard to the period of disease but no reliable evidence is indeed produced except for form no. 3784 which speaks of presence of this disease for last 2 years only.

10. As I have pointed out in form no. 3784 the period of existence of disease is mentioned as 2 years. This is the only reliable document available. As I have mentioned no death summary is produced which could have been still more reliable evidence in this regard. If the disease was there for 2 years prior to date of death, i.e. 16.12.2006 on the date of taking the policy on i.e. 10.03.2004 such disease did not exist or at least there is no evidence for its existence. Therefore, I conclude that there is no material evidence to come to the conclusion that indeed Mr. Makkar had suppressed material information with regard to this disease at the time of taking the policy.

11. In view of the above discussion it is directed that the nominee's claim should be allowed and should be confirmed to this office by 30.06.2009.

Case No. LI/ICICI Pru/60/09

In the matter of Ms. Anita Sikri

Vs

ICICI Prudential Life Insurance Company Limited

AWARD dated 27.07.2009 DEATH

1. The policy holder late Shri Gulshan Kumar died of a heart attack on 19.06.2008 at Deepak Memorial Hospital & Research Centre where he was admitted on 21.04.2008. The Insurance Company has repudiated the claim on the ground that the policy holder was suffering from Hypertension, which was not disclosed at the time of taking the policy on 08.05.2007.

2. At the time of hearing it is submitted that during earlier hospitalization during the period 21.04.2008 to 24.04.2008 in Kailash Hospital and Research Centre in the discharge summary it was mentioned that he was suffering from hypertension for last 8 years and was admitted for chest pain. It is also pointed out that he was on a tablet for hypertension namely Amtas AT, apart from being alcoholic. The representative of the Insurance Company submits that there is close link between hypertension and heart attack and therefore hypertension was a material fact which should have been disclosed by the policy holder at the time of taking the policy, in terms of section 45 of the Insurance Act.

3. On the other hand the wife of the deceased who appeared submitted that it was never known that her husband had a problem of hypertension and only on admission to the hospital they found that the BP to be higher. Therefore it could be said that there was no suppression of material fact at the time of taking the policy. To a query as regards the tablets taken, the representative of the Insurance Company could not show any specific prescription as to from what date he was taking this tablet Amtas AT, if at all. The Insurance Company is relying on the discharge summary where the mention of Hypertension is made. It was further pointed out by the complainant that the deceased had three other policies from Bajaj Allianz, Kotak Life and LIC of India and they had already allowed the death claim.

4. The Insurance policy talks of pre-existing disease. It does not speak of any link disease. The policy holder had died of heart attack. There is no evidence to show that at the time of taking the policy in 2007, he was diagnosed to have any heart problem as such. All that the Insurance Company is emphasizing is that he was suffering from hypertension which has a close link with heart disease. Though sometimes hypertension may lead to heart problem in all cases it does not. Further, heart disease is not necessarily caused by hypertension. Therefore, hypertension can be called at best a link disease and not pre-existing disease. In this case cause of death is not stated to be hypertension. It is because of heart attack. In this view of the matter I am of the opinion that the claim should not have been rejected.

5. It is directed that the claim should be allowed.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/002/010/L/09-10

Miss. Lipimoni Borah …….. Complainant - Vs -

SBI Life Insurance Co. Ltd. …….. Opposite Party/Insurer

Award dated : 28.05.2009

Mr. Amiya Borah, father of the Complainant, obtained a policy bearing No.07009104806 commencing from 18.07.2007. The Life Assured died on 14.12.2007. The Complainant, being nominee, lodged the death claim before the Insurer which was repudiated by the Insurer on the ground of suppression of material facts. Being aggrieved, the Complainant approached this Authority for redressal of her grievances.

The Insurer has contended in their "Self Contained Note" that although the Proposer was suffering from Pulmonary Tuberculosis before the inception of the policy but he did not disclose this fact in the proposal form and obtained the insurance cover fraudulently suppressing material facts.

During hearing, the Complainant stated that her father died on 14.12.2007 at their residence due to fever and he was treated about a week back from the date of his death by the Doctor. She has produced a medical document, in proof of taking treatment from the Doctor, but the said document shows that her father was treated for Pulmonary Tuberculosis since 04.01.2007 and he was further treated during 28.11.2007 to 03.12.2007. The representative of the Insurer has also produced some medical documents wherefrom it was revealed that the Proposer / Insured was suffering from Pulmonary Tuberculosis, which is a Lung Disease, and was under treatment of District Tuberculosis Centre, Kamrup, Guwahati since 04.01.2007. The representative has also produced another certificate which further proves taking treatment for Tuberculosis in the above Centre since 28.12.2006. It is proved that the proposal was submitted on 26.06.2007 in order to procure the above policy, at a time when the Proposer was suffering from Pulmonary Koch's (Tuberculosis) but while answering to the query in the proposal form, he had suppressed the above actual material fact. Due to suppression of material facts, repudiation of the claim is found to be justified. Complaint is accordingly closed.

Guwahati Ombudsman Centre
Complaint No. 25/008/0034/L/09-10/GHY

Shri Parimal Sen …. Complainant. -vs.-

Kotak Mohindra Old Mutual Life Insurance Co. Ltd. ... Opposite Party/Insurer

Award dated : 04.09.2009

Miss Priyanka Sen, daughter of the Complainant, submitted Proposal No. 01506992 under "Kotak Endowment Plan Limited" and made the Proposal Deposit amounting to Rs.10168/- vide cheque No. 372362 dated 18.02.2009 on Central of India, Guwahati. The said cheque was cleared on 21.02.2009 from the Bank by the Insurer. The Proposer Miss Priyanka Sen died on 05.05.2009 and it is alleged that the proposal deposit made by Miss Priyanka Sen was returned by the Insurer vide cheque No. 66869 dated 22.05.2009 cancelling the said proposal in order to avoid payment of death claim. Being aggrieved, the Complainant has approached this Authority for redressal of his grievances.

It is stated by the Insurer that the Company through its letter dated 24.02 2009 asked the Proposer to furnish her Income proof so as to process the proposal. However, Proposer failed to revert back and furnish the Income proof to the Company. The Company thereafter, due to non-submission of the income proof, rejected / cancelled the proposal. The Company further vide its letter dated 22.05 2009 intimated to the Proposer about rejection of the proposal and the refund of cheques amounting to Rs.10,168/-.

During hearing, the Complainant mentioned that his Daughter Priyanka Sen died on 05.05.2009 while she was studying at Handique Girls College, Guwahati. She died in a suspicious circumstances and Police also did postmortem examination on the dead body. The copy of the Postmortem Report proves that her death was caused due to asphyxia as a result of antemortem hanging which was suicidal in nature. The Complainant said that the Insurer illegally cancelled the proposal after the death of the Proposer without issuing the policy document in order to avoid payment of the claim. The representative of the Insurer stated that normally 5 days are required for issuing the policy, but in this particular case, the Insurer required documents from the Proposer regarding her income for underwriting the proposal and finding no response from the Proposer, the proposal deposit amounting to Rs. 10,168/- was returned to her stating the reason "CP-CPC NTU CASE" i.e. Not-taken up the case due to non-submission of requirements (income proof) vide cheque No.66869 dated 22.05.2009. Clause 3 of the proposal deposit receipt provides that " the Life Insurance Cover shall not be provided until the proposal has been examined, accepted and the Life Insurance Policy has been issued by Kotak Mohindra Old Mutual Life Insurance Ltd." It appears that the claim was lodged due to death of Priyanka Sen only on 27.05.2009 along with all documents, but the premium deposits were returned by the Insurer vide letter dated 22.05.2009 i.e. long before receipt of the death intimation / claim regarding the death of the Proposer. Since proposal was cancelled and deposit was returned before receipt of intimation of death of the Proposer, we also do not find any foul play in the matter and consequently the complaint is treated as closed.

Guwahati Ombudsman Centre
Complaint No. 21/001/008/L/09-10/GHY

Shri Pranab Das, ……. Complainant. -vs.-

LICI, Golaghat BO/Jorhat DO. …….. Opposite Party/Insurer.

Award dated : 01.07.2009

The Complaint is against repudiation of death claim under policy No. 442889249 by LICI. The complainant is the nominee under the policy. The policy was taken by Sri Paban Ch. Das for S.A. of Rs.1,00,000/- under Plan 149-15 years term, which commenced on 28.11.2006. The L.A. died on 18.02.2007, while taking treatment at International Hospital, Guwahati, As the claim occurred in about three months, LIC investigated the claim and ascertained that the Insured was a chronic alcoholic abuser at the time of taking the policy. On the basis of their investigation and evidences gathered, LIC has repudiated the claim.

According to the Insurer, the Insured did not disclose the material information regarding his health condition in the proposal form and in fact he had answered in the " negative" falsely while answering to question No. 11 (viii) & answered question No. 11(ix) that his health condition as " good " falsely. The insurer further contended that the insured was a chronic alcoholic abuser at the time of taking the policy which was concealed by him in the proposal form submitted for taking the policy. During hearing the representative of the Insurer has produced some Hospital Certificates which discloses that the insured was diagnosed to be suffering from "Acute Left Ventricular Failure" and he died due to that disease and secondary cause was stated to be "Substance abuse disorder". Further Registration form of the International Hospital recorded the finding that the insured was admitted in the hospital with history of ethanol abuse. According to the representative of the Insurer, they procured opinion on the term "Substance Abuse Disorder" from their "Zonal Medical Referee" who has clarified that "Substance Abuse Disorder" means that the person was a regular alcohol drinker. According to Medical Dictionary, "Substance Abuse Disorder" means any of a category of disorders in which pathological behavioral changes are associated with the regular use of substances that affect the central nervous system. That goes to indicate that the person suffering such from symptoms must be a regular user of drinks substance etc. The opinion expressed by the Medical Referee is that such a symptom develops due to regular use of alcoholic drinks.

The insured did not disclose the fact of his taking such alcoholic drinks in the proposal form submitted just before two and half months back from the date of his death which had affected the underwriting process of the insurer. The repudiation of the claim due to such non-

disclosure of material information by the Insured, cannot be said to be improper and unjustified. Hence complaint is treated as closed.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/006/190/L/08-09

Mr. Pulak Baidya …….. Complainant - Vs -

Birla Sun Life Insurance Co. Ltd …….. Opposite Party/Insurer Mumbai

Award dated : 27.04.2009

Mr. Amulya Kr. Suklabaidya, father of the complainant procured the above "Birla Sun Life Insurance Gold- Plus – II Policy" from the Birla Sun Life Insurance Co. Ltd. with the date of commencement on 28.03.2008. While the policy was in force, the Insured died on 15.08.2008 due to "Cardio Respiratory Failure". The death claim was preferred by the Complainant with the Insurer which was repudiated by the Insurer on the ground of suppression of material facts about his health condition in the proposal form.

According to the Insurer, during investigation, it was established that the Life Assured was actually suffering from High Blood Pressure and Epilepsy, since long before his application for insurance and he had also consulted Doctors and undergone several tests in connection with the same and hence all the aforesaid replies furnished by him in answer to question numbers 3 (a) & (b) and 4 (a) & (h) in the Medical Examiner's Report for insurance are false.

During hearing, the representative of the Insurer, has produced the Medical Examiner's Report as well as the proposal form wherein the answers furnished by the Insured in all the above questions were negative meaning thereby that he had not suffered from any ailments, nor consulted any Doctor for treatment of the above diseases. The representative has also produced some medical documents to prove that since 1998, the Insured was suffering from High Blood Pressure who had consulted Doctors and treated for that since 1998. The representative stated that the Insured had also Epilepsy attack which was treated at the Epilepsy Clinic. He has also submitted that the Insured had three episodes of tonic convulsion since 2000. The prescriptions issued by the Doctors who treated the Insured till 30.04.2005 discloses that he was advised to go for a number of lab. tests. All the above medical documents proves that the Insured was treated for Epilepsy and High Blood Pressure prior to submission of the proposal. The Complainant has also admitted in his statement that his father was suffering from High Blood Pressure for about eight years prior to the date of his death on 15.08.2008 and he was taking medicines for the same since then. He has further admitted that his father had undergone ECG test and was treated by three Doctors namely Dr. A.K. Das , Dr. J.C. Bhattacharjee, and Dr. A.S. Das. From all the above admitted position, it is established that the Insured was suffering from the diseases like

High Blood Pressure, Epilepsy, Convulsion and nervous disorders for which he was treated by a number of Doctors prior to inception of the policy which he had concealed and has furnished false information, while answering to the questions in the proposal form. Naturally, the Insurer was misled while taking underwriting decision. Repudiation of the claim is found to be justified for holding material information and accordingly the complaint is closed.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/012/025/L/09-10/GHY

Mrs. Narbada Devi Agarwal …….. Complainant - Vs -

MetLife India Insurance Co. Ltd …….. Opposite Party/Insurer

Award dated : 13.08.2009

Mr. Amiya Borah, husband of the Complainant, procured policy No.1200700302710 from the above Insurer commencing from 30.03.2007 for a Sum Assured of Rs.2,50,000/-. The Life Assured died on 17.11.2007. The nominee lodged the death claim before the Insurer which was repudiated by the Insurer on the ground that the policy was void ab-initio, cancelled & returned the premium deposited due to non disclosure of material facts by the Insured in the proposal form. Being aggrieved the Complainant approached this Authority for redressal of her grievances.

The Complainant has stated that her husband had undergone a specific test for Diabetes Mellitus as prescribed by the MetLife and finding the test results to be satisfactory, the policy was issued in the name of her husband. During hearing, the representative of the Insurer, stated that the Insured furnished declarations before the Doctor about his health condition and the Doctor thereafter issued a certificate before the policy was issued. The representative has also produced the Death Summary issued by the Christian Medical College, Vellore wherein it was stated that Radhe Shyam Agarwal was having Diabetes Mellitus for last eight years and was on regular medical treatment. This is the document relying on which, the Insurer had taken the decision to treat the policy as void ab-initio resulting repudiation of the claim due to non-disclosure of correct health condition. The Death Summary also discloses that the Insured Radhe Shyam Agarwal was admitted and treated during the period from 28.10.2007 to 17.11.2007 then he expired on 17.11.2007. The cause of death, as noted by the Hospital Authority shows that the Insured died due to complications of a number of ailments including Type II Diabetes Mellitus.

The above finding of the Hospital Authority recorded in Death Summary proves that the Insured was having “Diabetes Mellitus” and he was on regular medication since last eight years prior to the date of his admission in the said Hospital. The declaration furnished by the Insured in the proposal form on 31.03.2007 stating therein that he was not suffering from Diabetes is

found to be false and contrary to the findings recorded in the Death Summary and suppression of fact is proved. The repudiation of the claim is found to be without any irregularity and accordingly the complaint is treated as closed.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 21/001/153/L/08-09

Mrs. Nekjan Begum ..... Complainant - Vs -

L.I.C. of India, Hajo B.O. ..... Opposite Party/Insurer

Under Guwahati D.O.

Award dated : 17.04.2009

Md. Tamizuddin Ahmed, husband of the Complainant, had taken policy No. 483409343 from LICI, Hajo Branch under Guwahati D.O. commencing from 20.10.2004. The Life Assured died on 28.01.2006 due to "Cardio Respiratory Failure". The nominee lodged the claim with the Insurer which was repudiated on the ground of withholding of correct information by the Insured as regards his health condition. Being aggrieved the nominee approached this Authority for redressal of her grievances.

The Insurer has contended in their "Self Contained Note" that "Cause of death" was Cardio Respiratory Failure. Prior to death he was treated in Makkah by Indian Medical Mission from 23.12.2005 for Hypertension besides other ailments. Prior to that he was also treated at International Hospital, Guwahati from 14.11.2005 to 18.11.2005 and the problems reported by him before the Doctor were -

(1) Diabetes Mellitus for 2 months, (2) Pyrexia cough & expectoration for 2 weeks, (3) Cardio Vascular Accident - 3 years back.

This illness history was concealed in the proposal. CVA is a serious Cardiac Problem. If disclosed the proposal would not have been accepted.

During hearing, the representative of the Insurer, stated that the claim was repudiated relying on two documents (the letter dated 26.07.2007 issued by the International Hospital, Guwahati addressing the Manager (Claims), LICI and the statement in claim form No. 3816 (Claim Form – 'B1') issued by the said Hospital) which proves about sufferings from Hypertension by the Insured since 3 years back and also from CVA (Recovered) since 3 years. Relying on these two documents, the Insurer has held that the Insured was suffering from Hypertension and CVA since last three years prior to his death which was however not disclosed by him in the proposal form. It is seen that the above two documents only proves that Tamizuddin Ahemd was treated as an indoor patient in the said Hospital during the period from 14.11.2005 to

18.11.2005 for ailments like "Cough, Expectoration and Pyrexia" for which he was suffering since last two weeks there from. The medical examination report procured at the time of issuing the policy by the Insurer shows that the Insured was examined by the authorized Medical Practitioner of the Insurer, who of course, did not find any kind of ailments or any sign of operation / impairment and the Insured was found to be healthy. Proposal was accordingly accepted after such medical examination. Had there been any sufferings due to CVA – Rt. Hemiparesis there would have been at least some symptoms which could have been detected by the Attending Medical Officer who examined the Insured prior to acceptance of the proposal. Because of such circumstances, repudiation of the claim is found to be not justified and the Insurer is directed to settle the claim within fifteen days from the date of receipt acceptance letter.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 24/001/012/L/09-10/GHY

Mrs. Priyanka Das …….. Complainant - Vs -

L.I.C. of India, North Lakhimpur B.O. …….. Opposite Party/Insurer

Under Jorhat D.O.

Award dated : 17.06.2009

Mr. Nilkamal Das, husband of the Complainant, took policy No. 442041430 from LICI for Sum Assured of Rs.3,00,000/- with the date of commencement on 28.06.2003. The Life Assured was killed by the extremist on 19.07.2004 while the policy was in force. The nominee lodged a claim before the Insurer which was repudiated by the Insurer on the ground of suppression / withholding of the material information regarding previous insurance policy particulars in the proposal form. Being aggrieved, the Complainant had approached this Authority for redressal for her grievances.

The Insurer alleged that the Life Assured did not disclose existence of his previous policy No. 441169431 in the proposal form. The Insurer, in the repudiation letter, stated that had the previous policy No. been disclosed, it would have necessitated calling for Special Medical Reports viz ECG, CBC and ESR apart from Full Medical Report for consideration of the proposal and due to such non disclosure, the underwriting decision was affected.

The Medical Attendants Certificate, furnished in Form No. 3784 (Revised) (Claim Form 'B') and the complaint letter also proves that the deceased died due to multiple bullet injuries on 19.07.2004 and postmortem examination was done on the dead body. The death of the Insured appears to be an accidental one and not due to any other disease and the claim lodged under other policies bearing No. 441622296 and 441169431 were already settled by the same Insurer

with accidental benefits as stated by the Complainant. The letter dated 25.08.2007 filed before the Insurer by the Complainant also discloses that besides the District Administration, The Govt. of Assam has also sanctioned ex-gratia payment to the Complainant, being legal heir of the deceased as he was killed by the extremists. All the above documents proves that the death of the Life Assured was caused due to bullet firing by the extremists which can be termed to be an accidental death and not because of any ailment. Thus inability to procure Medical Report / Special Medical Report like ECG, CBC and ESR due to non-disclosure of previous policy No. at the underwriting stage, has not, in any way materially affected the Insurer. It may be termed to be a suppression of fact of the number but considering the circumstances under which the deceased died, such suppression appears to be without any affect on the claim and hence it is considered to be not a material suppression of fact. Under the above facts and circumstances, repudiation of the claim appears to be done on a flimsy ground which cannot be said to be justified one. The Insurer was directed to reconsider the matter and proceed to settle the claim.

INSURANCE OMBUDSMAN GUWAHATI CENTRE

Complaint No. 21/006/028/L/09-10/GHY

Mrs. Sewali Timung …….. Complainant - Vs -

Birla Sun Life Insurance Co. Ltd. …….. Opposite Party/Insurer

Award date = 03.08.2008

Mr. Anjan Das, husband of the Complainant, procured Policy No. 001835833 from the above Insurer for a Sum Assured of Rs.1,42,000/- with the commencement date of 28.07.2008. While the policy was in force, the Life Assured died on 22.01.2009 due to "Intractable rise of ICP due to spontaneous intracranial haemorrhage". The claim lodged by the Complainant was repudiated by the Insurer alleging suppression of material facts by the Insured. Being aggrieved, the Complainant has approached this forum for redressal of his grievances.

During hearing, the Complainant has stated that her husband Anjan Das was not suffering from any disease prior to his Hospitalization on 16.01.2009. According to her, he suddenly fell ill on 16.01.2009 and thereafter he was taken first to G.N.R.C. Hospital, Guwahati and finding no response from the said Hospital, Anjan Das was taken and admitted in the Dispur Polyclinic & Nursing Home, Guwahati for better treatment where he had undergone an operation and ultimately died on 22.01.2009. The Complainant has also stated that her husband was a Police Instructor and was never ailing prior to his Hospitalization on 16.01.2009 and due to sudden illness and complications, he died on 22.01.2009. The death certificate issued by the treating Hospital also shows that Anjan Das died on 22.01.2009 at about 8.45 P.M. due to

"Intractable rise of ICP due to spontaneous intracranial hemorrhage". The representative of the Insurer has stated that the Insured was suffering from Hypertension since last one year from the date of his admission in the Hospital on 16.01.2009 which has been revealed from the Hospital record. This is clear enough to indicate that Anjan Das had been suffering from Hypertension since last one year prior to 16.01.2009 and this fact was not disclosed by him while filling up the questions noted in (IX) (D) 3. (a) of the proposal form. The findings of the Hospital have not been challenged. This statement in the proposal form was answered in the negative on 04.07.2008 which was well within one year from the date of his admission in the Hospital on 16.01.2009 and hence suppression of fact has been established.

In view of the clear concealment of the fact of sufferings from High Blood Pressure by the Insured in the proposal form, the claim has been repudiated by the Insurer. The action taken by the Insurer appears to be in accordance with the policy terms and conditions and hence we find nothing wrong in the decision of the Insurer / LICI and such decision requires no interference from this Authority.

HYDERABAD

Hyderabad Ombudsman Centre

Case No: L-21-002-0521-2008-09

Smt.U.Jayalakshmi

Vs.

SBI Life Insurance Co.Ltd. Mumbai

Award Dated: 27.4.2009 **Award No: I.O. (HYD) L- 01-2009-10**

The complaint is about the repudiation of claim on Policy No.83001000507 by SBI Life Insurance Co.Ltd., Mumbai.

Shri Utnoor Gangakishan obtained Housing Loan from SBH, Dichpally and joined as a policyholder in the SBH Home Loan Insurance Scheme under the Policy No: 83001000507, by submitting a Good Health Declaration Form. The risk commenced from 01.08.2007 for the sum assured of Rs.5,67,000 and he died on 03.07.2008, within 11 months.

When the complainant claimed for the monies under the policy, the insurer, SBI Life Insc.Co.Ltd. rejected the Claim on the policy on the plea that the life assured had given a false Good Health Declaration at the time of entry into the scheme. The cause of death is directly attributable to the pre-existing medical

condition of the deceased at the time of enrolment under the scheme and since the policy does not cover deaths due to pre-existing illness, the claim is repudiated.

The complainant states that the life assured died due to heart attack on 03.07.2008 but the Insurance Co. rejected their claim on the policy.

Both the parties are heard in a personal hearing held on 22.04.2009 and all the documents submitted to us, were perused.

From the document Dhanvantari Health Camp, Son Village, Adilabad Regn.Data Card camp date 10.08.03, Sl. No.0184, the diagnosis made was: NIDDM, THD Angina, Koch's Lung and he was advised tests viz Echo, TMT, Urea Cr. etc.

The prescription sheet dt.26.09.05 by Sri Maithri Hospital, Nizamabad states that the life assured was diabetic. The prescription of Geetha Nursing Home, Armoor dt.12.07.2006 states that the life assured was a NIDDM Type II. The fasting Blood sugar reports dt.12.07.06, 03.06.07, 28.06.07, 15.07.07, 30.07.07, by Venkataramana Diagnostic Centre, Balkonda which showed beyond the normal range, were perused.

The Prescription slip dt. 03.06.07 by Dr.G.Keshav Chandar states that the life assured was a known case of Diabetes, and an old healed pulmonary TB.

The prescription slips dt. 25.05.06, 17.06.07, 28.06.07, 20.11.07 by Dr.K.Bhoomreddy, Nizamabad states that the life assured was a case of Diabetes, Healed Pulmonary Koch.

In the hearing held on 22.04.09, it was admitted by the complainant and her son that the life assured was having Diabetes.

From the above, it is clearly established that the life assured obtained the policy without disclosing the material facts of his health.

The policies of Life insurance are the policies of Utmost Good Faith, and both the parties to the contract shall have to reveal all the facts in full.

In view of non-disclosure of material facts and misrepresentation made by the deceased life assured, in the Declaration of Good Health submitted to the Insurer, it was held that the Insurer, SBI Life Insc.Co.Ltd., is fully justified in rejecting the Sum Assured on the policy.

The complaint is therefore, dismissed.

Shri M.G.Palani Swamy

Vs.

Tata AIG Life Insurance Co.Ltd. Mumbai

Award Dated: 27.4.2009 **Award No: I.O. (HYD) L- 02-2009-10**

The complaint is about the repudiation of claim on Policy No.601943699 by LIC of India, Divisional Office, Secunderabad.

Smt. A.Venkatamma, 46 years took a policy for Rs.50,000, bearing no:601943699, from LIC of India, which commenced from 28.3.2004. The policy lapsed due to non-payment of Premiums from March 05 and the same was revived on 27.6.2007 by submitting a Personal Statement of Health and Medical Report and also by paying all the arrears of premia with interest. She died on 21.7.2007.

When the complainant claimed for the monies under the policy, the insurer, LIC of India, rejected the Claim on the policy on the plea that the life assured was suffering from breathlessness since 7 days and fever since 3 days and admitted in a Govt.Hospital, Hyderabad on 27.6.2007 and the policy was revived on the same day. Further, Life assured was a known case of Hypertension and Diabetes since 3 years and on regular medication. The policy was revived while actually she was in Hospital undergoing treatment. She did not disclose these facts in her said Personal Statement regarding health.

The complainant states that the life assured died due to fever and motions and all the premiums under the policy were paid but the Insurer rejected the claim.

The policy was revived on 27.6.2007 by submission of PSH and a Medical Report both dated 13.6.2007 and payment of arrears of premia with interest of Rs.9,393=00. The Life assured died on 21.7.2007.

Both the parties are heard in a personal hearing held on 22.4.2009 and all the documents submitted to us were perused.

It is observed that the life assured is an illiterate and the agent Shri D.Ramakrishna, code no: 105516102 who procured the policy knew her for the last 5 years, as per his Report dt.31.3.2004.

It is also observed that at the time of revival also, he assisted her in filling up the PSH and also introducing her to the Medical examiner on 13.6.07. Nothing adverse was recorded either in the PSH or by the Medical Examiner in medical report dt.13.6.07. The policy was revived on 27.6.07 by payment of the arrears being Rs.9, 393=00.

In the claim enquiry report dt.10.9.07 wherein the investigating officer clearly stated that the agent and the dev.officer have colluded with the claimant in perpetrating a fraud and recommended for repudiation of the claim.

From the Case Sheet of the Govt.Hospital Regn.no.24646 it is noted that Smt.Venkatamma was admitted on 27.6.07 at 10.15 a.m. with complaints of breathlessness, cough and fever since 3 days. In the history, it was stated that she is a known case of HTN and DM since 3 years and on regular medication. It was also stated that she was suffering from breathlessness since 10 days, cough and fever since 7 days. She was discharged on 1.7.07.

From the above case sheet of the hospital, it is clearly established that as on the date of revival i.e.27.6.07 she was admitted into the hospital. The PSH & Medical examinations were done on 13.6.07 but the consideration amount for revival was paid only on 27.6.07. Thus, the reinstatement of the policy i.e. revival took place only after admission of the life assured into hospital.

Therefore, it was held that the Insurer, LIC of India is fully justified in repudiating the claim on the policy. But what action has been taken against the Agent/Dev.Officer, who was reported to have colluded with the claimant by the Insurer?

It was deposed in the hearing that the agent was already terminated from the books of the insurer w.e.f.1.4.2006 but he was the person who filled up the PSH and introduced the Life assured to the Medl.examiner, stating that he continues to be an in force agent.

The party in this case being illiterate was obviously misled by Sri D Ramakrishna, terminated agent. The Insurer LIC of India was directed to refund the revival amount collected on 27.6.07 to the complainant, as an ex-gratia. It is also suggested that the Insurer take suitable action against the agent and others responsible for the fraud after proven investigation into the whole issue. The complaint is partly allowed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0016-2009-10

Smt.Lakshmamma

Vs.

LIC of India, Divnl.Office-2, Bangalore

Award Dated: 20.7.2009 **Award No: I.O. (HYD) L- 21-2008-09**

The complaint is about the repudiation of claim on Policy No. 363109615 by LIC of India, Divisional Office-2, Bangalore.

Smt.Nagavenamma W/o Shri D.R.Narayanappa submitted a proposal dt.10.2.2004 to LIC of India and obtained a policy bearing no: 363109615 for a sum assured of Rs.30,000 under New Janaraksha Plan for 15 years. The policy commenced from 10.2.2004. She nominated her mother Smt.Lakshmamma, though her husband and minor children are alive. The policy lapsed due to nonpayment of premiums, from 10.8.04 and the same was revived on 2.9.2005 by payment of arrears of 3 Hly. Premiums, the amount being Rs.3,428=00 and by a personal statement of health dt.2.9.2005.

When the complainant claimed for the benefit under the policy, the insurer, LIC of India. rejected the claim, on the plea that the life assured was suffering "Throat Cancer" and had availed treatment for the same, which was deliberately suppressed while reviving the policy on 2.9.2005.

The complainant contended that the life assured unexpectedly suffered by illness and died and there is no source for leading of life to her children. She pleaded for settlement of the claim at least to the remitted instalments amount, for the benefit of her children.

After hearing both the parties, and perusal of all the documents submitted to us, it is observed from the Discharge Summary of Kidwai Memorial Institute of Oncology, Bangalore that the life assured was admitted on 3.9.05 and discharged on 17.11.05 and the diagnosis was Carcinoma Gr.III.

It is also observed from the case sheets of Doctor's Order of KMI of Oncology, Bangalore that the life assured had undergone biopsy and was diagnosed as Sq.cell Carcinoma – Grade III on 2.8.05 and was under continuous treatment by them and was admitted as Inpatient on 3.9.05.

It is also observed from Claim Form B1 that the life assured was first admitted into KMI of Oncology, Bangalore on 28.7.05 with IP No.8969/05 for soreness in mouth and was discharged on 29.4.06.

It is further observed that she submitted a personal statement of health dt.2.9.05, which was filled in English by an official of the Insurer's dev.officer, code No.97661 and the same was witnessed by him.

In view of the suppression of material facts on the part of the life assured, it was held that the repudiation of the claim on the policy is right and fully justified. However, considering the facts that she is not an educated person and the responsible officer who filled the PSH & witnessed did not report the facts, duly enquiring the facts to the questions of the PSH, the Insurer is directed to refund the amount paid for revival, as ex-gratia and I also suggest to examine the role of the dev.officer in reviving the policy and initiate suitable action against him, if found guilty.

The complaint is partly allowed.

Hyderabad Ombudsman Centre

Case No: L-21-007-179-2009-10

Smt.Rohini A.Shenoy

Vs.

Max New York Life Insc.Co.Ltd.

Award Dated: 20.7.2009 Award No: I.O. (HYD) L- 22-2008-09

The complaint is about the repudiation of claim on Policy No 328144019 by Max New York Life Insc.Co.Ltd.

Shri Ajay Kumar Shenoy, aged 54 yrs, submitted a proposal dt.5.9.2007 to Max New York Life Insurance Co.Ltd. and obtained a policy "Limited Pay Endowment to Age 75 (Participating) Plan" for a sum insured amount of Rs.3,05,489=00 and the policy commenced from 5.9.2007 with an annual premium of Rs.32,000. He died on 11.6.2008 due to brain haemorrhage.

When claimed for the monies, the Max New York Life Insc.Co. rejected the claim, on the plea that the life assured was suffering from Liver Illness for which he underwent transplantation of liver, which was not disclosed at the time of proposing for insurance.

The complainant contended that the life assured died on account of Brain Haemorrhage on 11.6.08 but the insurance co. had rejected the claim in spite of her submissions of all diagnostic reports and medical certificates of the medical treatment of earlier period, as called for by the company. Though he was undergoing medical treatment for liver illness for which he later underwent a liver transplant and he was recovering as per the doctor's certificate. However, he ultimately expired on account of brain haemorrhage, which was not existent at the time of issuing the policy. Therefore, the stand of the insurance company for not furnishing correct medical disclosures is not right.

After hearing the case ex-parte and perusing all the documents, It is observed from Claim Form C given by Dr.B.S.Satya Prakash, consultant Gastroenterologist & Hepatologist that the life assured was treated for liver disease and the date of consultation was 10.4.2006, prior to the date of proposal and the diagnosis was chronic liver disease.

Further, the Christian Medical College, Vellore Death Summary report states that the life assured was admitted on 18.3.2008 and he expired on 11.6.2008 and the cause of death was Decompensated Chronic Liver Disease – Cryptogenic Complications. The history mentioned was increased fatigability since June 2006, upper GI variceal bleed in June 2007, generalized distension of abdomen from January 2008. He was admitted for evaluation and consideration for liver transplant.

It is also observed from the document dt.17.6.09 of Clinical Gastroenterology and Hepatology of Christian Medical College, Vellore that the life assured underwent liver transplantation on 4.6.2008 and unfortunately died on 11.6.08 and the cause of death mentioned was brain hemorrhage.

The complainant admitted in her letter dt.20.5.2009 and also in the personal hearing that her husband, the life assured had not mentioned about the treatment he was undertaking for the ailment he was

suffering from. She stated that it was an unintended mistake while writing the proposal by the life assured.

Life Insurance Contracts are contracts of Utmost Good Faith and both the parties must disclose all material facts in respect of the risk to be covered by the contract.

In view of the suppression of material facts on the part of the life assured, it was held the repudiation action of the Insurer, Max New York Life Insurance Co.Ltd. is right and justified.

The complaint is therefore, dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0017-2009-10

Shri R.Swamy

Vs.

LIC of India, Divnl.Office-2, Bangalore

Award Dated: 20.7.2009 **Award No: I.O. (HYD) L- 23-2008-09**

The complaint is about the repudiation of claim on Policy Nos. 361168174 & 361311942 by LIC of India, Divisional Office-2, Bangalore.

Shri R.Ramegowda, took two policies bearing Nos.361168174 & 361311942 for Rs.60,000 and Rs.50,000 respectively, both with Accident Benefit on the policies. The life assured fell from staircase in his house and died on 18.5.07. No Police report, FIR, post mortem was done.

When the complainant claimed for the benefit under the policy, the insurer, LIC of India. settled the basic sum assured claims on both the policies and rejected the Accident Benefit, on the plea that the death is not solely, directly from the accident and no FIR, Post-Mortem were produced to them.

The complainant contended that he did not file any complaint with the police station as that was not the practice with the village and hence could not produce LIC's requirements of FIR, Post-Mortem report, Police Inque3st and B Report. But the report issued by Hanumanthapura Grama Lekhadhikari, Tq.Maddur, elders report by HB Vishveshware Gowda Ex.Chairman of the village and other 12 elders statement in this regard. The life assured had a fall from the stair steps in the house by accident and sustained head injuries and was admitted to the Rly.Hospital. After a checkup there, he was advised to be shifted to NIMHANS hospital that expressed their inability and shifted to Rly.Hospital and he died

there on 18.5.07. After hearing the case from both the parties on 16.7.09 and perused all the documents, it is observed from the letter of South Western Rly., Bangalore dt.1.7.08 that the life assured was reported sick at their hospital on 14.5.07 and again, he was brought on 17.5.07 by his relatives with history of fall from stair case in his village and injured his head. Then he was referred to NIMHANS who found to have severe head injury and serious condition and sent back to Rly.hospital on 18.5.07 for further treatment. He died there on 18.5.07. The post-mortem was not done, since there was no police complaint or FIR filed in police station. From the document dt.17.5.07 addressed to RMO, Nimhans, the provisional diagnosis was made as seizures with alcoholism, Diabetes mellitus with hypertension with head injury.

The corporation shall not be liable to pay the additional sum assured, if the death of the life assured shall be caused while the life assured is under the influence of intoxicating liquor, as per 10.7(b) condition of Accident benefit clause.

The Rly.hospital document dt.17.5.07 clearly states that the life assured was brought to the hospital with seizures and alcoholism and with head injury under the influence of intoxication at the time of injury. Hence, it is held that the rejection of accident benefit is right and fully justified. The insurer is advised to specify their grounds for rejection in their letter clearly and also to guide the beneficiary to approach the redressal machineries within and outside the industry.

The complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-006-148-2009-10

Smt.M.Hymavathi

Vs.

Birla Sun Life Insc.Co.Ltd., Mumbai

Award Dated:: 20.7.2009 **Award No: I.O.(HYD) L- 24-2009-10**

The complaint is about the repudiation of claim on Policy No.000969736, by Birla Sun Life Insc.Co.Ltd.

Shri M.Appa Rao, submitted a proposal dt.15.2.07 to Birla Sun Life Insc.Co.Ltd. and obtained a policy for a sum assured of Rs.16,16,000, which commenced from 22.3.07 and the life assured died on 17.8.2008 due to cardiac arrest.

When the complainant claimed for the benefit under the policy, the insurer Birla Sun Life Insc.Co.ltd. rejected the claim on the plea that the life assured was a known case of “Diabetes Mellitus” and was

under treatment much prior to the application for insurance and also that the reply to the question IX(D) Medical and Personal history of the life to be insured is false.

The complainant contended that the life assured had no diabetes and not under any treatment. Neither the life assured nor the family members knew that he had diabetes and BP. He did not take any medicine related to diabetes and he was a healthy person.

After hearing both the parties on 16.7.09, and perusing all the documents submitted., it is observed from the discharge summary of Wockhardt Hospitals, Bangalore that the life assured was admitted in the hospital on 5.1.2008 and was discharged on 10.4.2008, with chief complaints of chest discomfort, giddiness one episode etc. The past history recorded in the summary was known case of Hypertension since 4 years on treatment and known case of Diabetes Mellitus since 4-5 years on treatment. The final diagnosis was Hypoxic Encephalopathy sequelae, extra pyramidal syndrome, persistent vegetative state, viral myoipericarditis, Diabetes mellitus and hypertension. It is also observed from the discharge summary that the life assured was admitted on 9.7.2008 and was discharged on 2.8.2008 and past history recorded then was known case of hypertension since 4 years on treatment and also a known case of diabetes mellitus since 4-5 years on treatment. The hospital treatment certificate dt.4.11.08 also confirmed that the life assured was suffering from Diabetes since 4-5 years and hypertension since 4 years.

The complainant stated in the hearing that she was also admitted in the same hospital at the time of his admission into the hospital. It is evident that the life assured was suffering from Diabetes Mellitus, which he did not disclose in the proposal form, for consideration of risk. In view of the suppression of material facts on the part of the life assured, it was held that the repudiation action by the Insurer is right and justified.

The complaint is therefore, dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-001-199-2009-10

Smt.Sk.Mahaboob Bee

Vs.

LIC of India, Divnl.Office, Kadapa

Award Dated: 20.7.2009 **Award No: I.O. (HYD) L- 25-2009-10**

The complaint is about the repudiation of claim on Policy No653285636, by LIC of India, Divisional

Office, Kadapa.

Shri Sk.Ismail, aged 50 yrs submitted a proposal dt.18.1.2004 for an assurance of Rs.50,000 to LIC of India and obtained a policy bearing no:653285636 with date of commencement 28.1.2004 for a term of 10 years. He died on 1.7.2006 due to heart disease.

When the complainant claimed for the benefit under the policy, the insurer LIC of India rejected the claim, on the plea that the policy was under lapsed condition as on the date of death of the life assured. Further, they stated that the life assured absented to duties on Medical grounds during 1.1.2001 to 31.12.2001 and 1.1.2003 to 31.12.2003, prior to the date of proposal and did not disclose these facts in the proposal and also that the life assured absented from the duties during 25.5.04 to 9.9.04 and from 1.1.2006 to 30.6.2006 unauthorised for which period the wages were not drawn and as a result, the premiums were not recovered and remained unpaid, resulting lapsation of the policy.

The complainant contended that the life assured was working in APSRTC, Nandyal as Driver and APSRTC used to pay LIC premium. It was the duty of RTC department to pay the premiums regularly to LIC of India. Further, she stated that it not correct that the life assured was absent to the duties on medical grounds from 1.1.2001 to 31.12.2001 and 1.1.2003 to 31.12.2003, prior to the date of proposal. And also that it is incorrect that he absented for duties during the period 25.5.2004 to 9.9.2004 and from 1.1.2006 to 30.6.2006 for which period the wages were not drawn and premiums were not recovered and remain unpaid. She stated that from 10.9.2004 he attended the duties and he was not educated and so, the APSRTC is expected to pay the premiums from the salary of him. It is the duty of the employer to pay the amounts and if it is not paid, the LIC is entitled to recover the amount from the employer. She admitted that the life assured went on medical grounds from 1.1.2006 to 30.6.2006 and died on 1.7.2006 and so it is the duty of the employer to pay the premiums and stated that no LIC policy would be lapsed for six months and it is not so long a period to lapse this policy.

After hearing both the parties, and all the documents submitted were perused, It is observed from the certificate of employer claim form E ® dt.20.11.2007 that the life assured last attended the duties on 8.1.2006 and from the statement of record of absence during the period from 1.1.2001 to 31.6.2006 he availed sick leave and absented without pay, prior to the date of proposal, as below:

1.1.2001 to 31.12.2001 -- 8 days sick leave on Medical grounds (Sick certificates destroyed)

-- 37 days absent without pay

1.1.2002 to 31.12.2002 -- 12 days absent without pay

1.1.2003 to 31.12.2003 -- 7 days sick leave on Medical grounds (Sick certificates destroyed)

-- 5 days absent without pay

Further the employer stated that (i) the life assured was under un-authorized absence from 25.5.2004 to 9.9.2004 and wages were not drawn, (ii) the life assured was under un-authorized absence from 9.1.2006 to 30.6.2006 and wages were not drawn.

It was also noted that there were intermittent unpaid premiums in the month of July 04 and September 04; and also from Feb.2006 to June 2006 premiums, and hence, the policy got lapsed due to the unpaid premiums of 7 months, which fell due up to the date of death.

The complainant's argument that the employer is responsible to pay the premiums when the life assured was on leave on medical grounds from 1.1.2006 to 30.6.2006, and also that the insurer, LIC of India to recover the amount from the employer, is not tenable, as he was on unauthorized absence and no wages were drawn during the period.

It is further noted that the claims on three other policies of LIC, bearing nos: 651590887, 65159004 and 651594004 were settled by them, on ex-gratia basis.

It was also informed by the representative of LIC of India that the claim on this policy could not be considered by them on ex-gratia under the Chairman's guidelines, as the premiums were not received at least for a period of 2 years.

In view of the unpaid premiums and the lapsation status of the policy as on the date of death, it was held that the repudiation of claim by LIC of India is proper and the complaint is therefore, dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-004-262-2009-10

Smt.Konatham Kasamma

Vs.

ICICI Prudential Life Insc.Co.Ltd., Mumbai

Award Dated: 25.9.2009 **Award No: I.O. (HYD) L- 26-2009-10**

The complaint is about the repudiation of claim on Policy No.08899713 by ICICI Prudential Life Insc.Co.Ltd.

Shri Konatham Narayana Reddy, Head Constable submitted a proposal dt.15.5.2008 and obtained a Life Stage RP for Rs.2, 00,000 which commenced from 18.5.2008. He died on 11.9.2008 at Pragathi Cardiac Centre, Nizamabad.

When the complainant claimed for the benefit under the policy, the insurer ICICI Pru.Life Insc.Co.Ltd. rejected the claim, on the plea that the insured suppressed the fact that he was having ailments and had given wrong answers in reply to Q.No.22 (a), 23(c), 23(f), 23(h) in the proposal form.

The complainant contended that the health of Life assured was alright, at the time of taking the insurance policy. The life assured never had any health problems and even on the day just before his death, he was on duty. According to her, the life assured had never applied for any leave on grounds of ill health during the past 4 years. His death was sudden and unexpected. She stated that the insurance company has to come to the rescue of the family members of the deceased, since the purpose of insurance is not to put to suffering the dependants of the deceased, financially.

Both the parties were heard on 24.9.09 and all the documents submitted were perused.

The insurer contended that the life assured had answered to Q.No.22 (a) as positive and Q.No.23(c) (f) (h) in negative and at the claims stage, it was found that the information given was incorrect. The case history from Pragathi Cardiac Centre, Nizamabad dt.11.9.2008 reveals the final diagnosis as Old Coronary Artery disease (CAD) with anterior wall Myocardial infarction with post percutaneous transluminal coronary angioplasty (PTCA) with stent to left anterior descending artery in May 2004. The past history noted was that he had hypertension, smoking and family history of CAD and was alcoholic.

The cause of death was due to cardio respiratory arrest with old CAD-P TCA and stent to LAD and was admitted with extensive chest pain, Myocardial Infarction. The Insurer contended that the life assured had undergone PTCA with Stent to Left Anterior Descending Artery in May 2004 at Kamineni Hospital and had this information been disclosed at the time of taking the policy, they would not have issued the policy to him. The hospital records of Kamineni Hospital dt.3.6.2004 IP No.20040600256 where the life assured undergone operation in which stent was fixed, was produced.

It is therefore, held that the insurance company was justified by repudiation the claim, since the life assured did not mention in the proposal form about the surgical procedure that took place in May 2004. However, considering the plight of the bereaved members of the family, a sympathetic view was taken and the ICICI Pru.Insc.Co.Ltd. was directed to refund the fund value of Rs.15,000/- to the complainant, as Ex-gratia.

Hyderabad Ombudsman Centre

Case No: L-21-001-311-2009-10

Smt.I Chenna Kesavamma

Vs.

LIC of India, Divisional Office, Kadapa

Award Dated: 25.9.2009 Award No: I.O. (HYD) L- 27-2009-10

The complaint is about the repudiation of claims on Policy No.653513843, 653515557, 653736835 & 653736836 by LIC of India, Kadapa Divn.

Shri I.P.Veera Reddy, took 4 policies from LIC of India by submitting the proposals, as detailed below and died on 18.3.2006 and the insurer repudiated the claims on all the policies.

Pol.653513843 -- Dt.14.7.2004 – SA Rs.2,50,000 – P & T 149-20 – Doc 24.7.2004

653515557 -- 31.7.2004 -- 1,00,000 150-26 -- 9.8.2004

653736835 -- 28.12.2004 -- 1,00,000 150-26 -- 28.12.2004

653736836 -- 28.12.2004 -- 1,00,000 133-21 -- 28.12.2004

When the complainant claimed for the benefit under the policy, the insurer LIC Of India, rejected the claims on all policies, stating that the answers to Q.No.11 a,b,c,d,e,I,j of the proposal were false and the life assured was suffering from TB/HIV positive, prior to the dates of all proposals.

The complainant contended that the life assured died due to heart failure only. Her father-in-law's name was also Sri Iragamreddy Pothula Veera Reddy, who died on 24.4.2006 due to cancer and the proof of death of father-in-law was also submitted by her. The names are similar and their family members are having political rivalry and so, the people in their village wrongly represented before the LIC authorities that both the persons are the same.

Both the parties were heard on 24.9.09 and all the documents submitted were perused.

The insurer contended that they have irrefutable evidence to show that the life assured was detected with HIV+ on 13.7.2004 and he had started proposing for insurance from 14.7.2004 onwards concealing the facts about his health. He had proposed for high risk policies suppressing the material information and he stated that there was no dispute about the identity of the life assured. The evidences procured were all belonged to the life assured only.

It is observed that on 13.7.2004, the life assured consulted a doctor and was counseled for HIV reactive, vide PID No: MA-2509 by AHMPL Hospital and further he had consulted Arogyavaram Institute of Medical Sciences, on 5.11.2004, for cough, fever, breathlessness since 3 months and took treatment up to 4.12.2004 and the nature of disease was HIV+ and was treated by Dr.Y.V.Bhaktavatsalam. The signature given on the consent form of Patient's case record was verified with that of the proposal dt.14.7.04. The first proposal was dt.14.7.2004 and thereafter he proposed for insurance vide proposals dt.28.12.2004 and 28.12.2004. All these proposals resulted into policies bearing Nos; 653513843, 653515557, 653736835 and 653736836.

The Form B1 issued by Dr.Y.Bhaktavatsalam dt.23.7.2008 clearly stated the patient's case record. As per B1, the life assured was admitted in Arogyavaram Medical Centre on 5.11.2004 under admn.no.505017 for cough, fever, breathlessness suffering from 3 months and was diagnosed as HIV+ and was discharged from hospital on 4.12.2004, confirming the fact of having HIV+ before inception of all the policies that commenced on 28.12.2004 (commenced on or after 14.7.2004).

In view of the above documents, it is held that the repudiation of claim on all the four policies is proper and fully justified. Hence, the complaint is dismissed, without any relief.

Hyderabad Ombudsman Centre

Case No: L-21-001-307-2009-10

Smt.N.Savithramma

Vs.

LIC of India, Divisional Office, Kadapa

Award Dated: 25.9.2009 **Award No: I.O. (HYD) L- 28-2009-10**

The complaint is about the repudiation of accident benefit claim on Policy No.653054738 by LIC of India, Kadapa Divn.

Shri Krishna Murthy a/s Raja took a policy bearing no: 653054738 from LIC of India for a sum assured of Rs.30, 000 with accident benefit. He died on 21.3.2008 due to burns.

All the relevant reports such as FIR, Post Mortem, Final Report and Forensic report were submitted to the Insurer but the insurer settled only the basic sum assured and denied the accidental benefit.

Both the parties were called for a personal hearing on 24.9.09 but the claimant nor any authorized person on his behalf attended the hearing on the said date. All the documents FIR, PMR and the Final report submitted were perused.

The insurer contended that there was clear violation of the policy conditions relating to accident benefit clause as per 10 (b) (i) and (iv) which clearly excluded the death by intentional self injury/suicide etc.

Since the complainant did not attend the hearing or seek any adjournment, the matter was decided on ex-parte basis. The insured went to his house in an intoxicated mood on 18.3.2008 and threatened his lady friend stating that he would pour kerosene and commit suicide if she talks to her former husband.

She took it in a casual manner, as he was talking in an intoxicated state. After sometime, the deceased asked her to give a match box. Thinking that he asked the match box for smoking, she gave it to him and went out of the house. But after few minutes, the deceased came running out of the house in flames. The neighbours extinguished the fire and he was admitted in Govt.Hospital for treatment. He died on 21.3.2008 at 12.15 p.m. while undergoing treatment for burns at Govt.Hospital, Anantapur. The final report of Police of Anantapur I Town PS submitted to Hon"ble Magistrate, stated as below:

"The Judicial First Class Magistrate recorded the dying declaration of the life assured at 6.05 p.m. i.e. about four hours prior to the statement recorded by the police. In the dying declaration, the life assured categorically stated that he poured kerosene and lit fire to himself in an intoxicated state and was in a desperate mood to end his life."

Further, the deceased at the time of examination by the Medical Officer at the casualty also stated before the M.O. that he himself poured kerosene and set himself on fire. This fact is recorded in the medical admission register and the same was mentioned in the medical intimation also.

It is therefore, held that the repudiation of the accidental benefit under the policy is proper, as the life assure died due to self immolation and the policy condition 10 (b) (1) & IV has been correctly invoked. Hence, the complaint is dismissed without any relief to the complainant.

Hyderabad Ombudsman Centre

Case No: L-21-001-278-2009-10

Smt.S.Ghousiya

Vs.

LIC of India, Divisional Office, Kadapa

Award Dated: 25.9.2009 **Award No: I.O. (HYD) L- 29-2009-10**

The complaint is about the repudiation of accident benefit claim on Policy No.654295810 by LIC of India, Kadapa Divn.

Shri S.Abdulla aged 22 yrs. submitted a proposal dt.20.3.2007 and obtained a policy for a risk cover of Rs.1,00,000 with accident benefit. The policy commenced from 20.3.2007 and the life assured died on 7.8.2007 as reported while taking bath in a canal dam, accidentally. But, the matter was not reported to police authorities and there were no FIR or Post-mortem report.

When claimed for the monies under the policy, the insurer, LIC of India settled the basic sum assured under ex-gratia basis as full and final settlement.

Both the parties were called for a personal hearing on 24.9.09 and all the documents submitted were perused.

The insurer contended that the life assured died within 4 months 17 days and suicide clause under the policy is operative. Since suicide is not established and there is no police reports to prove death as accident, the claim was admitted as ex-gratia and the basic SA of one lakh was paid with the consent as full and final settlement of all claims under the policy.

The complainant stated that they were not aware that case should be filed with the police and gets it investigated. They were in deep grief on the loss of the life assured and hence not thought of the formalities to be completed and pleaded for payment of Accident benefit under the policy.

The life assured Shri S.Abdulla 22 yrs, was reported to have gone for bath into the canal at Hospet on 7.8.07 where he had been to attend a function. As per claim form A, the claimant stated that the life assured fell into canal water and died and the body was found on 8.8.2007. They did not inform the police and brought the body to Guntakal and buried there. Though the suicide clause is operative, the Insurer, considered the claim under ex-gratia and settled Rs.1,00,000 as a whole settlement. The proof of accident is not established by the claimant. The publication in Eenaadu about the missing of the life assured when he went to canal, does not stand as authentic proof of accident. Similarly, statements filed by the complainant from other members also could not be taken into consideration.

It is therefore held, that the repudiation of accident benefit by the Insurer was correct, as accident was not established by any official authority. The complaint is dismissed without any relief.

Hyderabad Ombudsman Centre

Case No: L-21-004-244-2009-10

Smt.M.Rupaparameswari

Vs.

ICICI Prudential Life Insc.Co.Ltd.

Award Dated: 25.9.2009 **Award No: I.O. (HYD) L- 30-2009-10**

The complaint is about the repudiation of claim on Policy No.6532630 by ICICI Prudential Life Insc.Co.Ltd.

Shri Maddukuri Narender, 30 yrs aged, submitted a proposal dt.27.10.2007 and obtained a policy for a risk cover of Rs.2, 50, 000 under Life Stage RP, with an annual premium of Rs.50, 000. He died on 14.7.2008due to Septicemia secondary to cellulites of leg with jaundice.

When claimed for the monies under the policy, the insurer, ICICI Pru.Life Insc.Co.Ltd. rejected the claim that the life assured was a known case of decompensate cirrhosis due to hepatitis C presented with hematemesis. As per the discharge summary from Global Hospital, Hyderabad dt.17.6.2008 it is evident that he was known case of cirrhosis and he died within 9 months of policy issuance. Further, he had history of Osteomyelitis and had undergone surgery for the same and being a doctor himself, he was very well in a position to understand the criticality of non-disclosure of these material facts.

Both the parties were called for a personal hearing on 24.9.09 and all the documents submitted were perused.

The insurer contended that as per the hospital records, the life assured suppressed material information. Had he disclosed the facts, the policy would not have been considered without medical examination. As a doctor, the life assured ought to have been aware of his health condition and given correct answers to the questions in the proposal.

The complainant stated that the life assured was not alcoholic and he might not have been aware of the surgery done in his childhood. He stated that the claims on policies with ING Vysya Life Insc. And Bajaj Allianz Life Insc.Co. were settled.

It is observed from the document of Global Hospitals, discharge summary produced that the deceased life assured was a known case of decompensate cirrhosis due to hepatitis C. Further, he had a history of surgery for Osteomylitis for which he underwent surgery 25 yrs. ago. But the benefit of doubt to the LA for non disclosure of Osteomylities could be given, as he was only a small child of five years old.

It is also observed that the life assured had taken policies with other insurance companies.

It is found that the deceased life assured did not disclose the facts while replying to Q.No.31 of the proposal dt.27.2.07. In view of the suppression of material facts on the part of the life assured, it is held that the repudiation action by the Insurer is right and justified. The contract of insurance is voidable and the insurer is right in avoiding liability under the policy.

However, considering the plight of the bereaved members and the fact that contract is only voidable, a sympathetic view is taken and the insurer is directed to return the fund value of Rs.37, 500 together with an amount of Rs.25, 000/- as exgratia. Thus, the insurer is directed to pay Rs.62, 500/- which would meet the ends of justice.

Hyderabad Ombudsman Centre

Case No: L-21-006-269-2009-10

Smt.B.Bixamaiah

Vs.

Birla Sun Life Insc.Co.Ltd.

Award Dated: 30.9.2009 **Award No: I.O. (HYD) L- 31-2009-10**

The complaint is about the repudiation of claim on Policy No.1467772 by Birla Sun Life Insc.Co.Ltd.

Shri K.Mallaiah, aged 43 yrs. submitted a proposal dt.11.2.2008 and obtained a policy for a coverage of Rs.2,50,000 with an annual premium of Rs.50,000 with premium payment period of 3 years. The policy commenced from 14.2.2008 and would mature on 14.2.2016. He nominated his nephew Mr.Bixmaiah, while the spouse is alive. The life assured died on 14.9.2008 in front of new cinema hall, Devarakonda.

When claimed for the monies under the policy, the insurer, Birla Sun Life Insc.Co.Ltd. rejected the claim that the life assured was suffering from Chronic Obstructive Pulmonary disorder at the time of application, which was not disclosed and also answered in negative to Q.No.IX D (3) of the application dt.11.2.2008 submitted for insurance.

Both the parties were heard in a personal hearing on 30.10.09 and all the documents submitted were perused.

The insurer contended that as per the medical attendant's certificate submitted by the claimant, the final diagnosis mentioned is COPD i.e. Chronic Obstructive Pulmonary Disease. According to medical consultant's opinion, it is a disease characterized by the presence of airflow obstruction due to chronic bronchitis and/or emphysema. The symptoms must have been present at least for 2 years. Hence, there was malafide intent to hide the pre-medical history.

The complainant stated that the life assured was healthy and death was sudden. He was asked why he was nominated to receive the policy monies when the spouse of the deceased is alive. To this, he replied that the deceased had no children and so, he nominated him out of love and affection.

It is noted that the insurer's presumption that symptoms of COPD would have been there for more than 2 years is not valid. It is difficult to say from the diagnosis arrived at by the hospital as to how long the life assured was suffering from this disease. There have been cases when patients have been suffering from disease but still, they may not know that. When asked whether they have any other evidence of the deceased life assured having taken any treatment prior to the date of proposal, the representative of the insurer stated that they do not have any proof to show that the life assured had taken any treatment prior to the date of proposal. She produced a medical consultant's opinion of Sainath Family Health Centre, Mumbai dt.20.3.09 signed by Dr.Asrani which stated that the symptoms must have been present for more than 2 years.

Since the Insurer has failed to produce any proof of the DLA having taken treatment for any disease prior to the date of application, it is not established that he had suppressed pre-medical history and the answers given by him to Q.No.(IX) (D)(3)(b) in the application were wrong.

It is therefore held that the action of the insurer is not justified and hence, the Insurer, Birla Sun Life Insc Co.Ltd. is directed to pay Rs.2,50,000 or the fund value whichever is higher on the policy. The complaint is allowed.

Hyderabad Ombudsman Centre

Case No: L-21-006-271-2009-10

Smt.Maloth Bujjy

Vs.

Birla Sun Life Insc.Co.Ltd.

Award Dated: 30.9.2009 **Recommendation No: I.O. (HYD) L- 33-2009-10**

The complaint is about the repudiation of claim on Policy No. 2486136 by Birla Sun Life Insc.Co.Ltd.

Shri Maloth Buchya, aged 44 years submitted a proposal dt. 27.01.2009 for a sum assured of Rs. 5,20,000 and the same was accepted by Birla Sun Life Insc. Co.Ltd. w.e.f. 28.01.2009. He died on 16.03.2009. The LA died suddenly due to heart attack but the insurer rejected the claim on the Policy that LA submitted fake driving license as age proof and also falsely replied to questions relating to his occupation and grossly overstated the annual income in the application.

Both the parties were heard in a personal hearing on 30.9.09 and all the documents submitted were perused.

The DLAs wife (complainant) and his son have submitted written statements to the Insurers' investigating officer which revealed that the LA was selling Ice Cream and her daily income was approximately Rs. 50 to Rs. 70/-. The complainant also produced original pahanis of the DLAs land holdings to the extent of 4.12 acres in Ootai Village, Kothaguda Mandal, Warangal Dist.; She stated that she cannot write but only sign in the vernacular. The investigating officer wrote the statement about occupation and income of her husband and asked her to sign which she did in good faith. The

complainant produced DLAs voter ID and ration card to prove that there has not been any false statement of age.

The complainant on her part has submitted to the Ombudsman:

(a) Copy of voter ID card

(b) Copy of ration card

(c) Income certificate issued by Sarpanch of Ootai Village, Kottaguda Mandal stating that the DLA was having agricultural lands to the extent of 4.12 acres which yield an annual income of Rs. 1,50 lakhs.

(d) Original pahanis of the land holding of the DLA

It is evident that the complainant has not submitted the above proofs to the insurer while requesting for reconsideration of repudiation of the claim. They were denied opportunity to examine the facts and reconsider their earlier decision. The insurers are not disputing the age of the DLA.

In view of the above it is recommended that the proof of income/age be submitted now to the insurers' for reconsideration of their earlier decision to repudiate the claim within 30 days from the date of receipt of this order. In case the complainant is not satisfied with the decision of the insurer after reconsideration they have a right to revert to this forum.

The complaint is disposed off accordingly.

Hyderabad Ombudsman Centre

Case No: L-21-001-0529-2008-09

Shri M.G.Palani Swamy

Vs.

Tata AIG Life Insurance Co.Ltd. Mumbai

Award Dated: 27.4.2009 **Award No: I.O. (HYD) L- 02-2009-10**

The complaint is about the repudiation of claim on Policy No.601943699 by LIC of India, Divisional Office, Secunderabad.

Smt. A.Venkatamma, 46 years took a policy for Rs.50,000, bearing no:601943699, from LIC of India, which commenced from 28.3.2004. The policy lapsed due to non-payment of Premiums from March 05 and the same was revived on 27.6.2007 by submitting a Personal Statement of Health and Medical Report and also by paying all the arrears of premia with interest. She died on 21.7.2007.

When the complainant claimed for the monies under the policy, the insurer, LIC of India, rejected the Claim on the policy on the plea that the life assured was suffering from breathlessness since 7 days and fever since 3 days and admitted in a Govt.Hospital, Hyderabad on 27.6.2007 and the policy was revived on the same day. Further, Life assured was a known case of Hypertension and Diabetes since 3 years and on regular medication. The policy was revived while actually she was in Hospital undergoing treatment. She did not disclose these facts in her said Personal Statement regarding health.

The complainant states that the life assured died due to fever and motions and all the premiums under the policy were paid but the Insurer rejected the claim.

The policy was revived on 27.6.2007 by submission of PSH and a Medical Report both dated 13.6.2007 and payment of arrears of premia with interest of Rs.9,393=00. The Life assured died on 21.7.2007.

Both the parties are heard in a personal hearing held on 22.4.2009 and all the documents submitted to us were perused.

It is observed that the life assured is an illiterate and the agent Shri D.Ramakrishna, code no:105516102 who procured the policy knew her for the last 5 years, as per his Report dt.31.3.2004.

It is also observed that at the time of revival also, he assisted her in filling up the PSH and also introducing her to the Medical examiner on 13.6.07. Nothing adverse was recorded either in the PSH or by the Medical Examiner in medical report dt.13.6.07. The policy was revived on 27.6.07 by payment of the arrears being Rs.9,393=00.

In the claim enquiry report dt.10.9.07 wherein the investigating officer clearly stated that the agent and the dev.officer have colluded with the claimant in perpetrating a fraud and recommended for repudiation of the claim.

From the Case Sheet of the Govt.Hospital Regn.no.24646 it is noted that Smt.Venkatamma was admitted on 27.6.07 at 10.15 a.m. with complaints of breathlessness, cough and fever since 3 days. In the history, it was stated that she is a known case of HTN and DM since 3 years and on regular medication. It was also stated that she was suffering from breathlessness since 10 days, cough and fever since 7 days. She was discharged on 1.7.07.

From the above case sheet of the hospital, it is clearly established that as on the date of revival i.e.27.6.07 she was admitted into the hospital. The PSH & Medical examinations were done on 13.6.07 but the consideration amount for revival was paid only on 27.6.07. Thus, the reinstatement of the policy i.e. revival took place only after admission of the life assured into hospital.

Therefore, it was held that the Insurer, LIC of India is fully justified in repudiating the claim on the policy. But what action has been taken against the Agent/Dev.Officer, who was reported to have colluded with the claimant by the Insurer?

It was deposed in the hearing that the agent was already terminated from the books of the insurer w.e.f.1.4.2006 but he was the person who filled up the PSH and introduced the Life assured to the Medl.examiner, stating that he continues to be an inforce agent.

The party in this case being illiterate, was obviously misled by Sri D Ramakrishna, terminated agent. The Insurer LIC of India, was directed to refund the revival amount collected on 27.6.07 to the complainant, as an ex-gratia. It is also suggested that the Insurer take suitable action against the agent and others responsible for the fraud after proven investigation into the whole issue. The complaint is partly allowed.

Hyderabad Ombudsman Centre

Case No: L-21-002-0537-2008-09

Shri V.Kumara Swamy

Vs.

SBI Life Insurance Co.Ltd., Mumbai

Award Dated: 5.5.2009 **Award No: I.O. (HYD) L- 04-2009-10**

The complaint is about the repudiation of claim on Policy No.86000051401 by SBI Life Insc.Co.Ltd., Mumbai.

Smt.L.Bhagawathi w/o Shri V.Kumara Swamy had applied for Swadhan Group Insurance Scheme under Master Policy No:86000051401, which commenced from 1.10.2007 for a sum assured of Rs.5,00,000, from SBI Life Insc.Co.Ltd. She died on 14.6.2008 in SVIMS, Thirupathi.

When the complainant claimed for the monies under the policy, the insurer, SBI Life Insc.Co.Ltd. rejected the Claim on the policy on the plea that the life assured had suppressed the facts and withheld material information regarding health and declared that she was of sound health, at the time of effecting the insurance.

The complainant states that the life assured suffered with Leptospirosis and she was admitted with severe fever on 2.6.2008 at SVIMS, Thirupathi and doctors prescribed the MAT Test on 10.6.2008 at Tamilnadu Veterinary University, Madhavaram, Chennai for detecting the Leptospirosis and the result came positive. In the course of treatment in SVIMS, she died on 14.6.2008. Further, the statement of SBI Life authorities that the cause of death is directly attributable to the pre-existing medical condition was completely false and not proven by doctors.

The Complainant sent a letter dt. 25.4.2009 and also informed over phone that he was not in a position to attend or depute representative for the personal hearing arranged on 29.04.2009 and hence the complaint is disposed on merits on the basis of written submissions.

All the documents submitted were perused.

It is observed from the Discharge Summary of SVIMS, Thirupathi (hosp.no:330055) that the life assured was admitted in Urology dept. on 10.6.06 and then shifted to Nephrology on 10.10.2006 and was discharged on 25.11.2006. The diagnosis was End stage Renal Disease (post renal allograft nephrectomy status), hypertension, cardiomyopathy with LV dysfunction, Cervical Tuberculous lymphadenopathy, Peripheral vascular disease – crural.

The case summary of Dept. of Nephrology, states that she is a known patient of end stage renal disease and hypertension on regular haemodialysis underwent right side renal allograft transplantation on 12.6.06.Subsequently she had graft arterial thrombosis and she underwent graft nephrectomy and external iliac artery thrombectomy on 22.6.06 by urologists and vascular surgeons. She also underwent of right brachio cephalic AV fistula surgery by urologist on 28.7.06.

The case summary of Dept.of Urology states that the life assured was operated on 12.6.2006 for Kidney transplantation, operated on 22.6.2006 for Graft Nephrectomy + External iliac artery thrombectomy, operated on 4.7.2006 for Exploration + Clot evacuation of RP haematoma; operated on 28.7.06 for creation of AV Fistula Rt.Upper limb and was discharged on 4.10.2006. The diagnosis was ESRD/HTN/CRF. The case summary also reveals that she underwent surgery for AV Fistula creation in December, 2004 in OGH, Hyderabad. Since then, she had been under Haemodialysis and referred to Urology for renal Transplantation.

The Complainant also admitted in his letter dt.25.4.08 that she underwent Nephrectomy in June 2006 but she was continuously attending her official duties after discharge from hospital till death.

The policies of insurance are contracts of Utmost Good Faith and both the parties to the contract shall disclose all material facts to the other. It is clearly established that the insured did not disclose all material facts.

It was therefore, upheld the decision of repudiation of claim on the policy by the Insurer, SBI Life Insc.Co.Ltd., as conveyed by their letters dt.6.10.2008 and 25.10.2008.

The complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0520-2008-09

Smt.J.Kanaka Ratnam

Vs.

LIC of India, Divisional Office, Visakhapatnam

Award Dated: 30.4.2009 **Award No: I.O. (HYD) L- 05-2009-10**

The complaint is about the repudiation of claim on Policy No.693523021 by LIC of India, Divisional Office, Visakhapatnam.

Shri J.Krishna, 51 years took a Unit Linked policy "Bimaplus", for a sum assured Rs.50,000 from LIC of India, which commenced from 30.09.2004 and he died on 2.10.2004, within 2 days.

When the complainant claimed for the monies under the policy, the insurer, LIC of India, rejected the Claim on the policy on the plea that the life assured had suppressed the facts and also made false statements and withheld material information regarding his health at the time of effecting the assurance.

The complainant states that the life assured paid the premiums till death. She had dependent daughters to look after and requested for the settlement of the claim.

Both the parties were heard in a personal hearing held on 29.4.2009 and all the documents submitted to us were perused.

It is observed that the life assured had undergone the Ultrasound abdomen as per the report dt.28.6.2004 conducted by Visakha medical Centre on referred by Deepthi Nursing Home, ID No:014118. The impression was Mild Hepatomegaly with Fatty Infiltration.

From the Outpatient slip Sl.No.29224 of Govt.Hospital, Visakhapatnam he was admitted on 2.10.04 and he died on 2.10.04 and the cause of death was Cardio respiratory arrest due to Post GE ARF with shock with Pulmonary edema.

It is also observed that the repudiation letter dt.31.3.2008 issued by Divisional Office, Visakhapatnam stating that the answers to Q.11 a,c,d,e,i,j,h in the proposal dt.30.9.04 are false, is not correct, as the proposal form No:300BP(NM) does not contain those questions at all.

However, the answers to question No.6 regarding health details of life to be assured are misrepresented and the life assured did not disclose the material information in assessing the risk on his life, by the Insurer. As the contracts of insurance are of Utmost Good Faith, each party to the contract, has to disclose all material information to the other.

It was informed by the representative of the Insurer that they had settled the bid value of the Units amounting to Rs.5,670=36 by cheque no.548237 dt.21.3.2009.

It was therefore, held that the repudiation of sum assured on the policy by the LIC of India is proper and fully justified and the case does not require my intervention.

The complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-016-530 -2008-09

Smt.JN Radhika

Vs.

Shriram Life Insc.Co.Ltd., Hyderabad

Award Dated:: 5.5.2009 **Award No: I.O.(HYD) L- 06-2009-10**

The complaint is about the repudiation of claim on Policy No.LN100700167966; LN100700167972 & LN 100800057593 by Shriram Life Insc.Co.Ltd.

Shri J. Yogananda Naga Raja Prasad aged 43 yrs, took two policies each for Rs.1,25,000 sum assured, with bearing LN100700167966 & LN100700167972 under Single premium of Rs.1,00,000 on each policy, by submitting two proposals both dated 15.11.2007, from Shriram Life Insc. Co. Ltd. Subsequently he took another policy for Rs.1,50,000 sum assured under Single premium by payment of Rs. 30,000, with bearing no:LN100800057593 by submitting a proposal dt. 27.03.08 from the Insurer. The risk cover on these policies had commenced from 28.11.2007, 28.11.2007 ; 28.3.2008 respectively. The Life assured died on 27.04.2008 due to heart attack.

When the complainant claimed for the monies under the policy, the insurer, Shriram Life Insc.Co.Ltd. admitted the claims on all the three policies for fund value and settled the fund values as communicated by their letter dt. 28.07.08. When represented for the payment of the Sum assured by letter dt. 22.10.2008 the Insurer informed her by letter dt.20.11.2008 that from their investigation report it was understood that the life assured was a smoker and also alcoholic and these habits were not disclosed by the life assured at the time of applying for insurance on 15.11.07 and on 27.03.08. It was also stated

that “on humanitarian grounds an Ex-gratia payment as mentioned below has been settled and not the full sum assured.”

The complainant states that they were paid net asset value only on the policies. On contacting the office for the difference, they were informed that the claim was not genuine and that the amount paid was purely on ex-gratia basis, the reason being the policyholder was a smoker and alcoholic. The Life assured was a teetotaler and was not addicted to any habits. They (even from the minor child), were made to give in writing that the LA was a smoker and alcoholic. But the Life assured was not a smoker and alcoholic, and he is the only breadwinner, and he had invested all the money in Shriram Life. These letters were obtained by misrepresentation and misleading them to believe that it is required to settle the claim.

Shri J.Yogananda Naga Raja Prasad had taken 3 policies of “Shri Plus” with Shriram Life Insc.Co.Ltd., as detailed below:

Pol.No.	Proposal date	Date of comm.	Sum Assured	Single Premium paid
LN 100700167966	15.11.2007	28.11.2007	Rs.1,25,000	Rs.1,00,000
LN 100700167972	15.11.2007	28.11.2007	Rs.1,25,000	Rs.1,00,000
LN 100800057593	27.3.2008	28.3.2008	Rs.1,50,000	Rs. 30,000

The Life assured died on 27.04.2008 due to heart attack.

Both the parties were heard in a personal hearing held on 29.4.08 and all the documents submitted were perused.

It is observed from the letters dt.28.7.2008 of Shriram Life Insc.Co.Ltd. that they admitted the claims for fund value on all the above three policies and accordingly, an amount as detailed below were paid:-

Policy No.	Fund Value	Cheque No.	Date	Amount
LN 100700167966	Rs.89,192=00	042188	28.7.08	Rs.89,192=00
LN 100700167972	Rs.88,969=00	042187	28.7.08	Rs.88,969=00
LN 100800057593	Rs.29,215=00	042186	28.7.08	Rs.29,215=00

When represented by letter dt.22.10.2008 by the complainant, the insurer, by their letter dt.20.11.08 clarified that during their investigations, it was understood from the report that he was a smoker and

also alcoholic. Those habits were not disclosed by the life assured at the time of applying for insurance. Therefore, on humanitarian grounds, an ex-gratia payment had been settled and not the full sum assured.

It is very clear that the Insurer, Shriram Life Insc.Co.Ltd. while admitting the claim, in the first instance, did not make it clear that they are denying the sum assured on the policies, but only stated that they admitted the claims for fund value. How could the Insurer, take a decision to admit the fund value alone without taking a decision on payment of Sum assured? And if a decision was taken on payment of Sum assured, why the same was not communicated to the complainant, in letter dt. 28.07.08. The insurer, as if settling the entire claim payment, acted smartly, stating that the claim was admitted for fund value.

While denying the sum assured, the Insurer should also follow the IRDA regulations of intimating about the Grievance Redressal Machinery within the Company to the complainant.

Only after receipt of a representation dt. 22.10.08, the insurer, clarified that the payments were settled on ex-gratia basis, considering on humanitarian grounds. There is no proper explanation as to why in the first letter dt .28.07.08 it was not mentioned as ex-gratia by the Insurer? It is observed that even in their second letter dt. 20.11.08, the Insurer, failed to inform the complainant to the grievance redressal machinery i.e. O/o Insurance Ombudsman.

The insurer could not produce any concrete evidence about the health or habits of the life assured, excepting the statements obtained from Minor daughter & wife of the life assured, stating that the life assured used to take drinks & cigarette in functions. They totally relied upon the investigation report stating that the life assured was having habits of drinking and smoking. The investigation report is not based on any evidence.

It was also admitted by the representative of the Insurer in the hearing that they had not obtained any report on moral aspects of the life assured from their agent at the time of considering the proposals for insurance. Further the representative also informed in the hearing that they got conducted another investigation on 21.4.09 and a report of investigation report dt. 29.04.09 was submitted to us on 29.04.09. I observe that the second investigation also could not fetch any conclusive proof excepting giving their opinion that the life assured was a thorough alcohol abuser/smoker. This is a self serving report tailor made to suit their convenience after admission of complaint in this office and hence cannot be taken into consideration.

It is very sad to note that the Insurer, perhaps knowing that the rejection of Sum assured is baseless, got conducted another enquiry, after registration of complaint by this Office. The Insurer is hereby instructed not to conduct any enquiry, in future, in cases when the complaint is registered by the Ombudsman Office. The Insurer is also instructed to adhere to the IRDA regulations in intimating the clients about the grievance redressal machineries operating within and outside their jurisdiction, in all their communications. The Insurer must also note to communicate specifically about the decision of denial of the death benefits on the policy, in future.

The insurer's letters dated 28.07.2008 are very categorical that "the Competent Authority has "admitted the claim." After admitting the claim they have no authority or justification to restrict it to only the fund value . If the claim is not admissible they should have repudiated the same and if it was decided to pay ex-gratia it should have been clearly stated so in the letters dated 28.07.08 and not as an after thought in response to the representation.

In view of the foregoing, it was held that the Insurer after admitting the claim should have paid the sum assured. Accordingly, the complaint is allowed and the insurer is directed to pay the full sum assured on all the three policies.

The complaint is allowed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0585-2008-09

Smt.Sheela Malvade

Vs.

LIC of India, Dharwad

Award Dated: 20.5.2009 **Award No: I.O. (HYD) L- 07-2009-10**

The complaint is about the repudiation of claim on Policy No.637291986 by LIC of India, Dharwad Divisional Office.

Shri Vivek Malavade, aged 47 yrs., submitted a proposal dt.10.1.2005 to LIC of India and obtained a policy for a sum assured of Rs.1,20,000 which commenced from 13.1.2005 and he died on 26.9.2006 due to Myocardial Infarction.

When the complainant claimed for the monies under the policy, the insurer rejected the claim, on the plea that the life assured had suffered from Hypertension and Diabetic Merllitus since 4 years for which, he had consulted a medical man and had taken treatment from a hospital. He did not disclose these facts in his proposal and gave false answers to the questions in the proposal.

The complainant contended that they disagree with the decision of the Insurer and it is their right to claim the policy.

Both the parties were called in a personal hearing on 19.5.2008 and heard and all the documents submitted to us were perused.

In the present case, the insurer repudiated the claim on the basis of B and B1 obtained from the Rly.Hospital, and his repudiation letter dt.20.3.2008 stated that the life assured was suffering from Hypertension and Diabetes Mellitus since 4 years. The repudiation is done by the Insurer, simply stating that the answers to Personal History of Q.No.11 a,b,d,e,I were false and the life assured made incorrect statement and withheld correct information regarding his health at the time of effecting the assurance.

The provisions of Sec.45 are applicable in the case and the insurer should prove that the information withheld was material; the life assured knew it at the time of taking insurance and also he proposed the insurance with a fraudulent intention.

Though the information given in format B and B1 by the Rly.Hospital is a material one, whether the life assured it at the time of proposing for insurance and also with a fraudulent intention he proposed, are not clearly established by the insurer. In the claim enquiry report, it is stated that 'no evidence is available about diabetes". Hence, the repudiation of claim is not fully justifiable and so, the LIC of India is directed to pay an amount of Rs.60,000 to the complainant as Ex-gratia.

Hyderabad Ombudsman Centre

Case No: L-21-002-0434-2008-09

Smt.Parvathamma

Vs.

SBI Life Insc.Co.Ltd. Mumbai

Award Dated: 20.5.2009 **Award No: I.O. (HYD) L- 08-2009-10**

The complaint is about the repudiation of claim on Policy No.86000045305 by SBI Life Insc.Co.Ltd.

Shri HM Chikkegowda, aged 41 yrs. Had enrolled himself into State Bank of Mysore Swadhan Group Policy, for a sum assured of Rs.1,00,000 by submitting a Declaration of Good Health and the risk cover on his life commenced from 1.12.2006 and he died on 19.3.2008.

When the complainant claimed for the monies under the policy, the insurer rejected the claim, on the plea that the life assured was a known case of IHD and HTN and was taking thrombolytic therapy before 5 yrs. prior to the commencement of risk.

The complainant contended that the life assured was in good health at the time of joining the scheme and he had suffered from heart attack only at the time of death.

Both the parties were called in a personal hearing on 19.5.2008 but the complainant did not attend the hearing and so the hearing was held ex-parte and the complaint is contended on merits on the basis of the submission in the complaint.

As per the clinical history report of Adichunchanagiri Hospital and Res.Centre, Nagara (IP 63707) Form – S2, the life assured was a known case of Ischamic Heart disease and Hypertensive, previously on thrombolytic therapy 5 years back and had previous heart failure attacks. He was on treatment for the condition previously, discontinued from 3 months ago. The past history stated was he was known case of IHD and HTN on treatment, but stopped 3 months ago.

The life assured gave a declaration of good health dt.13.10.2006 stating that he was in sound health and had never suffered or have been suffering from hypertension (blood pressure), which is not true and enrolled himself into the Group Policy.

Hence, the repudiation of the claim by the Insurer, SBI Life Insc.Co.Ltd. for suppression of material facts is justified fully and therefore, the complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-002-0612-2008-09

Smt.Suvarna Mallappa Akki

Vs.

SBI Life Insc.Co.Ltd. Mumbai

Award Dated: 20.5.2009 **Award No: I.O. (HYD) L- 09-2009-10**

The complaint is about the repudiation of claim on Policy No.83001000203 by SBI Life Insc.Co.Ltd.

Shri Mallappa S.Akki enrolled himself in a Group Policy "Super Suraksha for the borrowers of Housing Loan of State Bank of India; from SBI Life Insc.Co.Ltd. by submitting a declaration of Good Health dt.23.8.04, and the policy commenced from 23.8.2004. At any point of time, the death benefit would be the outstanding loan amount under the loan account. He died on 13.10.2006 in a road accident.

When the complainant claimed for the monies under the policy, the insurer rejected the claim, on the plea that the life assured had been suffering from Ischaemic Heart Disease and Triple Vessel Disease from 17.12.1998 prior to the commencement of risk, and that the Life assured was a known case of Diabetes Mellitus.

The complainant contended that the life assured died on 13.10.06 due to injuries caused in a road traffic accident and all the premiums on the policy were paid. But the insurer repudiated the claim saying that the reason of death is directly atgtributable to the pre-existing medical condition, is false.

Both the parties were heard in a personal hearing on 19.5.2008 and all the documents submitted were perused.

Shri Mallappa S.Akki met with a road accident on 9.10.2006 and was treated in Shakuntala Memorial Hospital, Hubli and died there on 13.10.2006. The report of Sri Jayadeva Institute of Cardiology, Bangalore (Cardiac Catheterisation Angiography and other interventional procedure report) Angio No.12334 IP No: 77356 dt.17.12.98 clearly stated the clinical diagnosis of the life assured as IHD and Triple Vessel disease and Coronary Angiogram was done and the life assured was advised medical line of treatment. Further, the outpatient slip of Shakuntala Memorial Hospital and Res.centre, Hosur, Hubli states that the life assured was a known case of diabetes. The life assured gave a declaration of good health dt.23.8.04, suppressing the above material facts and enrolled himself into the Group Policy. Therefore, the Insurer, SBI Life Insc.Co.Ltd. is fully justified and the complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0578-2008-09

Shri Jahnavi a/s Vaishali M.KarekarVs.

LIC of India, Divisional Office, Shimoga

Award Dated: 20.5.2009 **Award No: I.O. (HYD) L- 010-2009-10**

The complaint is about the repudiation of claim on Policy No.622415708 by LIC of India, Divisional Office, Shimoga.

Shri Manjunath R.Karekar, had taken a policy No.622415708 for a risk cover of Rs.5,00,000, which commenced from 28.12.2005 from LIC of India and he died on 13.7.2006 due to Heart attack.

When the complainant claimed for the monies under the policy, the insurer rejected the claim, on the plea that the life assured had not disclosed the particulars of his earlier policies and if disclosed, they would have called for Medical examination and also special reports like Chest ECG, Haemogram and

Elisa for HIV and only after considering the same, they would have apprised the risk on his life. Due to non-disclosure, the policy was given under non-medical scheme. .

The complainant contended that the life assured was very healthy and never had any health problems. He fell down from the staircase while getting down and expired on the way to the hospital.

It was observed from the documents that the Police registered a case and post-mortem was also done. The life assured, on his business tour, died on 13.7.2006. The final report of Dept.of Forensic Medicine states that the cause of death could be due to syncope as a result of myocardial infarction, consequent upon atherosclerotic changes in one of the anches (arteries) supplying heart.

The insurer came to know that the life assured had already 3 policies nos.632602893; 634239105, 663527474 which c commenced from 28.3.99; 28.3.2004, 21.12.2005 respectively, for a sum assured of Rs.50,000, Rs.6,00,000 and Rs.75,000 respectively. It is also observed that the policies were taken at Belgaum, Jamkhandi and Gulbarga branches.

Both the parties were heard on 19.5.2008, and all the documents submitted to us were perused.

Normally if a party seeks insurance at a place other than his residential place, it should be discouraged by the Insurer, as the moral hazard aspect is high and there is very less scope for verification of all his statements about his health and habits, income etc.

In the present case, the life assured was a resident of Goa and had taken policies at Belgaum, Jamkhandi and Gulbarga and all were accepted by the Insurer. Besides, the present policy was propose4d at Shimoga and the insurer had taken all precautions such as Moral Hazard report by their Asst.Br.Manager (Sales) before accepting the proposal.

The investigation conducted by the official of the insurer dt.28.10.2006 did not reveal any adverse factor about the health of the life assured. It is informed that all the claims on these 3 policies were considered under the Chairman's guidelines and exgratia of 50% of the sum assured was also paid.

The contention of Insurer that they would have called for a Medical report and other special reports such as ECG,Haemogram and HIV report, had he disclosed about the previous policies in his proposal dt.25.12.2005 for proper appraisal of risk, is fully justified. He is fully justified in repudiating the claim, due to non-disclosure of history of previous policies, as there was no proper appraisal of risk by them.

But, since the insurer accepted the risk at a place other than the residential place of the life assured and the MHR given by their ABM(S), could not elicit the history of previous policy information and any adverse factor of the life assured and also their claim investigation report officer could not get any adverse factor about the health of the life assured, LIC Of India is directed to pay an amount of Rs.10,000 to the complainant, as ex-gratia.

The complaint is partly allowed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0532-2008-09

Shri S.Malyadri

Vs.

LIC of India, Divisional Office, Nellore

Award Dated: 20.5.2009 **Award No: I.O. (HYD) L- 011-2009-10**

The complaint is about the repudiation of claim on Policy No.841643910 by LIC of India, Divisional Office, Nellore.

Smt.S.Lakshmi, 28 years, W/o Shri S.Malyadri took a policy No.841643910 from LIC of India, for a risk cover of Rs.50,000 with accident benefit of equal amount and the policy commenced from 28.8.2004. She died in a mysterious way and her body was identified by her mother in a putrefied state. The Insurer, LIC of India, settled the basic Sum assured and denied the accident benefit on the policy.

When the complainant claimed for the benefit under the policy, the insurer rejected the claim, on the plea that the cause of death is not established as accident.

The complainant contended that the life assured died in accident, by falling down from the train.

The complainant did not attend the hearing but the insurer was present and the hearing was done ex-parte.

It was observed from the documents that the Police found a dead body in a putrified state and during the course of investigation, the mother and sister of the life assured identified the body as the life assured. The body was in a highly decomposed state of condition, as per the certificate given by the Sub Inspector of Police, Singarayakonda P.S.

The Post Mortem certificate dt.12.8.06 of Area Hospital, Kandukur states that the rib cage of the body showed some fractures on left side. Hyoid bone is fractured. The cause of death was reserved pending report for further forensic investigations.

It is observed from the report of AP Forensic Science Laboratories dt.23.11.2006 that they finally concluded as no poisonous substance is found. The expert opinion certificate dt.4.9.2006 gave the opinion as under:-

"On examination Post Mortem loosening of the both greater comue of Hyoid Bone with the body. There is no ante mortem or Post-mortem Fracture of examined Hyoid Bone, the Hyoid Bone is intact."

The Sub Inspector of Police, Singarayakonda submitted a report to the Magistrate, S.Konda stating that

the final opinion cannot be given, as the body was in highly putrefied state and the death might have occurred 7-10 days prior to his examination and hence requested to drop further action in the case.

All the police records, Forensic reports were silent as to the cause of death and the Insurer, waived the investigation and taken a decision to reject the claim taking the basis of all these reports.

When the cause of death is not expressed by the Police, the Insurer should have conducted an enquiry into the matter and obtained the facts and then should have come to some conclusion. In the absence of cause of death expressly mentioned either by the Police or by the Insurer, it was proper to give the benefit of doubt to the complainant, and hence, the Insurer is directed to pay the Accident Benefit under the policy.

The complaint is allowed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0613-2008-09

Shri B.Raja Suresh

Vs.

LIC of India, Divisional Office, Kadapa

Award Dated: 10.6.2009 **Award No: I.O. (HYD) L- 12-2009-10**

The complaint is about the repudiation of claim on Policy No: 653816891 by LIC of India, Kadapa Divisional Office.

Smt.B.Anila Kumari, aged 28 years W/o Shri B.Raja Suresh submitted a proposal for insurance for Rs.1,00,000 and obtained a policy bearing no:653816891. The policy commenced from dating back to 5.4.05 and the life assured died on 11.5.06 due to heart attack.

When the complainant claimed for the benefit under the policy, the insurer, LIC Of India rejected the claim, on the plea that the life assured was having congenital heart disease and was admitted in SSSIMS, Puttaparthy on 2.12.05 prior to the date of proposal dt.15.12.05.

The complainant contended that the life assured was healthy and gave the proposal papers and money to the agent in the month of April 05 but the agent used the money and finally paid on 15.12.05. Their marriage was a love marriage and their elders were not willing. They made her to apply leave on medical grounds and they married after the expiry of medical leave.

Both the parties were heard and all the documents submitted were perused.

The Complainant stated that the premium and all the relevant proposal papers were signed and submitted to the agent Shri M.Satyanarayana, in the month of April 2005 but the agent submitted the same in the month of December, with date of proposal dt.15.12.05. But the policy risk was commenced from 5.4.05 and the agent convinced them accordingly, for the delay in submission of papers. The complainant further stated that their marriage was a love marriage and their elders were not willing to it. They therefore, made her to apply sick leave from 13.10.04 to 10.11.04 but she did not avail any treatment. He further stated that she was quite healthy at the time of submitting the proposal papers in April 2005 to the agent and it is the agent's fault that he submitted late to the Insurer. The agent convinced them showing that the risk already commenced from 5.4.05 by LIC of India. The claimant also produced a marriage certificate issued by Panchayat Office, Pedapalli stating that Shri Raja Suresh was married with B.Anil Kumari on 12.11.2004.

The Insurer, LIC of India obtained B, B1 forms from Satya Sai Institute of Medical Sciences, Puttaparthy. The B1 format states that the date of first time treatment as an out-patient was on 2.12.05 and the nature of ailment was Congenital Heart Disease.

It is observed from claim form E that the employer had furnished the periods of absence of the deceased employee on Medical grounds as under:

1 From 13.10.2004 to 10.11.2004
2 From 23.12.2005 to 20.1.2006
3 From 3.2.2006 to 22.2.2006

The Employer did not mention about the nature of illness and details of medical certificate produced by the employee, for those periods and the Insurer also did not obtain the details of illness/treatment taken during these periods.

The agent who introduced the case to the Insurer had stated that he knew the life assured since a year but did not give any adverse report about the health of the life assured.

It was informed in the hearing by the representative of the Insurer that the Insurer had called for the explanation from the Agent but did not receive the same from him. The insurer instructed the branch manager by their letter dt.3.6.09 not to solicit new business from the agent and not to release any commission till agent submits his explanation in writing.

Since the life assured had consulted the SSSIMS, Puttaparthy on 2.12.05, i.e. prior to the date of proposal 15.12.2005 it was held that the action of the Insurer, LIC Of India is fully justified technically in repudiating the claim on the policy, but taking a sympathetic view, LIC Of India is directed, to refund the premiums paid on the policy to the complainant, as ex-gratia. It is also suggested that an enquiry be made as to the facts and if the agent is found guilty, serious action be initiated against him, as he knew the life assured since a year and was not aware of her illness and treatment by SSSIMS and recommended the case for acceptance.

The Complaint is partly allowed.

Hyderabad Ombudsman Centre

Case No: L-21-004-0601-2008-09

Smt.M.Sarojamma

Vs.

ICICI Prudential Life Insc.Co.Ltd.

Award Dated: 22.6.2009 **Award No: I.O. (HYD) L- 13-2008-09**

The complaint is about the repudiation of claim on Policy No: 04892845 by ICICI Prudential Life Insc.Co.Ltd.

Shri Motakatla Penchal Reddy, aged 22 yrs. submitted a proposal dt.19.3.07 to ICICI Prudential Life Insc.Co.Ltd. and obtained a policy bearing no:04892845 for a risk cover of Rs.2,50,000. The policy commenced from 25.3.07 and after payment of 2 Yly premiums @Rs.50,000, the life assured died on 9.10.08 due to heart attack.

When the complainant claimed for the benefit under the policy, the insurer, ICICI Prudential Life Insc.Co. rejected the claim, on the plea that the life assured was treated by Dr.S.S.Ahmed and his father Dr.S.A.Khaleel Basha since childhood for Epilepsy, fever etc. as outpatient and these facts were suppressed in his proposal for insurance.

The complainant contended that the life assured died due to heart attack on 9.10.08 but the insurer repudiated the claim saying that he was suffering from Epilepsy since childhood, which is false. The life assured was hale and healthy and never suffered from Epilepsy.

After hearing the case from both the parties and perused all the documents, it is observed observe that the Agent Shri M.Sivanarayanareddy is the brother in law of the life assured and it is revealed in the proposal form. In such cases, to eliminate the moral hazard, independent enquiries have to be made by another person thoroughly and basing on the report, the Insurer shall accept the risk. But the Unit Manager who gave the Client Confidential Report could not elicit the true condition of health of the proposer, past/present illnesses suffered, treatment being taken since childhood, in his enquiries since the life assured had been stated suffering from the epilepsy since childhood i.e. for the last 22 years as on the date of the proposal. It is clear that the Unit Manager has not made any independent enquiries about the health and income of the assured.

It is also observed that the investigating official could not get any document/record from the Doctors who are postgraduate physicians at Kadapa, and who are stated to have given treatment for years

together for epilepsy and fever. They submitted a document dt.3.12.08 from Dr.S.Suhail Ahmed, Khaleel Nursing Home that the life assured was treated by him and by his father for epilepsy as an outpatient since childhood and also a letter dt.3.12.08 that the life assured was brought dead to their hospital on 9.10.08. No other proof such as prescriptions etc. could be submitted by the Insurer, though in the investigation report reference is made to other Doctors at Kadapa who purportedly treated the life assured for years together.

Though the repudiation of claim by Insurer, ICICI Prudential Life Insc.Co.Ltd. is justified on the grounds of non-disclosure of facts by the life assured but due to the lapses of Insurer, the Insurer is directed to refund the fund value of units as on the date of death to the complainant, as Ex-gratia.

The Complaint is partly allowed.

Hyderabad Ombudsman Centre

Case No: L-21-009-0502-2008-09

Smt.E Subhadra

Vs.

Bajaj Allianz Life Insc.Co.Ltd., Pune

Award Dated:: 16.6.2009 **Award No: I.O.(HYD) L- 14-2008-09**

The complaint is about the repudiation of claim on Policy No: 0088260198 by Bajaj Allianz Life Insurance Co.Ltd.

Shri T Rangappa, submitted a proposal dt.30.1.08 to the Corporate Agent of the Bajaj Allianz Life Insc.Co. and also submitted a DD for Rs.12,000 dt.30.1.08 towards the first premium. The Insurer issued a policy bearing no:0088260198 for a sum assured of Rs.4,08,000 with Accident Benefit. The policy commenced from 23.2.08 and the life assured died on 17.2.08 in a road accident, prior to the commencement of the policy.

When claimed for the monies, the Bajaj Allianz Life Insc.Co. rejected the claim, on the plea that the policy was issued on 23.2.2008 and by then the proposer died in road accident and thus made the contract as Unconcluded contract. They refunded the premium paid of Rs.12,000 on 4.8.08.

The complainant contended that the life assured submitted the proposal dt.30.1.08 along with the first premium DD of Rs.12,000, drawn on Andhra Bank, Bangalore. But the policy was issued by the Insurance co. with effect from 23.2.2008, more than 3 weeks after submission of the proposal. The proposal forms were routed through Ernestine Consultants Pvt.Ltd. (ECPL) and the papers reached the Insurance co. on 20.2.08. The proposal papers were lying unprocessed at the end of ECPL. Bajaj Allianz

Life Insc.Co.Ltd. claims that ECPL was their channel partner/Corporate Agent. For any acts of delay or omissions on the part of their Channel Partners/Agents, the Insurer is responsible, since they are acting on his behalf. The claim is unjustly rejected by the Insurer, without ascertaining the reasons as to when and where the proposal form was lying. The Insurance policy should have been issued within a reasonable period of 7-10 days from the date of application. As the delay in issue of the policy cannot be attributed to the delayed submission of the proposal from our side, the rejection of claim is unjust. She pleaded to examine all the facts and render justice in the case.

After hearing the case ex-parte and perused all the documents, it is noted that from the zerox copies of proposal papers, it is evident from the inward date seal that the insurer received the papers on 20.2.2008 and the same were processed and the policy commenced from 23.2.2008 and the policy document was also dispatched on 26.2.2008.

The insurer came to know that the life assured was not alive as on the date of commencement of policy, only from the death intimation given.

The contract of insurance will be concluded only when the party to whom an offer has been made accepts it unconditionally and communicates his acceptance to the person making the offer. Silence does not denote consent and therefore, no binding contract arises until the person to whom an offer is made says or does something to signify acceptance of it. Mere delay in giving an answer cannot be construed as an acceptance, as prima facie, acceptance must be communicated to the offerer.

In this case, the complainant could not produce any acknowledgement of receipt of papers by the Corporate Agent. Even then, the delay in reaching the proposal papers to the Insurer cannot be attributed to the Insurer as his delay, as the agent acts on behalf of the proposer, till the submission of papers to the Insurer and it is the responsibility of the proposer to ensure that they reach the insurer immediately on submission, without any delay, and he should also obtain the authentic receipt for the remittance he tendered, from the Insurer.

The life assured was not alive as on the date of commencement of policy nor even on the date of receipt of the proposal papers by the insurer and hence I hold that it is an Unconcluded contract and the action of the insurer to refund the First Premium, canceling the policy is fully justified.

It is regretted that no representative was present from the Insurer, to defend the case.

The complaint is dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-009-0021-2009-10

Shri Shaik Basheer Ahmed

Vs.

Bajaj Allianz Life Insc.Co.Ltd., Pune

Award Dated: 22.6.2009 **Award No: I.O. (HYD) L- 15-2008-09**

The complaint is about the repudiation of claim on Policy No75580180 by Bajaj Allianz Life Insurance Co.Ltd.

Shri Shaik Noor Ahmed, 56 yrs. Aged submitted a proposal dt.19.11.07 and obtained an insurance policy from Bajaj Allianz life Insc.Co. for a sum assured of Rs.60,000, this commenced from 7.1.2008. The life assured died on 9.2.2008.

When claimed for the monies, the Bajaj Allianz Life Insc.Co. rejected the claim, on the plea that the life assured had history of Rheumatic Heart Disease – Mitral Stenosis for the last 20 years and he consulted as Outpatient in October 2007 for Mitral Stenosis, in Usha Mullapudi Cardiac Centre and these facts were not disclosed in his proposal for insurance.

The complainant contended that the life assured was in good health condition. He was body builder of AP State and he is GYM Fitness coach also. They could not get him to hospital aid, as he expired within half-an-hour while changing his dress in house. But the company rejected the claim stating that the life assured had a history of heart disease from last 20 years, which is false.

After hearing the case on 10.6.2009 in which the insurer was absent, the case was decided on merits. All documents submitted were perused. It is noted that LIC of India settled claims on three policies on 28.3.2008 and another Insurer ING Vysya Life Insc. Also settled the claim on policy for Rs.1,50,000 on 25.8.08 but this Insurer, Bajaj Allianz Life Insc. Co. rejected the claim on the policy.

From the document dt.17.1.08 – Discharge summary from Ushal Mullapudi Cardiac centre , it was evident that the life assured was admitted on 17.1.08 and got discharged on 18.1.08 and it states that the life assured was a known case of RHD-MS for the last 20 years. He was also seen in their OPD in October 2007 and found to have severe mitral stenosis (patient had DOE NYHA II + orthopnea + PND) with normal LV function. He was advised to undergo PBMV. He was diagnosed as CAD-Double Vessel Disease.

The contracts of Life insurance are contract of Utmost Good Faith and both the parties shall disclose all material facts, in full. Here in the case, the life assured had not disclosed the illness and the consultation of Usha Mullapudi Cardiac centre as outpatient prior to the date of the proposal. Hence, the repudiation action by the Insurer is just and hence the complaint is **dismissed**. The Insurer is advised to appear before the Ombudsman and defend his cases in future and also to submit proper and detailed self contained notes with supporting documents instead of brief and telegraphic type ones as in this case.

Hyderabad Ombudsman Centre

Case No: L-21-001-199-2009-10

Smt.Sk.Mahaboob Bee

Vs.

LIC of India, Divnl.Office, Kadapa

Award Dated: 20.7.2009 **Award No: I.O. (HYD) L- 16-2008-09**

The complaint is about the repudiation of claim on Policy No653285636, by LIC of India, Divisional Office, Kadapa.

Shri Sk.Ismail, aged 50 yrs submitted a proposal dt.18.1.2004 for an assurance of Rs.50,000 to LIC of India and obtained a policy bearing no:653285636 with date of commencement 28.1.2004 for a term of 10 years. He died on 1.7.2006 due to heart disease.

When the complainant claimed for the benefit under the policy, the insurer LIC of India. rejected the claim, on the plea that the policy was under lapsed condition as on the date of death of the life assured. Further, they stated that the life assured absented to duties on Medical grounds during 1.1.2001 to 31.12.2001 and 1.1.2003 to 31.12.2003, prior to the date of proposal and did not disclose these facts in the proposal and also that the life assured absented from the duties during 25.5.04 to 9.9.04 and from 1.1.2006 to 30.6.2006 unauthorisedly for which period the wages were not drawn and as a result, the premiums were not recovered and remained unpaid, resulting lapsation of the policy.

The complainant contended that the life assured was working in APSRTC, Nandyal as Driver and APSRTC used to pay LIC premium. It was the duty of RTC department to pay the premiums regularly to LIC of India. Further, she stated that it not correct that the life assured was absent to the duties on medical grounds from 1.1.2001 to 31.12.2001 and 1.1.2003 to 31.12.2003, prior to the date of proposal. And also that it is incorrect that he absented for duties during the period 25.5.2004 to 9.9.2004 and from 1.1.2006 to 30.6.2006 for which period the wages were not drawn and premiums were not recovered and remain unpaid. She stated that from 10.9.2004 he attended the duties and he was not educated and so, the APSRTC is expected to pay the premiums from the salary of him. It is the duty of the employer to pay the amounts and if it is not paid, the LIC is entitled to recover the amount from the employer. She admitted that the life assured went on medical grounds from 1.1.2006 to 30.6.2006 and died on 1.7.2006 and so it is the duty of the employer to pay the premiums and stated that no LIC policy would be lapsed for six months and it is not so long a period to lapse this policy.

After hearing both the parties, and all the documents submitted were perused, It is observed from the certificate of employer claim form E ® dt.20.11.2007 that the life assured last attended the duties on

8.1.2006 and from the statement of record of absence during the period from 1.1.2001 to 31.6.2006 he availed sick leave and absented without pay, prior to the date of proposal, as below:

1.1.2001 to 31.12.2001 -- 8 days sick leave on Medical grounds (Sick certificates destroyed)

-- 37 days absent without pay

1.1.2002 to 31.12.2002 -- 12 days absent without pay

1.1.2003 to 31.12.2003 -- 7 days sick leave on Medical grounds (Sick certificates destroyed)

-- 5 days absent without pay

Further the employer stated that (i) the life assured was under un-authorised absence from 25.5.2004 to 9.9.2004 and wages were not drawn, (ii) the life assured was under un-authorised absence from 9.1.2006 to 30.6.2006 and wages were not drawn.

It was also noted that there were intermittent unpaid premiums in the month of July 04 and September 04; and also from Feb.2006 to June 2006 premiums, and hence, the policy got lapsed due to the unpaid premiums of 7 monthlies, which fell due up to the date of death.

The complainant's argument that the employer is responsible to pay the premiums when the life assured was on leave on medical grounds from 1.1.2006 to 30.6.2006, and also that the insurer, LIC of India to recover the amount from the employer, is not tenable, as he was on unauthorized absence and no wages were drawn during the period.

It is further noted that the claims on three other policies of LIC, bearing nos: 651590887, 65159004 and 651594004 were settled by them, on ex-gratia basis.

It was also informed by the representative of LIC of India that the claim on this policy could not be considered by them on ex-gratia under the Chairman's guidelines, as the premiums were not received at least for a period of 2 years.

In view of the unpaid premiums and the lapsation status of the policy as on the date of death, it was held that the repudiation of claim by LIC of India is proper and the complaint is therefore, dismissed.

Hyderabad Ombudsman Centre

Case No: L-21-001-0594-2008-09

Smt.S.Peeramma

Vs.

LIC of India, Divisional Office, Kadapa

Award Dated: 30.6.2009 **Award No: I.O. (HYD) L-17 -2009-10**

The complaint is about the repudiation of claim on Policy No 653955742 by LIC of India, Divisional Office, Kadapa.

Shri Sunkesula Chinnaiah S/o Chowdaiah, aged 41 years took a policy of insurance from LIC of India, by submitting a proposal dt.4.5.06 under Non-Medical scheme and the policy commenced from 5.5.06. He died on 6.2.07, within one year, due to chest pain.

When claimed for the monies, the Insurer, LIC Of India, rejected the claim, on the plea that the life assured gave false answers to Q.No.11 a,b,c,d,e,l,j of the proposal dt.4.5.06 and he suffered from Malarial fever and had taken treatment in a hospital prior to date of proposal. Further, he was on medical leave as on the date of proposal and he did not disclose all these facts in the proposal.

The complainant contended that the life assured availed sick leave on some urgent personal work when no other leave was available for him. He had not suffered with any ill health.

Both the parties were called for a personal hearing and all the documents submitted were perused.

Hyderabad Ombudsman Centre

Case No: L-21-001-0614-2008-09

Shri J.Anjaneyulu

Vs.

LIC of India, Divisional Office, Kadapa

Award Dated: 30.6.2009 **Award No: I.O. (HYD) L- 18-2008-09**

The complaint is about the repudiation of claim on Policy No: 653691382 by LIC of India, Divisional Office, Kadapa.

Shri J.Anjaneyulu, aged 39 years submitted a proposal dt.3.10.2005 to LIC of India and obtained a policy for an insurance of Rs.1,00,000. The policy commenced from 4.10.05 and the same is lapsed due to non-payment of premiums. The policy was revived on 23.10.06 by payment of arrears of premia and

also by submission of Personal Statement of Health dt.23.10.06 by the Insurer and the life assured died on 27.10.06, within 4 days after revival. The nominee under the Policy is his brother.

When the complainant claimed for the benefit under the policy, the insurer, LIC Of India rejected the claim, on the plea that the life assured was suffering from Pulmonary Tuberculosis and had taken Treatment for the same on 8.12.2004, prior to the date of the proposal, which fact was suppressed by him.

The complainant contended that that their native place was Velpanur but some 15 yrs. Back they left that place and shifted to Velugodu. His brother was staying with him. They enquired at Velpanur and took the decision. However, the Insurer settled claim on another policy 652982228 wherein the wife of the deceased was nominee and rejected the claim on policy 653691382 wherein he is nominee

Both the parties were heard in personal hearing and all the documents submitted were perused.

It is observed that the proposal was booked by a Chairman's Club Member Shri Syed Meervali, Agent Code 6265H under Non-medical basis; who also witnessed the Personal Statement of Health dt.23.10.06 for revival. The policy was revived with arrears of premia of 2 Hly. on 23.10.2006. The Agent by his letter dt.nil states that the life assured himself got the revival done on 23.10.06 by visiting the branch office and he was recommending the settlement of the claim.

It is also observed that there are two claim enquiry reports entrusted to two different Branch Managers of Atmakur (K) branch, for two different policies, separately. One official gave a clean chit on policy 652982228 and another produced the Tuberculosis Identity Card, which states that the treatment started on 8.12.2004 for Pulmonary TB, on Policy 653691382. The Insurer settled the claim on Policy 652982228 which commenced from 27.1.03 and rejected the claim on policy 653691382.

It is further observed that the nominee is the brother of the deceased in policy 653691382, though the life assured has wife and children. The Insurer has not examined the insurable interest in the case, at the time of issuing the policy.

It is evident that the life assured suffered from Pulmonary Tuberculosis prior to the date of the proposal dt.3.10.05 and not revealed the same either in the proposal or in the Personal Statement of Health dt.23.10.06.

The contracts of Insurance are contracts of Utmost Good Faith and both the parties to the contract should disclose all material facts in full.

It was therefore, held that the repudiation of claim on the policy by the Insurer, LIC of India on Policy 653691382 is proper and I suggest to the Insurer to examine the role of the agent who recommended the proposal for acceptance and suitable action be taken against him.

The complaint is dismissed.

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-529/2008-09

Smt.Lalitha Bai A.G.

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 29.04.2009

The complainant's husband, Late P.D.Shivakumar, had taken a Unit Gain policy for an assured sum of Rs.1,00,000/- by submitting a proposal dated 10.01.2007. He died on 30.04.2008 due to Toxic Epidermal Necrolysis [TEN] and acute renal failure. The claim was repudiated on the ground that the insured was a known case of psoriasis and the policy was taken by suppressing the existence of this illness. As the policy was obtained by fraudulently suppressing material information, they are not liable to make any payment under the policy.

It was submitted by the complainant that her husband never had psoriasis nor had he taken treatment for the same any time. He was only having dandruff. The doctor told him that it was psoriasis. The claim was repudiated only on the ground that the insured was suffering from psoriasis for the last 3 years which he had not disclosed while taking policy. Hence the only question to be considered is whether the insured was having psoriasis and if so, whether he was aware of it. The hospital records produced clearly shows that there is no lesion at the time of admission. The insurer has submitted that they have no document to show that the proposer was treated in any hospital for any ailment before taking the proposal. The complainant also submitted that her husband had not taken any treatment for psoriasis before. Also it is to be noted that in the proposal form, there is no question regarding the existence of psoriasis or any skin disease. Hence it cannot be said that the insured was aware of having psoriasis and he had fraudulently suppressed the same while taking the policy. The repudiation has, therefore, to be set aside and award is passed directing the insurer to pay the sum assured of Rs.1,00,000/- with 8% interest and a cost of Rs.2,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-002-601/2008-09

A.L.Bindu

Vs

SBI Life Insurance Co.Ltd.

AWARD DATED 10.06.2009

The husband of the complainant was holding a group insurance policy of SBI Life Insurance Co.Ltd. w.e.f. 01.01.2006. He expired on 20.02.2008 due to hepatitis, while the policy was in force. The claim was repudiated on the ground that at the time of taking the policy, he was hypertensive and was under treatment for the same. Had it been disclosed, the policy would not have been issued on the same terms and conditions and hence they are not bound to honour the claim. While taking the policy, the LA had signed a declaration of health in which he has stated that he never underwent any illness nor taken any treatment for any disease. However, the insurer was able to produce evidence to show that while taking the policy, he was under treatment for hypertension. As per discharge card produced from Muthoot Hospital, he was under continuous treatment from 04.02.2005. On 01.12.2007, he was admitted in MGM Hospital. According to discharge summary, he was a known case of hypertension since 5 years. As per the records produced from Lakeshore Hospital, the immediate cause of death was hypertension. His leave records also show that he had availed 34 days leave from 15.6.2004. Hence the insurer was able to prove that at the time of taking the policy, the LA was hypertensive and he was well aware of it. As the policy has run only for 1 year and 3 months, the insurer is entitled to repudiate the claim. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-001-591/2008-09

A.Vasanthakumari

Vs

LIC of India

AWARD DATED 29.05.2009

The complainant's son, Late Shri S.Salosh Kumar, was issued a policy for an assured sum of Rs.1,00,000/- w.e.f. 28.03.2006. He committed suicide on 11.08.2006. The claim was repudiated invoking suicidal clause.

Admittedly the policy was commenced on 28.03.2006. There is no dispute to the fact that the insured committed suicide by hanging on 11.08.2006. Policy condition is very specific that death by suicide is not covered during the first year of the policy. Hence repudiation has to be upheld and complaint is to be DISMISSED.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-216/2009-10

Ally Sudhakaran

Vs

LIC of India

AWARD DATED 26.08.2009

The complaint under Rule 12[1] [b] read with Rule 13 of RPG Rules 1998 is against repudiation of a claim under life insurance policy. The complainant's husband had taken a life insurance policy from LIC of India for an assured sum of Rs.1,00,000/- w.e.f. 28.03.2006. He expired on 02.02.2008. The claim was repudiated on the ground that the policy was obtained by suppressing some material information.

The policy was issued pursuant to proposal dated 31.03.2006. In the proposal all the health related questions were answered as if the life assured was hale and hearty and he had never undergone treatment for any disease or illness. However, the insurer has produced hospital records to prove that the deceased life assured had undergone IP treatment at Medical Trust Hospital, Ernakulam from 29.12.2003 to 22.01.2004 for nephrolithiasis with hydronephrosis, hemorrhids, hepatitis, etc. But the policy was taken non-disclosing all these ailments. The insured died within 2 years of taking the policy. Hence mere suppression of material facts is sufficient to repudiate the claim. Hence the repudiation has to be upheld and complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-036/2009-10

Smt.Anandavally

Vs

LIC of India

AWARD DATED 29.05.2009

The complainant's husband was issued a policy for an assured sum of Rs.1,00,000/- w.e.f. 05.12.2003. The policy was allowed to lapse by non-payment of premium and was later revived on 27.06.2006 on the strength of a declaration of health dated 27.06.2006 by paying all arrears of premium with interest. The insured expired on 09.04.2007. The claim was repudiated on the ground that the revival was effected by submitting a false declaration of health. At the time of submitting the declaration, he was actually undergoing treatment for retroviral infection and cerebellar toxoplasmosis. But all the questions in the declaration were answered as if he was in good health and never undergone treatment for any illness. As the revival is effected by means of a fraudulent declaration, revival has to be treated as null and void and hence claim is repudiated.

The hospital records produced clearly show that at the time of revival, he was not in good health. He has undergone OP treatment on 30.11.2004 from Medical College Hospital, Thiruvananthapuram. He was admitted there on 07.01.2005 and also he was HIV positive for which treatment was taken too. Hence by no doubt it can be said that revival was obtained by fraudulent means. But it is to be noted that based on the observation of Hon.Supreme Court in Mithoolal Nayak Vs LIC of India and Hon.High Court of Kerala judgment in Sosamma Punnans Vs LIC of India, it is not possible for the insurer to repudiate a claim merely on the ground that revival was obtained by means of a fraudulent declaration. The insured had the protection of Sec.45 of Insurance Act. For interpreting Sec.45 of Insurance Act, 2 years period is to be taken only from the date of commencement and not from the date of revival. As the Hon.High Court judgment and Hon.Supreme Court judgment is very specific in this regard, the repudiation is to be set aside. An award is, therefore, passed directing the insurer to pay the death claim benefit under the policy with 8% interest p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-190/2009-10

Smt.Bindu sabu

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 30.06.2009

The complainant's husband Late T.J.Sabu had taken a Unit Gain Policy from Bajaj Allianz Life Insurance Co.Ltd. by submitting a proposal dated 14.05.2007. He expired on 12.10.2007 on account of ruptured pseudoneurysm, massive hemoptysis and cardiac shock. The claim was repudiated on the ground that the policy was obtained by suppressing material information; thereby the insurer was denied the opportunity for assessing the risk correctly. 26 years back at the age of 23, the DLA had undergone a bypass grafting and had a dilatation of aorta in 1990. The policy was obtained by suppressing this material information. As the claim is a very early claim, the DLA having died within 5 months of taking policy, and the policy was obtained by suppressing material information, they have repudiated the claim. During the time of hearing, the complainant had admitted that the DLA had undergone such treatment. But that was about 20 years before taking the policy and after that he got married and has 3 children. At the time of taking the policy, he was not having any such complaints.

The policy was issued pursuant to a proposal dated 14.05.2007 and the insured expired on 12.10.2007. Hence this is a very early claim. Non-disclosure of a material fact is enough to repudiate the claim. There is no dispute to the fact that the insured underwent bypass grafting in 1989 and dilation of aorta in 1990. These procedures were done while the insured was at the age of 23. Hence it is evident that he was well aware of these at the time of taking the policy. But all the health related questions in the proposal were answered as if he had not undergone any treatment for any ailment earlier. As the non-disclosure of material facts have been established, the death claim under the policy has to be repudiated. However, this is a unit gain policy, where a portion of the premium paid is invested in units on behalf of the insured. The claimant is eligible for the fund value of the invested amount. An award is, therefore, passed directing the insurer to pay the fund value of Rs.13,000/- with 8% interest pa and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-161/2009-10

Smt.C.Chandrika

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 30.07.2009

The complainant's husband Late Muraleedharan was issued with a New Family Gain Policy w.e.f. 28.09.2006 based on proposal dated 11.09.2006. The policy was for a sum assured of Rs.2,00,000/- with an annual premium of Rs.5,000/-. The insured expired on 18.07.2007 due to cardiac arrest and the claim

was repudiated on the ground that the policy was obtained by non-disclosing some material information. The insured had a no-healing injury on his leg and also a leg ulcer. This was not disclosed while taking the policy. As material facts have been concealed while taking the policy, the contract has become null and void and nothing is payable under the policy. It was submitted by the complainant that there was only a minor injury on his leg sustained on contact with the pedal of a bicycle. This was not material for disclosure and hence, he is eligible for claim amount.

The cause of death is cardiac arrest, sepsis, hyperkalemia and leg ulcer. The hospital records produced show that the insured had undergone treatment for renal failure. He was admitted in the hospital for a non-healing injury. Foot amputation was done as the leg was affected by gangrene. There was ulceration on the left foot too. It is clear from the hospital records that there was ulcer on the left leg for 18 years. 7 years ago, grafting was attempted, but failed. The complication had developed to such a stage as requiring foot amputation. But the policy was taken by concealing all these pre-existing ailments. The insured was well aware of all these facts at the time of taking the policy. Death occurred within one year of taking policy and hence, mere mis-representation of material facts is enough for repudiation. Hence repudiation is to be upheld. However, considering the financial condition of the claimant, an ex-gratia payment of Rs.5,000/- is awarded.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-227/2009-10

C.Surendran

Vs

LIC of India

AWARD DATED 13.08.2009

The wife of the complainant was issued with a life insurance policy for an assured sum of Rs.1,00,000/- w.e.f. 28.01.2005. After payment of 2 years premium, the policy was allowed to lapse and subsequently revived on the strength of a declaration of health by paying all outstanding premium with interest on 29.01.2008. She expired on 24.06.2008 due to breast cancer, which was diagnosed on 23.12.2005 i.e, before revival of the policy. The claim was repudiated on the ground that the policy was revived on the basis of a declaration of health which was fraudulently made. At the time of revival, the insured was aware that she was suffering from breast cancer and the same was fraudulently concealed while reviving the policy.

The complainant has admitted that his wife was suffering from breast cancer at the time of revival. Hence there is no dispute to the fact that revival was obtained by submitting a false declaration. But the

question to be considered is whether on the basis of a wrong declaration made at the time of revival, claim under a policy can be repudiated. The policyholder has the protection under Sec.45 of Insurance Act. In Mithoolal Nayak Vs LIC of India, the Hon.Supreme Court has categorically stated that merely on the basis of a wrong declaration at the time of revival, an insurer cannot repudiate claim under a policy of insurance. The same contention was reiterated by the Hon.High Court of Kerala in Sosamma Punnans Vs LIC of India. As the decision of the Hon.High Court of Kerala and the Hon.Supreme Court is binding to all tribunals in India, the repudiation of claim on the basis of a wrong declaration made at the time of revival is to be nullified. There is no point that the policy was obtained by misrepresentation of a material fact. An award is, therefore, passed directing the insurer to pay all the benefits under the policy with 8% interest and a cost of Rs.2,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-001-581/2009-10

Smt.Geetha Udayakumar

Vs

LIC of India

AWARD DATED 14.07.2009

The policy commenced on 15.02.2001 was allowed to lapse w.e.f. 05/2004 and was revived on 26.011.2004. While the policy was in force, the insured expired on 04.09.2006. The claim was repudiated on the ground that the policy was revived by submitting a false declaration. At the time of revival, the insured was under treatment of carcinoma stomach and the policy was revived by non-disclosing this material information.

The insurer was able to prove with clinching evidence that the insured was under treatment for carcinoma stomach at the time of revival. During the time of hearing, the claimant also admitted that her husband was cancer patient at the time of revival. But revival was obtained by non-disclosing this material information. On going through the specific verdict of Supreme Court in Mithoolal Nayak Vs LIC of India and High Court verdict in Sosamma Punnan Vs LIC of India, it can be seen that merely on the ground of non-disclosure of material fact at the time of revival, a claim under the policy of insurance cannot be repudiated. The claimant is eligible to get protection under Sec.45 of Insurance Act. In interpreting Sec.45 of Insurance Act, 2 year period has to be taken from the date of commencement and not from the date of revival. Here there is no case that the policy was obtained by non-disclosure of material fact on the basis of the above 2 Court verdicts and hence it is not possible to repudiate the claim.

The repudiation is, therefore, set aside and an award is passed directing the insurer to pay the sum assured of Rs.50,000/- and other benefits under the policy with interest @ 8%.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-002-035/2009-10

Jayasree Girish Babu

Vs

SBI Life Insurance Co.Ltd.

AWARD DATED 21.05.2009

The complainant's husband, Late Shri Girish Babu, had availed a home loan from SBI for Rs.8,00,000/- on 07.05.2008. On that day, he was admitted to the group insurance policy of SBI Life Insurance Co.Ltd. on the basis of a proposal submitted on the very same day. On 06.12.2008, Shri Girish expired while undergoing treatment at Mother Hospital, Thrissur. The claim was repudiated on the ground that at the time of submitting the proposal, he was suffering from liver cirrhosis and diabetes. Policy was obtained by suppressing all these illness. However, it was submitted by the complainant that her husband was of good health while taking the policy. He never had diabetes or hypertension. He was engaged in his day to day activities without any difficulty till the time he was admitted in the hospital.

The policy was issued based on a declaration dated 07.05.2008 declaring that he was of good health and never had any critical illness, diabetes, hypertension or liver disease. However, the hospital records produced show that he was admitted in Mother Hospital, Thrissur, from 29.12.2001 to 13.01.2002 and took treatment for cirrhosis of liver, hypertension and diabetes. The policy was obtained by suppressing this material information. All the questions in the health declaration was answered as if he is of good health and not taken any treatment for any illness before taking the policy. Also the employer certificate shows that he was on medical leave from 07.05.2007 to 28.07.2008. Hence it is clear that at the time of proposal, the insured was suffering from liver cirrhosis, diabetes mellitus and hypertension. As the insurer was able to prove that material facts have been suppressed, the repudiation is to be upheld and complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-089/2009-10

K.K.John

Vs

LIC of India

AWARD DATED 17.06.2009

Pursuant to proposal submitted on 31.03.2006, the complainant's daughter was issued with a Bima Gold Policy of LIC of India for an assured sum of Rs.5,00,000/-. On 23.03.2007, the insured was admitted in Lakeshore Hospital for a minor surgery and during the post operative period, she died on 27.03.2007, due to a sudden fall in BP and heart failure. The claim was repudiated on the ground that the insured was having some deformity which was not disclosed in the proposal. She was diagnosed to have some thoracic deformity due to which, she had spine imbalance and rib humb on the right side. The surgery was done to repair this deformity and the insured succumbed to death in the post-operative period. As this deformity was not disclosed in the proposal, the correct assessment of risk was not possible while issuing the policy. This being a very early death within one year proposal, the claim was repudiated. It was submitted, on behalf of the complainant, that, though she was having some deformity at the time of death, it was not known to the insured at the time of proposal. The deformity was first noticed only after submitting the proposal. The insured was a very bright student of MBBS. Hence there is no mis-representation of material facts.

The hospital records produced show that the insured was having some spinal imbalance and the disease was diagnosed as 'Adolescent Idiopathic Scoliosis'. She was also having a rib humb. The claim was repudiated by the insurer on the basis of the opinion of their Medical Referee that the illness was there from childhood and hence, the insured might be aware of the same. But it is to be noted that as per the medical reports produced, the diagnosis was Adolescent Idiopathic Scoliosis, which manifests only during adolescent age. Hence the observation of the Medical Referee is difficult to believe. The insured was first admitted in the hospital only on 22.03.2007 and there, she reported that the illness was there for almost one year. But this one year is only an approximation. By this statement, it cannot be said with certainty that the ailment was there at the time of taking policy, one year before this date. This illness usually manifests during adolescence. The insured died at the age of 19. Hence it cannot be said with certainty that the illness was there at the time of proposal. In case of ambiguity, it must be interpreted so as to advance the purpose of insurance. The purpose of insurance is to compensate the risk and not to deny it. Hence the repudiation is to be set aside and an award is, therefore, passed directing the insurer to pay the claim with 8% interest p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-049/2009-10

Smt.L.Subhaga

Vs

LIC of India

AWARD DATED 09.07.2009

The complainant's husband was issued with a life insurance policy for an assured of Rs.20,000/- w.e.f. 28.11.2008. The policy was allowed to lapse w.e.f. 28.11.2002 and thereafter, it was revived on 16.11.2006 on the strength of a declaration of health by paying all arrears of premium with interest. The insured died on 16.12.2006 within one month of revival. The claim was repudiated on the ground that the policy was revived on the strength of a fraudulent declaration of health and at the time of revival and submitting health declaration, the insured was under active treatment of carcinoma stomach.

The insurer was able to prove that the insured was under treatment of carcinoma stomach at the time of revival. At the time of hearing, the complainant also admitted that her husband was under treatment for carcinoma stomach. Hence the policy was revived on the strength of a false declaration of health. However, on going through the verdict of Hon.Supreme Court of India in Mithoolal Nayak Vs LIC of India and the verdict of Kerala High Court in Sosamma Punnan Vs LIC of India, it can be seen that it is not possible for an insurer to repudiate the claim merely on the ground that revival is obtained by a false declaration. In both these verdicts, the court has made it clear that in interpreting Sec.45 of Insurance Act, the period of 2 years is to be reckoned from the date of commencement of the policy and not from the date of revival. Hence there is no case that the policy was obtained by non-disclosure of any material fact. Hence the repudiation is to be set aside and an award is, therefore, passed directing the insurer to pay the sum assured of Rs.20,000/- and other benefits together with interest @ 8% p.a. and cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-590/2008-09

Smt.M.P.Ambika

Vs

LIC of India

AWARD DATED 20.05.2009

Late Shri K.V.Suresh Kumar, husband of the complainant, expired on 15.05.2007 as hit down by a train, while crossing the rail. At the time of death, he was having 6 policies. However, claim in respect of only 2 policies were paid and claim in respect of other policies were repudiated on the ground that, while taking the policies, existence of previous policies were not disclosed fully, and thereby, the insurer was not able to make proper assessment of risk. As this non-disclosure is a material one, they are not liable to pay claim under the policies. It was submitted by the complainant that all the policies were taken from the same branch of the insurance company and hence, existence of all these policies were known to the insurer and hence, they are not liable to disclose the fact that is known to the insurer.

The claims in respect of 4 policies were repudiated on the ground that existence of prior policies was not fully disclosed while proposing for insurance. The non-disclosure of this material information has affected the assessment of risk. It is relevant to note that the claim was repudiated within 2 years. Hence even if suppression was not a fraudulent one, the insurer is at a liberty to repudiate the claim. Only thing that is to be looked into is whether the non-disclosed fact is material to underwriting. On going through the records produced, it can be seen that in respect of Pol.No.794843643, the non-disclosure had affected the underwriting decision. Had this been disclosed, medical reports might have been called for. Instead the proposal was accepted on non-medical basis. Claim in respect of Pol.No.795196916 for a sum of Rs.5,00,000/- was repudiated on the ground that taking into consideration of policy taken from other insurance company, calling of special report became necessary. As it was not disclosed, the proposal was accepted without calling for special report. However, underwriting guidelines is very clear that policies taken from other insurance companies need not be taken for consideration for underwriting requirement. Hence the insurer is entitled to repudiate the claim under Pol.No.794843643 only. Pol.No.795197823 being a CDA policy is eligible to get premium waiver benefit.

All the policies except CDA policy covers DAB also. DAB was denied due to the fact that the LA died while crossing a railway track which is an offence. The body was found 20 meters away from the railway gate and hence the accident took place not at the railway gate, but while crossing the railway line, which is an offence. But it is to be noted that when a train running at a high speed hits a person, it is quite natural that the body is taken to a distance due to momentum of train. Hence DAB also is payable wherever applicable.

An award is, therefore, passed directing to pay basic sum assured, DAB and vested bonus in all policies except 794843643 and 795197823 and allow premium waiver benefit under Pol.No.795197823, with a cost of Rs.5,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-086/2009-10

Mini Suban

Vs

SBI Life Insurance Co.Ltd.

AWARD DATED 17.06.2009

The complainant's husband, Late Subin Mathew, was issued a policy w.e.f. 07.05.2007 on a single premium of Rs.9,468/- on the basis of a proposal dated 24.07.2007. On 22.06.2008, he expired due to cirrhosis of liver and portal hypertension. As the claim was repudiated, she approached this forum for justice. In the complaint, it is stated that her late husband never had any complaint of liver cirrhosis and the cause of death is not known to her.

The LA expired within one year of taking the policy. Hence the claim is liable to be repudiated if there is non-disclosure of material facts at the time of taking the policy. The insurer has produced IP case sheet of Caritas Hospital. The LA was hospitalized in from 01.09.2004 to 03.09.2004 for alcoholic cirrhosis and hypertension. The hospital records show that he was in the habit of taking alcohol in excess. But in the proposal form, all health related questions were answered as if he is of good health and never taken treatment for any illness. It was also stated that he was not alcoholic. The policy was obtained by suppressing material information. It was submitted by the insurer that had it been disclosed, they would not have issued the policy at the same terms and conditions. Hence this is a fit case for repudiation. The complaint, therefore, stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-285/2009-10

P.T.Vikramakumar

Vs

LIC of India

AWARD DATED 27.08.2009

The complainant's wife, Late C.R.Santha, had taken a policy for an assured sum of Rs.1,00,000/- fro LIC of India, w.e.f. 21.02.2006. She expired on 22.11.2007. The claim raised was repudiated on the ground that policy was obtained by suppressing some material facts. At the time of taking the policy, she was under treatment of liver disease and also she died due to chronic liver disease. As policy was obtained by non-disclosing material information, the contract has become null and void and hence, the claim was repudiated. It was submitted by the complainant that as he had recently married, he was not aware of his wife's past illness. The policy was taken after medical examination satisfactory to the insurer.

The insured died within 2 years of taking the policy. Hence mere suppression of material fact is only sufficient to repudiate the claim. The policy was issued on 21.02.2006. The insurer has produced treatment records from Parathuvayalil Hospital. There it is stated that she had treatment from that hospital from 13.09.2006 and before taking treatment from there, she had undergone treatment from other hospitals too. The patient's case history shows that she was having the disease since 1 ½ years. It looks that she continued treatment there till October 2006. Apart from that, she has been suffering from jaundice also. But all the questions in the proposal form were answered as if she was of good health and never taken treatment for illness before taking the policy. As non-disclosure is evident from the hospital records produced, this is a fit case for repudiation and the complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-004-338/2009-10

Paul Panthalookaran

Vs

ICICI Prudential Life Insurance Co.Ltd.

AWARD DATED 30.09.2009

In pursuance of proposal submitted on 19.12.2006, the complainant's wife was issued with a 'Life Time Super' Life Insurance Policy w.e.f. 14.02.2007 for an assured sum of Rs.1,25,000/-. While the policy was in force, she expired on 29.04.2008 on account of SLE. The claim raised was repudiated on the ground that the policy was obtained by suppressing material facts. It was submitted by the insurer that the insured was suffering from SLE since 20 years and was on treatment for the same. They produced medical reports from Lisie Hospital, which shows that she was under treatment for SLE since 1988. She was

admitted at Lisie Hospital from 15.11.2000 to 31.01.2001 and taken treatment for the same. The policy was taken by suppression of material facts. During the course of hearing and also in the complaint, it was submitted by the complainant that his wife was having SLE in 1988 but the same was fully cured. After that, she had even undertaken foreign tour. Till its onset again at the time of her death, there was no symptom of the illness.

The fact that the insured was having SLE before taking the policy was admitted. But in the proposal form, all health related questions were answered as if she never had any illness nor taken treatment for the same. As non-disclosure is evident from the records produced, the repudiation is to be upheld. However, this is a unit linked policy where a portion of premium is invested in units. Insurance coverage is only for sum assured in excess of fund value. Even if the claim is repudiated, it will affect only the risk portion and the invested amount will still remain in the account of the insured. Hence the complainant is eligible for the fund value. An award is, therefore, passed for payment of the fund value of Rs.41,335/- with 8% interest and a cost of Rs.2,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-203/2009-10

R.Sajikumar

Vs

LIC of India

AWARD DATED 09.07.2009

The complainant's nephew had taken a life insurance policy for an assured sum of Rs.50,000/- w.e.f. 09.12.2006. The policy was allowed to lapse w.e.f. August 2008 after paying premium for 1 ½ years. He died on 19.11.2008. The claim was repudiated as the policy was in a lapsed condition at the time of death. There is no dispute to the fact that the policy was in a lapsed condition at the time of death. Premium was paid only for 1 ½ years and hence, not acquired paid up value also. As at the time of death, the policy was in a fully lapsed condition without acquiring paid up value, the claim has to be repudiated. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/24-003-412/2008-09

Rani Thomas

Vs

Tata AIG Life Insurance Co.Ltd.

AWARD DATED 22.04.2009

In pursuance to proposal dated 27.09.2007, a policy for Rs.5,00,000/- was issued to the husband of the complainant on 05.11.2007. On 20.04.2008, the insured expired due to brain hemorrhage. The death claim was repudiated on the ground that material information was suppressed while submitting the proposal form. The medical report of Pushpagiri Heart Institute states that the life assured was hypertensive since 10 years and had dyslipidemia for 15 years and CAD for 2 years. The patient record shows a record of history of Trans Urethral Resection Therapy [TURT] for carcinoma bladder. But all the questions in the proposal were answered as if he is of sound health and never undergone any treatment for any disease. It was submitted on behalf of the insurer that had any of these illnesses been disclosed, they would not have issued policy in the same terms and conditions. They are not liable to honour the death claim, as the policy was obtained by fraudulent misrepresentation. During the time of hearing, the son of the insured also admitted that his father was hypertensive for more than 10 years. As the insurer was able to prove that material facts have been suppressed while taking the policy, they are free to repudiate the claim and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-444/2008-09

Smt.Rema Amma C.

Vs

LIC of India

AWARD DATED 24.04.2009

Pursuant to proposal dated 28.08.2002, a policy for sum assured of Rs.3,00,000/- was issued w.e.f. 28.08.2002. The policy was allowed to lapse and then revived on 08.04.2005 on the

strength of declaration of health by paying all arrears of premium with interest. The life assured died on 14.06.2007. The claim was repudiated on the ground that the revival was effected by a false declaration of health. The insured was under treatment for HCV related cirrhosis since November 2004 and he was well aware of it. Had he disclosed the same, the policy would not have been revived and hence, they are justified in repudiating the claim.

The insurer was able to prove with clinching evidence that the insured was under treatment for HCV related cirrhosis since November 2004. It is true that the policy was revived on the basis of a wrong declaration of health. The insured was well aware of this and hence, the non-disclosure is fraudulent and intentional. The revival is obtained by non-disclosure of material facts. However, on going through the Supreme Court verdict in Mithoolal Nayak Vs LIC and also Hon'ble High Court of Kerala verdict in Sosamma Punnan Vs LIC, it can be seen that a policy of insurance cannot be repudiated merely on the ground that the revival was effected by misrepresentation. The policyholder is eligible to get the protection of Sec.45 of Insurance Act 1938. In interpreting Sec.45, the period of 2 years is taken from the date of commencement of policy and not from the date of revival. There is no case that the policy was obtained by non-disclosure of material facts. Hence the repudiation is to be nullified and an award is, therefore, passed directing the insurer to pay the sum assured of Rs.3,00,000/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-052/2009-10

S.A.Rahiyana

Vs

LIC of India

AWARD DATED 30.07.2009

The complainant has taken a life insurance policy for an assured sum of Rs.75,000/- by submitting a proposal on 26.03.2006. On 04.05.2007, he died due to stomach cancer. The claim was repudiated on the ground that the insured expired due to a pre-existing disease and at the time of taking policy, he was very much aware of the illness. Aggrieved by the repudiation, he approached this forum.

It was submitted by the insurer that the LA died due to carcinoma. He was diagnosed to have stomach cancer, hypertension, bronchial asthma and tuberculosis. He had undergone total gastrectomy on 27.06.1998. But these facts were not disclosed in the proposal. All the health related questions were answered as if he was in good health and never undergone treatment for any illness before taking the policy. The insurer produced copy of discharge summary from KMC Hospital, Manipal, wherefrom he had undergone gastrectomy. As the insurer was able to prove with clinching evidence that at the time of taking the policy, the insured was a cancer patient and was undergoing treatment for the same, the repudiation has to be upheld. The complaint, therefore, stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-526/2008-09

S.Ramankutty

Vs

LIC of India

AWARD DATED 08.05.2009

The complainant's wife was issued with a life insurance policy for an assured sum of Rs.30,000/- w.e.f. 15.07.2003. The policy was allowed to lapse w.e.f. 15.04.2005 and was later, revived on 16.12.2006 by remitting all arrears of premium with interest, on the strength of a declaration of health. On 20.01.2008, the insured died and the claim was repudiated on the ground that at the time of revival, the insured was a cancer patient and she was undergoing treatment for the same. As the policy was revived by suppressing this material information, they have repudiated the claim under the policy, treating the revival as null and void.

Hospital records produced shows that at the time of revival, the insured was a cancer patient. Surgery of breast was done at Medical College Hospital on 12.10.2006. The policy was revived on 16.12.2006 by non-disclosing this material information. The insurer was able to prove with clinching evidence that the revival was effected by non-disclosing material information. At the time of revival, she was under active treatment for breast cancer. Hence revival was obtained on fraudulent means. However, it is to be noted that on going through the verdict of Supreme Court in the case of Mithoolal Nayak Vs LIC of India and the judgment of High Court of Kerala in Sosamma Punnan Vs LIC of India, a claim on the policy of insurance cannot be repudiated merely on the ground that revival was obtained by fraudulent means. In interpreting Sec.45 of Insurance Act, 2 year period is to be taken from the date of commencement of policy and not from the date of revival. There is no case that the policy was obtained by fraudulent

means. Hence the repudiation is to be revoked and an award is, therefore, passed directing the insurer to pay the sum assured of Rs.30,000/- with bonus, interest @ 8% p.a. and cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-001-441/2008-09

Shereena Nazar

Vs

LIC of India

AWARD DATED 24.04.2009

The complainant's husband was issued with a policy for Rs.2,50,000/- w.e.f. 17.08.2003. The quarterly premium due 17.05.2007 was not paid even during grace period ending on 17.06.2007. The same was paid at 13:36 hrs. on 04.07.2007 with interest; by the time, the insured died at 11:30 hrs. The claim was repudiated on the ground that at the time of death, policy was in a lapsed condition. The premium was paid after the death and there is no provision to revive a lapsed policy after the death of the insured. It was submitted by the complainant that her husband was admitted at the Alpha Hospital at 08:00 hrs and from there, he was referred to PVS Hospital. On the way to PVS Hospital, he died at 11:30 hrs. The only dispute is with regard to the time of death. If the insured died after payment of premium, the claim will sustain. The contention of the complainant is that the time of death given by the hospital authorities cannot be taken as proof. The hospital authorities were hostile to her, as on death of her husband, a commotion took place attributing the cause of death due to negligence of hospital. The police came to the scene and registered a complaint. The copy of the FIR was not produced by the complainant. FIR would show the exact time of the incident. In the absence of FIR, the time given by hospital authorities can only be believed. The certificate given by the hospital shows that he was admitted at 08:00 hrs and referred to PVS hospital and on the way to PVS hospital, he died at 11:30 hrs. There is no dispute to the fact that the premium is paid at 13:36 hrs i.e., after death. At the time of death, the policy was in a lapsed condition and the complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-002-286/2009-10

Smt.Sushama

Vs

SBI Life Insurance Co.Ltd.

AWARD DATED 27.08.2009

The complainant's husband had taken a home loan from SBT. While availing loan, he was admitted to a Home Loan Insurance Policy of SBI Life by paying a single premium of Rs.11,941/-. The sum assured under the policy is outstanding loan amount as on the date of death. On 17.07.2006, the insured expired. The claim was initially repudiated on the ground of non-disclosure of material facts. Later on representing, the CRC has admitted the claim and the claim amount was credited to home loan account. Even after adjusting the claim amount, the complainant has to pay an amount of Rs.56,874/- towards loan. It was submitted by the complainant that the shortfall in loan amount occurred only due to delay in settlement of claim. Had they settled the claim in time, the sum assured would be equal to the outstanding loan and nothing is required to be paid towards housing loan. It was argued on behalf of the insurer that the shortfall in loan amount occurred due to default made by the insured in monthly repayment.

As per policy condition, the liability of the insurer is outstanding loan as on the date of death, had the EMI instalments have been made in time. From the records produced, it can be seen that the insured had defaulted 12 instalments. Hence as on the date of death, a higher amount has become due. This is because the insured made default in EMI payment. The 12 instalments itself comes to Rs.48,000/-. It will attract penal interest also. The insurer is not liable to make this payment arisen due to default of the insured. However, there is considerable delay in paying the claim amount. Had the EMI been paid on time, the amount of loan outstanding as on the date of death will be Rs.2,65, 269/-, which was paid by the insurer. But the complainant is eligible for interest for the delayed payment. Hence an award is passed directing the insurer to pay interest for the amount of Rs.2,65,269/- @ 7.75% p.a. from the date of claim till settlement date.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-004-034/2009-10

Smt.Swapna Vinod

Vs

ICICI Prudential Life Insurance Co.Ltd.

AWARD DATED 22.06.2009

On the basis of proposal submitted on 11.04.2007, 3 policies were taken for a total sum assured of Rs.5,00,000/-. The insured died on 27.02.2008 due to alcohol related liver cirrhosis and hypertension. The claim was repudiated on the ground that at the time of taking policy, the insured was a known alcoholic and also was suffering from liver cirrhosis. The life assured had misled the insurer in assessing the risk by deliberately giving wrong answer to the questions in the proposal. Along with the policy documents, copies of proposal forms were also sent for his rectification. He never disputed the answers given in the proposal form. Hence it is very clear that non-disclosure is intentional and fraudulent. Within 15 days of taking the policy, he was admitted in the hospital with alcohol related chronic liver cirrhosis with history of GI bleed and portal hypertension. As it takes years to reach such a stage, it indicates long term history of alcoholism.

The repudiation is made on the ground that material facts have been suppressed while taking the policy. All the health related questions were answered as if he was of good health and not taken any treatment for any illness before taking the policy. Also he was not in the habit of consuming liquor. But within 45 days of taking the policy, he was admitted in the hospital with chronic alcoholic related liver cirrhosis and portal hypertension. Hospital records show that he had previously undergone treatment for liver cirrhosis. Also he was in the habit of taking alcohol in excess quantum. The patient was brought to the hospital in a conscious state. It is likely that all the answers to the questions in the hospital records were given by the patient himself. As the insured died within 2 years of taking the policy, suppression of material facts alone is sufficient for repudiation and hence the repudiation has to be ratified. However, this being a unit linked policy, the nominee is eligible for the fund balance in the investible fund. An award is, therefore, passed directing the insurer to pay the balance fund value of Rs.1,14,670.12 under 3 policies with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/LI/21-009-324/2009-10

Smt.Thresiamma John

Vs

Bajaj Allianz Life Insurance Co.Ltd.

AWARD DATED 25.09.2009

The complainant's husband was issued with a policy w.e.f. 06.11.2007 at an annual premium of Rs.50,000/- for an assured sum of Rs.5,00,000/-. During the currency of the policy, the insured died on 11.01.2009 while undergoing treatment for CAD. 2 yearly premiums amounting to Rs1,00,000/- was paid under the policy. The claim was repudiated on the ground that before taking the policy, the insured had undergone CABG. This was not disclosed while taking the policy. The policy was obtained by non-disclosure of material facts. As this non-disclosure is willful and fraudulent, the contract is to be treated as null and void and all monies paid stands forfeited to the insurance company. Hence the request for refund of premium paid was also turned down.

In the complaint and also at the time of hearing, the complainant had admitted that her husband had undergone CABG before taking the policy. Hence non-disclosure of material fact is evident and repudiation is to be ratified. The contention of the insurer is that as the policy is treated as null and void, she is not eligible to get refund of premium paid. But it is to be noted that this is a unit linked policy where risk premium is deducted by cancelling units. Non-disclosure of material fact will not affect the savings element. Premium paid is invested in units for the benefit of the insured. Hence even if risk portion is repudiated, the nominee is eligible to get the fund value of amount held in units. From the policy condition also, it looks that on the death of the insured, either the fund value or the insured amount, whichever is higher, is only paid. If fund value is more than the insured amount, the insured amount is not paid. Hence the fund value of invested amount is bereft of the insured amount. Even if the insurance coverage is repudiated, the nominee is eligible to get the fund value. An award is, therefore, passed for payment of fund value of Rs.63,676/- with 8% interest and a cost of Rs.1,000/-.

KOLKATA

Death Claim

Kolkata Ombudsman Centre

Case No. 620/21/001/L/01/08-09

Smt. Arati Dey
Vs.
Life Insurance Corporation of India

Award Dated : 21.04.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant is the wife of Santi Ranjan Dey and nominee for his policy no. 423820020 (DOC 28.07.2003, SA – Rs.3,00,000/- T/T – 14-25, Hly premium Rs.8213/-, FUP 01/2005). The Life Assured (LA) expired on 31.08.2004 at the age of 52 years. Claim intimation was given to the insurer on 14.12.2004 but the claim was repudiated on 02.01.2007 and the repudiation was upheld by ZCRC and intimated to the claimant on 31.03.2008.

The complainant stated that her husband, a Railway Employee, died at Eastern Railway Hospital due to Cardio Vascular Arrest. The policy was in full force at the time of death. The insurer called for some outdoor treatment documents but she replied on 26.11.2005 that her deceased husband did not get any treatment facilities from the Out Patient Department of Railway Hospital. According to her, the repudiation was illegal, malafide and with ulterior intention. She felt that the insurer did not disclose what evidence they possessed about suppression of material facts. She further stated that her husband was detected as a Diabetic after 30.07.2003 (after commencement of risk). Being a poor house wife she requested for consideration of her case by this forum. She submitted P-forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

Intervention was made with the insurer and we received their Self Contained Note (SCN) dated 31.03.2009. The letter of repudiation as well as the SCN showed that the proposer's answers to Question 11 (i), (iv), (v) and (ix) in the proposal form were incorrect because the proposer suffered from Diabetes Mellitus and Hypertension and was under treatment. However, that was suppressed in the proposal. They conveyed their consent for mediation by the Ombudsman in this matter.

HEARING:

In response to a notice of hearing both the parties attended. The complainant was also accompanied by her son.

The representative of the insurance company stated that the deceased was suffering from diabetes for few years and therefore, it could be presumed that the deceased life assured (DLA) was having diabetes before the inception of the policy, as the policy ran only for 1 year 28 days. Because of this, the information given in the proposal form would be wrong as the proposer did not mention his status of health with regard to DM. Further, she has given a letter stating that the deceased has mentioned his date of birth as 1/2/1953 in his proposal form submitting School Final Certificate. However, the employer (Eastern Railway) issued a certificate in which the date of birth was mentioned as 6/1/1946 as per the service record maintained by that office. The death certificate issued by the Hospital, Claim Form B signed by the attending Physician as well as the Doctor's prescription all show age corresponding with employer's record. Therefore, the representative of the insurance company pleaded that there was almost a 7 years difference between the age mentioned in the proposal form and the service record that has been produced. According to the representative if the actual date of birth was mentioned at the

time of proposal, the determination of risk under the underwriting manual would have been different and the premium or medical requirement would have been different for higher age group policyholder. Therefore, she pleaded that there was definite suppression of material facts and therefore, claim was correctly repudiated by the insurance company.

On the other hand, the complainant stated that the DLA was not suffering from DM before the inception of the policy and that there was difference in age certificates as increased age was given at the time of joining the service. However, she pleaded that her case may be considered favourably.

DECISION:

The representative of the insurance company gave irrefutable proof that there was a difference in the date of birth as per the service record of the DLA and as per the certificate produced at the time of filling up the proposal before the inception of the policy. It is also fairly clear that the DLA was suffering from diabetes and the doctor belonging to the Eastern Railway Hospital certified that the patient was suffering from DM for a few years. However, the exact onset of suffering from DM was not mentioned in any prescriptions. The stand of the complainant that the DLA was not suffering from DM cannot be proved as they did not have any documentary evidence to prove the fact that they are insisting on.

The complainant was informed that the determination of if there has been any discrepancy in age is not within the powers of this forum as the Insurance Ombudsman does not have the wherewithal to determine the correctness of claim of age as per the proposal signed by the insured before the inception of the policy.

Keeping in view the above, we have no other alternative but to confirm the decision of the insurance company and uphold the same. In the result, the complainant does not get any relief.

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Death Claim

Kolkata Ombudsman Centre

Case No. 658/21/005/L/01/08-09

Shri Debasis Kundu

Vs.
HDFC Standard Life Insurance Co. Ltd.

Award Dated : 27.04.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant is the husband of Kanchan Kundu and nominee for her policy no. 10971505 (Unit Linked Endowment Suvidha Plan), date of issue 22.03.2007, SA – Rs.2,50,000/-, yearly premium of Rs.50,000/-, Policy term 10 years. The Life Assured (LA) expired at Cancer Centre Welfare Home and Research Institute on 16.09.2008 at the age of 49 years. The complainant submitted claim forms but the claim was repudiated by the insurer. The claimant maintained that the deceased life assured (DLA) was suffering for 9 months (i.e., after commencement of risk) and was treated at Purulia, Bokaro and Kolkata. He approached this forum and submitted P-forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

Intervention was made with the insurer and they have furnished SCN. However, it appears that the insurer, after receiving the death intimation, policy and Discharge Voucher, called for Dr's certificate who declared death of the LA. The letter of repudiation showed that on investigation they found out that the LA was diagnosed with "Carcinoma – Endometrium" prior to the issue of policy but this was not disclosed in the policy application dated 07.03.2007. They stated that the policy could not be issued on existing terms and condition had the information been provided by the proposer. Therefore, they repudiated the claim.

HEARING:

In response to a notice of hearing both the parties attended. The representatives of the insurance company stated that there was suppression of material facts with regard to the health of the L.A. as the hospital record of Bokaro General Hospital had indicated Carcinoma-Endometrium" and that the Life Assured (LA) was operated 3 & ½ years back privately. The policy ran only for little more than one year and therefore, according to them, there was certain suppression of material facts in contravention to declaration under Section D in the proposal form signed by the proposer which is as under :-

"I am in good health and free from disease or disability or symptoms thereof (relating to conditions other than minor impairments such as cold, cough or flu) and I am not receiving any regular medical treatment and have not done so in the last 12 months.

I have never been treated or told that I have diabetes/raised blood sugar, heart condition, high blood pressure, stroke/paralysis, any lung conditions, cancer, tumor or any kind hepatitis, kidney disorder, mental or nervous disorder, HIV infection or a positive test to HIV."

According to them, the above condition was breached. Therefore, they stated they were correct in taking the decision of repudiation of the death-claim.

On the other hand, the complainant stated that his wife was not suffering from any cancer and he did not remember that she had been operated three and half years back. Further, he was shown doctor's/hospital's certificate in which it was mentioned that there was a pre-existing disease called Endometrium Carcinoma 3 years back and her haematology was done in Septemeber,'05. This information was given in the claim form by the L.A.'s husband, (Shri Debasish Kundu), who was the complainant. The declaration made by him clearly indicated that she was suffering from Endometrium Carcinoma since 3 years back. However, he pleaded that the proposal form was filled-up without adequate knowledge of the health condition and therefore, according to him, claim should be considered favourably.

DECISION:

On going through the records, we find that the insurance company has produced irrefutable evidence to show that the LA was suffering from Carcinoma of Endomerium and she was operated 3 & half years back privately. This information with regard to surgical procedure and existence of carcinoma should have been mentioned in the proposal form before taking of the policy. In a recent decision in the case of P.C. Chako vs. LICI, the Hon'ble Supreme Court held that any surgical procedure or any information with regard to existence of a disease before the inception of the policy which would affect the underwriting capacity of the insurer would make the contract void or the contract gets vitiated. Respectfully following the decision of the Hon'ble Supreme Court, we do not have any other alternative but to dismiss the petition without any relief to the complainant.

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Death Claim

Kolkata Ombudsman Centre

Case No. 715/21/001/L/02/08-09

Shri Somnath Misra

Vs.

Life Insurance Corporation of India.

Award Dated : 22.05.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against less payment of death-claim.

The complainant is the father of Prerana Misra and proposer for policy no. 424028194 on the life of his minor daughter. The policy was accepted with date of commencement (DOC) : 13.11.2003 for Sum Assured (SA) Rs.50,000/- under T/T 102/18. The age at entry was 2 years – date of birth of the LA was 08.03.2001. The Life Assured (LA) expired on 21.05.2008 at the age of 7 years. The claimant stated that in spite of submitting claim papers LICI did not pay Accident Benefit (AB) and settled death-claim for Rs.12474/- only instead of full SA with bonus amounting to Rs.61250/-.

Being dissatisfied with the less payment by the insurer he approached this Forum and submitted P-forms giving his unconditional and irrevocable consent for the Hon'ble Ombudsman to act as mediator for the resolution of the complaint.

Intervention was made with the insurer but we did not receive their Self Contained Note (SCN).

HEARING:

In response to a notice of hearing both the parties attended. According to the complainant, the child died due to burn injury and therefore, the LICI should have paid full sum assured and accident benefit, if any. He also stated that the LICI did not explain to him the reasons for not paying full death-claim so far. He was unhappy that the LICI did not bother to give a full explanation by not giving the reasons while declining the claim payable.

On the other hand, the representative of the insurance company stated that the policy condition showed that risk would commence only after 2 years after the DOC or from the policy anniversary falling immediately after the attainment of 7 years of the age by the Life Assured whichever is later. According to him, in this case the child completed 7 years on 08/03/08 and the death occurred on 21/05/08 and the policy anniversary immediately after child attaining 7 years of age fell on 13.11.08. Therefore, risk would commence only on 13.11.2008 but the child died earlier. Therefore, according to him, as the child died on 21/05/08, there was no liability on the part of the LICI as policy anniversary falls on 13.11.08 and hence they stated that they have correctly repudiated the claim. However, as per the policy conditions, the proposer would get back all the premiums paid until the time of death. With regard to accident benefit, it is allowed only after the LA attained the age of eligibility i.e., 18 years of age. Therefore, according to them, AB was not payable.

DECISION:

From the reading of the policy condition, it may be stated that policy anniversary after completion of 7 years would fall on 13/11/08 and the death took place on 21/05/08. Therefore, clearly the LICI was correct in stating that the proposer was not eligible for the sum assured. Also the question of risk commencing 2 years after DOC (i.e. on 13.11.2005) did not arise since the child did not complete 7 years in age. This is a peculiar condition in the child benefit policy where risk is not covered even after 2 years from DOC and also completing 7 years in age from date of birth. Probably, this has been decided by the policy makers of the LICI keeping in view the International Medical Standards that the health parameters are available only for children beyond 7 years of age. However, keeping in view the peculiar nature of this case wherein the child died just 6 months before the policy anniversary after attainment 7 years age looks little harsh on the face of it. Keeping in view that the LICI has correctly repudiated the claim as per the policy conditions, we propose to grant a small ex-gratia payment to meet the ends of justice. Therefore, we direct the LICI to pay an amount of Rs.20,000/- on or above the refund of the premium already made. However, no accident benefit is eligible.

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Death Claim

Kolkata Ombudsman Centre

Case No. 714/21/001/L/02/08-09.

Smt. Shaibya Roy

Vs.

Life Insurance Corporation of India.

Award Dated : 22.05.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant is the wife of Pradip Kumar Roy and nominee for his policy no. 416298694 with date of commencement (DOC) : 28.04.2004 for Sum Assured (SA) Rs.1,00,000/- under T/T 107-20 (15). The Life Assured (LA) expired on 08.11.2005 at the age of 36 due to a bus accident near Pailan. The nominee submitted claim intimation and after scrutiny it was revealed by the insurer that the due premium for 07/2005 was deposited on the date of death at 1.43 p.m. while death occurred at 11.20 A.M. As per version of the claimant the premium was handed over to their agent in cash 2 (two) days before the date of deposit. But the claim was repudiated by the insurer and there was no risk at the time of death as the premium was not deposited during his lifetime.

The nominee appealed before the LICI higher authorities stating that she was living in distress along with her three minor children as her husband was the only earning member of the family. But the repudiation was upheld by the ZCRC. So, she approached this forum for the Insurance Ombudsman to act as a mediator for the resolution of the complaint. She has also submitted the P-forms.

The insurer stated in their Self Contained Note (SCN) that they had repudiated the claim as policy no. 416298694 was accepted in the month of January 2005 by way of adjusting three quarterly instalments with DOC : 28.04.2004. The policy was dated back the date of proposal being 15.1.2005. Insurer verified the payment particulars and found that the policyholder died at 11.20 A.M. on 08.11.2005 and the quarterly premium due on 07/2005 had been deposited on the date of death of LA at about 1.43 P.M. As the duration of the policy was within one year and the last premium was outstanding for more than a month, it was in lapsed condition. So the claim was not payable and the same had been repudiated by the insurer. The insurer submitted the consent for the Insurance Ombudsman to act as a mediator between the complainant and the insurer.

HEARING:

In response to a notice of hearing both the parties attended and the complainant was represented by her brother-in-law.

The representatives of the insurance company stated that the premium was due on the above mentioned policy in July, ’05. The premium was not paid within one month grace period offered as per the policy condition. But the assured paid the premium before the expiry of 6 months on 08/11/05 with late fee (without requirement of DGH) at 1.43 p.m. However, unfortunately, the insured died at 11.20 a.m. on the same day. Therefore, according to them, there was no risk existing at the time of death of the assured. Therefore, according to them, they have correctly repudiated the claim as there was no policy cover at the time of risk.

On the other hand, the representative of the complainant has stated that they paid the premium due along with the interest to the agent and the agent did not pay the amount in due time. She further stated that it was not possible for the agent to know that the death of the LA occurred and that the premium amount was paid to the insurance company without the knowledge of the death of the

assured. Therefore, she pleaded that there was no fault on the part of the of the assured and the nominee should not suffer. Since premium was deposited at LIC Office though death occurred only 2 hours before on that day (as death certificate indicated time of death as 11.20 a.m.), and the person paying the amount was unaware of the death, she pleaded that her case should be considered favourably and sympathetically.

DECISION:

From the evidence available it can be seen that the policy was in lapsed condition at the time of death at 11.20 a.m. on 08/11/2005 as premium was paid only at 1.43 p.m. on that day. The reason given by the representative of the complainant that the money was handed over to the agent for payment of the premium but could not produce any concrete evidence of that contention. Therefore, we are unable to agree with the arguments that the assured/representatives of the assured were not responsible for delay in payment of premium. The fact remains that there was no life risk under this policy at the time of the death of the deceased. Therefore, we have to agree with the LICI that the repudiation of the claim has been done according to the policy conditions. However, keeping in view that there is a possibility that the agent could have paid the premium within 2 to 3 hours after death of the assured without knowing the actual happening of the evidence of the death could be a matter that should be taken into consideration in favour of the complainant. Keeping in view this, it is felt that certain amount of ex-gratia payment would meet the ends of justice. Therefore, we hold that repudiation was correctly done and treating this case as rarest of rare cases where death occurred a few hours before the payment of the premium we propose to grant an ex-gratia payment of Rs.1,00,000/- to the complainant.

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Death Claim

Kolkata Ombudsman Centre

Case No. 717/21/001/L/02/08-09.

Smt. Minati Sasmal

Vs.

Life Insurance Corporation of India.

Award Dated : 22.05.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant is the wife of Sanat Kumar Sasmal and nominee for his policy no., 426326914 with Date of Commencement (DOC) 28.11.2004 for Sum Assured (SA) Rs.85,000/- under T/T 14/09. The Life Assured (LA) expired on 11.12.2007 at the age of 64 years at CMRI due to "Cardio arrest in a case of Pneumonia and ARDS". The nominee submitted claim forms but, after investigation, the insurer repudiated the claim alleging suppression of material facts.

The nominee appealed before the LICI higher authorities stating that had she any malafide intention she would not hand over all the treatment papers of the Deceased Life Assured (DLA) to the insurer. But the repudiation was upheld. So she approached this forum and submitted P-forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

They stated in the letter of repudiation and also in the Self Contained Note (SCN) that they had evidence that the DLA was suffering from COPD and Hypertension prior to 11/2002 (i.e. before submission of proposal). He also suffered from acute exacerbation of COAD requiring ventilatory support, Bilateral Sensory Neural Hearing Loss and Hypertension in the year 2000. They submitted discharge summary of Woodlands Hospital and medical documents in support of their opinion. According to them, the LA did not mention these pre-existing diseases in the personal history column in the proposal form which amounted to suppression of material facts. So, they repudiated the claim.

HEARING:

In response to a notice of hearing both the parties attended. The complainant was represented by her son.

The representative of the insurance company stated that they had irrefutable proof to show that the complainant was suffering from COAD as per the discharge summary given by Woodlands Hospital in November,'02. Further, he has also suffered from acute exacerbation of COAD requiring ventilatory support, bilateral sensory neural hearing loss & hypertension in the year 2000. According to him, the proposal form did not contain any information with regard to the previous treatment and suffering from any disease by the Life Assured. Hence, he stated that the LICI was correct in repudiating the claim as there was suppression of material facts.

On the other hand, the representative of the complainant has stated that it was true that his father suffered and was treated in the hospital but according to him, at the time of taking the policy he was in good health and the insurance company took medical reports before granting him the policy. Hence, he pleaded that non-mentioning of disease should not stand in the way of the payment of the claim. Therefore, he prayed for favourable consideration of the payment of the claim.

DECISION:

From the documents submitted by the insurer in the form of a discharge summary for treatment at Woodlands Hospital between the 26/11/2000 and 06/02/2000 it can be found that the assured was diagnosed as under :-

"1. ACUTE EXACERBATION OF COAD REQUIRING MECHANICAL VENTILATORY SUPPORT.

2. BIOLATERAL SENORI-NEURAL HEARING LOSS.

3. HYPERTENSION.

Various Pathological tests were done and MRI report was suggestive of congenital block vertebrae at C2, C3 & C4 levels with scoliosis and degenerative changes in the cervical spine. The same Dr. also treated him on 30.01.2002. So it appears that the problem was persisting and the LA should have been aware of his illness.

The proposal papers did not indicate any of the diseases or treatment in the personal history and therefore, it can be held that the policyholder was in the knowledge of the disease and treatment before signing the proposal form and that he did not mention the same for the reasons of his own. It is absolutely certain that if these diseases and treatment were mentioned in the proposal form, the insurer would not have agreed to give the policy at the age of 60/61. In a recent decision by the Hon'ble Supreme Court in the case of P.C. Chako vs. LICI, it has been held that suppression of material facts with regard to medical procedure or surgical procedure or not mentioning of any disease which may affect the contract of insurance - insurance contract automatically gets vitiated.

Keeping in view the above decision of the Hon'ble Supreme Court of India from the evidence available , it can be seen that the policyholder did not indicate the treatment he had undergone and the diseases he had suffered which would affect the contract of insurance between the policyholder and the insurance company. Obviously, the insurance company would not have issued any policy to this policyholder. Under these conditions, we hold that the LICI was correct in repudiating the claim. Therefore, we have no other alternative but to dismiss the petition without any relief to the complainant.

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Death Claim

Kolkata Ombudsman Centre

Case No. 780/21/001/L/03/08-09

Smt. Gouri Mandal

Vs.

Life Insurance Corporation of India

Award Dated : 12.06.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant, Smt. Gouri Mandal, W/o Kalipada Mandal and nominee for his policy no. 424337999, purchased from LICI/Kandi Branch with DOC : 05/11/2004 for SA of Rs.50,000/- under T/T 14/20/20, FUP 05/2007 and quarterly premium of Rs.814/- . She stated that her husband died on 28.05.2007 and since she was at Chennai Hospital for treatment of her husband, at that time she could not pay the outstanding premiums in time. She added that it was not possible for her to know the rules and regulations about the insurance claim settlement due to non-standard education and approached this Forum to consider her case sympathetically because all her deposited money was spent for the treatment of her husband and her financial condition is very poor to maintain the dependents. She has not submitted P-forms.

The insurer stated that the Life Assured (LA) took the policy from Kandi Branch for Sum Assured (SA) of Rs.50,000/- with Date of Commencement (DOC) being 05.11.2004. Premiums were paid regularly up to 11/2005 and the policy was allowed to lapse. The policy was revived on 08.09.2006 paying premium from 2/2006 to 8/2006 on the strength of Declaration of Good Health (DGH) made by the deceased on 08.09.2006. Deceased expired on 28.05.2007 FUP at death was 5/2007 and Smt. Gouri Mandal (wife and nominee) preferred the claim for death benefit.

The insurer stated that they had evidences that about four months before the revival of the policy the LA had suffered from Moderately Differentiated (Grade III) Squamous Cell Carcinoma for which he was under medical treatment and consulted two hospitals in Kolkata and had undergone Biopsy and also had undergone Radiotherapy treatment as advised by the Hospitals and he did not disclose all these facts in his said Personal Health Statement for revival on 08.09.2006 to the LICI. Instead he gave false answers without mentioning true status of his health. The insurer also stated that the DLA had made incorrect statements and withheld correct information from the Corporation regarding his health at the time of revival of the policy and hence in terms of policy contract, the claim was repudiated and accordingly, the Corporation was not liable for any payment under the above policy and all money that have been paid in consequence thereof belonged to the Corporation. The decision was conveyed to the claimant vide letter ref: KSDO/CLMS/Repd. No. 581 (07-08) Kandi/ab dated 06.04.2008. The ZCRC has also upheld the decision vide letter ref: Z/Mktg./CS/68/08-09/796 dated 20.09.2008. They gave their consent for mediation by the Ombudsman for the resolution of the complaint.

HEARING

In response to a notice of hearing both the parties attended.

The representative of the insurance company reiterated what they had stated in the Self Contained Note (SCN). According to them, the policy was revived after the assured was diagnosed with carcinoma on 8th May,'06 by the Apollo Gleneagles Hospitals which was before the revival date i.e., 08/09/06. The Declaration of Good Health (DGH) filed at the time of revival did not indicate any disease suffered by the assured during the period of lapsation of the policy. Therefore, they stated that they had correctly denied the claim.

On the other hand, the complainant stated that they had given the money in due time for the revival of the policy but it was done by the agent only w.e.f. 08/09/06. However, they did not comment about non-mentioning of the disease in the DGH.

DECISION

On going through the records it becomes abundantly clear that the assured was diagnosed on 18th May, '06 as having a tumor composed of malignant squamous epithelial cells. Later, he went through radiotherapy from 31/05/2006 to 08/07/2006. All these information should have been mentioned in the DGH before policy was sought to be revived. As this has not been done, there is suppression of material facts. If these facts had been correctly mentioned in the DGH, the LICI authorities might not have revived the policy. As this suppression of material facts affects the contract of insurance, we have to hold that the contract is vitiated and we take support from the decision given by the Hon'ble Supreme Court in the case of P.C. Chako vs. LICI decided in the year 2007.

Following the decision of the Hon'ble Supreme Court we have to agree with the decision of the LICI with regard to the repudiation of the claim. Therefore, the petition is dismissed and the complainant does not get any relief.

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Death Claim

Kolkata Ombudsman Centre

Case No. 783/24/001/L/03/08-09

Shri Chinmoy Dey

Vs.

Life Insurance Corporation of India

Award Dated : 15.06.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against non-payment of death-claim.

The complainant, Shri Chinmoy Dey, is the son of the deceased Panchu Gopal Dey and nominee for his policy no. 551587916 with date of commencement (DOC) 11.07.2001 purchased with single premium of Rs.1,00,000/- under T/T 144/00/01. The Life Assured (LA) expired on 03.02.2007. He lodged the claim with all necessary papers on 12.08.2008 at the LICI Branch, Chaibasa but till date it was not settled though several letters were submitted. The Claim Forms A & C were submitted on 12.08.2008. First letter for settlement of claim was submitted on 02.05.2008 with all documents (Xerox) including Original Policy Bond but till date there was no response from the insurer. Finally, he decided to lodge the complaint to the Insurance Ombudsman for speedy disposal of the claim and submitted P-forms giving his unconditional and irrevocable consent for mediation by the Insurance Ombudsman.

We received Self Contained Note (SCN) from the insurer on the date of hearing.

HEARING

In response to a notice of hearing only the representative of the insurance company attended. He submitted a SCN dated 6th June, '09 at the time of hearing. He stated that the final payment of the death-claim was made by cheque no. 809420 dated 06/06/09 for Rs.1,00,000/- drawn on Bank of India, Chaibasa. It is learnt that the complainant has also received the cheque from the LICI Branch.

DECISION

It is felt that no further interference is called for as the complaint has been substantially redressed.

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Death Claim

Kolkata Ombudsman Centre

Case No. 745/21/003/L/03/08-09

Shri Ram Prit Roy Vs.

Tata AIG Life Insurance Co. Ltd

Award Dated : 30.06.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant, Shri Ram Prit Roy, husband and nominee for the policy no. U 005766077 of Late Sumitra Devi who purchased the said policy from TATA AIG Life Insurance Co. Ltd on 30/05/2008

with yearly premium of Rs.20,000/- and Sum Assured (SA) of Rs.5,00,000/-. He stated that an Agent/Adviser of TATA AIG Life Insurance Co. Ltd., trapped his wife Sumitra Devi by taking her signature on a blank proposal form and filling the form in his own way and canvassing wrongly. The TATA AIG Life Insurance Co. Ltd., issued policy document in haste without conducting any medical check-up/test. He stated that his wife Sumitra Devi expired on 28/07/2008 due to failure of Cardio Respiratory System during Malarial Fever and repeated vomiting and against the death-claim the TATA AIG was ready to pay Rs.12918.82 only whereas Rs.20,000/- had been paid against premium. He made several representations to the insurer but received no response from them till date. So, he approached this Forum seeking justice as a senior citizen and pensioner like him and submitted P-forms giving his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

The insurer stated in their Self Contained Note (SCN) that Sumitra Devi (LA) was issued the policy no. U 005766077 on 30/05/2008 relying on the information furnished by the Life Assured (LA) in the application form without medical examination. The Life Assured (LA) is reported to have died of Cardio Respiratory Arrest on 28/07/2008 and the duration of policy was less than 2 months. The insurer also added that during the investigation, the husband of the LA stated that the assured was suffering from diabetes since 20 years and had high blood pressure for 10 years and despite the above, the LA had replied in negative to the questions in the application form. The company was, therefore, satisfied that the life assured had knowingly and falsely replied to the questions in the application for insurance, but for which the Company would not have issued the policy on the existing terms. The Company has therefore repudiated the claim.

HEARING

In response to a notice of hearing both the parties attended. The representative of the insurance company stated that they had irrefutable proof that the patient was suffering from DM-II, HTN & ischemic heart disease before the inception of the policy and produced as evidence a prescription given by Dr. K.K. Yadav, dated 18/03/08 which clearly had mentioned that the patient was suffering from the above ailments. Under the policy conditions, the policyholder was supposed to mention the details of health which were likely to give some information with regard to the health of the policyholder and the insurance company would have the option for calling for further tests which were denied to them. Therefore, according to them, there was suppression of material facts and hence, the Company was correct in repudiating the claim. They further stated that the policy commenced only on 30/05/08 and the death took place on 28/07/08 and the duration of the policy was only 1 month 29 days. Therefore, they have graciously agreed to pay the unit value of the investment portion of the premium which would be around Rs.12918/-.

On the other hand, when the complainant was asked whether his wife was actually suffering from DM, HTN & Ischemic Heart Disease, he stated that she was suffering from DM & HTN and did not know

what were the points mentioned in the proposal form as it was filled-up by the agent. Therefore, he pleaded that the claim may be allowed or they should at least be refunded the amount of premium paid.

DECISION

On going through the documents available on record, we find that there is irrefutable proof to show that the policyholder was suffering from DM-II, HTN & Ischemic Heart Disease and therefore, the Insurance Company was correct in declining to pay the claim. However, keeping in view the request made by the complainant and keeping in view the duration of the policy which was less than 2 months, we propose to grant an ex-gratia payment equivalent to the premium paid of Rs.20,000/- without disturbing the decision taken by the insurance company. Therefore, the insurance company is directed to pay the above-mentioned ex-gratia payment of Rs.20,000/-.

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Death Claim

Kolkata Ombudsman Centre

Case No. 21/21/001/L/04/09-10

Smt. Sakina Bibi
Vs.
Life Insurance Corporation of India

Award Dated : 16.07.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant, Smt. Sakina Bibi is the wife of Deceased Life Assured (DLA) Late Golam Mohiuddin and nominee for the policy no. 463536319. She added that her husband purchased the policy with Date of Commencement : 26/12/1998 and paid premium up to 12/2005. The policy was revived on 01/06/2006 and Life Assured (LA) died after three days i.e., on 03/06/2006. The cause of death was Nephropathy. The complainant had submitted the claim papers on January, 2007. After some days the repudiation letter was received by them. They appealed to the Zonal Manager also but no favourable decision was received by them.

She submitted P-forms along with unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for resolution of the complaint.

As per Insurance Company the policy no. 463536319 was taken by the policyholder on 26/12/1998 and was got lapsed from 12/2002 and was revived on 01/06/2006. Subsequently, the LA died on 03/06/2006

at 5.30 A.M. As per insurer, the cause of death was Nephropathy as mentioned by the Nursing Home in the Death Certificate. The certificate showed that DLA was suffering from Diabetes and Nephropathy. As per the Declaration of Good Health (DGH), their DMR, the DLA had not indicated suffering of any disease. So, according to the insurer, the DLA deliberately suppressed the material facts to cheat the LIC.

HEARING:

In response to a notice of hearing both the parties attended. The representatives of the insurance company have stated that the policy commenced on 26/12/98 and was in the lapsed condition from December, 2002. The policy was revived on 01/06/06 and the Life Assured (LA) expired on 03/06/06 two days after revival. According to them, the DGH did not indicate that he was suffering from any kidney disease but the death certificate indicated that the DLA was suffering from diabetes & nephropathy. They felt that the kidney disease could not have developed within three days. Therefore, they were correct in repudiating the claim. However, they further stated that the LA received survival benefit of Rs.10,000/- before the revival and paid-up value consisted of some bonus accrued up to 12/2002 which was due to be paid.

On the other hand, the complainant stated that she was solely dependent on the agent who did not advise them properly. Therefore, she prayed that the claim may be allowed.

DECISION:

It is clear that the LA was suffering from kidney disease before the revival of the policy and the same had not been reflected in the Declaration of Good Health (DGH) submitted by the LA before revival. As the LA died within three days from revival, it is absolutely clear that the LA was in the knowledge of the disease before reviving the policy. Therefore, we have to hold that the LICI was correct in repudiating the claim. However, they are directed to pay whatever paid-up value is due to the complainant as per the policy conditions.

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Death Claim

Kolkata Ombudsman Centre

Case No. 141/24/001/L/05/09-10
Smt. Satnam Kaur
Vs.
Life Insurance Corporation of India
Award Dated : 24 .08.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against nonpayment of death claim.

The complainant, w/o of the Deceased Life Assured (DLA) ,submitted death claim intimation of her husband (death occurred on 25/03/2005). The claim was not settled in spite of several follow-ups with LICI Officials. The DLA was an employee of IISCO and this was an old SSS policy. She had not submitted the P-forms.

Self Contained Note (SCN) showed that only 10 monthly SSS premiums were adjusted. They reportedly verified the invoice of the concerned PA up to the year 1995 and there was no trace of such premium in the schedule. The insurer had not mentioned any claim investigation report or Doctor's report.

HEARING:

In response to a notice of hearing both the parties attended. The complainant was also accompanied by her brother-in-law. The representative of the insurance company submitted a Self Contained Note (SCN) dated 14/07/09 at the time of hearing and stated that they had written a letter dated 17/06/09 to the complainant requesting them to submit a employer's certificate regarding deduction particulars of premium. The representative of the complainant stated that though he had received the letter he was unable to get the employer's certificate due to the fact that his brother, who was the DLA, took voluntary retirement early. Further, he was requested to get the certificate as early as possible.

DECISION:

In the light of the claim by a poor widow, we request the employer i.e., M/s. IISCO to help the widow by issuing a certificate with regard to deduction of premiums during the service of the DLA. This would greatly help the insurance company to determine the quantum of death-claim payable. Further, we request the representative of the complainant to make efforts to get an employer certificate as early as possible.

On receipt of the employer's certificate, the insurance company is directed to settle the claim

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Death Claim

Kolkata Ombudsman Centre

Case No. 285/21/001/L/06/09-10

Smt. Basanti Devi
Vs.
Life Insurance Corporation of India
Award Dated : 14 .09.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant is the wife and nominee of the Life Assured (LA). The LA expired on 07/06/2002 and as per the wife's version he was suffering from illness (not defined) and was under treatment from 04/2002. She further stated that the proposer was in good health at the time of submission of proposal. She approached this Forum since the claim was repudiated and submitted P-forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

The letter of repudiation showed that they had indisputable proof to show that 1 ½ - 2 years before the proposal, the proposer was suffering from restlessness and palpitation which were not disclosed in the proposal form. The Self Contained Note (SCN) noted that the LA was a patient of Dilated Cardio Myopathy – C Hypertension since 18/12/1997 as evident from his Medical Attendant's Certificate who happened to be his Terminal Medical Attendant also. There was deliberate concealment of the pre-existing disease in the proposal form which influenced the underwriting decision for such high risk plan. So the claim was repudiated by their Zonal Office.

HEARING:

In response to a notice of hearing both the parties attended and the complainant was also represented by her son, Mukesh Kumar. The representative of the insurance company stated that they had irrefutable proof to show that the deceased was suffering from diluted cardio myopathy & HTN and the first consultation took place on 13/05/02. This certificate was issued by the doctor on 31/03/04 (nearly 2 years after death). Similarly, the claim Form-B indicated that the DLA was suffering from restlessness and diluted cardio myopathy for 2 years. Therefore, the insurer's representative stated that the insurance company had correctly repudiated the claim. At this juncture, the various documents were discussed with the representative of the insurance company. The repudiation letter given by the insurance company was dated 31/03/2004 in which they mentioned that the symptoms like restlessness and palpitation were existing 1 ½ years to 2 years before the death and therefore, the disease was pre-existing and hence, they held that there was suppression of material facts. The representative was informed that restlessness & dysphoria were only symptoms and they could not have been mentioned in the proposal form. Form No.5152 mentioning the disease of Dilated Cardiomyopathy was signed by the doctor on 31.03.2004. The same doctor signed Claim form-B on 29.4.2003. It is peculiar that the letter of repudiation, also dated 31.3.2004 did not mention any such disease. Further the insurance company did not collect any other documents/evidence to prove that the DLA was suffering from dilated cardio myopathy before the inception of the policy. Therefore, they were informed that they do not have adequate evidence to state that there was suppression of material facts.

On the other hand, the complainant has stated that they were not in the knowledge of any disease suffered by the DLA and the age at the time of death of the DLA was nearly 34 years. Therefore, they pleaded that the claim may be settled favourably.

DECISION:

In this case, the actual repudiation took place nearly more than 5 years back and they have confirmed the repudiation only in April, 2009. Therefore, we do not find that there is any delay in submitting the petition before the office of the ombudsman. Further, as discussed above, we do not find that there is irrefutable evidence to state that there is suppression of material facts in the proposal before taking the policy. The reasons mentioned in the repudiation letter i.e., restlessness and palpitation are only symptoms and they need not be mentioned in the proposal. Therefore, we hold that there is no evidence that has been furnished to us which would prove that there was suppression of material facts. Hence, we hold that the claim is exigible. Therefore, we direct the insurance company to pay the claim as per the terms and conditions of the policy

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Death Claim

Kolkata Ombudsman Centre

Case No. 236/21/001/L/06/09-10

Smt. Ferdausi Begam
Vs.
Life Insurance Corporation of India

Award Dated : 15.09.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant is the nominee of the Deceased Life Assured (DLA). The Life Assured (LA) had taken a policy from LICI/Howrah DO. The nominee stated that her husband had only one policy. Other than this he did not have any insurance or any other savings. So far as her knowledge, she knew that her husband's policy was in force. She was not aware of the Rules and Regulations of the policy conditions. She was intimated by the insurer that the revival of the policy had been declared as void. On the other hand, her husband was actively engaged in his work even 10 days prior to the date of death i.e. 18.02.2008. Her husband was strong and stout. There was an attack of Adeno Carcinoma as per Histopathology Report. She had 3 minor children and was in great financial crisis after the demise of her husband. She appealed to the ZCRC but the repudiation decision was upheld by the Competent Authority. So, she approached this forum seeking justice for the above grievance and has submitted the P-forms and the unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant.

The Self Contained Note (SCN) submitted by the insurer dated 24/08/2009 confirmed the fact that the policy was revived on 27/09/2007 accepting due premium since September, 2003. The policyholder died on 18/02/2008 due to Haematemasis with Malina and severe Anemia. On the basis of Claim Form B and B1 and Histopathology Report dated 16.04.2007 it had been confirmed that the DLA was undergoing treatment for Adeno Carcinoma before reviving the policy on 27/09/2007. On the basis of the sufficient documentary evidence available at their end the case was repudiated due to suppression of material information regarding health of the LA at the time of reviving the above noted policy.

HEARING:

In response to a notice of hearing both the parties attended. The representatives of the insurance company have reiterated the facts stated in the Self Contained Note (SCN) dated 24th August, '09 which was received in this office on 7th September, '09. The details of the SCN are as under.

Policy in question was taken on 28/09/2002 and was revived on 27/09/07 with a declaration of good health form. This revival was done after adjusting the amount of the survival amount (available on 28.9.2006 for in-force policy) with outstanding premium that was payable for 4 years from September, '03 to September,,'06. However, they had irrefutable proof indicating that he was suffering from moderately differentiated Adino Carcinoma with surface ulceration which was diagnosed on 16/04/07 prior to the revival of the policy on 27/09/07. These facts were not disclosed by the policyholder in the DGH. Therefore, the insurance company held that there was suppression of material facts. Hence, they stated that the claim was repudiated and according to the representatives of the insurance company the decision of repudiation was correctly taken by them.

These facts were brought to the notice of the complainant and her brother-in-law and they were informed that non-mentioning of disease that was suffered by the policyholder before revival made the contract void. The complainant pleaded that they were in financial distress and they were not knowing why the policyholder did not mention the disease he was suffering. Therefore, they requested that the claim may be considered for payment favourably.

DECISION:

From the evidence that has been placed before us it is absolutely clear that the policyholder was suffering from a disease which was not mentioned in the DGH prior to the revival. Therefore, we have to hold that the insurance company was correct in repudiating the claim. However, keeping in view the financial distress the families put to, which is felt that certain amount of ex-gratia may be granted keeping in view the certain amount of premium paid after the adjustment of survival benefit that could have been received by the policyholder. Therefore, it is felt that an amount of Rs.6,000/;- (Rupees Six Thousand Only) would meet the ends of justice keeping in view the total amount of premium paid by the policyholder.

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Kolkata Ombudsman Centre

Case No. 219/21/001/L/06/09-10

Smt. Padma Pandit
Vs.
Life Insurance Corporation of India

Award Dated : 15.09.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant is the sister of the Deceased Life Assured (DLA). The DLA had taken a policy no. 437432348 on 23.02.2006 for Rs.60,000/- under T/T 174-16 with quarterly premium of Rs.875/- only. The complainant stated that her brother was of good health since childhood and was very hardy. He played football and achieved many certificates in his childhood (Certificates enclosed). She added that her brother suffered from Endocardites only 1 ½ months prior to death. He was admitted in CMC Vellore and died of heart attack on 21/11/2007. The said claim was repudiated by the insurer on the ground that the DLA had suffered from Exertional Dysphonia since childhood. So, she approached this forum seeking justice for the aforesaid grievance and submitted the P-forms along with unconditional and irrevocable consent to the Insurance Ombudsman to act as a mediator between the insurer and the complainant.

The Self Contained Note (SCN) submitted by the insurer dated 20/08/2009 confirmed the fact that the policyholder died on 21.11.2007 due to Valvular Heart Disease, infective Endocardities as confirmed from Claim Form & B1 and CHS of CMC Vellore. They had sufficient proof that the DLA had a history of external Dysphonia Class I since childhood, which he suppressed at the time of taking the policy. The claim was repudiated due to suppression of material facts relating to history of past illness and the state of health of the LA at the time of signing the proposal.

HEARING:

In response to a notice of hearing both the parties attended and the complainant was represented by the brother of the deceased. According to the representatives of the insurance company the repudiation of the claim was correctly done and they reiterated the facts that had been stated in the SCN dated 20/08/09 received in this office on 02/09/09 . The details of the SCN are as under.

The policy in question was taken on 23/02/06 with quarterly premium that was received only up to 08/2007, the policyholder died on 21/11/07 due to valvular heart disease. The hospital authorities stated that the policyholder was suffering from dysphonia since childhood and died of Endocardites which was existing only 1 ½ months prior to death.

On the other hand, the complainant stated that the policyholder was a good sportsman and there were several achievements to his credit and various certificates had been produced as evidence of the fact that the policyholder was a good footballer. Therefore, the question of non-mentioning of Exertional Dysphonia from childhood did not arise at the time of taking the proposal. Therefore, according to the nominee of the policyholder the repudiation was not justified and they prayed for favourable settlement of the claim.

DECISION:

On going through the evidence it is clear that the policyholder had only symptoms of valvular heart disease which were in the form of exertional dysphonia and were not disclosed at the time of inception of the policy. On the evidence available it is clear that there was suppression of material facts. However, the question arose whether the policy contract would be vitiated or not due to non-mentioning of valvular heart problem which was known to the policyholder only in the form of symptoms like exertional dysphonia. However, we feel that the policyholder was only in the knowledge of the exertional dysphonia and was not in the knowledge of the cardiac disease suffered by him. Therefore, keeping in view of these facts and giving the benefit of doubt to the policyholder for non mentioning the disease in the proposal form we hold certain amount of ex-gratia payment would meet the ends of justice. Therefore, we direct he insurance company to pay an amount of Rs.30,000/- (Rupees Thirty Thousand Only) which would meet the ends of justice.

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Death Claim

Kolkata Ombudsman Centre

Case No. 080/24/001/L/04/09-10

Shri Ashok Kumr Mishra
Vs.
Life Insurance Corporation of India

Award Dated : 13.07.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The Deceased Life Assured (DLA) had taken a policy no. 437047464 under T/T 133-30 for Sum Assured (SA) Rs.1,05,000/- on 20/02/2006. The complainant is the brother of the DLA and the nominee of the said policy. He stated that his brother expired on 12/12/2006 and subsequently, he submitted all the claim forms to the insurer but the claim was denied by the Insurance Company. As per repudiation letter dated 12/09/2008, the claim was repudiated on the ground that DLA was suffering from Cirrhosis of Liver for more than one year and had taken hospital treatment for long period and the facts were not disclosed at the time of taking the policy. The complainant stated that he had appealed to the Zonal Review Committee but repudiation decision was upheld by the Higher Authorities. So, he approached this Forum seeking justice for the above mentioned grievance and submitted P-forms and consent for the Insurance Ombudsman to act as a mediator between the Insurance Company and the complainant.

The Self Contained Note (SCN) submitted by the insurer on 06/06/2009 stated that the DLA had taken the said policy on 20/02/2006 under T/T 133-30 for Sum Assured (SA) Rs.1,05,000/-. The DLA died due to Cirrhosis of Liver on 12/12/2006 when the duration of the policy was 9 months 22 days. The insurer also pointed out that the DLA had undergone treatment at Midnapore Medical College and Hospital from 02/04/2006 to 02/05/2006. The death certificate given by Dr. P.K. Dey on 12/12/2006 stated that the DLA had been suffering for the last seven months but the same doctor answered question no. 5 (c) in Claim Form 'B' about duration of disease "I think more than one year". The BHT submitted also gave a suspicion how long the deceased had been suffering from the said disease. The insurer had referred to the opinion of Zonal Medical Referee. The ZMR stated that as Dr. P.K. Dey's writing – (one in his prescription, other in the LIC paper) shows discrepancy, the first mentioned 7 months of disease and second mentioned one year of disease, it is very unlikely that the person started suffering Dyselectrolytemial /Precoma in the month of April, 2006 after he took policy Feb, 2006. So ZMR also recommended for upholding repudiation decision on the ground of suppression of material facts.

HEARING:

In response to a notice of hearing both the parties attended. The representative of the LICI has stated that the policy no. 437047464 was commenced on 20/02/06 and the assured died on 12/12/06 due to Cirrhosis of Liver. He submitted some prescription papers in which it was clearly stated that the patient was suffering from Cirrhosis of Liver and was diagnosed on 05/04/06. Therefore, according to him, as the policy commenced on 20/02/06, Cirrhosis of Liver was existing prior to the inception of the policy and these facts had not been mentioned in the proposal for this high risk product in which the nominee of the assured would get three times the assured sum in case of death of DLA. He also stated that they had paid the nominee death-claim in another policy as they could not have information that the assured was suffering from Cirrhosis of Liver for more than one year. In this case, the documents revealed that the deceased was suffering from Cirrhosis of Liver for more than one year and the policy period is less than 10 months. Therefore, he pleaded that the LICI had correctly repudiated the claim as there was suppression of material facts.

On the other hand, the complainant has stated that the assured was not in the knowledge of Cirrhosis of Liver until he was hospitalized in April, '06 and therefore, the question of mentioning the disease in the proposal form did not arise. He requested that the claim may be considered favourably.

DECISION:

From the evidence available, it is found that the deceased was suffering from Cirrhosis of Liver at least from 5th of April, '06 i.e., less than two months after the inception of the policy. Normally, the Cirrhosis of Liver is a prolonged process which does not develop within two months even in a case of a person who does not have any alcoholic habits. The circumstantial evidence in the form of taking two high risk policies out of which one has already been paid by the LICI indicates that there was an effort on the part of the insured not to indicate the disease he had in the proposal form. The evidence will tend to lead to a premise that the assured was in the knowledge of the disease and did not mention the same to avoid scrutiny by the Insurance Authorities. The mention of these diseases would have changed the underwriting capacity of the Insurance Authorities and the Insurance Company may not have issued these policies.

In a recent decision by the Hon'ble Supreme Court of India in the case of P.C. Chako vs. LICI, it has been held that suppression of material facts which will affect the contract of insurance would entail the policy contract void. Respectively, following the decision, after coming to a conclusion that the assured was in the knowledge of the disease which he was suffering on circumstantial evidence, it is felt that the insurance company was denied the right to properly underwrite the risk. Because of this denial, the policy contract has been vitiated as there was suppression of material facts. Hence, we do not have any other alternative but to dismiss the petition without any relief to the complainant.

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Death Claim

Kolkata Ombudsman Centre

Case No. 29/24/001/L/04/09-10

Smt. Indrani Gupta
Vs.
Life Insurance Corporation of India

Award Dated : 13.07.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against non-payment of death claim.

The complainant is the wife of Late Benoy Bhushan Gupta and nominee for his policy no. 416508019 with Date of Commencement (DOC) : 28/07/2004 for Sum Assured (SA) Rs.1,00,000/- under T/T : 14-15 taken under SSS Scheme.

The Life Assured (LA) went missing on 07/01/2005, Missing Diary was made with the Phulbagan P.S. and the dead body was retrieved on 09/01/2005 from Subhas Sarobar. The claimant stated to have submitted all claim papers but the claim remained outstanding. So, she approached this Forum giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

They requested the claimant to furnish certified copies of Final Report of UD Case No. 31 dated 09.01.2005 of Phulbagan P.S. with C.E.'s observations. They furnished Self Contained Note (SCN) dated 06/07/09 stating that as per their information, it was a case of death by drowning and in spite of several reminders, the claimant did not furnish Police Final Report. The case remained pending since it was very difficult to ascertain whether the death was suicidal or accidental in nature. They also gave their consent for mediation by the Ombudsman.

FURTHER FACTS

The Insurer apparently accepted the death of the LA and the identity of the claimant. It is found from records that they received premium up to 01/2005 against the policy although some amount was kept in deposit under wrong policy no. 41650809. So, the policy was in full force at the time of death. However, death occurred within six months from DOC in mysterious condition. The insurer kept the decision pending since Suicide Clause of one year from the date of acceptance might be applicable in this case of unnatural death. However, Phulbagan P.S. certified on 25/07/05 that no case was reported there. Police FIR and Final Report did not mention any suicide or homicide. PMR noted that the death was due to the fact of drowning and ante-mortem in nature. All these reports mentioned death of an unknown male of 50 years of age which tallies with the Policy Master. There was a missing diary in respect of the DLA and LICI did not question the identity of the deceased. They also could not produce any document in support of suicide and the claim remained pending for more than four years.

HEARING:

In response to a notice of hearing only the representatives of the insurance company attended. The complainant did not attend. However, the agent of the complainant who is not normally allowed to attend the hearings has submitted all the documents that are required for processing the claim.

The representatives of the Insurance Company have stated that they could not finalize the settling of the claim due to lack of several documents which have not been received by them.

DECISION:

In the paragraph under "Further Facts" it has been mentioned that there was no clear indication with regard to committing of suicide by the Life Assured. However, it was recorded that the LA whose identity had not been questioned had died due to drowning i.e., unnatural death. There is no proof to show that he committed suicide. Therefore, it is recommended that the Insurance Authorities should treat it as a natural death allowing benefit of doubt in favour of the claimant and pay the claim as per terms and conditions of the policy.

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Kolkata Ombudsman Centre

Case No. 725/21/001/L/02/08-09

Shri Kanai Lal Ghosh
Vs.
Life Insurance Corporation of India

Award Dated : 13.07.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant is the father of late Bhaskar Ghosh and nominee for his policy no. 425354155, purchased from LICI/Lake Town Branch with Risk Date 23.2.2006, Sum Assured (SA) : Rs.5,00,000/- under T-T : 174-20 and yearly premium of Rs.15,604/-. He added that he has submitted the application claiming the death benefit of his son Late Bhaskar Ghosh who died on 20/02/2007 by committing suicide. The insurer denied the claim. The claimant submitted the copy of the First Premium Receipt where it was found that the commencement of the risk was 13/02/2006. The claimant submitted P-forms giving his unconditional and & irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

The Insurance Company has submitted the Self Contained Note (SCN) dated 24.05.09 on 4.6.09. They maintained that the DLA committed suicide on 20/02/2007 and date of risk was 23/02/2006. So, 'Suicide Clause' was applicable and they denied the claim. They gave their consent for mediation by the Ombudsman.

HEARING:

In response to a notice of hearing, both the parties attended. And the same was adjourned at the request of the representative of the LICI to investigate further and accordingly, the case was adjourned to 30/06/09. However, as both the parties did not attend, a fresh notice of hearing was issued to both the parties for hearing on 10/07/09. Both the parties attended on 10/07/2009.

At the time of first hearing, a question was raised with regard to DOC of the policy so that applicability of 'Suicide Clause' could be verified. The FPR clearly indicated the Date of Commencement (DOC) of the policy as 13/02/06 but according to the Insurer, the DOC of risk was mentioned as 23/02/06 in the policy bond. Therefore, the representative was asked to find out the correct date of risk by verifying with the proposal form. However, even after taking adjournment for nearly a month, they could not trace the proposal form or policy docket. According to the insurer, if the DOC as mentioned in FPR is taken into

consideration, the committing of suicide by the insured was occurred after more than one year from DOC. But if the date of commencement of risk as in policy bond is taken into consideration from the duration of the policy till suicide is falling short of one year by three days. Since cause of death was suicide, he felt that the insurance company has correctly decided to decline the claim applying 'Suicide Clause'.

The complainant on the other hand has stated that going strictly as per the F.P.R., the DOC should be taken into consideration as 13/02/06 and since the death occurred on 20/02/06, it was more than one year from the inception of the policy. Therefore, he pleaded that the claim may be considered favourably.

DECISION:

The Insurer could not produce any documentary evidence of risk commencing on 23/02/2006 neither could they confirm whether there was any delay in adjustment of the proposal for insurance due to any requirement not complied with by the proposer whereas the complainant submitted a copy of the First Premium Receipt, which is a valid document, showing the date of risk as 13/02/2006. So, the complainant should get the benefit of doubt if there is any discrepancy in the date of risk.

Under these circumstances, we hold that the insured has committed suicide one year after the commencement of the policy on 13/02/06. Therefore, we direct the LICI to settle and pay the claim as per the terms and conditions of the policy

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Death Claim

Kolkata Ombudsman Centre

Case No. 01/21/001/L/04/09-10

Shri Sujan Kumar Barui
Vs.
Life Insurance Corporation of India

Award Dated : 10.07.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant, Shri Sujan Kumar Barui is the husband of Late Kalpana Barui and nominee for her policy no. 434326100, Date of Commencement (DOC) : 28/06/2001, under T/T 14/16/16, First Unpaid

Premium (FUP) : 06/2004, Sum Assured (SA) : Rs.1,07,000/- and yearly premium of Rs.7485/-. The Life Assured (LA) died on 09/08/03 due to heart attack. He lodged the complaint against repudiation of death-claim and expressed that he had told some wrong dates to the Nursing Home due to nervousness. However, he admitted in the 'P'-forms that the Deceased Life Assured (DLA) was hospitalized in the year 2002 (after acceptance of policy) with urine problem and pain in lower abdomen. He requested the authority to ignore that comments and re-consider the repudiation case for payment. He further added that the Insurance Company had released two claims against two policies out of three cases. As the policy no. 434326100 was not settled in time the claimant submitted the complaint to this Forum. He submitted P-forms along with unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator for the resolution of the complaint.

Insurance Company did not submit the Self Contained Note (SCN). So, it was not clear why the payment has not been released. The Insurance Company mentioned in the Repudiation Letter that the LA was ill prior to purchase of policy. As the Insurance Company had not submitted the SCN, the details of illness could not be verified.

HEARING:

In response to a notice of hearing both the parties attended. The complainant was also represented by his son-in-law. In this case, the representatives of the Insurance Company stated that out of all the three policies, two policies having policy nos. 433207211 & 430894633 had been settled and claim against another policy having the no. 434326100 was repudiated as the deceased was suffering from kidney dysfunction for the last four years with a history of BP. They also found out that the patient was treated by a Nephrologist in S.S.K.M. Hospital, Kolkata but the exact date of treatment was not known. Since the Doctor had certified in Claim Form-B that the kidney dysfunction was existing four years back, they assumed that she was suffering from such diseases before the inception of the policy. Since the proposal did not contain any information with regard to kidney dysfunction, they held that there was suppression of material facts with regard to the status of the health.

On the other hand, the complainant stated that they were not in the knowledge that such kidney dysfunction had been noted by the doctor, as if, it was existing for four years. They also stated that they did not have any treatment papers. They further requested that the claim may be settled favourably.

DECISION:

The Insurance Authorities totally depended on claim form B-1 wherein the doctor certified that the patient was suffering from kidney dysfunction for the last 4 years, but there is no documentary evidence of the date of exact onset of the disease. This cannot be treated as irrefutable proof of deliberate suppression of pre-existing disease by the proposer. The insurer settled death-claim of 2 other policies of the same Life Assured and duration of the policy in question was more than 2 years from Date of Commencement. The Insurer is directed to obtain irrefutable proof that the disease was existing prior to the inception of the policy and that the DLA was aware of this.

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Kolkata Ombudsman Centre

Case No. 101/21/009/L/05/09-10

Smt. Girja Devi
Vs.
Bajaj Allianz Life Insurance Co. Ltd

Award Dated :06.08.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The Life Assured (LA) expired on 31/12/2007. The complainant (nominee) submitted death-claim but it was repudiated. She sought payment of death-claim (estimated fund value of Rs.40,000/-).

P-forms and consent letter which were sent to her were returned undelivered.

The insurer stated in their letter dated 09/06/2008 that the Deceased Life Assured (DLA) was under medical treatment since the year 2002 and had CVA one year back. As these material facts, known to the LA, were not disclosed in the proposal, the claim was repudiated and that the decision of repudiation was upheld by their higher office.

Self Contained Note (SCN) was submitted at the time of hearing. Letter of repudiation showed that some investigation was conducted. Insurer furnished prescription given by Rajeswari Hospital dated 31.12.2007 in which it was noted that the patient was having DM-II, HTN, Septicemia, DKA and Gangrene. Patient was put on I.V. fluid. Treatment summary showed the patient was 61 years old (age tallies with policy records). He had undergone operation of Ureteric Stones and B/L Hydrocele one month back. He had also developed scrotal smelling few days after he was unconscious and restless but responded to painful stimuli at the time of hospitalization.

HEARING:

In response to a notice of hearing both the parties attended. According to the representative of the insurance company, the deceased life assured (DLA) was under medical treatment since the year 2002 and had C.V.A. (Cardio Vascular Accident) and therefore, the insurance policy was taken by suppressing material facts with regard to the status of the health. He submitted documents for fever and some pathological tests conducted for treatment in the year 2002. At this juncture, on examination of the documents, it was found that the DLA suffered only with some symptoms like blood pressure, diabetes and there was no diagnosis of any disease. With regard to suffering of CVA- mention of one year was only an estimated guess and did not indicate irrefutably that the DLA was suffering from CVA before the inception of the policy. These points were brought to the notice of the representative of the insurance company.

On the other hand, the son of the complainant was also represented at the time of hearing stated that his father was having some problems with regard to stones only. However, they pleaded that the claim may be settled in their favour.

DECISION:

The evidence that have been produced by the representative of the insurance company was not sufficient to prove that a serious ailment within the knowledge of the deceased was existing before the inception of the policy. The treatment for stones was about five years' old before this policy was taken. At the time of the inception of the policy, the DLA was 61 years old and as in normal practice, the insurance company should have called for medical reports. This seems to not have been done. This policy is a single premium policy and in the event of the death of the policyholder, the sum assured will be receiving either the value of the units or Rs.50,000/- whichever is higher.

As discussed above, we find that there is no irrefutable proof to say that there was suppression of material facts and giving benefit of doubt to the insured, we hold that the claim is exigible. Therefore, we direct the insurance company to pay the claim as per terms and conditions of the policy.

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Death Claim

Kolkata Ombudsman Centre

Case No. 214/21/001/L/06/09-10

Smt. Nila Saha
Vs.
Life Insurance Corporation of India

Award Dated : 10.08.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death-claim.

The complainant is the wife of Deceased Life Assured (DLA). She stated that her husband expired on 20/12/2007 and subsequently all the claim forms were submitted to the insurer for settlement of death benefit. However, the claim was repudiated. She was not aware of the fact that her husband was suffering from any serious ailments. She appealed to ZCRC but received no positive response. She submitted P-forms and consent letter.

Repudiation letter showed that the Life Assured (LA) had a history of treatment by Anti-Tubercular Drugs (ATD) since 1966. He had history of splitting blood in 01/2007. The said policy was revived twice on 01.02.2006 and 26.02.2007 and the insurer had sufficient documentary evidence to prove that the LA was ill prior to taking the policy or reviving the policy . The DLA had suffered from dry cough, Upper Respiratory Tract infection for which he had consulted the Doctor which was not disclosed in the personal statement for revival dated 01.02.2006 or in the proposal dated 15.02.2003. They submitted Self-contained note.

Claim investigation report not made available.

No documentary evidence like doctor's opinion was submitted by the insurer. The insurer stated that DLA consulted Dr. Sinha on 31/12/2006 with a history of dry cough for last 10-15 days. Dr. Sinha advised for Chest X-ray & Blood test. He had some X-ray dated 21.01.2007 as a follow-up case of UTRI, OPD – Patient Card dated 21.08.2007 of Dr. B.N. Bose at S.D. Hospital. Personal History of taking ATD 44/45 years back, was available.

HEARING:

In response to a notice of hearing both the parties attended. The representative of the insurance company stated that the policy was revived first on 01/02/06 and second on 26/02/07. At this time of the second revival of the policy on 26/02/07, the DLA was treated for continuous cough and x-ray and other tests were taken to diagnose the disease and however, the hospital authorities did not make any diagnosis. According to him, the insured should have mentioned these details in declaration of good health (DGH). Since these details were not mentioned in the DGH, he stated that there was suppression of material facts and hence the claim was not payable.

On the other hand, the complainant stated that her husband was only suffering from dry cough and no disease was diagnosed before the death though the DLA died due to Bronchogenic Carcinoma. Therefore, she pleased that the death-claim may be settled favourably.

DECISION:

On going through the records we find that the insurance company had prescriptions dated 21/01/07 before the revival of the policy on 26/02/07 which indicated suggestion of x-ray and other blood tests. The patient was definitely suffering from dry cough and after the x-ray follow-up treatment was given in the S.D. Hospital. All these evidences though indicated certain treatment they have not diagnosed any disease. Therefore, there is a doubt whether any disease was existing before the revival of the policy.

Just not mentioning x-ray and other tests as per DGH does not make the contract void. The contract of insurance is at most voidable. It is true that the insurance company was denied the option of not reviving the policy or postponing the revival by 6 months as per their underwriting guidelines.

Therefore, keeping in view the above and giving benefit of doubt with regard to existence of any disease prior to the revival, it is felt that a certain amount of ex-gratia payment would meet the ends of justice. We hold that though repudiation was correct the same may be extremely harsh as the contract is voidable in nature. Hence, we direct the insurance company to pay an ex-gratia sum of Rs.25,000/- (Rupees Twenty Five Thousand only) which will meet the ends of justice

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Death Claim

Kolkata Ombudsman Centre

Case No. 181/21/001/L/06/09-10

Smt. Ganga Rani Barui
Vs.
Life Insurance Corporation of India

Award Dated : 12.08.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant stated that her husband expired on 26/05/2005 and after submitting all the claim forms and medical documents, the said claim was repudiated by the insurer. She stated that her husband, a poor van driver, was first admitted to Mogra Hospital from where the family got him released signing bond. Apparently he was then taken to Medical College and expired on the way home. Mogra Hospital issued death certificate but did not furnish any admission or medical record. As such she was unable to submit Claim Form B1. She had appealed to the ZCRC but received no positive response.

Repudiation letter revealed that the claim was repudiated because they had sufficient documentary evidence which proved that the LA was undergoing treatment for Liver enlargement and Lymph Gland enlargement as per prescription dated 15.11.2004 and the Doctor advised him for USG of upper abdomen. The policy was in lapsed state since July, 2004 and was revived on 18/02/2005 and the LA did not disclose these facts of treatment during lapsed state in his personal statement dated 18/02/2005.

No Self Contained Note (SCN) or any documentary evidence like doctor's opinion was submitted by the insurer.

HEARING:

In response to a notice of hearing both the parties attended. According to the representatives of the insurance company, the policy commenced on 28/01/2003 and it was in lapsed state from July, 2004. Thereafter, it was revived on 18/02/2005. According to them, the Life Assured (LA) did not disclose the facts of treatment during the lapsed period in the medical status to be furnished at the time of revival. According to them, from the outdoor ticket dated 15/04/05 and doctor's prescription dated 15/11/04, the LA was supposed to have malignant lymph at the abdomen at the time of reviving the policy and was undergoing treatment for liver enlargement and lymph gland enlargement as per prescription dated 15/11/04 and the doctor advised the LA to undergo the USG of upper abdomen. According to them since these details were not mentioned in the DGH, the LA suppressed material facts with regard to his health and therefore, they were correct in repudiating the claim.

On the other hand, the complainant stated that the DLA was in good health at the time of revival and the DLA was not in the knowledge that he was suffering from some ailments as they were detected only after the revival. Therefore, he pleaded that the claim may be settled favourably.

DECISION:

On going through the prescription dated 15/11/04 we find that there were only some medicines that had been prescribed and was advised USG. No USG was taken until after revival. Only on 15/04/05 (i.e., after the revival of the policy) it was found that the LA was suffering from *Lymphadenopathy*. From this it is clear that the Insurance Company did not produce any irrefutable proof that the DLA (Deceased Life Assured) was suffering from any ailments concerned with Liver or Lymph Gland. Further, it is found that the DLA died when he was 44 years old and definitely the benefit of doubt goes in favour of the DLA as he might not be in the knowledge of any disease at the time of revival of the policy.

Therefore, keeping in view the above, we hold that the insurance company was not correct in repudiating the claim without any irrefutable proof that the LA was suffering from any disease prior to the revival of the policy. Further, the Section 45 of the Insurance Act would be clearly applicable as more than 5 years passed between the date of commencement and the date of repudiation and there is no proof that a fraud had been committed with respect to suppression of material facts. We hold that the claim is exigible. Hence, we direct the insurance company to pay the claim as per terms and conditions of the policy

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Death Claim

Kolkata Ombudsman Centre

Case No. 237/21/001/L/06/09-10

Smt. Sima Choudhury
Vs.
Life Insurance Corporation of India

Award Dated : 15.09.2009

FACTS AND SUBMISSIONS:

This is a petition filed by the complainant against repudiation of death claim.

The complainant is the wife of the Deceased Life Assured (DLA). The DLA had a policy no. 436636225 with DOC : 01/02/2005 under T/T 169-05 for SA of Rs.50,000/- with yearly premium of Rs.11,665/-. The complainant stated that her husband himself and the concerned Agent were aware about the facts of the Bypass surgery of DLA. But the policy was undertaken after conducting medical examination. Nothing was revealed in the standard Medical Report regarding the fact of operation and her husband expired on 21/01/2008. The complainant also added that she was not aware of the said facts and as the 3 years premiums were already paid before the demise of her husband. According to her, Section 45 of the Insurance Act, 1938 was operative. The claim for the said policy according to the complainant must be paid by the insurer. She admitted that the guilt was of the agent and her husband and felt that she should not be deprived from the claim amount. She appealed to the ZCRC but the decision for repudiation was upheld by the Competent Authority. So, she approached this forum seeking justice for the aforesaid grievance and has submitted the P-forms giving her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between the insurer and the complainant.

Self Contained Note (SCN) submitted by the insurer dated 04/09/2009 confirmed the fact that the policyholder died on 21/01/2008 due to acute Cardiogenic shock. The claim forms B, B1 and documentary evidence relating to treatment papers of Gandhi Memorial Hospital, Kalyani showed that the DLA was suffering from complete heart block and Pace Maker was implanted before taking the policy. The said claim was repudiated on the ground that there was suppression of material facts on the part of the LA while taking the policy. Subsequently, on request of the claimant, ZCRC also reviewed the noted death claim and decided to uphold repudiation decision.

HEARING:

In response to a notice of hearing both the parties attended. The complainant was represented by the son of the deceased. The representatives of the insurance company stated that they had irrefutable proof that the deceased had implantation of pacemaker on 15/12/2001 which was definitely before the inception of the policy on 01/02/05. The policyholder did not reveal this fact in the proposal form prior to the inception of the policy. Therefore, according to them, there was definite suppression of material facts and the policyholder did not reveal the same.

On the other hand, the complainant requested for the refund of the premium if the death claim is not payable.

DECISION:

On going through the records it is absolutely clear that the policyholder did not reveal the facts of pacemaker that was implanted in December, '01. This is definitely suppression of material facts. Therefore, the insurance company was correct in repudiating the claim. However, we find that the insurer conducted a medical examination before acceptance of the proposal and the doctor from Gandhi Memorial Hospital certified that there was no aliment in the case of the policyholder and therefore, the insurance company could enter into the contract with the insured. If the doctor had correctly mentioned the existence of pacemaker probably the insurance company would not have entered into the contract and consequently, the policyholder could have been saved of the premium paid.

Keeping in view this particular evidence, we are of the firm view that the insurance company has correctly repudiated the claim. In spite of the claim being repudiated we feel that the certain amount of ex-gratia payment would meet the ends of justice since the LIC Panel Doctor also ignored installation of pace-maker. As the policyholder has paid certain premium we propose to grant an amount of Rs.15,000/- (Rupees Fifteen Thousand only) as ex-gratia which will meet the ends of justice.

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MUMBAI

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI-179 (2009-2010)

Award No. IO/MUM/A/ 155 /2009-2010

Complainant : Shri Sachin Sangare

V/s

Respondent : Life Insurance Corporation of India, Mumbai Division III

AWARD DATED 4TH AUGUST 2009

Shri Hradaynath P. Sangare had taken a life insurance policy from LIC of India, Nagpur Divisional Office. The SA was Rs.25,000/-. The DOC was 18.11.2000. The policy lapsed on 18.5.2003 and was revived on 16.12.2006.

Shri Hradaynath P. Sangare expired on 30.12.2007 due to Aspiration neumonia obstructive hydrocephalus in a case of tuberculosis meningitis. His brother Shri Sachin Sangare submitted a claim to LIC. LIC of India, repudiated all liability under the policy on account of the deceased having withheld material information regarding the health at the time of revival of his policy.

The documents produced at this Forum have been perused. The Insurer repudiated the claim on the grounds of non disclosure of material facts regarding his health and treatment taken prior to revival of the policy. As per the Certificate of Hospital Treatment (Claim Form B-1) dated 15.05.2008 and the Medical Attendant's Certificate (Claim Form B) dated 28.03.2008 signed by Dr. Praveen Kumar Raghunath Jorag, RMO, LTMG Hospital, the life assured was admitted on 25.10.2007 and detected as TBM with c/o vomiting, neck stiffness. The history reported by the deceased and relatives - was case of Schizophrenia since 1998. The diagnosis arrived at was Aspiration pneumonia obstructive hydrocephalus in a case of tuberculosis meningitis.

The Insurer has produced the case papers of the deceased life assured who was taking treatment from Dr. Hemant Belsare, MD, D.P.M., Consultant Psychiatrist / Forensic Psychiatry, from 1998 till his date of death. There is a copy of letter dated 25.12.2007 addressed to the Casualty Officer – wherein the Doctor has stated – He is a known case being treated in Psychiatric Dept at Sion Hospital. He is in a catatonic phase and is not in a position to be treated on OPD basis. His general condition is bad. Please take opinion of the relevant faculty and oblige. The Insurer has also produced case papers of LTMGH Hospital. In the various case papers there are notings as – h/o altered behaviors since 1997, c/o not working, demanding for things muttering, gesticulating, altered sleep, appetite, fearfulness. Pt failed twice in school, then left school, Pt not working, demanding for things like money, vehicles, new wrist watches and when objected, gets angry and for 1-2 months this behaviors consist. Not much communicating. Pt has h/o muttering and gesticulating. There is a noting on 1.10.2007 stating Pt. not taking medicines, lying about medicine to parents, not going out of house, poor self care, c/o fearfulness, someone is going to kill , h/o excessive roaming around. The deceased life assured had been on medication for his treatment from 1998 onwards.

These documents prove beyond doubt that the life assured was suffering from various serious ailments prior to the date of proposal and revival of his policy but he had not revealed his medical and mental condition at the time of revival of his policy. In fact, he was under treatment and medication even before his proposal for assurance. Suppression of material facts is evident. The claim was denied.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 118 (2008-2009)

Award No. IO/MUM/A/ 116 /2009-2010

Complainant : Shri S.S. Shende

V/s

Respondent : LIC of India, Nagpur Divisional Office

AWARD DATED 30.6.2009

Shri Sudhir Sukhdeorao Shende had taken a Life Insurance Policies from LIC of India, Nagpur Divisional Office. The details are given below:-

Policy No.	972056283	821262222
Sum Assured	Rs.50,000/-	Rs.2,00,000/-
Plan/ Term	93-25 (Money back)	111-25 (Bima Kiran)
Mode of Payment	SSS	SSS
Date of Birth / Age at entry	03.08.1965 – 28 years	03.08.1965 – 29 years
Date of Commencement	28.02.1993	28.08.1994
Date of Death	06.10.2006	06.10.2006
First Unpaid Premium	SSS – 05/1997	SSS – 10/1994

Shri Sudhir Sukhdeorao Shende expired on 06.10.2006. His father Shri S.S. Shende preferred the claim. LIC of India informed him that under policy No.821262222 only initial two premiums were paid, hence nothing is payable under the said policy. As regards policy No.972056283, policy was reduced paid up condition at the time of death of the life assured and only paid up value is payable.

Shri Sudhir S. Shende was in the service of Thermal Power Station, Chandrapur and the policies were taken under SSS mode of payment. He expired on 06.10.2006 and as per the Insurance Company, the premium position according to Chandrapur Branch II under Nagpur Division, for both the policies were in lapsed condition on the date of death of the life assured. According to the Insurer, under policy No.821262222, only the first two SSS premiums stand paid and no further SSS premiums were remitted. Under the circumstances, under this policy No.821262222, stands in a lapsed condition on the date of death of Life Assured and hence nothing is payable as per policy conditions.

According to the Insurer, under Policy No.972056283, the first unpaid premium under this policy is SSS due May 1997 and there were 4 SSS gaps due from 04/1993 to 07/1993. Hence on the date of death i.e. 06.10.2006, the policy was in lapsed state but had acquired paid up value.

The complainant, produced two salary slips for the month of May 1995 and June 1995 where deduction of Rs.427/- towards premium under both the policies is made. The employer – Chandrapur Super Thermal Power Station, vide their letter have certified that LIC deduction of Rs.203/- towards Policy No. 821262222 and deduction of Rs.224/- towards Policy No. 972056283, the total of which Rs.427/- were regularly deducted from his salary from November 1996 to April 1997. They also stated that the deceased life assured was absent w.e.f. 01.05.1997 to 07.01.2001 and thereafter resigned w.e.f. 08.01.2001.

Under Policy No. 821262222 (Bima Kiran) the policy condition – Payment of Premium states "A grace period of one month but not less than 30 days will be allowed for payment of yearly, half-yearly or quarterly premium and 15 days for monthly premiums. If death occurs within the period and before the payment of the premium, the policy will still be valid and the Death Benefit paid after deduction of the said premium as also unpaid premium/s falling due before the next anniversary of the policy. If the premium is not paid before the expiry of the days of grace, the policy lapses". Even if we consider on the basis of salary slips that premiums were deducted up to April, 1997 by the employer i.e. 2 years 8 months premiums were paid, on the date of death, the policy was in lapsed condition and no claim was payable. Bima Kiran is a term assurance policy and as per the policy terms and conditions nothing is payable. The Insurer cannot be faulted for rejecting the claim under Policy No.821262222.

Under Policy No.972056283, it was also in lapsed condition as on the date of death. As it had acquired paid-up value on the date of lapse, the same is payable on death and accordingly it was offered by the Insurer. However, in this case, LIC of India is directed to recalculate the paid up value.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 131 (2009-2010)

Award No. IO/MUM/A/ 128 /2009-2010

Complainant : Smt. Sujatha M. Alva

V/s

Respondent : Life Insurance Corporation of India, Mumbai SSS Division

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AWARD DATED 13.7.2009.

Shri Mohandas Vittal Alva had taken a Life Insurance Policy from Life Insurance Corporation of India, under SSS Division, Mumbai. The SA was Rs.1.00 lac under plan and term 174-12 (Bima Gold Money Back) The DOC was 31.3.2006.

Shri Mohandas Vittal Alva expired on 27.06.2007 due to Acute Myocardial Infarction. When the claim was preferred by his wife, Smt. Sujatha M. Alva, LIC on account of the deceased having withheld correct information regarding his health at the time of effecting the assurance.

On the claimant's representation, the case was referred to the Western Zone Claims Review Committee of LIC of India for review of the case, but the decision was upheld vide their letter dated 21.04.2009.

The deceased Life Assured was working as a Sr. Manager in Abhyudaya Co-op Bank in their Sewree Branch, Mumbai. As per the Medical Attendant's Report (claim form B) received from Dr. Arun M of Kasturba Medical College, Manipal, Udupi, Karnataka, the deceased was boarding at Ramakrishna Hotel and vomited. He was taken to the Kasturba Medical Centre where he was declared death. A Post Mortem was performed. As per the Post Mortem Report and the information furnished by Police, the deceased who was boarding at Ramakrishna Hotel, Udupi, on 27.06.2007 at 1.00 A.M. vomited and fell unconscious. Brought to KMC, Manipal where he was declared dead. It was also said that the deceased was a known patient of blood pressure and diabetic and might have died due to the same. According to the Post Mortem Report, the final opinion as to the cause of death of Mr. Mohandas Alva from autopsy findings histopathological examination and RFST report is due to Acute Myocardial Infarction.

From the pathology reports with reference of Dr. Uday M. Jadav, Consulting Physician and Cardiologist, submitted by the insurer shows :

1. 12.03.2005 – fasting blood sugar 310 and fasting urine sugar present ++++
2. 22.04.2005 – Lipid profile serum cholesterol, serum triglycerides, cholesterol / HDL cholesterol ratio and serum low density lipoproteins are above normal range.
3. 22.04.2005 – from same doctor shows fasting blood sugar – 132
4. Certificate of same doctor dated 09.05.2005 shows BP 142/90 – same treatment to be continued.

The certificate received from the employer Abhyudaya Co-op Bank states that the deceased life assured had availed sick leave from 10.05.2005 to 31.05.2005 for which a certificate was issued by Dr. Uday M. Jadhav, Consulting Physician & Cardiologist stating that he was suffering from severe Hypertension and Diabetes Mellitus.

From the above facts, it is evident that the deceased life assured suppressed material information and made misstatement regarding his health at the time of proposal and also suppressed the material information regarding his health, thereby denied an opportunity to L.I.C to probe in the matter and take appropriate underwriting decision before issue of policy. Had he declared his treatment of Hypertension and MD and Lipid Profile, it would have affected the underwriting decision The cause of death i.e. Acute Myocardial Infraction is directly related to the suppressed information. The claim was denied.

MUMBAI OMBUDSMAN OFFICE

Complaint No. LI - 147 (2009-2010)
Award No. IO/MUM/A/ 144 /2009-2010
Complainant : Smt. Mamata A. Nawghare
V/s
Respondent : Life Insurance Corporation of India, Nagpur Divisional Office

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AWARD DATED 30.07.2009

Shri Arundatta Diwakarrao Nawghare had taken a life insurance policy from LIC of India, under Nagpur Divisional Office for SA Rs.1.00 lac under Plan / Term 174 - 20. The DOC was 28.3.06

Shri Arundatta Diwakarrao Nawghare expired on 01.06.2007, due to an auto-rickshaw accident. His wife, Smt. Mamata A. Nawghare submitted a claim LIC. repudiated all liability under the policy on account of the deceased having withheld material information regarding the health at the time of effecting the assurance.

The documents produced at this Forum have been perused. The Insurer repudiated the claim on the grounds of non disclosure of material facts regarding his health prior to proposal for assurance. The Life Assured died on 01.06.2007 due to an accident. The life assured met with an accident while traveling in an auto rickshaw on 29.05.2007. According to the FIR lodged with the Police after the accident, states that the Life Assured was suffering from spondolysis for which he was being taken to Sevagram Hospital, Wardha when the accident took place. He was rushed to the Kasturba Hospital Sevagram from where he was discharged on 01.06.2007 for undergoing MRI Scan at the MRI Centre Nagpur. On 01.06.2007 he was again taken back to Sevagram Hospital, Wardha, where he expired on the same day. According to the case summary dated 30.05.2007 from Kasturba Hospital, the L.A. was a k/c/o Lumbar Canal Stenosis and is paraplegic since 2 – 3 years. The Report of MRI from Dr. Shyam Babhulkar, Neurosurgeon, Nagpur, the life assured had earlier signs of Lumbar Canal Stenosis with claudication 3-4 years (progressive). In the Post-Mortem Report it reports that death was due to sub-dural haematoma (and hemorrhage) as a result of head injury (Unnatural).

The Hospital has mentioned in the Case summary as Kn/c/o Lumbar Canal Stenosis, Paraplegic since 2 – 3 years.

The meaning of 'Paraplegia" as per Concise Oxford Dictionary - Tenth Edition states as – "paralysis of the Legs and lower body, typically caused by spinal injury or disease. Thus, it is clear from the above that the insured had some problem of the spine before taking the policy, which he did not disclose in the proposal papers. The above problem was further supported from the MRI Report, that the life assured had earlier signs of Lumbar Canal Stenosis.

In the facts and circumstances, the repudiation of the claim by LIC of India is justified.

BEFORE THE INSURANCE OMBUDSMAN

Complaint No. LI – 149 (2009-2010)

Award No. IO/MUM/A/ 180 /2009-2010

Complainant : Shri Sumati S. Naik

V/s

Respondent : LIC of India, Goa Divisional Office

AWARD DATED 14.08.2009.

Shri Vilas Saulo Naik had taken Policy from LIC of India, Goa Divisional Office. The SA was Rs.50,000/- under Plan / Term – 75 -20. The payment of premium was through SSS monthly mode. The DOC was 6.10.2004. Shri Vilas Saulo Naik expired on 12.10.2007. His sister, Smt. Sumati S. Naik, nominee under the policy preferred the claim. LIC of India informed her that on the date of death of the life assured, the policy was in lapsed condition without acquiring any paid up value. Even then the case was considered under exgratia for notional paid-up value under Chairman's Relaxation Rules. Regarding Accident benefit, as per the clause 10 (b) of policy conditions and privileges printed on the back of the policy, the injury sustained due to accident shall result in death within 180 days of its occurrence. In the said case, the date of accident was 23.03.2007 and date of death was 12.10.2007, i.e. 202 days after accident. Hence accident benefit is not payable.

The documents produced at this Forum have been examined. According to the various documents produced by the complainant and the Insurer, along with FIR, Police Report, Spot Panchnama, Post Mortem report, Certificate of Death, it is proved that the DLA met with a motor cycle accident on 23.03.2007 and expired on 12.10.2007 due to head injury. He was in coma till the date of his death. The company has admitted the above facts.

According to the Insurance Company, they had received the premiums regularly from the employer but there were three initial gaps. The first unpaid premium was 04/2007 with 3 initial gaps for 12/2004, 01/2005 to 02/2005. After shifting back the premiums to fill these gaps, they have treated the first unpaid premium as January,.2007 and accordingly they treated the policy in lapsed condition on date of accident and hence the claim was admitted for notional paid-up value under Chairman's Relaxation Rule 1987 on ex-gratia basis. When the claim was considered on ex-gratia basis, then in such cases the double accident benefit claim is not payable. However in this case since the death had occurred after 180 days, the accident death cover was not available.

The Central Office circular of LIC with Ref: CO/CRM//PS/608/23, dated 25.10.2007 and 28.05.2008 states as under: -

"Under the Clause Accident Benefit of the terms and conditions of the policy, if the policy is in force on the date of accident, then, an additional sum assured, equal to the basic sum assured, together with the basic sum shall be payable irrespective of whether or not the policy is in force at the time of death, provided the claim is otherwise admissible as claim by accident". In this case the insured had

expired after six months and as per the policy condition, the accident death benefit risk covered up to six months from the date of accident and hence it was denied by the insurer.

Full basic sum assured claim was not admitted by the Insurer as they have treated the policy in lapsed condition treating the first unpaid premium as January 2007 after shifting premiums for previous gaps. The DLA met with an accident on 23.03.2007. The employer was remitting the monthly premium regularly till the LA met with an accident but there were three initial gaps 12/2004, 01/2005 and 02/2006.

According to the CO circulars referred above, if the policy is in force on date of accident, then an additional sum assured equal to the basic sum assured, together with the basic sum shall be payable irrespective of whether or not the policy is in force at the time of death, provided the claim is otherwise admissible as claim by accident. In this instant case, death was due to accident, has been proved beyond doubt but it was after 180 days from the date of accident. As per the policy conditions and privileges 10.2 (b) printed on the back of the policy "Death of the Life Assured" - "To pay an additional sum equal to the Accident Benefit Sum Assured under this policy, if the Life Assured shall sustain any bodily injury resulting solely and directly from the accident caused by outward violent and visible means and such injury shall within 180 days of the occurrence solely directly and independently of all other causes result in the death of the Life Assured". Here death had occurred after 202 days from the date of accident and hence the accident benefit is not payable. It was observed from the various notings that after accident and till his death, the insured was in Coma. Though he was alive during this period but virtually he was a vegetable and therefore in such a critical case, denying the Accident cover beyond 180 days may be technically correct but on humanitarian grounds, it can't be justified. Under the facts and circumstances, the claim was allowed on ex-gratia basis to meet the end of justice.

Complaint No.LI-166 of 2008-2009
Award No. IO/MUM/A/ 95 /2009-2010
Complainant : Smt. Vijaya Dilip Jadhav
V/s.
Respondent : SBI Life Insurance Company Ltd.

AWARD DATED 11.6.2009.:

The deceased Life Assured, Late Shri Dilip Shankar Jadhav, had applied for Swadhan Group Insurance Scheme under Master Policy No. 86000053509, through Membership Form No.1409732 dated 08.11.2007. The commencement of risk was from 01.12.2007 for a Sum Assured of Rs.3.00 lakhs with a yearly premium of Rs.3,805/-. His Group Member ID No. was 13978354. The Group Swadhan Scheme was for State Bank of India Mumbai LHO Account Holders.

Shri Dilip Shankar Jadhav expired on 24.12.2007 due to heart failure. When Smt. Vijaya Dilip Jadhav, wife of the deceased life assured preferred a claim from SBI Life Insurance Co. Ltd., they rejected the claim stating that the date of commencement of policy was January 01.12.2007 and the death occurred within 24 days from the date of commencement of the risk. The date of commencement of policy is from 01.12.2007 and as per the Schedule III of the Master Policy, Terms and Conditions, Point 5 – Forty-five day Exclusion of the policy, the company shall not be liable for payment of any benefit under the master policy in respect of a Member, if the claim event takes place within 45 days of the Date of Commencement of cover for that Member.

The Claimant's contention is that her husband's premium was debited from his account on 08.11.2007 and he died on 24.12.2007 i.e. he died on the 47th day from the date of receipt of premium and hence death occurred on the 47th day and therefore the Forty-five day Exclusion does not apply.

As per the written submission of the company, in Group Insurance Schemes the privities of contract are between the Master policyholder and the Insurer. As an evidence of contract, a Master Policy containing all the terms and conditions of the insurance coverage will be issued to the Master policyholder which is binding on the individual members.

As per the Master Policy, Schedule III, point No. 5 - Forty-five day exclusion of the policy states as under

> "The company shall not be liable for payment of any benefit (including riders, if any) under this master policy in respect of a Member, if the claim event takes place within 45 days of the Date of commencement of cover for that member. However, this exclusion will not apply where death occurs due to accident".

As per the Schedule III, point No. 2 - Commencement of Cover of the policy states as under

"Insurance Cover for a Member shall only commence on the first of the month immediately following the date of draft containing the premium for that Member, provided he/she within the definition of Member (hereinabove given) and the details pertaining to such Member are furnished to the Company in the format prescribed by the Company at the time of joining".

In the instant case, the premium was paid on 08.11.2007. However the commencement of risk was from the 1st of the next month i.e. on 01.12.2007. As per the policy condition, the commencement of risk will be taken as on 01.12.2007 as per the policy condition and not as on the date of payment of premium as objected by the complainant. The DLA is reported to have expired on 24.12.2007. As per Schedule III, point No.2 the commencement of risk is from 01.12.2007 and death occurred within 24 days from the date of commencement of risk. Thus in terms of the Master Policy point No.5 of Schedule III, no claim is admissible if the death occurs within 45 days of the commencement of the risk. The claim was denied.

BEFORE THE INSURANCE OMBUDSMAN

Complaint No. LI – 200 (2009-2010)

Award No. IO/MUM/A/ 189/2009-20010

Complainant : Smt. Bhagyashree Gopal Pardeshi

V/s

Respondent : LIC of India, Satara Divisional Office

AWARD DATED 25.08.2009

The deceased Life Assured, Shri Gopal Maniklal Pardeshi had taken a Life Insurance Policy from LIC of India, under Satara Divisional Office for SA Rs.50,000/- under Plan/Term – 14/16. The DOC was 10.8.2006 The details are given below:-

Shri Gopal Maniklal Pardeshi expired on 23.06.2008. His wife, Smt. Bhagyashree G. Pardeshi preferred the claim. The Insurer, LIC of India informed the complainant vide letter dated 30.04.2009 that as on the date of death of life assured i.e. 23.06.2008, the SSS premium due from 05/2008 to 06/2008 were not received by the office and the last premium received was SSS due 04/2008 and hence the policy was in lapsed state on the date of death of the life assured and according to the insurer, no claim was paid under the policy.

The documents produced at this Forum have been examined. Shri Gopal Maniklal Pardeshi was working with M.S.R.T.C. in their Satara Depot as a Conductor. He had proposed for a policy on 10.08.2006 through Salary Savings Scheme. The SSS premiums were received up to monthly due April 2008 by the Insurer. He expired on 23.06.2008. His premium for the months of May, 2008 and June, 2008 were not received by the Insurer. LIC had written a letter dated 23.09.2008 to his employer, M.S.R.T.C., Satara, to find out whether the premiums for the months of May, 2008 and June 2008 were

deducted from the DLA's salary and remitted to LIC or whether salary for the said months were not drawn by him. The employer, M.S.R.T.C., vide their letter dated 24.09.2009 stated that they had not deducted the premium from the salary from May onwards as he was on medical leave. The life assured expired on 23.06.2008. The last SSS premium received was for April, 2008. Before his death he was on medical leave. The payment of his salary after medical leave was drawn on 7th July 2008 and so premium was not deducted. It is noted from the above letter that the gross amount for salary for the month of May 2008 was Rs.175/- only. From the above it is observed that the amount was not sufficient to cover the premium. Moreover, it was paid in July, 2008, whereas the employee had expired in June 2008. In the above case, technically it is correct that LIC did not receive the terminal premium and the employer could not deduct the premium as the employee had already expired and also the salary fell short of the premiums. The denial of the claim by the Insurer is technically correct but there was hardly any opportunity for the life assured to pay the premiums directly as monthly mode because by the time he could have known that due to sick leave no salary was paid, but unfortunately by that time he had expired. In the facts and circumstances and looking to the appeal made by the complainant and the family background, it will be appropriate to allow Rs.25,000/- on ex-gratia basis.

The Insurer had informed the claimant on 30.04.2009 that as on the date of death i.e. 23.06.2008, the SSS premium due from May 2008 and June 2008 were not received by LIC office and the last premium remitted by the employer was for April 2008. Hence the policy was in lapsed condition on the date of death of the life assured and therefore, no claim is payable under the policy.

From the above facts, it is evident that SSS premium due May 2008 and June 2008 remained unpaid on the death of the life assured meaning thereby that the policy was in lapsed condition on the date of death. As the policy was in a lapsed condition on the date of death, the repudiation of the claim by LIC of India is tenable.

From the above facts of the case and in view of the terms and conditions of the policy, the Insurer cannot be faulted for rejecting the claim under the above policy.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 452 (2008-2009)

Award No. IO/MUM/A/ 127 /2009-20010

Complainant : Smt. Sumitrabai C. Chichale

V/s

Respondent : LIC of India, Nagpur Divisional Office

AWARD DATED 13.7.2009:

The deceased Life Assured, Shri Rajendra Chaitlal Chichale, had taken a Life Insurance Policy from LIC of India, Gondia Branch Office under Nagpur Divisional Office. The SA was Rs.1.00 lac. The DOC was 2.3.2006 under monthly SSS.

Shri Rajendra Chaitlal Chichale committed suicide and expired on 09.07.2007. His mother Smt. Sumitrabai C. Chichale preferred the claim. The Insurer, LIC of India informed the complainant that as on the date of death of life assured i.e. 09.07.2007, the SSS premia due from 05/2006 to 07/2006 were not received by the office and the last premium received was SSS due 05/2007 and hence the policy was in lapsed state on the date of death of the life assured (due to 2 terminal SSS gaps) and according to the insurer, no claim was paid under the policy.

The documents produced at this Forum have been examined. Shri Rajendra C. Chichale had proposed for a policy on 28.02.2006 through Salary Savings Scheme. The SSS premia were received up to monthly due April 2007 with initial gaps of 05/2006, 06/2006 and 07/2006. The life assured expired on 09.07.2007 by committing suicide. The last SSS premium received was for April, 2007. The Insurer has produced the SSS ledger sheet of the policy showing that the SSS premia due June 2007, July, 2007 & August, 2007 were paid at the cash counter of Gondia Branch Office of LIC on 19.12.2007 i.e. after the death of the life assured which is a deliberate act on the part of some one. The Gondia Branch Office had informed the claimant on 19.04.2008 that as on the date of death i.e. 09.07.2007, the SSS premia due from 05/2006 to 07/2006 were not received by the office and the last premium remitted by the employer was for 05/2007. Hence the policy was in lapsed condition on the date of death of the life assured and therefore, no claim is payable under the policy. The claimant had also submitted a letter dated 06.06.2008 stating that the life assured was on sick leave from May 2007 to July 2007 and hence his salary was not drawn and hence the above unpaid premia were remitted to LIC office in December 2007.

From the above facts of the case and in view of the terms and conditions of the policy, the Insurer cannot be faulted for rejecting the claim under the above policy. However, the Insurer is directed to refund the premiums received after the death of the life assured in the month of December 2007 at Gondia Branch Office.

MUMBAI OMBUDSMAN CENTRE

Complaint No.LI-462 (08-09)
Award No. IO/MUM/A/ 94 /2008-2009
Complainant : Shri Ankush Dharma Patil
V/s.
Respondent : Life Insurance Corporation of India, Nasik D.O.

AWARD DATED 11.6.2009

Smt. Jagruti Ankush Patil had taken life insurance Policy No.960657054 from LIC for sum assured Rs.1.00 lac under plan & term 174-20 (Bima Gold Money Back) with Accident Benefit Rider. The Half-yearly premium amount was Rs.1756/-. The date of proposal was 15.03.2006 and date of

commencement of the policy was 03.03.2006. Smt. Jagruti Ankush Patil expired on 23.12.2006 due to Thermal Burns. Shri Ankush D. Patil preferred a claim to LIC for the full Sum Assured as also the Accident Benefit. The Insurer admitted the claim as per provision of Clause 4 (b) by only refund of premiums paid by the insured. The deceased life assured was self employed having a diary business with an annual income of Rs.40,000/- and was aged 18 years at proposal stage, therefore, as per their rules, a restrictive clause i.e. Clause 4(b) was applicable to this policy. As per the provision of this clause, if the life assured dies due to accident at a place other than public place, within three years from the date of risk, the benefits under the policy are not payable and the Corporation's liability shall be limited to the sum equal to the total amount of premiums (exclusive of extra-premiums, if any) paid under this policy without interest.

From the Police papers – Police Panchnama & Inquest Panchnama, it seems that Smt. Jagruti Patil expired due to stove bursting at her residence. According to the Post Mortem Report which was performed at S.B.H.G.M.C & General (Civil) hospital, Dhule, she sustained 75% burns and the cause of death was due to thermal burns. According to Claim Forum B – Medical Attendant's Certificate signed by Dr. S.C. Patil and Dr. R.K. Gadhari, Smt. Jagruti Ankush Patil expired on 23.12.2006. The primary cause of death was Septicemia due to thermal burns. The Inquest was held by Shri R.R.. Fulpagare, A.S.I, Dhule City P.S. The post Mortem examination was held at Civil Hospital Dhule by Dr. S.C. Patil and Dr. R.K. Gadhari and the cause of death was due to septicemia due to thermal burns. When the Claimant, Shri Ankush D. Patil, preferred the claim, LIC rejected the claim as per restrictive Clause 4(b) imposed on this policy. The Clause 4 (b) reads as under:

"Notwithstanding anything within mentioned to the contrary it is hereby declared and agreed that in the event of death of the life assured occurring as a result of intentional self injury, suicide or attempted suicide, insanity, accident other than an accident in a public place or murder at any time on or after the date on which the risk under this policy has commenced but before the expiry of three years from the date of this policy, the Corporation's liability shall be limited to the sum equal to the total amount of premiums (exclusive of extra premium, if any, under this policy without interest).

"Provided that in case the life assured shall commit suicide before the expiry of one year reckoned from the date of this policy, the provisions of the clause under the heading "SUICIDE" printed on the back of the policy shall apply".

The Insurer has rejected the claim on the basis of this clause. The duration of the policy was for only 9 months and 20 days. Since a special Clause 4(b) is imposed on this policy for the first three years, therefore, the claim for the full Sum Assured as also the Accident Benefit is not payable. However, as per provision of Clause 4 (b), only refund of premiums is payable to the claimant.

Award No. IO/MUM/A/20/2009-2010

Complainant : Smt. Ujwala Prafulla Holkar

V/s

Respondent : Life Insurance Corporation of India , Kolhapur Division

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AWARD DATED 20.4.2009.

Shri Prafulla Devhid Holkar had taken a LIC Shri Prafulla Devhid Holkar expired on 12.12.2006CRF with Pulmonary Koch with DM with HTN. The claim was preferred by his wife Smt. Chhaya Nandkumar Rokade. Life Insurance Corporation of India repudiated the claim on account of the deceased having withheld material information regarding his health at the time of effecting the assurance.

LIC of India, however, stated that they have evidence and reasons to believe that the Life Assured was suffering from Diabetes Mellitus as recorded in a reputed hospital and going beyond the date of proposal. He did not, however disclose these facts in his proposal dated 30.07.2005.

LIC therefore, repudiated the claim on the ground that the life assured had made deliberate mis-statements and withheld correct information regarding his health at the time of effecting the assurance and hence, in terms of the Policy Contract and the Declarations contained in the form of Proposal for Assurance the Insurer repudiated the claim.

The documents on record have been perused. As per the Medical Attendant's Certificate (Claim For B) and Certificate of Hospital Treatment (Claim Form B-1) signed by Dr. Rajeev Gandhi, MD of Miraj Medical Centre, Wanless Hospital, Miraj, states that Shri Prafulla Holkar was admitted on 19.11.2006 and expired on 12.12.2005. The diagnosis arrived at in the Hospital was Diabetic Nephropathy with chronic renal failure with Hypertension with neck femur with pulmonary koch. The primary cause and secondary cause of death was Chronic Renal failure with Pulmonary Koch with Diabetes Mellitus with Hypertension. To the question - How long had he been suffering from the disease before his death? – He has answered " 7-8 months". What were the symptoms of illness? – "Nausea, vomiting, cough, fever, malnutrition". To the question - What other disease or illness preceded or coexisted? "Diabetes, Hypertension" and date when first observed - "k/c/o DM – 3-4 years". The history was reported by the patient himself. In the case papers of Wanless Hospital. The past History it is mentioned - k/c/o DM since 15 years and on treatment. As per the Investigation Report, the DLA was on medical leave from 17.12.2004 to 15.01.2005. As per claim form E – Certificate by Employer, the DLA was an employee of Indira Gandhi Memorial Hospital, Ichalkaranji Nagarparishad, No medical certificate for sick leave was available with the employer.

The Insurer repudiated the claim wholly on the grounds that the DLA had not disclosed that he was suffering from Diabetes and taking treatment. Before proposing for assurance, it is the bound duty of the proposer to disclose all material facts in the proposal form. Had he disclosed the correct information, LIC would have called for relevant medical reports and taken appropriate underwriting decision. The claim was rejected.

MUMBAI OMBUDSMAN CENTRE
Complaint No.LI - 536 of 2008-2009

Award No.IO/MUM/A/ 115 /2009-2010

Complainant : Smt. Kavita R. Kanjer

V/s.

Respondent : Aviva Life Insurance Company India Ltd.

AWARD DATED 30.6.2009

Shri Rajendra Ratan Kanjer had taken a life insurance policy No. WLG1518635 from Aviva Life Insurance Company India Ltd. The SA was Rs.6.6.lacs. The DOC was from 31.3.07. The half-yearly premium was Rs.10,000/-.

Shri Rajendra Ratan Kanjer expired on 05.08.2007 i.e. within 4 months & 4 days of date of risk.. The claim was preferred by his wife, Smt. Kavita R. Kanjer. Aviva Life Insurance Company India Ltd. repudiated all liability under the policy stating that as per the information available with them, the financial and occupational information disclosed by the deceased at the time of initiating the policy is not correct and in actual he used to work as daily wage laborer and earn Rs.50/- per day, which means neither he had any fixed job nor any fixed income In the light of this, it is apparent that he had falsely declared his income as Rs.2.00 lacs and occupation as Trader. This amounts to non-disclosure of material facts which is a violation of the terms and conditions of the insurance policy.

The relevant records pertaining to the case have been scrutinized. From the documents on record, a proposal dated 24.03.2007 was submitted to the Company by Shri Rajendra Ratan Kanjer. The Company issued a policy for Sum Assured Rs.6,60,000/- based on the information given in the proposal and Financial Statement As to the question in the proposal "Exact nature of duties" – to which he answered "Trading". "Your designation" – he answered "Owner". The annual income mentioned in the proposal was stated as Rs.2.00 lakhs and in the Financial Statement signed by the DLA, net worth was Rs.8.00 lakhs by way of cash, investments, real estate etc. The deceased life assured expired on 24.06.2007. The company initiated investigation to check the authenticity of the claim and gave the matter for investigation to CRP Technologies (India) Pvt. Ltd. According to the investigation carried out by the investigators it was revealed that the Life Assured belongs to lower class income group, residing in village type hut since past 15 years. The residence of the Life Assured falls into remote village, where there are hardly 12-15 houses and it has been provided by Indira Gandhi Scheme to the backward class

people. The village of Life Assured is approx. 30 km. from Nandurbar City, where the transport facility is very poor and there is no electricity in the village. Also no chemist, clinic or doctor was found in the village of Life Assured at the distance of 20-25 kms. They have also reported that he was working on daily wages for Rs.50/- per day. A letter from the Sarpanch Shri Jagdish Himatrao Patil, states that "Shri Rajendra Ratan Kanjer was a permanent resident of Bhaler Village and he was working on daily wages of approximately Rs.50/- per day.

The complainant has produced various certificates obtained from the Gram Sevak, the Asstt. Sarpanch of Bhaler Village, from Smt. Jyotibai J. Patil, Member, District Parishad, Mr. Dinesh Vikram Patil, President of Youth Congress, Shri Naresh Pawar, President of Schedule Caste / Schedule Tribes, certifying that Shri Rajendra Ratan Kanjer was a permanent resident of Bhaler Village, that he was a cloth Trader and his earnings were approximately from Rs.1.00 lac to Rs.2.00 lacs per year.

From the above documents produced at this Forum, the material facts are contradicting in nature. To resolve a dispute of this nature where contradictory statements are placed, will involve detailed investigations, which could not be held in the summary proceedings under the provision of the RPG Rules 1998. In view of this, the complaint was closed at this Forum with a liberty to the claimant to approach any other appropriate Forum for resolving her dispute.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI-572 (07-08)

Award No. IO/MUM/A/ 99 /2009-2010

Complainant : Shri Aba B Sonar

V/s

Respondent : LIC of India, Nasik

AWARD DATED 12.06.2009.

Shri Ashok Aba Sonar had taken a Life Insurance policy No. 960834424 with S.A. 5.00 lacs. The DOC was from 28.10.2003.

Shri Sonar died on 25th January, 2004. His wife Smt Sarla Ashok Sonar, preferred a claim with the Insurer, it was repudiated by LIC stating that the deceased Life Assured had withheld material information regarding his health at the time of effecting the assurance with the Insurer.

All available documents have been perused. As per the Medical Attendant's Certificate issued by Dr.Lokendra E Mahajan, the primary cause of death of Shri Sonar was Cardio

Respiratory Arrest due to Congestive Cardiac Failure due to Dilated Cardiomyopathy. The doctor had stated that the Life Assured had suffered from the symptoms of the illness since last 3 ½ months. As per a separate certificate issued by Dr. Rajeshwar Patil of Shraddha Hospital, Jalgaon, Shri Sonar was suffering from Chronic Active Hepatitis since two years. This certificate is dated 17th January, 2005. As per the letter dated issued by Dr. Lokendra Mahajan dated 25.3.04, he has stated that he had treated Shri .Sonar for the first time on 23.12.03 and then on 4.1.04 for Congestive Cardiac Failure. He has further stated that due to the poor financial condition of the patient, he could not take further investigation to complete cardiac work up and expired on 25th January, 2004, at home. Though the financial condition was stated to be poor but he had taken a policy for Rs.5.00 lacs, needs to be examined.

In this case the son of the complainant Shri Shyam Aba Sonar and brother of the deceased life assured has denied that his brother had taken any treatment from Dr. Rajeshwar Patil before signing the proposal as stated by LIC, which is the basis of repudiation by the Insurance Company. In order to resolve such issues, deeper investigation is required. Proceedings before this Forum are essentially summary in nature. The complex factual position required that the case to be probed by examining the other parties involved in this case, which is not possible with the limited powers under RPG Rules 1998. In view of the above, the complaint was closed at this Forum with a liberty to the complainant to approach any other suitable Forum for redressal of his grievance.

MUMBAI OMBUDSSMAN CENTRE

Complaint No.LI-626 of 2008-2009

Award No.IO/MUM/A/ 101 /2009-2010

Complainant : Smt. Chhaya Raju Kamble

V/s.

Respondent : Life Insurance Corporation of India, Nanded D.O.

AWARD DATED 17.6.2009

Shri Raju Kaluji Kamble had taken a life insurance policy No.983508993 from Life Insurance Corporation of India, Nanded Divisional Office with SA Rs.1.00 lac under Plan & Term 75-20 with DOC 8.1.2007.

Shri Raju Kaluji Kamble expired on 12.05.2007 due to HIV+. When the claim for the policy moneys was preferred by his wife, Smt. Chayya Kamble, Life Insurance Corporation of India repudiated all liability under the policy on account of the deceased having withheld correct information in the proposal form dated 08.01.2007 regarding his health at the time of effecting the assurance.

The relevant records pertaining to the case have been scrutinized. As per the Certificate of Hospital Treatment signed by the City Tuberculosis Control Officer, Pimpri Chinchwad Municipal Corporation, Pune, the DLA was suffering from Pulmonary TB since 5 months and having HIV reactive status. Patient was on DOTS, AKT, CAT- I with Immunocompromised with Renal disease since last 5 months at Jalna District Hospital. As per the District TB Office, Jalna, dated 14.08.2008, the DLA was taking treatment of TB since 21.12.2006 as it was detected in TB Centre Pimpri Chinchawad Corporation, Pune, as per Lab. No.2528, dated 19.12.2006. After the treatment started, the follow-up was done in the District TB Centre, Jalna vide Lab.No.368, dated 26.2.2007. He was known HIV positive and was on treatment and the history was reported by the patient himself.

From the above records in the file, it is evident that the insured was not keeping good health before proposing for insurance. He did not disclose these facts in his proposal dated 08.01.2007 for assurance, instead gave a false declaration that he was in good health. Had he disclosed these facts at the time of proposal, the underwriting decision would have been different. The claim was denied.

MUM BAI OMBUDSMAN CENTRE

Complaint No. LI – 648 (2008-2009))

Award No. IO/MUM/A/ 01/2009-20010

Complainant : Smt. Kavita Dinesh Sareen

V/s

Respondent : Bajaj Allianz Life Insurance Company Ltd.

AWARD DATED 02.04.2009

Shri Dinesh Kumar Sareen had taken a Life Insurance Policy from Bajaj Allianz Life Insurance Company Ltd. Shri Dinesh Kumar Sareen expired on 04.06.2008 due to Chronic Liver Disease with Jaundice. His wife Smt. Kavita Dinesh Sareen preferred the claim. The Insurer, Bajaj Allianz Life Insurance Company Ltd. repudiated the claim on account of the deceased having withheld material information regarding his health at the time of effecting the assurance. The basis for such decision was at the time of proposal for assurance dated 18.05.2008, the life assured had a history of Jaundice on 12.02.2008 and was admitted for chronic liver disease with jaundice on 20.05.2008. This change in health was known to Late Shri Dinesh Kumar Sareen and he had not disclosed the same in the proposal form and also prior to issuance of policy on 22.05.2008. The insurer stated that had these facts been disclosed, the company would not have covered the risk for the said policy under the same term and conditions. Hence, the claim was repudiated due to non-disclosure of material fact.

The documents produced at this Forum have been examined. As per the Medical Attendant / Hospital Treatment Certificate signed by Dr. Mukesh Parikh, DM. (Card) M.D. (Med.), Shri Dinesh Sareen was admitted on 20.05.2008 at Hindu Maha Sabha Hospital. He was diagnosed as Hepatic

Encephalopathy Chronic Liver disease since 2-3 months. He was admitted with Anorexia / loose motions 3 -5 times a day / yellowing of skin 2-3 months. The history was given by the patient himself. The case papers of the hospital also mention as "Chronic alcoholic". He expired on 04.06.2008 and cause of death was Chronic Liver Disease with Jaundice The patient was seen by him for the 1st time on admission.

There is a certificate from the family Doctor dated 28.07.2008, signed by Dr. Rakesh Chand, MBBS. The family doctor states that the patient was his brother and he treated him for jaundice from 12.02.2008. The LA under the consultation of Dr. Rakesh Chand had undergone certain medical tests that where prior to the proposal date. There are various medical reports submitted which are dated prior to date of proposal There is an Ultrasound Report dated 22.04.2008 stating "Liver Parenchymal Disease". The USG report dated also 22.04.2008 of Upper Abdomen states "enlarged liver with generalized increased echogenecity (grade II) with slightly altered echotexture". The "Hepatic Profile" dated 24.04.2008 shows the Investigation findings are not in the normal range and are on the higher range in respect of the Total Bilirubin, Direct Bilirubin, Indirect Bilirubin and S.G.PT. The Haemogram report also indicates that the Haemoglorin count was 6.5 much lower than the normal range. His E.S.R. shows 122 mm/hour to that of normal range of 01-15.

It is evident from the documents produced that the DLA was suffering from Jaundice since 12.02.2008 that is before the proposal for assurance. His various medical reports are dated prior to the proposal for assurance. He was admitted to the hospital on 20.05.2008 for Chronic Liver Disease with Jaundice. The date of commencement of policy was from 22.05.2008. The DLA was well aware of his ailments which he did not disclose in the proposal form. He was also admitted to hospital before the issue of the policy. If this history would have been disclosed by the LA, the Insurer would have called for special medical reports and the underwriting decision might have been changed.

In view of this legal position the Insurer cannot be faulted for repudiating the claim for deliberate misstatements and suppression of material facts by the life assured. Hence the decision of Bajaj Allianz Life Insurance Company Ltd. does not warrant any interference from this Forum. However, as this was a Unit Gain Plan which has investment component, the Insurer is directed to pay Rs.10,000/- on ex-gratia basis to the complainant.

MUMBAI OMBUDSMAN CENTRE
Complaint No.LI - 654 (08-09)
Award No. IO/MUM/A/ 111/2009 - 2010
Complainant : Shri Vilas Ganpat Avhad
V/s.
Respondent : Life Insurance Corporation of India, Nasik D.O.

AWARD DATED 29.6.09:

Shri Vilas Ganpat Avhad had taken life insurance Policy No.960344887 from Life Insurance Corporation of India, Nasik D.O for sum assured Rs.1.00 lac under Plan & Term 89-17 (Jeevan Sathi Double Cover Joint Life Policy with Profits with Accident Benefit). The yearly premium amount was Rs.6798/-. The date of proposal and date of commencement of the policy was 15.06.2007. Smt. Sangita

Vilas Avhad wife of Shri Vilas Ganpat Avhad expired on 14.03.2008 due to Burns. Shri Vilas Ganpat Avhad preferred a claim to LIC. The Insurer admitted the claim as per provision of Clause 4 (b) by only refund of premium paid by the insured. The deceased was a housewife aged 24 years at proposal stage, therefore, as per their rules, a restrictive clause i.e. Clause 4(b) was applicable to this policy. As per the provision of this clause, if the life assured dies due to accident at a place other than public place, within three years from the date of risk, the benefits under the policy are not payable and the Corporation's liability shall be limited to the sum equal to the total amount of premiums (exclusive of extra-premiums, if any) paid under this policy without interest.

The documents submitted to this Forum have been perused. From the Police papers – Police Panchnama, Spot Panchnama & Inquest Panchnama, it seems that Smt. Vilas Ganpat Avhad expired due to stove bursting at her residence and she suffered severe burns. As per the Inquest Panchnama, the body was identified by Shri Anonda M. Sanap, father of the deceased. According to the Post Mortem Report which was performed at the District Hospital, Nasik, the cause of death was Shock due to Septicemia due to Burns. According to Claim Forum B – Medical Attendant's Certificate signed by Dr. Sanjay H. Dhurjad, of Sudarshan Hospital, Nasik, Smt. Sangita was brought to the hospital on 10.03.2008 and she expired after 4 days on 14.03.2008. The primary cause of death was due to burns. When the Claimant, Shri Vilas Ganpat Avhad, preferred the claim, LIC rejected the claim as per restrictive Clause 4(b) imposed on this policy. The Clause 4 (b) reads as under:

"Notwithstanding anything within mentioned to the contrary it is hereby declared and agreed that in the event of death of the life assured occurring as a result of intentional self injury, suicide or attempted suicide, insanity, accident other than an accident in a public place or murder at any time on or after the date on which the risk under this policy has commenced but before the expiry of three years from the date of this policy, the Corporation's liability shall be limited to the sum equal to the total amount of premiums (exclusive of extra premium, if any, under this policy without interest).

"Provided that in case the life assured shall commit suicide before the expiry of one year reckoned from the date of this policy, the provisions of the clause under the heading "Suicide" printed on the back of the policy shall apply".

The Insurer has rejected the claim on the basis of this clause. The duration of the policy was for only 8 months and 29 days. Since a special Clause 4(b) is imposed on this policy for the first three years, therefore, the claim for the full Sum Assured as also the Accident Benefit is not payable. However, as per provision of Clause 4 (b), only refund of premiums is payable to the claimant.

AWARD DATED 15.5.2009

Shri Ashok Bhaulal Burad had taken a Life Insurance Policy from LIC of India, Mumbai D.O. II. The SA was Rs.2.00 lac with DOC 21.2.06

Shri Ashok Bhaulal Burad expired on 14.11.2007 due to Jaundice. His wife Smt. Kiran Ashok Burad preferred the claim. The Insurer, LIC of India rejected the claim vide their letter dated 29.09.2007 stating that since the policy was in lapsed condition as on the date of death of the deceased life assured, no claim concession can be made applicable in terms of the policy condition. As such nothing is payable under this policy.

The documents produced at this Forum have been examined. Shri Burad had proposed for a policy through his wife Smt, Kiran A. Burad, who is an Agent of LIC of India with Agency Code No.42588A. The date of commencement of his policy was from 21.02.2006. Total 3 half-yearly premiums were paid. The date of first unpaid premium became due on 21.08.2007 and the policy lapsed due to nonpayment of premium within grace period of one month which expired on 21.09.2007. Shri Burad expired on 14.11.2007 due to Jaundice. The death had occurred after the grace period. According to the policy condition a Grace period of one month but not less than 30 days is allowed for payment of yearly, half-yearly and quarterly premiums. If a premium that has become due, if not paid before the expiry of the days of grace, the policy lapses. The policy has also not completed 3 years of policy period to acquire paid-up value. Only three half-yearly premium were paid and as the policy was in a lapsed condition on the date of death, no claim concession is applicable and according to policy conditions, nothing is payable.

From the above facts of the case and in view of the terms and conditions of the policy, the Insurer cannot be faulted for rejecting the claim.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 700 (2008-2009))

Award No. IO/MUM/A/ 027 /2009-20010

Complainant : Smt Chaaya Madhukar Adhamgale

V/s

Respondent : Tata AIG Life Insurance Company Ltd.

AWARD DATED 7.5.2009

Shri Madhukar Sabaji Adhamgale had taken a Life Insurance Policy from Tata AIG Life Insurance Company Ltd. with SA 2.00 lacs. The DOC was from 28.2.07.

Shri Madhukar Sabaji Adhamgale expired on 02.09.2007 due to Acute Mayo Cardinal Infraction. His wife Smt. Chaaya M. Adhamgale preferred the claim. The Insurer, Tata AIG Life Insurance Company Ltd.. repudiated the claim on account of the deceased having withheld material information regarding his health at the time of effecting the assurance. The basis for such decision was at the time of proposal for assurance dated 28.02.2007, the life assured was suffering from Aortic Aneurysm since 1998 and this history was not disclosed at the time of application for insurance. The Company stated that this material information was known to Late Shri Madhukar Adhamgale and he had not disclosed the same in the application form. The insurer stated that had these facts been disclosed, the underwriting decisions would have been different.

The documents produced at this Forum have been examined. The Deceased Life Assured was a Government Employee working in the Mumbai Port Trust. During the claim investigation, the Company obtained a letter dated 25.01.2008 from Dr. J.P. Tamaskar, Asstt. Chief Medical Officer of Port Trust Hospital. The said letter mentions that Shri Madhukar Adhamgale was a known case of Aortic Aneurysm on treatment and regular follow up in the said hospital since September 2002. His periodical Health Check up was done on :

1. November 1998 – Aortic Aneurysm.
2. August 2003: Aortic Aneurysm

As per the Port Trust Hospital, Indoor Record:

1. Patient was admitted on 02.08.2007 in Port Trust Hospital for Carbuncle on back. He was given conservative treatment and was discharged on 07.08.2007
2. Patient was again admitted on 01.09.2007 at 11.25 A.M. with a case of Chest Pain radiating to back for about 1-2 hours.

Patient had past history of Aortic aneurysm with dissection. His ECG showed hyper acute ASWMI with Reciprocal change in Ant. Lead. Patient was started on Stand line of treatment and thrombolized with Streptokinase. However the patient's chest pain was not relieved and it recovered after 3.00 P.M. Case was discussed with Asstt. Chief Physician, Port Trust Hospital and was shifted to K.E.M. Hospital, Mumbai.

The Cause of Death Certificate issued by K.E.M. Hospital, Mumbai states that the provisional cause of death was Acute Myocardial Infarction in a k/c/o Abdominal Aortic Aneurysm.

It is evident from the documents produced that the DLA was suffering from Aortic Aneurysm since November 1998 that is before the proposal for assurance.

From the above facts, it is evident that the deceased life assured suppressed material information and made misstatement regarding his health at the time of proposal and thereby denied an opportunity to the Insurer to probe in the matter and take appropriate underwriting decision before issue of policy. The claim was denied.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 701 (2008-2008)

Award No. IO/MUM/A/ 017 /2009-2010

Complainant : Smt. Sharadha R. Charnia

V/s

Respondent : Life Insurance Corporation of India , Pune Division II

The brief facts of the case as per complaint are as under:

Shri Ramesh Daiyalal Charnia had taken a Life Insurance Policy 953796068 from LIC of India for SA Rs.1.00 lac. The DOC was 14.11.2005. Shri Ramesh Daiyalal Charnia expired on 13.12.2006 due to Acute Terminal Cardiac Respiratory Arrest. The claim was preferred by his wife Smt. Sharadha Ramesh Charnia. LIC repudiated the on account of the deceased having withheld correct / material information regarding his health at the time of effecting the assurance.

The documents on record have been perused. As per the Medical Attendant's Certificate (Claim Form B) and Certificate of Hospital Treatment (Claim Form B1) dated 07.03.2007, signed by Dr. Anitha M.S, Shri Ramesh Charnia was admitted to the Civil Hospital, Solapur on 13.12.2006 and expired on the same day due to Acute Terminal Cardio Respiratory Arrest. To the question "How long had he been suffering from the disease before his death" – The answer stated was "6 years" "What were the symptoms of illness" – "Chest Pain". To the question "What was the date on which you were first consulted during the illness? "04.05.2001". It is also mentioned that he was a chronic smoker. In the Certificate of Hospital Treatment, it is mentioned that the DLA was admitted on 04.05.2001 to 12.05.2001 for Myocardio Infraction in ESI Hospital. The history and information was recorded by the DLA himself. There is a letter from the S.S.M.S.R. Hospital, Solapur mentioning that DLA was Non-MLC, hence all the records are destructed on 16.07.2007. But they are having the register and as per their register, the DLA was admitted for Anterior Wall Myocardial Infarction on 04.05.2001 and discharged on 12.05.2001.

It is evident from the above documents on record that the deceased life assured was admitted to that hospital before proposing for assurance which was not disclosed in the proposal form. Had he disclosed the correct information, LIC would have called for relevant medical reports and taken appropriate underwriting decision. The claim was rejected.

Complaint No. LI-711(08-09)

Award No. IO/MUM/A/ 96 /2009-2010

Complainant : Smt. Bharti R Lade

V/s

Respondent : ICICI Prudential Life Insurance Co.Ltd., Mumbai

AWARD DATED 12.6.09

Shri. Rajiv Shivrampant Lade had taken a Life Insurance Policy from the ICICI Prudential Life Insurance Company, The DOC was from 17.3.07 and SA was Rs.1.2 lacs

Due to the unfortunate death of Shri Lade on 22.7.2008, the nominee and wife of the deceased life assured, Smt Bharati R Lade, preferred a claim with the Company which was repudiated by them stating that they had noted that the deceased Life Assured was suffering from Rheumatoid Arthritis since four years and was on treatment with Leflunomide and Methotrexate and the Life Assured expired due to Steven Johnson Syndrome Secondary to Drug Toxicity – Leflunomide with Fungal Septicemia. They further stated that these facts were not mentioned in the proposal for insurance dated 17th March, 2007, filled by the late Shri Lade.

Consequent to the hearing, the complainant had submitted certain consultation papers pertaining to the deceased Life Assured. In the undated consultation papers of Wockhardt Hospital of Dr. Kaushal C. Malhan, the following noting could be observed : "Mr. Rajiv Lade, 49 years, multiple joint pain and swelling. H/O Synvectomy, Synovial thickening. Advice ..? R.A."

The records have been perused. As per the Medical Attendant's / Hospital Certificate issued by the doctor of Lilavati Hospital and Research Centre dated 19.8.2008, the primary cause of death of Shri Lade was Steven Johnson Syndrome and the secondary cause of death is drug toxicity – Leflunomide with Fungal Septicemia. The details of illness/symptoms have been mentioned as "k/c/o rheumatoid Arthritis since 4 years. And the history was mentioned by the patient himself" In the family doctor's certificate dated 30.8.2008 issued by Dr. C M Ashtekar, he had mentioned that Shri Lade was a " k/c/o Rheumatoid Arthritis, was on Rx for the same by Dr.Akerkar." In the Transfer Summary issued by Sai Hospital, it is noted as follows: "Patient k/c/o Rh.arthritis of 4 years on T Hydroxychloroquine, leflunomide/indomethacin." In the Case Summary issued by Lilavati Hospital dated 6th August, 2008, it has been noted that Shri Rajiv Lade was a known case of Rheumatoid Arthritis.

From all the above reports, it could be ascertained that Shri Lade had indeed suffered from rheumatoid arthritis prior to proposing for insurance. The repudiation of the claim by the Insurer was on the ground that the deceased Life Assured suppressed the fact that he was suffering from the above

disease which needed to be disclosed in the proposal filled up by him in March, 2007. It could be established from various hospital papers and doctor's statements that Shri Lade had known about the existence of the disease prior to March, 2007 and still have chosen not to disclose the same . Thus, the Insurer has proved with cogent evidence that the life assured had suppressed material facts. The claim was denied.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 98 (2009-2010)

Award No. IO/MUM/A/ 162 /2009-20010

Complainant : Smt. Sushama Rahate

V/s

Respondent : Life Insurance Corporation of India, Mumbai Division II

AWARD DATED 7.8.2009

Shri Nishikant Prabhakar Rahate had taken a Life Insurance Policy from LIC for SA Rs.8.00 lacs under plan/term 164-15 Anmol Jeevan. The date of commencement was from 1.8.05. The mode of payment was annual.

Shri Nishikant Prabhakar Rahate expired on 15.11.2006 due to Cirrhosis of Liver with Hepatitis C with Abdominal Lymphadenitis due to Koch's disease.. His wife Smt. Sushama Rahate preferred the claim. The Insurer, LIC of India rejected the claim stating that since the policy was in lapsed condition as on the date of death of the deceased life assured, no claim concession can be made applicable in terms of the policy condition. As such nothing is payable under this policy.

The documents produced at this Forum have been examined. Shri Rahate had proposed for a policy on 20.11.2005. The date of commencement of his policy was from 01.08.2005. The date of first unpaid premium became due on 01.08.2006 and the policy lapsed due to nonpayment of premium within grace period of 15 days Shri Rahate expired on 15.11.2006. The death had occurred after the grace period. According to the policy condition under Table 164 (Anmol Jeevan) the Grace period for payment of premium in terms of policy condition No.2, if the premium is not paid before the expiry of the days of grace, the policy lapses. Policy Condition 2 states:-

"Payment of Premium: A grace period of 15 days will be allowed for payment of yearly, half-yearly or quarterly premiums. If death occurs within this period or before the payment of the premiums then due, the policy will still be valid and the sum assured paid after deduction of the said

premium as also unpaid premiums falling due before the next anniversary of the policy. If the premium is not paid before the expiry of the days of grace, the policy lapses".

As per the above policy condition, the policy was in lapsed condition as on the date of death. The death had occurred after the due date and grace period. Further under this plan claim concessions are not applicable. Only one yearly premium was paid and as the policy was in a lapsed condition on the date of death, nothing is payable.

From the above facts of the case and in view of the terms and conditions of the policy, the Insurer cannot be faulted for rejecting the claim.

MUMBAI OMBUDSMAN CENTRE

Complaint No. LI – 127 (2009-2010)

Award No. IO/MUM/A/ 100 /2009-2010

Complainant : Smt. Kiran Deepak Jagtiani

V/s

Respondent : Life Insurance Corporation of India, Mumbai D.O.III

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AWARD DATED 12.6.2009

The deceased, Shri Deepak Gul Jagtiani had taken a Life Insurance Policy from LIC for SA 1.5 lac with DAB. The DOC was from 28.3.06. The policy lapsed on 28.9.06 and was revived on 2.4.07.

Shri Deepak Gul Jagtiani expired on 09.04.2008 due to Myardial Infarction and hypertension. When the claim was preferred by his wife Smt. Kiran D. Jagtiani, LIC repudiated the claim on account of the deceased having withheld correct information regarding his previous policy at the time of effecting the assurance.

It has been revealed from the proposal form dated 30.03.2006 for the policy under dispute that the life assured did not disclose details of his previous policy No.902749220 taken by him in March 2006. To a specific question in the proposal for assurance – Is your life now being proposed for another assurance or an application for revival of a policy on your life or any other proposal under consideration in any office of the Corporation or any other insurer? If so, give details. To this question the insured had answered "No". "Please give details of your previous

insurance (including the policies surrendered / lapsed during the last 3 years), the DLA had disclosed one policy taken in August 2004. He however, did not disclose the recent policy which he took on 03.03.2006 from Branch No.918 under Mumbai Division-I as also policy No.902421211 (Jeevan Kishore). The policy under dispute was proposed on 30.03.2006 from a different branch under Mumbai Division III in the same month. It is also noted from the proposal form that initially the sum proposed was for Rs.5.00 lacs. However it was later changed to Rs.1.5 lacs for the reasons best known to the proposer.. Under the Insurance law, the proposer is required to disclose all the material facts including details of the previous policies held by him at the time of applying for a new policy. This information is required by the Insurer to make a reference to previous policy records to ascertain the previous set of measurements which may indicate change/deterioration of the health of the life assured and other material information disclosed in the previous proposals which would enable the underwriter to take appropriate decision in the latest proposal. These details are also required by the Insurer to arrive at "Sum Under Consideration" (SUC) since various special reports required for underwriting the proposal depends on SUC.

In this case, it is established that the previous policy details which was material for underwriting the proposal was not disclosed by the life assured,. Had he disclosed the correct information, LIC would have called for relevant Special Medical Reports like ECG, Haemogram, BST, Lipidogram, RUA, Elisa for HIV would have been mandatory for taking into account previous policies and the current proposal and taken appropriate underwriting decision. It is also noted that in the beginning of March, 2006, he applied for insurance from a branch under Mumbai Division I and at the end of March, 2006, he submitted yet another proposal under different branch under Mumbai Division III.

The complainant's contention that the proposal forms were filled by Agents hastily and there was pressure to sign the proposal and that is why the previous proposal was unintentionally not mentioned does not deserve acceptability because it is well settled in law that once a person puts his signature on the proposal form, the proposer is responsible for the correctness of the answers as per the declaration irrespective of the fact that who has completed the form. The claim was denied.

MUMBAI OMBUDSMAN OFFICE

Complaint No. LI – 548 (2008-2009)

Award No. IO/MUM/A/ 018/2009-2010

Complainant : Smt. Nilofar Dildar Shaikh

V/s

Respondent : Life Insurance Corporation of India , Pune Division I

The brief facts of the case as per complaint are as under:

Shri Dildar Subhedar Shaikh had taken 2 Life Insurance Policies from LIC of India.ife Insurance Corporation of India.

Shri Dildar Subhedar Shaikh expired on 31.12.2006 due to Pneumonectomy. The claim was preferred by his wife Smt. Nilofar Shaikh. Life Insurance Corporation of India repudiated the claim vide their letter dated 05.03.2008 on account of the deceased having withheld correct information regarding his health at the time of effecting the assurance.

LIC of India, however, stated that the Life Assured was suffering from Pneumonetomy for which he consulted medical men and was on regular treatment. He did not, however disclose these facts in his proposals for insurance.

The documents on record have been perused. Discharge Summary of Anand Rishiji Hospital and Medical Research Centre, Ahmednagar, states that Shri Dildar Shaikh was admitted on 24.12.2006. The Diagnosis given was "Pneumonectomy". The past history mentioned – "Pneumonectomy in 1975" As per the Medical Attendant's Certificate (Claim For B) and Certificate of Hospital Treatment (Claim Form B-1) dated 30.10.2007, signed by Dr. Mrunali K. Nakhale, M.B.B.S., of Ruby Hall Clinic, Pune, states that Shri Dildar Shaikh was admitted on 27.12.2006 and expired on 31.12.2006. The Primary cause of death was DIC with Sepsis with Lt. Lung Consolidation with ® Pneumenectomy. The date on which the disease first observed by the patient. The answer given was "In 1983". And the history was given by him brother-in-law. Though the period is different, it is clear that he had pneumonectomy before taking the policy.

In a written submission dated 21.04.2009, Smt. Nilofar Shaikh stated that according to her knowledge, her husband was operated at the age of eight for pneumonectomy and not 10 years back However, as per the medical records, the history was reported by his brother-in-law, Shri Zhiyash Mohamed Shaikh.

The Insurer repudiated the claim wholly on the grounds that the DLA had not disclosed that he was suffering from Pneumonectomy and taking treatment. Before proposing for assurance, the proposer should disclose all information relating to health & habits truthfully in the proposal form. Had he disclosed the correct information, LIC would have called for relevant medical reports and taken appropriate underwriting decision. The claim was rejected.

Award No. IO/MUM/A/ 131 /2009-2010

Complainant : Smt. Kanta L. Nimbarte

V/s

Respondent : Life Insurance Corporation of India, Nagpur Divisional Office

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AWARD DATED 16.7.2009

The deceased, Shri Laxman Bisanji Nimbarte had taken a Life Insurance Policies from Life Insurance Corporation of India

Shri Laxman Bisanji Nimbarte expired on 29.02.2008 due to renal failure. When the claim was preferred by his wife Smt. Kantabai L. Nimbarte, Life Insurance Corporation of India repudiated the claim on account of the deceased having withheld correct information regarding his previous policies at the time of effecting the assurance.

On the claimant's representation, the case was referred to the Western Zone Claims Review Committee of LIC of India for review of the case, but the decision was upheld and conveyed by Nagpur Divisional Office

The documents produced at this Forum have been perused. The deceased life assured had proposed for two policies. The first Policy No.975367752, with date of proposal 13.03.2007, he had not disclosed in the proposal form of his previous Policy No.974957157 (Date of commencement 25.10.2005 with sum assured Rs.1.00 lac). In the second Policy No. 975723721 with date of proposal 24.12.2007 with sum assured Rs.65,000/-, he had not disclosed Policy No.975367752 of 03/2007 but only disclosed Policy No.974957157 of 10/2005. Under the Insurance law, the proposer is required to disclose all the material facts including details of the previous policies held by him at the time of applying for a new policy. This information is required by the Insurer for underwriting the risks and to decide about the medical requirements. These details are also required by the Insurer to arrive at "Sum Under Consideration" (SUC) since various special reports required for underwriting the proposal depends on SUC.

In this case, it is established that the previous policy details were not disclosed in the proposal papers. Had he disclosed the correct information, LIC would have called for relevant Special Medical Reports like Fasting Blood Sugar etc to underwrite the case depending upon the Sum Under Consideration.

The complainant's contention is that all the insurance policies of her husband were taken from the same Branch of LIC of India (Bhandra Branch No.97A under Nagpur Divisional Office) and that the Insurer had all access to his records and they would have had no problem to verify the material facts. In the absence of the details it is not possible for the Insurer to connect to the previous policies.

The previous proposal was not mentioned and that the insurer had access to the previous records does not deserve acceptability because it is well settled in law that once a person puts his signature on the proposal form the proposer is responsible for the correctness of the answers as per the declaration irrespective of the fact that who has completed the form. The dispute is for the non-disclosure of previous insurance in the proposals for assurance which was material for acceptance of the risk. In view of this the rejection of the claim by LIC of India is justified.