Case of:- Ms.Megha Shah Vs The Oriental Insurance Co. Ltd.
Complaint No. AHD-G-050-1718-0183-0184-0185-0186

Date Of Award: 21/06/2017 **Policy No.** 530000/48/2016/507

The Complainant was a member of a group policy issued to "Jain International Organisation(HNI Policy)" under the name "Group Mediclaim Tailormade Policy -Floater scheme" issued by the Oriental Insurance Co Ltd in for the period of 16/02/2016 to 15/02/2017 for a sum insured of Rs. 20,00,000/-. The Complainant was hospitalized at HCG Cancer Center for chemotherapy treatment Four times. When a claim was filed for reimbursement, the Company had rejected the claim mentioning other reason. Aggrieved by the decision she had approached the Forum for redressal.

The complainant is a beneficiary of group policy issued to "Jain International Organisation(HNI Policy)" under the name "Group Mediclaim Tailormade Policy -Floater scheme" issued by the Oriental Insurance Co Ltd for the period of 16/02/2016 to 15/02/2017 for a sum insured of Rs. 20,00,000/-. Under subject policy pre-existing disease is covered from day one as per terms and condition of the policy. The Respondent had repudiated the claim on the ground of "Other Reason" without specifying the reason in the repudiation letter.

8(Eight) claims settled by the company in current policy period and the claim filed in August-2016 & thereafter were rejected by the company, on the ground that the disease for which treatment was taken, was pre-existing and the same was not disclosed by the insured "Jain International Organisation". If the pre-existing disease is covered from day 1, then disclosure or non disclosure of pre-existing would not have made any difference. It is also not known, why the company has earlier paid 8 similar claims under the impugned policy.

The complaint is thus admitted. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing, the Respondent is hereby directed to pay in all Four claim amount aafter deduction of Co-Payment in payment more than 50000/- as per t&c- to the Complainant**

Case of: SHRIS SESHAN V/s THE NEW INDIA ASSURANCE COMPANY LIMITED
Complaint No: BNG-G-049-1617-0793

Date of Award: 8th May, 2017
Repudiation of Claim for non-compliance of policy conditions – Upheld.

The Complaint was for non-settlement of bills submitted in 2014 & 15 for treatment of prostrate carcinoma, in the form of Harmone Therapy.

The Complainant questioned why the Respondent Insurer did not settle **standalone harmone therapy** whilst the same were settled when given along with the expenses for the treatment with radiotherapy.

On careful scrutiny of the documents on record, it is observed that there was no hospitalisation as required by the policy terms for the administration of the injections and the said administration of injection is also not found in the list of the Day Care Procedures, qualifying for its admissibility.

Therefore, the Forum had no opportunity interfere in the decision of the Respondent Insurer.

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Complaint No: BNG-G-048-1617-0804
Case of Shri K.V RAMANAIAH V/s NATIONAL INSURANCE COMPANY LIMITED
Date of Award: 09.05.2017.
Replacement of Implanted Pulse Generator – As per internal company guidelines not payable – As it is not part of policy condition not binding – ALLOWED.

The dispute was with regard to repudiation of the claim for reimbursement of hospitalisation claim for change of Implanted Pulse Generator, which was a lifesaving treatment and but for this treatment, the Complainant would not be able to live a normal life and was done through a surgical procedure under medical care at Hospital only.
The Respondent Insurer was relying on the policy conditions applicable as per the Tender process and state that they have been incorporated as part of the policy and also claim settlement guidelines of the Company. The above said treatment was not an exclusion under the policy and also was not inclined to accept the Respondent Insurers' contention that the claim was not payable as per circular and Claim settlement guidelines, as the same was only an internal guideline and was not part of the policy condition. Hence, the complaint was ALLOWED.

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Complaint No: BNG-G-048-1617-0738

Case of: Shri JAYAPANDIAN V/s NATIONAL INSURANCE COMPANY LIMITED

Date of Award: 09.05.2017.

Post Hospitalisation expenses – As the advance payment towards prosthetic leg had been made before 60 days, claim was ALLOWED.

The dispute is with regard to repudiation of the claim under post-hospitalisation benefit for reimbursement of cost of Prosthetic leg costing ₹.1,60,000/-. The Complainant had placed the order for the supply of prosthetic leg and had made the payment of ₹.85,000/- as advance within the permitted period of post-hospitalisation. The Respondent Insurer contended that the Final invoice was made after the completion of the post-Hospitalisation period and hence, the claim was not payable. As the Claimant had incurred the expense by placing the order for the prosthesis and making a substantial advance payment for the same as it was a patient specific and the date of the final receipt for the payment for the supply of the prosthesis was of not much consequence. As such, the benefit under the policy cannot be denied. Hence, complaint was ALLOWED.

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Complaint No: BNG-G-003-1718-0004

Case of SHRI RAVIKIRAN.P V/s APOLLO MUNICH HEALTH INS CO LTD

Date of Award: 09.05.2017.

Treatment mainly of various types of body massages undergone at Naturopathy centre –— Not payable – DISMISSED.

The complaint was for rejection of claim incurred at Naturopathy & yoga centre. The ground for rejection was that the treatments undergone did not require hospitalisation. This Forum noted that the treatment undergone by the Complainant did not come under the scope of the policy as the treatment taken did not require hospitalisation as per the terms of the policy. Hence, the complaint was DISMISSSED.

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Easy Health Insurance Group

Case of Shri PRAMOD ABRAHAM KORAH V/s APOLLO MUNICH HEALTH INSURANCE COMPANY LIMITED

Complaint No: BNG-G-003-1617-0837

Date of Award: 9th May, 2017

Repudiation for absence of active line of treatment – Upheld

This complaint emanated from the repudiation of the claim on the grounds of absence of active line of treatment during the hospitalisation.

On careful scrutiny of the hospital records, it was observed that except the investigations, no active line of treatment was provided to the patient and the discharge advice was also the continuation of the previous medication only and thus the present hospitalisation fell under the exclusion no. xiv of the Policy. Hence, the repudiation of the claim was in order. Therefore, the Forum had no opportunity to interfere with the decision of the Respondent Insurer.

Complaint No: BNG-G-051-1617-0746
Case of: SHRI S.K. GOVINDEN V/s UNITED INDIA INSURANCE CO LTD

Date of Award: 10.05.2017.
Repudiation of claim for hospitalisation of less than 24 hours – DISMISSED.

The Complainant aged about 79 years, was hospitalised for Viral Fever He was insured under Group Health Insurance policy by his previous Employer with the Respondent Insurer. He was admitted into Hospital at 19.07 hrs and was discharged at 13.48 hrs on 23.05.2016. Further, he underwent ultrasonography at different Hospital at 21.03 hrs on 23.05.2016.
The Respondent Insured rejected his claim stating that the duration of hospitalisation was less than 24 hours. The Complainant's contention was that when both the treatments were considered, it would exceed 24 hour and hence, claim should be paid. The decision of the Respondent Insurer in repudiating claim was as per policy conditions. Hence the complaint was Dismissed

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Complaint No: BNG-G-051-1617-0796
Case of SHRI INDHUDHAR M PATIL V/s UNITED INDIA INSURANCE CO LTD
Date of Award: 10.05.2017.
Short settlement of claim – Room rent more than entitled category - ALLOWED

The dispute was with regard to short settlement of hospitalisation claim. The Respondent Insurer contended that the Insured person had availed higher room of his eligibility hence, there was deduction of other charges proportionately. As per the policy condition in case the Insured opts for a room with rent higher than the entitled category, the charges payable shall be limited to the charges applicable to the entitled category. +
The Forum was not presented with any condition that the charges would be reduced proportionately. As the Respondent Insurer had failed to support of their decision, the benefit of doubt was extended to the Complainant. Hence, Respondent Insurer was advised to re-workout the claim payable without invoking the applicability of the non-existent proportionate clause and settle the claim accordingly.
Hence, claim was ALLOWED.

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Mediclaim Insurance Policy (Group)
Case of: SHRI VAMSIDHAR TOKALA V/s THE ORIENTAL INS CO LTD
Complaint No: BNG-G-050-1617-0827
Date of Award: 10.05.2017
Repudiation for non-compliance of Policy terms and conditions – Upheld
The complaint was denial of oral administration of Tab. Tykerb for treatment of cancer for Complainant's mother.

The Forum, after careful scrutiny of the Policy pertaining to the parents of the employees and its relevant conditions, it was observed that Sl. 18 of the Special Conditions was applicable to this claim. In the instant case, though this stipulation was expressed by the Respondent Insurer's representatives that a doctor's certificate was required confirming the necessity of administering oral medication. The Complainant has however not offered any comments about the availability of the said doctor's certificate.

In such a case, the Forum has found the non-compliance of the said condition due to absence of such doctor's certificate. However, this being a requirement for payment of the claim, the TPA of the Respondent Insurer should have called for the certificate specifically before rejecting the claim. Therefore, the Respondent Insurer was advised to call for the said certificate and on receipt of the said certificate and settle the claim.

Thus, the complaint was conditionally ordered.

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Tailormade Group Mediclaim Policy

Case of: SHRI GOVINDARAJAN C V/s UNITED INDIA INSURANCE CO LTD

Complaint No: BNG-G-051-1617-0843

Date of Award: 10th May, 2017

Repudiation for absence of active line of treatment - Dismissed

The claim of the Complainant's wife was repudiated by the Respondent Insurer stating that the investigations were only carried out without any active line of treatment and it could have been managed on OPD basis without involving hospitalisation.

The Forum, after close scrutiny of the records and submissions made, observed that pre-hospitalisation condition was such that she had giddiness and had a fall of 3 times in a kitchen and was unconscious for a while, itself indicates that her condition was so fragile that would require her to be taken to the hospital for medical care.

On further scrutiny of the hospital records, it was observed that the patient was provided with infusions and GRBS on almost all days of hospitalisation, which goes to say that she had been given with treatment. The admission into the hospital and the duration of stay of 7 days in the hospital were, as per the advices of the treating doctors and not at the discretion of the patient.

The Forum further opined that the investigations (one treatment for about 24 hrs observation) conducted were in the nature of ascertaining the condition of the patient to provide required treatment including dosage, as evidenced in the Discharge Summary.

Thus, the decision of the Respondent Insurer was found to be contrary to what it should have been. Hence, the complaint was Allowed.

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Cancomfort Insurance Certificate
Case of: SHRI R G MUNDHRA V/s UNITED INDIA INSURANCE CO LTD
Complaint No: BNG-G-051-1617-0760

Date of Award: 10th May, 2017

Short settlement of claim restricting to GIPSA Rates – Dismissed

The complaint arose out of the short settlement of the claim, on the ground of restricting to GIPSA rates. The Complainant contended that the Policy issued to him did not have such stipulation and his claim was to be settled in full, since the SI was adequate.

The Forum, on careful scrutiny of the policy, observed from the Condition no. 4 that, if treatment was taken on Package basis, it would be considered subject to adequacy of the Sum Inured without any riders. Further, the policy issued had no sub-limits like on room rent, pharmacy, doctors' fees, treatment charges and no cap for any form of hospital charges.

The TPA, Meditek in their cashless approval letter addressed to hospital, in a crystal clear terms that the cashless approval given for ₹. 1,86,500/- was full and final, as per GIPSA package and no amount should be collected from the patient, and if it was collected, it would be deducted from the pay out of the Hospital. Therefore, the approval was very categorical.

Upon careful scrutiny of papers/documents submitted by both the parties, the Forum observes that the treatment having been taken in a Network Hospital, it is the sole responsibility of the TPA/Respondent Insurer to ensure the implementation of pre-agreed rates/packages and the deviation, if any, would be at their risk. Therefore, it was an issue to be settled between the Respondent Insurer and its network hospital. The Insured cannot be penalised for the breach made by the hospital of the agreement with the Insurer, as its TPA had not advised the Insured about the pre-agreed package rate and had not warned them against any additional payment.

Therefore, the Respondent Insurer was advised to release the balance amount to the Complainant.

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Complaint No: BNG-G-049-1617-0792
SHRI C.V.SATHYANARAYAN V/s THE NEW INDIA ASSURANCE CO LTD

Date of Award: 10.05.2017.

Claim for Lab Test which was not covered under the policy–Disallowed.

The complaint was for reimbursement of amount incurred for Pathological test of CA-125. Respondent Insurer admitted that limitation of 24 hours hospitalisation was not applicable to certain surgeries/procedures as per policy and the test CA-125 was not mentioned in the list. As the rejection was as per policy terms, the complaint was DISALLOWED.

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Complaint No: BNG-G-044-1617-0839
SHRI HITESH JAIN V/s STAR HEALTH & ALLIED INSURANCE CO LTD

Date of Award: 10.05.2017
Treatment for SPMF rejected – COMPROMISED.

The Complainant was for rejection of claim for Sequential Programmed Magnetic Field (SPMF Treatment). The Respondent Insurer had repudiated the claim on the ground that the said therapy was an unproven experimental and this should have been taken as a day care procedure. With the intervention of this Forum, the matter was compromised.

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COMPLAINT REF:NO: GUW-G-051-1617-0077 (Order dt. 24/04/2017)

Mr. Akhtar Husain V/S The United India Insurance Co. Ltd.

In Complainant's words:Post hospitalization & discharge of Complainant's mother all requisite documents were submitted through Complainant's Employer Allahabad Bank, Zonal Office, Guwahati to the TPA concerned on 17/06/2016. All queries raised by the TPA were answered. But the TPA kept repeating the same queries & sought compliance of the same set of requirement(s). The Claim remains unsettled till date.

After taking into account facts & circumstances of the case and on perusal of the available documents it is observed that vide TPA's settlement note on behalf of the Insurer dated 24/03/2017 the Claim stands already disposed of and remitted by NEFT to the ALLAHABAD BANK (Complainant's Employer) WELFARE FUND on the same date. Complainant is, *prima facie*, unaware of the development.

Hence, the complaint is treated as CLOSED.

COMPLAINT REF:NO: GUW-G-051-1718-0014 (Withdrawn on 24/07/2017)

Rajib Sarker V/S The United India Insurance Co. Ltd.

WITHDRAWN IN WRITING ON THE DATE OF HEARING.

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Complaint No. I.O.(HYD) G -11.51.0012 / 2017-18
Mr. B. Krishna Reddy VS. United India Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0001/ 2017-18 Dt.10.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri B. Krishna Reddy being an employee of Punjab National Bank was covered under Tailor-made Group Mediclaim Policy, issued by the insurer to Indian Bank's Association, along with his wife and children, for a floater SI of Rs. Four Lacs from 01.10.2015 to 30.09.2016. The complainant underwent treatment for Acute Anal Fissure, Spasmodic Sphincter with Proctitis in M/s Shreyas Hospital, Surat on 14.04.2016 and incurred Rs.45,272/- for the treatment. The TPA rejected the claim stating that 'AYUSH' treatment is covered only when it is taken in a Government recognized hospital. The complainant represented to the insurer to review the decision stating that the Surat Municipal Corporation is not registering the Medical institutions and submitted other documents in support of his claim. There was no revision in the decision of the insurer.

FINDINGS

The claim of the insured person for 'AYUSH' treatment was declined by the insurer on the ground that the hospital was not recognized by the Govt. nor it has any accreditation with NABH. The complainant contended that local authorities not registering the medical institutions and the hospital was recognized by Maharashtra govt. and it had all other facilities like any other allopathic hospital. The insurer rejected the claim stating that the claim for ayush treatment was admissible only when treatment was undergone in a govt. recognized hospital. Since the hospital where the insured person had undergone the treatment was not recognized by the govt. the claim was not admissible in terms of the policy.

DECISION

The main issue to be decided in the present complaint is whether the reimbursement for surgical procedure done by an Ayurvedic doctor in Surat is admissible under the terms and conditions of the policy issued to and held by Indian Banks' Association. The insurer 'United India' relied on policy condition no. 3.3.1 which speaks of Ayurvedic treatment where hospitalization expenses are admissible only when the treatment has been undergone in a government hospital or in any institute recognized by the government or accredited by quality council of India or National Accreditation Board on Health. The treating doctor is registered under Gujarat Medical Practitioner's Act by Gujarat Board of Ayurvedic and Unani systems of Medicine his registration was renewed up to 31st December 2016 by Central Council of Indian Medicine. But no evidence was produced before this Forum about registration of the Hospital with the Gujarat State Government under Gujarat Board of Ayurvedic and Unani Systems of Medicine. Since the policy specifies admission of Ayurvedic treatment expenses in a government hospital or its recognized hospitals only there is no scope for intervention in favour of the complainant. Complaint is dismissed.

Complaint No. I.O.(HYD) G -11.51.0074 / 2017-18
Mr. K.V. Subrahmanyam VS. United India Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0002/ 2017-18 Dt.10.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri K V Subrahmanyam, a retired officer of State Bank Of Hyderabad was covered under a Group Mediclaim Policy taken by the Bank with the insurer from 01.11.2016 to 31.10.2017. He underwent TURP surgery at KK Hospitals, Vijayawada from 29.01.2017 to 02.02.2017 and incurred Rs. 74,419/- for the surgery. The insurer/TPA settled the claim for Rs.41,629/- and deducted Rs.32,790/- of which Rs.30,000/- related to the surgeon's fee. He represented to the insurer to review the decision as the surgery charges were unreasonably deducted without any valid reason. There was no further revision in the settlement.

FINDINGS

The complainant contended that while settling the claim the servicing TPA unreasonably deducted Rs.30,000/- from the surgeon charges and allowed only Rs.15000/- on the alleged ground that the surgeon charges was in excess. Though there were other deductions amounting to Rs.2,790/- his prime concern relates to the surgeon charges which was unreasonably settled for only Rs.15000/- by the TPA/Insurer. It was strongly contended by the insurer that the hospital unreasonably charged Rs.45000/- towards surgeon charges. For the same procedure, in Vijayawada other hospitals, which are of equal quality by all means, charge less than Rs.15,000/- towards surgeon's fee. In this connection the servicing TPA 'Paramount Health Services (TPA) Pvt. Ltd.' Vide their letter dated 18.07.2017, furnished package rates agreed by 4 hospitals which had similar infrastructure facilities in Vijayawada. M/s Kamineni Hospitals, Vijayawada charges Rs.48,750/- for TURP procedure and the surgeon charges are only 25% to 30% of the total bill which is around Rs.12,000/- only. M/s Vijay Super Speciality Hospital, Vijayawada charging a package rate of Rs.25000/- for TURP procedure excluding implants for which is surgeon charges are around Rs.10,000/- only. M/s Vijayawada Multispecialty Hospital, Vijayawada charges package rate of Rs.36,000/- for TURP procedure for which surgeon charges are around Rs.10,000/- only. M/s Lifeline Hospitals Trimurthy Center, Vijayawada charges, for major surgeries like TURP, only Rs.10,000/- towards surgeon's fee. Hence, the deduction of Rs.30,000/- was justified under the policy clause 1.1 read with clause 2.33 'Reasonable & Customary charges'.

DECISION

They have submitted to the forum the package rates prevailing in and around the vicinity of the same hospital of similar quality and infrastructure where the insured patient underwent surgery. Thus on perusal of the bill the forum finds that the surgeon fees alone is more than 60% of the total which is not in conformity with the prevailing rates. The insurer is justified in reimbursing as per policy condition only the reasonable and customary charges which they proved with documentary evidence. Hence, the complaint is dismissed.

Complaint No. I.O.(HYD) G -11.51.0001 / 2017-18
Mr. K.Sudharshan VS. United India Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0003/ 2017-18 Dt.10.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri K. Sudharshan being a member of M/s Telugu Film & TV Dancers & Dance Directors Association was covered under a Tailor-made Group Health Policy, issued by the insurer along with his wife and children for a floater SI of Rs. One Lac from 22.04.2016 to 21.04.2017. He underwent treatment for chronic sinusitis in MAA ENT Hospital from 02.01.2017 to 04.01.2017. The insurer approved cashless treatment claim for Rs.44,452/- as against the hospital bill for Rs.51,497/-. After discharge the insured preferred reimbursement claims for Rs.497/-, Rs.5227/- and for Rs.14210/-. The insurer settled the claims for Rs.497/- & rs.5227/- in full and in the claim for Rs.14210/- made a deduction of Rs.11,276/- as the bills claimed were prior to 30 days of hospitalization period. The insured represented to the insurer to consider the same as he could not go for surgery within 30 days of initial diagnosis of his ailment as he met with a road accident.

FINDINGS

The complainant stated that unfortunately he met with a road accident on 17.12.2016 and had sustained lacerated injury on his right foot. He underwent treatment in Tulasi Hospital from 17.12.2016 to 20.12.2016 as he could not move his leg due to eight stitches to his injured foot. The insurer admitted his claim for sinutisitis and rejected the claim for diagnostic tests on simple reason that they were prior to 30 days of hospitalization period. The complainant pleaded that there was only one day difference and the same could have been condoned by the insurer as the planned surgery was delayed because of his road accident. The insurer pleaded that the disallowance was made in terms of the policy which restricted the pre & post hospitalization expenses for 30 days and 60 days respectively and requested for absolving them from any further liability. The bills claimed were dated 02.12.2016 and the hospitalization period was from 02.01.2017 to 04.01.2017.

DECISION

The date of Hospitalisation is 02nd January 2017 and the bills for pre hospitalization were dated 2.12.2016. The pre-hospitalisation limit is not one month as contended by the complainant but it was only 30 days as per policy. Hence, the claim for pre-hospitalization expenses was rejected rightly in terms of the policy. The complainant stated that one bill pertaining to D Vitamin test done on 03.12.2016 was also declined which fell within 30 days. On verification insurer stated that the payment bill for the test was raised on 2.12.2016 and hence it was not paid though the test was done and the report was dated 03.12.2016. The insurer is directed to admit the D-Vitamin test cost of Rs.1500/- and to pay interest in terms of Rule 17(7) of Ins. Ombd. Rules, 2017.

Complaint No. I.O.(HYD) G -11.51.0100 / 2017-18
Mr. P. Satyanarayana VS. United India Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0013/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri P. Satyanarayana, a retired officer of SBH, preferred claim for cataract surgery under Tailor-made Group Mediclaim Policy taken by SBH through Indian Banks Association. He incurred Rs.65,800/- towards right eye cataract surgery at Dr. Harikishan Eye Care Hospitals, Hyderabad. The TPA approved Rs.40,000/- towards cashless treatment. The balance amount of Rs.25,800/- was paid by the complainant and later preferred claim for reimbursement. The claim was rejected by the Insurer for the excess amount collected by the hospital from the complainant.

FINDINGS

The complainant stated that the hospital estimated the cataract surgery cost at Rs.65,800/-. The servicing TPA approved the surgery for Rs.40,000/- only and the remaining amount of Rs.25,800/- was paid him. The insurer submitted that the insured person underwent RE Cataract Surgery on 23.12.2016 and TPA received pre-authorization request from the hospital for Rs.40,000/- and the authorization form was also signed by the complainant. The TPA gave authorization for the same amount and on discharge the hospital sent final bill for Rs.40,000/- which included OT charges, Phaco charges, Anesthetist charges, Surgeon charges, Foldable IOL charges, OT drugs, disposables, room rent and nursing charges. Subsequently, the complainant filed a reimbursement claim for Rs.25,800/- on 13.01.2017 for the same hospitalization/surgery and for the same charges. The hospital raised another bill to recover the multifocal lens cost since the complainant opted multifocal lens. The complainant instead of going for normal cataract surgery of monofocal lens which would have rectified his vision and restored his normal eyesight, gone for a premium multifocal cataract surgery. Hence, reimbursement claim was rejected under policy clause 1.1, 1.2 & 2.34 of the policy.

DECISION

The complainant stated that as he was suffering from 'Anxiety neuroses' the doctor advised him to go for multifocal lens had gone for multifocal lens and claimed the balance amount. Since the insured opted for multifocal lens, the extra amount was charged by the hospital to the insured. The hospital raised two separate bills for same surgery. Out of two bills presented the one for Rs. 40,000/- was approved for cashless by TPA and the second bill was denied on the ground that multifocal lens cost does not fall under customary charges. The second bill does not contain Lens charges. On being questioned about any proof of recommendation of multifocal lens by the treating doctor he referred to a certificate issued by the treating doctor but that does not speak about any recommendation for multifocal lens. Hence, the complaint is dismissed.

Complaint No. I.O.(HYD) G -11.48.0096 / 2017-18
Mr. Ch. Srinivasa Murthy VS. National Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0022/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri Ch. Srinivasa Murthy, opted coverage under Floater Mediclaim Policy through Indian Health Organization (IHO) and paid premium of Rs.2897/- for SI of Rs.2 Lacs on 11.04.2016. The IHO acknowledged receipt of premium and issued receipt on 14.4.2016. He received Certificate of Insurance issued by the respondent insurer with inception date of policy being from 01.05.2016. He suffered from severe chest pain and was admitted in M/s Sunshine Hospitals, Secunderabad on 16.05.2016 and had undergone CABG surgery on 17.05.2016. The claim preferred by him for reimbursement of hospitalization expenses was repudiated by the insurer citing pre-existing illness exclusion. He represented to the insurer to review the decision on the plea that his claim should not be rejected on the ground that he had suppressed material information since no proposal was collected from him.

FINDINGS

The complainant stated that he had not submitted any proposal and he should not be blamed for suppression of declaration of his health condition. He confirmed that he was diabetic since 2006 and there was no medical record that his health complications were attributable to diabetes only. The rejection of claim under PED exclusion is unfair. The insurer stated that as per the policy pre-existing diseases are covered only after 13 months from the date of taking the policy. Hence claim is repudiated.

DECISION

On perusal of the papers, it is noted that the proposer obtained the policy through, IHO who had not obtained any proposal and hence there was no opportunity to the complainant to declare about his health conditions. The correspondence of the insurer with the complainant confirms the fact that the insurer terminated the agreement with the IHO in view of certain discrepancies. In the certificate of insurance against the coverage details pre-existing diseases are categorically mentioned as covered without any exclusion or qualification. Only under the co-payment clause PED after 13 months of inception of the policy attracts. To an ordinary insured this certainly gives an impression that the pre existing disease stands covered without any exception save co-payment. Thus there was lack of clarity in the certificate. Since there is an ambiguity in the certificate regarding coverage the benefit of its interpretation should go to the complainant-insured. Even though the insurer argued that the complaint-insured suffering from PED, the issue for consideration is not the duration of PED but its coverage under the policy. Thus the insurer is not justified in rejecting the claim. Complaint is allowed.

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Complaint No. I.O.(HYD) G -11.49.0099 / 2017-18
Mr. C. Sundaraiah VS. The New India Assurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0027/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri C. Sundaraiah, a retired Development Officer of LIC of India, was covered under a Group Mediclaim Policy with the respondent insurer, availed by LIC for its serving and retired employees, from 1.4.2016 to 31.03.2017 for a family floater SI of Rs. 4 Lacs. He was hospitalized in Sunshine Hospitals, Secunderabad from 28.01.2017 to 01.02.2017 for acute back pain associated with knee pains. The claim preferred by him for Rs.1,17,000/- was rejected by the insurer stating that there was no active line of treatment during the hospitalization period and admission is only for investigation purpose.

FINDINGS

The complainant submitted that on 28.01.2017, due to sudden dizziness and blurred vision he had a fall from bike and fell unconscious. Due to severe swelling in the legs, back pain he was unable to walk or even stand on his legs and had dizziness. He was unable to bend his legs and move his neck. After several tests and investigations, the doctors diagnosed his ailment as "Grade II Prostatomegaly with significant post void residue". He was further advised surgery if no relief from oral medication. The insurer contended that the complainant intimated in his claim intimation letter that he had a fall from bike and he was taken to hospital in an unconscious and serious condition. But as per the discharge summary of the hospital he was conscious and oriented. During hospitalization period the insured patient was treated with injections and medication for pain, muscle stiffness, anti-depressant and vitamin D for prostatic hyperplasia and insulin for diabetes. There was no active management during the hospitalization period and the patient was primarily admitted for various diagnostic tests. The need for hospitalization was not justified.

DECISION

During the hearing and also at the time of lodging the claim the complainant stated that he had a road traffic accident, became unconscious and was rushed to the hospital. However, hospital record made no reference to any accidental fall or injury and confirms that the patient was conscious at the time of admission. The discharge summary confirms conduct of various tests in confirmation of acute back pain and knee pains. Thus, the hospital stay is not confirmed to be the result of any accident as claimed by the complainant and there is no active line of treatment for any disease. Hence, the insurer is justified in rejecting the claim as per the terms of the policy. Complaint is dismissed.

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Complaint No. I.O.(HYD) G -11.49.0099 / 2017-18
Mr. C. Sundaraiah VS. The New India Assurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0027/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri C. Sundaraiah, a retired Development Officer of LIC of India, was covered under a Group Mediclaim Policy with the respondent insurer, availed by LIC for its serving and retired employees, from 1.4.2016 to 31.03.2017 for a family floater SI of Rs. 4 Lacs. He was hospitalized in Sunshine Hospitals, Secunderabad from 28.01.2017 to 01.02.2017 for acute back pain associated with knee pains. The claim preferred by him for Rs.1,17,000/- was rejected by the insurer stating that there was no active line of treatment during the hospitalization period and admission is only for investigation purpose.

FINDINGS

The complainant submitted that on 28.01.2017, due to sudden dizziness and blurred vision he had a fall from bike and fell unconscious. Due to severe swelling in the legs, back pain he was unable to walk or even stand on his legs and had dizziness. He was unable to bend his legs and move his neck. After several tests and investigations, the doctors diagnosed his ailment as "Grade II Prostatomegaly with significant post void residue". He was further advised surgery if no relief from oral medication. The insurer contended that the complainant intimated in his claim intimation letter that he had a fall from bike and he was taken to hospital in an unconscious and serious condition. But as per the discharge summary of the hospital he was conscious and oriented. During hospitalization period the insured patient was treated with injections and medication for pain, muscle stiffness, anti-depressant and vitamin D for prostatic hyperplasia and insulin for diabetes. There was no active management during the hospitalization period and the patient was primarily admitted for various diagnostic tests. The need for hospitalization was not justified.

DECISION

During the hearing and also at the time of lodging the claim the complainant stated that he had a road traffic accident, became unconscious and was rushed to the hospital. However, hospital record made no reference to any accidental fall or injury and confirms that the patient was conscious at the time of admission. The discharge summary confirms conduct of various tests in confirmation of acute back pain and knee pains. Thus, the hospital stay is not confirmed to be the result of any accident as claimed by the complainant and there is no active line of treatment for any disease. Hence, the insurer is justified in rejecting the claim as per the terms of the policy. Complaint is dismissed.

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Complaint No. I.O.(HYD) G -11.51.0061 / 2017-18
Mr. M. Kondal Reddy VS. United India Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0030/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri M. Kondal Reddy opted coverage under AB Arogyadan Policy, issued by the Respondent insurer under bancassurance tie-up with Andhra bank, from 09.06.2015 to 08.06.2016 along with his wife for a floater SI of Rs. 2 Lacs. His wife underwent treatment for removal of polyp in uterus at M/s Padmaja Fertility Centre & Nursing Home from 23.05.2016 to 24.05.2016. The reimbursement claim filed by him was repudiated by the TPA stating that his wife's treatment was for secondary infertility and it was not covered under the policy.

FINDINGS

The complainant submitted that when his wife consulted a doctor on 09.03.2016 she was advised to undergo abdominal scan and in the scan report it was noted there was endometrial polyp. At the advice of treating doctor, she got admitted in M/s Padmaja Fertility Centre & Nursing Home on 23.05.2016 for diagnostic hystero laparoscopy and got discharged on 24.05.2016. The tissue bits were sent to biopsy report to a central reference laboratory and they confirmed on 28.05.2016 it as "complex hyperplasia with atypia". As the treating doctor had the impression of cancer again a sample was sent to Yashoda Hospital and they too confirmed the same. Without looking into the complications of the treatment, without proper analysis of the case, the insurer and TPA rejected the claim treating it as a treatment for "secondary infertility" and quoted clause 6.9 of the policy. The insurer contended that the insured person was admitted for treatment of GPLA Status, A1 with secondary sterility from 23.05.2016 to 24.05.2016. The claim filed by the complainant was rightly repudiated by the TPA in terms of Arogyadan Policy vide exclusion clause 6.9.

DECISION

During the course of regular check up for infertility, polyps were found and the same were removed and sent for histopathology report to rule out the possibility of cancer. During the course of hearing the representatives of the Insurer were asked to produce medical evidence that the surgery done was for correction of infertility only to justify their ground of repudiation. The insurer sent a mail at 5.38 PM on 10.08.2017 wherein they have stated that though the provisional diagnosis was endometrial polyp, the histopathology report and the specimen sent for histopathology investigation was found to be endometrial scrapings and polypoidal endometrium but not polyp. However, this Forum finds out polypoidal endometrium is a growth in the female uterus which may be benign or malignant which appear to be affected by hormone levels and grow in response to circulating estrogen. This may sometime cause problem with fertility. Therefore, it is beyond any doubt to this Forum that infertility may result from this growth but not the other way round. It can be safely concluded that the surgery was for the removal of the growth which might turn malignant. Therefore, the insurer is not justified in repudiating the claim. The insurer is directed to pay Rs.37100/- with interest in terms of Rule 17(7) of Ins. Ombd. Rules, 2017.

Complaint No. I.O.(HYD) G -11.020.0038 / 2017-18
Mr. Rajesh Banala VS. ICICI Lombard Gen. Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0035/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Mr. Rajesh Banala, an employee of M/s TalentPro India HR Pvt. Ltd. is covered under Group Mediclaim Policy taken by his employer with M/s ICICI Lombard Gen. Ins. Co. Ltd., from 01.08.2016 to 31.07.2017. As per the complaint filed, he underwent treatment in M/s Aditya Hospitals, Hyderabad for perianal abscess from 16.11.2016 to 22.11.2016. He preferred a reimbursement claim for Rs.1,08,857/-. The insurer rejected the claim alleging discrepancy in the claim documents submitted by him.

FINDINGS

The insurer stated that during the investigation it was found that the complainant submitted a bill for Rs.9000/- for dressing charges but the doctor in charge had given the written statement confirming that he had charged Rs.6000/- only for dressing charges but on the request of the insured Rs.3000/- extra amount was added to the final bill. Hence, it is a case of misrepresentation and inflation of bill. Hence the claim was rejected.

DECISION

The insurer rejected the total claim of Rs.1,08,857/- on the ground that the claimant preferred inflated bill for dressing charges to the extent of Rs.3000/-. The insurer did not verify about hospital bills of Aditya Hospitals and Susheel Hospital but took its decision based on the sole confirmation given by the Dr. Babajan Shaik that he had received only Rs.6000/- and Rs.3000/- was added at the request of the insured. During the hearing the complainant was questioned as to why he had obtained inflated bill to the extent of Rs.3000/- for which he stated that he had purchased dressing material and medicine and requested for inclusion of that amount in the bill. During the hearing the representative of the insurer raised objection only to this particular dressing bill of Rs.9000/- in a total claim of RS.1,08,857/-. The representative was questioned as to how they could rely solely on the statement of a doctor who gives false bills. The Forum therefore directed that the bill for Rs.9000/- be excluded and to allow the claim for remaining expenses incurred for the treatment. They were further directed to state the admissible claim amount. The insurer informed the admissible claim amount as Rs. 83,116/- after excluding the bill for Rs.9000/-, in terms of the policy. The insurer is directed to pay Rs.83116/- with interest in terms of Rule 17(7) of Ins. Ombd. Rules, 2017.

Complaint No. I.O.(HYD) G -11.50.0011 / 2017-18
Mr. P. Rajender VS. The Oriental Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0036/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri P. Rajender is a retired branch manager of United India Ins. Co. Ltd. And was covered under Staff Group Mediclaim Policy taken with Oriental Insurance Co. Ltd. from 01.04.2016 to 31.03.2017 for a SI of Rs.15 Lacs. As per the complainant, his claim for Left Eye Subhyaloid heme treatment with Lucentis injection was declined by the insurer stating that it is not a listed day care procedure and not covered under the policy.

FINDINGS

The complainant stated that his earlier claims for the same treatment on 03.03.2012 & 25.09.2015 were admitted by the TPA/Insurer and the present claim was declined by the new TPA and concurred by the insurer. The insurer repudiated the claim stating that it is not a listed day care procedure and hence, not covered under the policy.

DECISION

It is noted from the papers that the insurer rejected the claim for the same line of treatment which was allowed previously for two occasions without any valid reason. It is found that the same injection is being administered for 3rd time also and the insurer did not cite relevant policy condition for rejecting this claim, when the same was allowed two times earlier. The representative of the insurer, during the hearing stated that the policy was issued by Chennai office and since no copy was provided to them he was unable to make any presentation. Since no valid exclusion for the treatment under gone by the insured was cited by the insurer, the complaint is allowed. The insurer is directed to pay Rs.28,000/- along with interest in terms of Rule 17 (7) of the Insurance Ombudsman Rules, 2017.

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Complaint No. I.O.(HYD) G -11.51.0090 / 2017-18
Mr. Raghavendra N VS. United India Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0043/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri Raghavendra Nyalkalkar, a retired officer of State Bank Of Hyderabad was covered under Tailor-made Group Mediclaim Policy taken by the Bank to its retired employees through Indian Banks Association, with the respondent insurer from 01.11.2016 to 31.10.2017. As per the complaint filed, he underwent right eye cataract surgery on 10.02.2017 and preferred the claim at Rs.40,000/-. The insurer settled the claim only for Rs.21000/- and disallowed Rs.19,000/-. He represented to the insurer to review the decision stating that his claim for left eye cataract surgery undergone by him on 10.01.2017was approved for Rs.40,000/-.

FINDINGS

After filing the complaint by the complainant, the insurer further reviewed the claim and reprocessed it and approved the claim for another sum of Rs. 19000/-. When this Forum contacted the complainant and he confirmed receipt of amount to his bank and requested to close the complaint.

DECISION

The complaint is treated as allowed.

Complaint No. I.O.(HYD) G -11.50.0014 / 2017-18
Mr. Bijay Jain VS. The Oriental Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0044/ 2017-18 Dt.11.08.2017 **GROUP MEDICLAIM**

FACTS

The complainant, Sri Bijay Jain, an account holder of Oriental Bank of Commerce obtained cover for himself and his wife under OBC Group Mediclaim Policy from 03.02.2015 for a floater SI of Rs.5 Lacs and it was renewed. The insured underwent CABG surgery in Apollo Hospitals, Hyderabad from 11.04.2016 to 21.04.2016. He preferred the claim for Rs.4,56,320/- under 2016-17 policy. The insurer rejected the claim under PED exclusion of the policy. The complainant represented to review the decision stating that he was covered under the Individual Mediclaim Policy from 2006 and the denial on the ground of PED is not in order. The insurer intimated that the matter has been taken up with their HO and shift from Individual Policy to Group Policy does not fall under portability guidelines of IRDAI and hence there was no revision in their decision.

FINDINGS

The complainant submitted that the Oriental Bank staff told to him to shift his policy from Individual to OBC Mediclaim Policy and all accrued benefits would continue. Trusting them, he had opted coverage under OBC Mediclaim Policy on 03.02.2015 though his individual policy was expiring on 25.03.2015. On rejection of his claim he submitted all his previous years Individual Mediclaim Policy copies to review the decision and for payment of his claim. The insurer contended that since the insured shifted from retail individual policy to a Group Policy the continuity benefits were not available and it would be treated as a fresh policy. As per the Mediclaim Policy terms and conditions, the enhanced SI is applicable only after completion of 3 years from the date of enhancement of SI.

DECISION

On perusal of the papers it is noted that the insured is continuously renewing the policy with OIC DO 6 for a SI of Rs. One lac from 2006 till 2015. Then he shifted to OBC Floater Mediclaim Policy for Rs.5 lac on the assurance given by the bank employees that benefits will be continued and protected. A claim was reported during April 2016 for CABG surgery. The insurer rejected the claim on the ground that the portability does not apply when ported from individual to group policies since the case papers revealed diabetes, the same can be covered after 2 years waiting period. He was also under the genuine impression that since he was subscribing for the past 10 years with the same Oriental Insurance Co. he was also convinced with the version of the bank officials and subscribed to the OBC Mediclaim policy. Since the SI prior to porting is One lac the insurer is directed to settle the claim for Rs.One lac.

Award No. IO/KOC/A/GI/0005/2017-2018

Complaint No. KOC-G-051-1718-0008
Award passed on : 20.04.2017

Mr. K.G. Unnikrishnan Nair Vs The United India Insurance Co. Ltd.
Repudiation of claim under a Group Mediclaim policy

The complainant is a bank employee covered under the IBA Mediclaim scheme (Health Card NoBLR-UI-10588-001-0010663). A claim (of Rs120000/-)was preferred with the Insurer with regard to hospitalization of the complainant. A grievance was filed, however no reply was received till date. Repeated reminders to the insurer and the TPA remains unanswered. Hence this complaint seeking immediate settlement of claim amount.

Decision : settle the claim as per offer made.

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Award No. IO/KOC/A/GI/0013/2017-2018

Complaint No. KOC-G-051-1718-0020
Award passed on : 20.04.2017

Mr. Bonny John Vs The United India Insurance Co. Ltd.
Repudiation of claim under a Group Mediclaim policy

The complainant was covered under a valid group Mediclaim policy with the respondent Insurer(No 5004002816P110627266). After discharge from hospital, claim for reimbursement was preferred with the Insurer with regard to hospitalization of the complainant's wife for maternity/delivery from 02.10.2016 to 07.10.2016. Claim was partially denied (infant expenses allowed but not that of complainant's wife) stating that the hospital admission date (02.10.2016 was one day before the policy start date (03.10.2016) and she was not covered under the policy. Appeal made to insurer was rejected. Hence this complaint seeking immediate settlement of her maternity claim amount.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0034/2017-2018

Complaint No. KOC-G-049-1718-0037
Award passed on : 16.06.2017

Mr. S. Mritheunjayan Vs The New India Assurance Co. Ltd.
Repudiation of claim under Group Mediclaim

The Complainant was covered under a Group Medi-claim Family Floater Policy taken by his erstwhile employer for their retired employees. A claim for Rs.3485/-preferred with the TPA on 14/05/2016, towards reimbursement of OCT Scan charges has not yet been settled by the TPA, in spite of several reminders. He says that all details of the Scan, report, bills, Certificate from the treating Doctor etc have been submitted to the TPA, along with the claim papers. He appealed to the Grievance Cell of the Insurer on 27/02/2017, requesting their intervention in the matter, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim with cost.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0060/2017-2018

Complaint No. KOC-G-049-1718-0080
Award passed on : 16.06.2017

Mr. K Janardanan Vs The New India Assurance Co. Ltd.
Repudiation of claim under Group Mediclaim

Complainant was covered under the health policy of the respondent Insurer. He had undergone eye treatment in the Aravind Eye Hospital on 26.11.2016. He raised claim for with the Insurance Company for the reimbursement which was denied stating that the ailment has a limit under the policy which exhausted under earlier claim. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Case No. 037-1617-0691
Mrigen Mukhopadhyay
Vs
Religare Health Insurance Co.

Award Dated 27/04/2017

Complainant's wife was wrongfully enrolled under the Group-Care Plan whilst Life Insurance coverage was the basic requirement. Further his son , an NRI residing in USA , was advertently enrolled under the Group-Secure Plan with the age of his son wrongly depicted in the Policy bond and carrying forged signature. Accordingly his spouse & son was enrolled as Insured members with premium having been deducted by the Master Policy Holder. All these were instances of mis-selling & fradulent activities. Due to financial crisis he requested the insurance company to cancel the said policy certificates and thereafter refund the entire premium amount paid. His representation to the Insurance Company went without any result. In case the Certificate of Insurance is to be cancelled the premium amount of Rs.358/- & Rs.722/- becomes payable to the Master Policyholder ie. M/s Destimoney Securities Pvt. Ltd only as per Insurance Company. It is confirmed that Insurance Company has received from M/s Destimoney Securities Pvt. Ltd. , the Master Policy Holder of Group-Care & Group-Secure Scheme, an amount of Rs.358/- & Rs.722/- towards annual premium in respect of the Insured Members. It is also confirmed that Complainant has paid to M/s Destimoney Securities Pvt. Ltd an amount of Rs.30,000/- by Cheque# 000448271 dated 25/08/2016 , but for what purpose the said amount was transacted could not be ascertained. It is opined that Insurance Company is not responsible for any default in service that has aggrieved the Complainant. M/s Destimoney Securities Pvt. Ltd , a stock broker , is answerable for this unfair trade practice . The Forum , being bound by jurisdiction , is not in a position to adjudicate the Complain. The Complaint , being set aside , stands closed.

Case No. 051-1617-0797
Pradip Kumar Dey
Vs
The United India Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant and his family was covered under the Group Health Master Policy for New Retirees & non member of State Bank of India Retired Employees. He submitted a Medical Bill of Rs.3,309/- with the entire set of papers including dental X-Ray Plate to the Insurance Company for reimbursement under Domiciliary treatment of the Scheme. Insurance Company has stated that the patient was suffering from acute pulpitis and doctor advised extraction of tooth . Since extraction of tooth is not covered in OPD list , except RCT , the said Claim was repudiated vide Exclusion clause 3.18 . It is understood from the proceedings that the Complainant has no grievance relating to repudiation of his Claim , as it was in order. Complainant's main contention was the inordinate delay on the part of the Insurance Company to inform him of the Repudiation. Since the contention of the Complainant is a matter beyond the jurisdiction of the Forum he may wish to take up the issue with the Insurance Company directly. Complainant's claim towards return of original treatment papers is legitimate. The Complaint stands closed .

Case No. 051-1718-0001
Dipankar Ghosal
Vs
The United India Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant was covered under Group Mediclaim Scheme 2015-16 for United Bank of India Employees. He was hospitalized with serious neurological problem being diagnosed with Focal seizure involving right lower limb and Sensorimotor polyradiculo neuropathy of both lower limbs . The Reimbursement claim, including Pre & Post Expenses, for Rs.35,721/- was repudiated as per Exclusion Clause 4.7 which states that the Company shall not be liable to make payments in respect of Charges incurred at Hospital or Nursing Home primarily for diagnosis X-Ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment , sickness or injury , for which confinement is required at a Hospital / Nursing Home , unless recommended by the attending doctor. It is observed that all treatments undertaken have been under the recommendation of the attending doctor . Further expenses towards X-ray , CT scan , MRI as advised by the attending doctor and treatment of all Neurological disorders are covered under the Group Tailor made Scheme under reference . The complaint being allowed , the Respondent was directed to pay Rs.35,721/- less any inadmissible expenses.

Case No. 051-1718-0010
Niva Sen
Vs
The United India Insurance Co. Ltd.

Award Dated 19/07/2017

Complainant was covered under the Group Medical Insurance Policy offered to retired DVC Employee's & their family. She was hospitalized being diagnosed with Double vessel Artery disease with history of HTN. She underwent PTCA with stent to LAD & OM1 . Hospitalization Claim for Rs.2,80,274/- , including Pre & Post Expenses , could not be settled due to non-submission of valid documents viz. Original tax invoice of implant , Duly paid Original Final Hospital Bill . On scrutiny of documents it is observed that Complainant had written to Sh. K L Kunjilwar , Deputy General Manager , United India Insurance Co. Ltd. , Kolkata Regional Office dated 22/09/2016 requesting for his intervention to settle her long pending Claim . The said letter was received by DGM Secretariat dated 23/09/2016 while copy of the said letter was marked to Deputy Manager (Insurance & Claims) , C & M Dept. , DVC . That both the documents comprising of Original Tax Invoice of Implants & Paid Original Final Hospital Bill has been submitted to the Insurance Company / TPA duly substantiated by the Complainant . The Complaint was allowed while the Respondent was directed to pay Rs.2,80,274/- Claim Amount less In-admissible Expenses . In view of the harassment and financial loss suffered by the Complainant and also because of delay in Claim settlement on the plea of un-substantiated requirements , Insurance Company is directed to pay interest @2% above Bank rate on the Claim amount for the period from the date of submission of full requirements by the Complainant till the date of final settlement .