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SYNOPSES OF AWARDS 2008-09

Half Year: OCT 2008 TO MAR 2009

4. GENERAL=GROUP MEDICLAIM

Award dated 26-11-2008

Case No. 11-002-0191-09

Mr. Prakash S. Trivedi Vs. New India Assurance Co.Ltd.

Group Mediclaim Policy

Complainant's son was covered under LIC Group Mediclaim Policy issued by New India Assurance Co. Ltd. and admitted at hospital for treatment.

Claim lodged by complainant towards hospitalization expenses was repudiated by the Respondent as per investigation and opinion of Medical Referee that there was no hospitalization.

The Indoor record register shown the date of admission and Ref.No. etc. Complainant's son was hospitalized due to swelling in intestine as per advice of doctor and all necessary papers submitted to the Respondent. Claim repudiated by the Respondent stating that hospitalization was not necessary.

Respondent could not produce any documentary evidence which proves that there was no hospitalization. Therefore Respondent's decision to repudiate the claim is set aside and directed to pay the claim amount as full and final settlement of the subject claim.

Award dated 26-11-2008

Case No.11-002-0198-09

Mr. Kirit K Mehta Vs. The New India Assurance Co.Ltd.

Group Mediclaim Policy

Complainant was an LIC employee and covered Group Mediclaim Policy issued by The New India Assurance Co.Ltd. Claim lodged for Rs. 2,71,901/- towards hospitalization expenses was repudiated by the Respondent.

Repudiation on the ground of late submission of claim papers i.e. after 52 days from the date of discharge from hospital.

Complainant submitted that the intimation of hospitalization was given timely to the LIC authorities, the master policy holder and they have sanctioned advance Rs.1,54,000/- for treatment. Delay on the part of the complainant is on genuine ground though the delay in submission of claim form and intimation of hospitalization is on the part of LIC. It is deserving case for condonation of delay in terms of clause 5.4.

As there is discretionary power to condone the delay on merit by the Respondent which was not exercised in this case, it would be just and fair on the part of the Respondent to review the case and advised to pay admissible amount under the claim.

Award dated 12-12-2008

Case No.11-002-0194-09

Mr. Amrutlal K Patel Vs. The New India Assurance Co. Ltd.

Group Mediclaim Policy

Complainant was a member of LIC employees and covered Group Mediclaim Policy issued to LIC by New India Assurance Co. Ltd.

Claim was repudiated by the Respondent on the ground of delay in submission of claim papers and not intimated claim within the stipulated time limit mentioned in policy condition 5.3 and 5.4.

The ground for delay of 25 days in claim intimation and submission of claim papers given by complainant was that he was in hospital and claim intimated to his Patan branch. In fact complainant had not given claim intimation but given leave application to his branch office.

The Respondent has not exercised discretionary power to condone delay as reasons for delay was not extreme hardship and not satisfactory.

The forum observed negligence of the complainant for intimating claim and submission of claim papers to Respondent Insurance company, so decision of repudiation of claim is upheld and case dismissed.

Award dated 15-12-2008

Case No.11-002-0173-09

Mr. Karshanbhai P Metiya Vs. The New India Assurance Co.Ltd.

Group Mediclaim Policy

Complainant's son was covered under Group Mediclaim Policy issued to LIC employees by The New India Assurance Co.Ltd.

Claim lodged for expenses of various treatments of the insured like Enteric fever, abdominal pain and various diagnostic examinations such as Ultrasonography of abdomen and Pelvis, Haemogram, X-ray etc.was repudiated by the Respondent. Repudiation on the grounds of hospitalizations was not required and claim is not payable as exclusion clause 4.10.

Complainant proved the hospitalization and treatment given to the insured was as per advice of a Pediatrician and the case of a child evidentiary value of Pediatrician's opinion will prevail our any other opinion given by consulting surgeon.

As per the policy condition 5.17 "Diagnostics tests Viz. MRI, CT Scan and Sonography without hospitalization shall be covered" hence Respondent's decision to repudiate the claim is set aside and directed to settle the claim.

Award dated 21-01-2009

Case No. 11-004-0239-09

Mr. Parsotambhai M Solanki Vs. United India Insurance Co. Ltd.

Group Mediclaim Policy

The repudiation of claim was for exclusion of pre-existing disease/injury.

The patient was admitted for treatment of Lt. Eye Cataract who was suffering from DM – Dimness of vision since 2 years which was prior to the inception of policy.

The documents on record proved that the patient was OPD patient with history of Dimness of vision but no reason was recorded by the doctor.

Since the cataract operation was done on 25-06-2008 that falls after 2 years of policy and is payable as per terms and condition of policy which had 3 claim free years earlier the complaint succeeded on merit.

The Respondent was directed to settle the claim.

Award dated 28-01-2009

Case No.14-004-0199-09

Mr. Nathalal V. Savjani Vs. United India Insurance Co.Ltd.

Group Mediclaim Policy

The complainant was admitted for Dyspnoea on exertion, L.V angio, Mild MR but the claim was repudiated as there was no existence or presence of ailment as per diagnosis. However the admission at hospital as per policy condition was under medical advice for acute chest pain.

Thus other things submission of papers etc. were as per rule the claim becomes admissible.

The Respondent was directed to settle the claim keeping aside the repudiation.

Award dated 18-02-2009

Case No. 11-002-0272-09

Mr. Bhupendra C. Shah Vs. The New India Assurance Co.Ltd.

Group Mediclaim Policy

Claim of the LIC employees Group Mediclaim was settled for lessor amount besides the inordinate delay. Complainant asked for Rs.880/- which was deducted from claim and interest on delayed payment.

The deducted amount was towards the certain amount spent for Cotton bandage, Gloves, Plastic Drape, Hot water bag etc. are not reimbursable which was accepted by the forum.

But the delay in payment warranted interest was agreed and Respondent was directed for payment of interest for delay.

Mental torture, postage Xerox copies was however denied as it was not within the jurisdiction of the forum.

Thus complaint partially succeeded.

Award dated 25-02-2009

Case No.11-002-0264-09

Mr. Sureshchandra K Thakar Vs. The New India Assurance Co.Ltd.

Group Mediclaim Policy

Claim was repudiated on the grounds of wrong statement of actual hospitalization dates.

It was proved on investigation by the Respondent that the insured was not available in the date of inspection amounting to fabrication and wrong claim.

There was difference in the dates of hospitalization and attending doctors statement in r/u date and timings.

The Respondents rejection on the grounds that claim is fabricated is justified and case was dismissed.

Award dated 30-03-2009

Case No. 11-002-0342-09

Mr. A.M. Modi Vs. The New India Assurance Co. Ltd.

Group Mediclaim Policy

Claim was repudiated on the grounds that Clause 4.8 excludes general debility Run Down Psychiatric treatment etc.

The documents pleading in the case revealed that the insured was treated for nutritional anemia and was given 3 bottles of blood transfusion to avoid critical case saving life. Respondent did not provide evidence to prove that blood transfusion was for general debility or nutritional anemia.

The Respondent was directed to settle the claim keeping aside the repudiation.

BHOPAL

BHOPAL OMBUDSMAN CENTRE

Case No.: GI/NIA/1208/83

Mr. A.S. Khan V/s The New India Assurance Co. Ltd.,.DO, Jabalpur

Order No.: BPL/GI/08-09/37 Date of Order:- 27.01.2009

Brief Background

Mr. A.S. Khan is covered under **Group Mediclaim** policy No. 12070048064100000007 issued to LIC of India for the period 1.4.06 to 31.3.07 & 12070034074100000056 for the period 1.4.07 to 31.03.08 to cover their employees obtained from The New India Assurance Co. Ltd., Mumbai under which claim was lodged with Jabalpur Office of the Respondent.

As per the Complainant his son Mr. Kaifee was hospitalized in Yadav Hospital (P) Ltd. Nagpur for the treatment of fistula for the period

19.03.07 to 20.03.07. He himself was hospitalized in the same hospital for the period 10.04.07 to 15.04.07 for the complaint of chest pain etc. He intimated to the Respondent vide intimation letter dated 27.04.07 and wrote to their office i.e. LIC of India, Jabalpur for issuance of Claim form so that he can submit the original medical papers for reimbursement. Finally his office had sent claim form vide their letter dated 18.02.08. The complainant placed his claim with the Respondent who rejected the claim based on exclusion clause 4.5 of Mediclaim Policy.

The Respondent in its reply stated that the Complainant had lodged a claim for the treatment of himself and his son after inordinate delay of nearly 334 days. It further mentioned that under the policy condition No. 5.4, the claim must be filed with in 10 days of discharge from the hospital.

Observations:

On going through the intimation letter dated 27.04.2007 which has been placed to L.I.C. of India, Jabalpur for further action. Similarly, the letters written to his employer LIC of India where he asked for medical claim form for necessary submission of claims. When he received the claim form, the medical papers were submitted to the employer. During course of hearing, he reiterated that he was in touch with his employer i.e. LIC of India, Jabalpur for necessary claim forms but due to non receipt of claim form, he could not submit the claim in time. As and when he received the claim form, he submitted both the claims.

Decision:-

In view of the circumstances stated above the decision of the Respondent to repudiate the claim is unfair and unjust. Since the delay caused on the part of his employer LIC of India, Jabalpur, the complainant should not be penalized for non settlement of claims. In group mediclaim policy, the delay in submission of claim due to genuine reason may be

considered on the part of Respondent. The reason mentioned by the complainant for non receipt of claim form seems to be genuine. Hence, the Respondent is directed to settle the admissible claims as papers submitted by the Complainant

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BHOPAL OMBUDSMAN CENTRE

Case No.: GI/NIA/0908/72

Shri Satya Narayan Mishra V/s The New India Assurance Co. Ltd.,.

Order No.: BPL/GI/0809/30 11th day of November 2008

Brief Background

Mr.Satya Narayan Mishra and his wife Smt. Dipti Mishra were covered under Group Mediclaim policy No. 120700/34/07/41/00000056 for S.I of Rs. 60000.00 for the period 01/04/2007 to 31.03.08 from The New India Assurance Co. Ltd., D.O.120700 17-A, cooperage road, Mumbai.

As per the Complainant her wife was admitted in Anupam Prasuti Grah Netra Chikitsalaya, Rewa on 28.9.2007 for child birth and discharge on 29.9.2007 and the claim for Rs. 5487.00 was submitted to Respondent where the claim is settled for Rs. 3943.00 after deducting Rs. 1544.00, then he represented his case with respondent on 5.1.2008 for short payment of Rs. 1544.00 In response thereof, the Respondent replied him vide their letter dated 11.1.2008 giving the facts and reason for deduction of Rs. 1544.00, but the Complainant was not satisfied with the reason of deduction.

As per self contained note of Respondent, the deduction for Rs. 1544.00 are because of exclusions under the Maternity benefit clause 5.13 to 5.16 special condition 01 to 09 of the Policy. Respondent also clarified that a Bill for Rs. 3900.00 was raised by Anupam Prasuti Grah Netra Chikitsalaya, Rewa including medicine used during her confinement, which is paid in full to complainant. Further they found two cash memos of Annapurna Drug house No. 1684 dated. 29.9.2007 for Rs. 310.00 and Cash memo No. 11693 dated 1.10.2007 for Rs. 1277.00, which found not payable being incurred after discharge. However, they considered Rs. 43.00 out of Rs. 310.00 as payable for one day treatment i.e. for the day of discharge while remaining amount of Rs. 1544.00 not paid due to not payable under the Policy clause & condition.

Observations:-

There was only dispute for Rs. 1544.00 being paid less to Claimant by Respondent. On going through the Bill No.1684 dated 29.9.2007 for Rs. 310.00 and found that the medicines are well prescribed by Nursing home within the date of confinement in Hospital while the another bill No. 1693 dated. 1.10.2007 for Rs. 1277.00 is for prescription & Purchasing of medicines after the discharge from Hospital.

Decision:-

In view of the circumstances stated above, the decision of deduction for Rs. 1277.00 by Respondent is just & fair as the Policy condition No. 5.16 1 & 5 for Maternity benefit expenses clearly speaks that the Post natal expenses &/or the expenses which are not incurred during the confinement period are not covered under the scope of Policy. However, the payment of Rs. 43.00 out of Rs. 310.00 for the bill dated. 29.9.2007 found not technically justified, because the same is well prescribed and incurred during the confinement period of hospitalization, moreover, the respondent also did not seek any medical opinion from doctor about the split of Bill/amount for one day, Hence, the Respondent is directed to pay the difference of claim amount for Rs. 267.00 which was deducted from the Bill No. 1684 dated. 29.9.2007 to the claimanant (as found payable from the medical claim papers and Bill No. 1684 for Rs. 310.00 submitted by the Complainant to us)

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CHENNAI

Chennai Ombudsman Centre
Case No.IO(CHN) 11.02.1225/2008 – 09
Mr. B. Rajendran
Vs
The New India Assurance Co. Ltd
Award No.057 dated 10/11/2008

The Complainant Shri B Rajendran was covered under Group Mediclaim Insurance Policy for LIC employees with a sum insured of Rs.80,000/-. The insured was hospitalized for severe pain in the right elbow and shoulder. The insurer rejected his claim under Exclusion Clause 4.10, on the ground that only various tests had been undergone by the insured and it was not followed by active treatment.

The point to be considered is whether the insurer is justified in rejecting the claim on the grounds that hospitalization is not necessary for diagnosis/investigations, which are not followed by active treatment.

The discharge summary is quite comprehensive and the hospitalization should not be considered as one for treatment only of pain in elbow. Besides, the policy offers coverage for pre existing ailments also. As explained by the insured at the hearing, he had been advised to go to this hospital by the local doctor whom he consulted. The insurer has rejected the claim since the diagnostic tests do not require hospitalization but have not checked up with the hospital whether the hospitalization was necessary. Further they have not asked for the X-Ray report, which might have revealed the necessity relating to treatment of pain in the hand. X Ray charges were mentioned in the bill but no reports seem to have been summoned. Certain steps in this direction might have helped the insurer to prove their stand, which they have not taken. Hence, the complaint is allowed as Ex gratia.

Chennai Ombudsman Centre

Case (CHN) 11.04.1252 / 2008-09

Mr. R. Rangarajan
Vs
United India Insurance Co. Ltd
AWARD No. 070 dated 26/12/2008

The Complainant, Mr. R. Rangarajan and his wife were covered under Group Mediclaim Insurance Policy (IOB HEALTH CARE PLUS POLICY) issued to account holders of IOB by United India Insurance Co. Ltd.,. Mrs. R. Anuradha, wife of the complainant was hospitalized on 26/03/08 with complaints of Asthma and Gastritis. The insured lodged a claim for Rs 9,891/. The insurer settled the claim for Rs 8,055/-, disallowing an amount of Rs 1,836/- on the grounds that the same was not admissible.

The insurer contended that the insured was having 'Drug induced gastritis, duodenal erosions" for which they have settled the claim and disallowed expenses towards Bronchial Asthma which was preexisting. However, on his

representation they were willing to consider an additional amount of Rs.600/- towards gastritis.

The case thus came up for hearing on 17/11/2008.

After hearing the parties and perusing documents such as Terms and Conditions of the IOB Health Care Plus Policy, Medical Laboratory Report and OESOPHAGO-GASTRO-DUODENOSCOPY REPORT of ABC Hospital, Trichy, Copy of Proposal Form, Discharge Summary of ABC Hospital, Trichy were examined. On scrutiny of the records, it was found that the insured was hospitalized for severe persistent asthma and Drug induced gastritis/Duodenal erosions and the patient had been a chronic wheezer for many years. There was a short settlement of Rs.1836/- and the TPA had come forward to reconsider the related to gastritis expenses. The insurer was directed to confirm the release of the additional amount of Rs 600/- already offered by them.

The complaint was dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02.1285 / 2008-09

Mrs. K. Karkuzhali
Vs
The New India Assurance Co. Ltd
AWARD No. 075 /2008-09 dated 29/12/2008

The Complainant, Mrs Karkuzhali, an employee of LIC of India is covered under the Group Mediclaim policy issued by New India Assurance Company Ltd. to employees of LIC of India. The eligible Sum insured for employees in her cadre is Rs 60,000/- and she had opted for enhanced sum insured of Rs 1.00 lac. She was hospitalized for Caesarian and submitted a bill for Rs 1,37,855/. The insurer restricted the claim settlement to Rs 50,000/- only, on the grounds that it is the maximum amount payable under the policy for maternity. .

Insurer contended that the insured was admitted in the hospital for maternity. As per the policy conditions, the maximum amount payable under this head is Rs 50,000/- .

The case thus came up for hearing on 21/11/2008.

After hearing the parties, documents such as Discharge Summary, Operative Record of the hospital for 24/01/2008 and 25/01/2008, Anaesthetic record sheet for 25/01/2008 were perused. It was seen that the complainant had been initially admitted for an elective caesarean surgery. The surgery was performed on 21/01/2008 and a female baby was delivered. Thereafter the uterus and abdomen were closed in layers. It was observed that during the surgery, there was significant loss of blood. To mitigate the loss, blood transfusion had been done pn 24/01/2008. However, complications set in thereafter and on the following day, ie 25/01/2008 relaparotomy was done, the abdomen was reopened and the blood evacuated. The hospital authorities had erroneously put the same date for both the procedures in the discharge summary. The recordings in the indoor case papers also establish the sequence of events. Extraordinary measures were adopted to save a life. Taking into account the seriousness involved, it was held that even though the admission into the hospital was for childbirth, the relaprotomy etc are to be considered a separate incident and should not be clubbed with 'maternity'. A sum of Rs 30,000/- was awarded as Ex-Gratia in addition to the sum of Rs 50,000/- already paid by the insurer.

The complaint is partly allowed**.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.14.1251 / 2008-09

Mr.R. Ravichandran

Vs

Cholamandalam MS General Insurance Co. Ltd

AWARD No. 078 dated 31/12/2008

The Complainant Shri R. Ravichandran and his wife are covered under Group mediclaim policy issued to employees of M/s Sai Mira Innopharma Pvt. Ltd by M/s United India Insurance Co. Ltd for the period 17/04/2007 to 16/04/2008. The complainant's wife was hospitalized from 5/05/2007 to 6/05/5007 and underwent an Inevitable Abortion. The Insured claimed an amount of Rs 18,279/- whereas the TPA offered to pay Rs.12,599/- only, although as per the policy, maternity expenses cover was up to Rs 50,000/-.

The insurer stated that they had disallowed only the consultation charges of Rs.5, 500/- which is exorbitant and exceeded the nominal consultation charges. Further, the Insurer observed that there was inconsistency in the receipts and dates of some bills submitted by the complainant.

The case thus came up for hearing on 17/11/2008.

After hearing the parties ,documents such as Discharge Summary,policy copy and Maternity Benefit Extension Endorsement, Gynecologist's bills ,Mediclaim computation sheet were perused .It was found that the patient was admitted on 5/5/2007, procedure of suction evacuation had been done under General Anesthesia and had been discharged on 6/5/2007 and he has claimed Rs 18,178/-.According to the Maternity benefit extension endorsement of the policy, a maximum amount of Rs 50,000/- is payable for hospitalisation expenses and Rs 2,500/- or 5 % of sum insured (whichever is more) for pre and post hospitalisation. (4.2)

As per the repudiation letter the claim has been settled for Rs 12,599/- and Rs 5,500/- of the consultation fees has been disallowed as 'exceeds nominal fees' and Rs 180/- miscellaneous charges as 'not payable'.

Held that the claim has been processed as per the terms and conditions of the policy.

The Complaint was dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02. 1377 / 2008-09

Ms. V.S. Nirupama
Vs
The New India Assurance Co. Ltd
AWARD No. 081 dated 29/01/2009

The Complainant, an employee if LIC of India had been covered under the Staff Mediclaim Policy. She underwent Zyoptix surgery for her eye and submitted the claim for Rs 36,570/-. The claim was rejected under exclusion 4.14 of the Group Mediclaim Policy.

The insurer stated that the insured was having the history of using glasses for the past 18 years and the error of refraction of both the eyes was (-)3 at the time of recruitment and the refractive error as per the patient data given by the hospital is refraction sph (dptr) (-)6.5. Since the refractive error is less than (-)7 and power of (-)3 was present at the time of inception of cover, they had rejected the claim.

The case was heard on 19/12/2008.

The complainant expressed her inability to attend the hearing. Her contentions were read out and the insurer presented his case. Thereafter the documents such as Discharge Summary, Mediclaim Policy Clause 4.14, treating doctors Certificate, Indoor case sheet and Orbscan reports were perused.

It was observed that sccording to the certification by the treating doctor it is observed that the insured was having vision defect of (-)7 in both eye at the time of going in for surgery. But it is crucial to note that even at the time of joining the scheme as a new recruit in the company, the complainant had defective vision and the power had been (-) 3.0 even then. As per the LIC group Mediclaim Policy the relevant policy condition reads as under:

"Lasic laser treatment performed to get rid of spectacles and/or contact lenses, unless the treatment is for Keratotomy of insured having more than (-7) refractive error, if the refractive error develops after the date of coverage, therapeutic reasons like recurrent corneal erosions, nebular opacities and non healing ulcers". The policy provides for coverage if the error is more than (-7). In the instant case the refractive error being (-) 7 but not more than (-7), the rejection of the claim by the insurer on this

ground cannot be faulted since the specific value has been mentioned in the policy.

The complaint was dismissed.

Chennai Ombudsman Centre
Complaint No.IO(CHN) 11.02.1373 / 2008-09
P. Ponnusamy
Vs
The New India Assurance Co. Ltd
AWARD No. 083 dated 29/01/2009

The Complainant Mr. P. Ponnusamy has been covered Group Mediclaim policy for LIC employees issued by New India Assurance Co. Ltd. He was admitted in the hospital for sudden onset of cough and vomiting. Doctor advised him for admission since there was a possibility of further deterioration in his health due to age. After evaluation at the hospital, the insured claimed for the hospitalization of about Rs 9875/- .

The insurer contended that though the insured was admitted in the hospital, no active line of treatment had taken place. Instead a periodical evaluation has been done which does not warrant hospitalization. Hence, the claim has been repudiated.

The complainant expressed his inability to attend the hearing which was held on 19/12/2008, due to his poor health.

Documents such as Discharge Summary, ECG Reports, X Ray, Internal case sheet and Medical opinion were scrutinized.

It was seen that the insured was admitted to the hospital at 2 AM at night with attacks of severe cough with oppression in chest and vomiting. BP reading was 140/110 and the ECG showed subtle changes Although other diagnostic tests indicate no illness, internal case sheet reveals that medicines have been administered to bring the person to normalcy though the diagnostic tests were normal.The stand of the insurer that only periodical evaluation was done is not acceptable since as per the discharge summary the complainant is neither having diabetes nor hypertension The internal case sheets also explain the medicines administered which is consistent with the complaints for which hospitalization was resorted to.

It was held that the decision of insurer to reject the claim in full was unjustified and a sum of Rs. 5,000/- was awarded as Ex-Gratia under Rule 18 of Redressal of Public Grievance Rules, 1998

The complaint was partly allowed as Exgratia.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02. 1372 / 2008-09

Mrs. Nirmala Parthasarathy
Vs
The New India Assurance Co. Ltd,
AWARD No. 085 dated 29/01/2009

The Complainant has been covered under the Citibank Mediclaim Policy since 2001. She was having severe pain in both the knee joints for one month during 2005 and diagnosed as Osteo Arthrosis. She was on treatment under physiotherapy and Ayurvedha system. Her claims for the same were paid by the insurer. Later, she underwent bilateral total knee replacement and the claim for Rs 2.75 lacs was rejected by the TPA on the grounds that the ailment was a pre-existing one.

The insurer contended that the insured is a known case of OA in both knees for the past 17 years. Since, the disease is pre existing prior to inception of first year policy in 2001; the TPA had denied the cashless facility. The insurer further contended that the documents submitted in respect of Ayurvedic treatment did not disclose the duration of the said ailment and based on the same the claim was settled. Otherwise, they would have rejected that claim also. Moreover, the settlement of earlier claim did not prevent them from rejecting the present one under condition 4.1 of the policy since; the documents submitted relating to the earlier claim had not revealed the pre-existing nature of the disease.

The case was heard on 23/12/2008.

After hearing the parties, documents such as Good Health Policy certificate, Pre Authorization Request form (wherein Duration of ailment is recorded as 10 years **and Past history of chronic illness is recorded as** Diabetes -9 years, Hypertension -9 years, Heart disease- 9 years and Osteoarthritis as 17 years.) **Discharge Summary of Apollo**

Specialty (where surgery performed was Total Knee replacement of both knees and history of knee pain is stated as 6 years) **,Repudiation letter, Consultation papers, Certificate from the treating Certificate from the treating doctor stating that the period of 17 months has been incorrectly recorded as 17 years in the discharge summary and pre hospitalisation form and it is not possible for a person to carry on for 17 years without surgical /medical intervention.**

But, neither the insurer nor the complainant has been able to conclusively prove the actual date of commencement of the disease. From the records and documents submitted it is not possible to arrive at the exact date for onset of the disease. Definitely the symptoms of the ailment have started several years earlier and the condition has slowly degenerated. Since the exact date of onset of osteoarthritis has not been conclusively established to conclude the pre existing nature of the disease and to render justice to both parties, a sum of Rs 1.00 lacs (Rupees One Lakh only) was awarded as Ex-Gratia.

The complaint was partly allowed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02. 1366 / 2008-09

Prof. Dr. G.S. Kandasamy

Vs

The New India Assurance Co. Ltd

AWARD No 086 dated 29/01/2009

The Complainant was covered under the Citibank Mediclaim Policy and underwent three cycles of chemotherapy. He submitted his claim for about Rs 98,000/ which was rejected because the hospital where the insured had taken treatment was neither a registered one nor has a minimum of 15 beds. It did not meet the policy conditions which define a hospital.

Documents such as Good health Policy Certificate, three claim forms which add up to Rs 98,528/-. Discharge Summary of Chennai

Cancer Care Hospital and of Rai Memorial Medical Centre, Histopathology Report of Apollo Speciality Hospital, repudiation letter of TPA, Medical certificate of TPA were perused.

It was seen that the complainant was administered three cycles of Chemotherapy at the Chennai Cancer Care which does not Qualify as a hospital as per the policy terms of the insurer. The hospital has confirmed that there are only 4 beds for chemotherapy but no operation theatre in the hospital although qualified doctors and nurses available.

It was noted that Chemotherapy is generally a day care/out patient procedure which normally requires no hospitalization. Condition 2.3.1 also has a flexibility wherein the minimum period of 24 hours hospitalization is dispensed with for chemotherapy treatment since hospitalization is not required. The issue boils down to one of technical in nature wherein the treatment requirements are met whereas the infrastructure standards pertaining to number of beds, operation theatre and registration could not be complied with. The TPA/Insurer have also not questioned about the medicines administered, the skill of the doctors or the treatment given. Held that the decision to reject the claim in full is unjustified.An amount of Rs.40,000/- (Rs Forty thousand only) was awarded as Ex-Gratia

The complaint was partly allowed as Exgratia

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02.1238 / 2008-09

Mr. R. Ananthanarayanan

Vs

The New India Assurance Co. Ltd

AWARD No. 087 dated 30/01/2009

Mr R Ananthanarayanan, a retired employee of LIC was covered under Group Mediclaim Insurance policy issued by M/s New India Assurance Co.

Ltd. He was hospitalized during 2007-2008 for severe chest pain. He was treated for Obstructive Sleep Apnoea and submitted a claim for Rs 17,000/-. His claim was rejected by the insurer on the grounds that the tests were conducted for diagnostic purposes only without positive existence of any ailment and no active line of treatment was undertaken, citing exclusion under the policy.

The insurer stated that the insured's hospitalization was for diagnostic purposes only without positive existence of any ailment and no active line of treatment was taken.

The case came up for hearing on 16/10/2008 during which the complainant was heard. The insurer was heard on 19/12/2008.

After hearing the parties, documents such Polysomnography Test Report, Discharge Summary, Write up on sleep apnoea, Certificate from treating doctor stating that the complainant had undergone a sleep study (Baseline and titration) and the cost of the study had been labeled under "Pulmonology charges" were perused.

It was found that the charges for the sleep study were categorized as "Pulmonology charges" and neither the insurer nor the doctors at the TPA could understand the actual situation. But rather seeking clarification from the insured or the hospital, they had concluded that 'pulmonology' was not related to the present complaint. It was also noted that the complainant is neither a diabetic nor having hypertension. Therefore the possibility that the complainant was admitted for routine tests did not arise.

Held that contention of the insurer that the tests were not warranted was unjustified. The insurer was directed to process and settle the claim as per other terms and conditions of the policy issued.

The complaint was allowed**.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.03.1367 / 2008-09

Mr. P. Manoharan

Vs

National Insurance Co. Ltd

AWARD No. 089 dated 30/01/2009

The wife of Mr Manoharan was covered under the Staff Mediclaim Policy of National Insurance Co. Ltd for a SI of Rs.1,10,000/-. In 1997, her maternity for twin children was settled. On 17/01/2007, she delivered a baby boy and submitted the claim. The claim was rejected by the insurer on the ground that as per the policy terms, cover was available for two living children only

The insurer contended that as their policy conditions, coverage is available only for two living children or in the absence of the same, reimbursement of expenses was available for two confinements under maternity benefit section. In the instant case, since insured is having two living children, the current maternity was for a third child and hence claim for second confinement was rejected.

The case was heard on 18/12/2008.

After hearing the parties, documents such as the terms and conditions along with administrative instructions of the Group Policy, Discharge Summary from hospital were perused. The point to be considered was whether the rejection of the claim for delivery expenses for the second confinement for the third child (the first confinement being twins) by the insurer on the grounds that the insured already had two living children, was in order.

On scrutiny of the records, it is found that the case related to group Mediclaim policy issued by public sector insurer to its employee whose wife delivered twin babies during 1997 and a third baby on 17th January 2007. The clarification received by the insurer from their controlling office states " If the female employee gives birth to twins in the first delivery (who are surviving), she will not be eligible for reimbursement of expenses for the second confinement. (2) The intention of the policy is to admit only two confinements per insured." It was seen that this condition was wrongly interpreted as "If either of the conditions viz. two surviving children or two confinements is fulfilled, then the employee would not be eligible for reimbursement of expenses under maternity benefit section of group Mediclaim policy for the third child" although the condition that company would pay for two confinements was expressly stated.

It was held that in the absence of clarity with regard to the use of the term "confinement", the decision of the insurer to repudiate the claim in was unjustified and a sum of Rs 25,000/- was awarded as Exgratia as per Rule 18 of Redressal of Public Grievance Rules, 1998 without precedence.
Complaint was partly allowed **on Exgratia basis.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02.1292 / 2008-09

Dr. Vimala Jepegnanam
Vs
The New India Assurance Co. Ltd
AWARD No. 091 dated 25/02/2009

The Complainant and her husband have been covered under Good Health policy through Citibank and continuously covered since 1999. The complainant's husband Dr. Johnson Jepagnanam had been hospitalized for kidney failure in 2004 and has been undergoing dialysis since October 2005. The insured submitted the claim for the dialysis expenses which was rejected.
The insurer contended that the insured's hospitalisation was for end-stage renal disease and he is a known diabetic for 30 years. Since the policy was effective from 01/10/1997 only, diabetes was excluded under the policy and the ailment is due to complication of pre-existing disease, they had rejected the claim under the exclusion clause 4.1 of the policy.
The case thus came up for hearing on 18/12//2008 and her son presented her case.
After hearing the parties, documents such details of policy- period - wise expenses showing amounts paid, Discharge Summary, Claim form with month wise break up of dialysis expenses, policy copy along with terms and conditions for 1999, 2005-06 and 2007-08, Certificate from treating doctor were perused.

It was seen that the insured was a senior citizen and the complainant and her spouse had a continuous policy since 1999 and diabetes had been declared at the time of obtaining the cover. The terms of the policy at that time did not exclude complications arising out of pre existing ailments and the claim has arisen in the 8th policy year. Total repudiation was not justified and an Exgratia amount of Rs. 45,000/- **was awarded under Rule 18 of Redressal of Public Grievance Rules, 1998.**

The complaint was partly allowed as Exgratia.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02.1376 / 2008-09

Mr. P. K. Ravichandran
Vs
The New India Assurance Co. Ltd
AWARD No. IO (CHN)/G/095/2008-09 dated 25/02/2009

The Complainant, Mr. P.K. Ravichandran, an employee of LIC of India, has been covered under the Group mediclaim policy of New India Assurance Co. Ltd. He was admitted in the hospital for severe neck and back pain and subsequently hospitalized for severe fever, headache and wheezing. He submitted the claim papers for reimbursement of Rs 29,705/- .

The insurer rejected the claim on the grounds that the tests conducted were not consistent with the diagnosis for which the patient got admitted. Hospital papers submitted suggest that only investigations were carried out apart from the regular test for his sugar which is not consistent with the diagnosis for which he was hospitalized.

The case thus came up for hearing on 09/01//2009.

After hearing the parties, documents such as Discharge Summary dated 28/10/2006 and 10/11/2006 from M.V. Hospital For Diabetes (P) Ltd, Discharge summary for the period 01/11/2004 to 05/11/2004 from Raju Hospitals (P) Ltd and from 14/12/2004 to

15/12/2004 from Lifeline Rigid Hospital, treating doctor's opinion, Certificate from hospitals, Scan reports were perused.

It was seen that the insured was suffering from diabeties for a long time and for any hospitalization of a diabetic patient, it is customary for the hospitals to carry out test for diabeties to finalize the line of treatment, to avoid adverse reactions between different drugs and diabetic control related drugs. Hence, the contention of the insurer that tests were carried out only to diagnose diabetic status is not correct. Further, taking into account the previous history of various consultations the insured had on outpatient basis also, it was held that hospitalisation was necessary and treatment administered did not fall under exclusions of the policy. Held decision to repudiate the claim was unjustified.

The complaint was allowed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02. 1413/ 2008-09

Mrs. A. Latha
Vs
New India Assurance Co. Ltd.,
AWARD No097 dated 26/02/2009

The Complainant, Mrs.A.Latha was covered under Group Mediclaim Policy issued by New India Assurance Co. Ltd. During the policy period, she was hospitalized on three occasions for pain in knee joints under Siddha system of treatment at Melamoochal in Nagercoil District. Her three claims totaling Rs 41,300/- was rejected by the insurer.

The insurer rejected the claim on the grounds that the treatment is under Naturopathy, that the treatment could have been taken as outpatient and did not warrant hospitalization and hence not payable under the terms of the policy.

The case thus came up for hearing on 28/01/2009.

After hearing the parties, documents such as Case sheets, Hospital certificates , Discharge card, Scan report etc were perused.

It was seen that treatment was taken under Siddha system of medicine by staying in the hospital due to the special medication given. It is evident that Siddha is an Indian system of medicine practiced in this part of the country. Insurer has considered Siddha to be same as that of Naturopathy. The policy condition has

specifically disallowed only Natruopathy and it is incorrect to consider siddha as same as naturopathy. The system of medicines Siddha and Ayurveda only are comparable.

Held that total repudiation of claim under Excl 4.13 (Naturopathy treatment) of the policy given to LIC employees is unjustified.

The insurer was directed to process and settle the claims on par with the eligibility for Ayurveda system i.e. up to 25% of the eligible sum insured, subject to other terms and conditions of the policy.

The Complaint was allowed.

Chennai Ombudsman Centre
Complaint No.IO(CHN) 11.02.1432 / 2008-09

Mr. D. Arnold

Vs

The New India Assurance Co. Ltd

AWARD No 098 dated 26/02/2009

The Complainant, Mr D.Arnold had been covered under LIC Staff Group Mediclaim Insurance policy issued by M/s New India Assurance Co. Ltd. The complainant was hospitalized during the policy period for chest discomfort, epigastric pain & vomiting. The complainant lodged the claim with the insurer for Rs 6,707/-.

The claim was rejected by the insurer on the grounds that he was a known case of hypertension, diabetes mellitus and angina admission in the hospital was only for investigation purpose without involving any active line of treatment.

The case thus came up for hearing on 21/01/2009.

After hearing the parties, documents such as Discharge Summary for earlier hospitalisations in1992, 1999 as well as the present one were perused. It was found that insured was hospitalized during 1992 for Diabetes Mellitus and CAD-Acute inferior wall myocardial infarction. He had been again hospitalized during 1999 for coronary artery disease. The present hospitalization during 2008 is for acute

gastritis, diabetes mellitus, hypertension and angina.The complainant is a 75 year old senior citizen, who has been suffering from diabetes mellitus, hypertension and has been treated earlier for myocardial infarction is on continued medication and had to be hospitalized in the early hours in an emergency condition due to chest pain suffered. It seems that the insured had acted the way a normal person would act in such a situation. But the discharge summary for the present hospitalisation is very sketchy, if the complete details had been given, it would have been clear to the insurer that a medical emergency had arisen. Held that decision of the insurer to repudiate the claim was unjustified directed to process and settle the claim as per other terms and conditions of the policy.

The complaint was allowed**.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02.1450 / 2008-09

Mr. S. Raghavan
Vs
The New India Assurance Co. Ltd
AWARD No 099 dated 26/02/2009

The Complainant was covered under LIC Staff Mediclaim /Group Mediclaim Insurance of New India Assurance and was hospitalized during the policy period for Right Inguinal Hernia and Para Umbilical Hernia. The complainant lodged the claim with the insurer for Rs.53, 651/-. The insurer settled the claim for Rs.44, 151/- disallowing an amount of Rs.9, 500/-. The insurer had not stated any reasons for disallowing Rs.9, 500/-.

The insurer contended that the amount charged by the hospital is on the higher side when compared to other high caliber hospitals in the city. They compared the expenses with one of the premium hospital of the city and in their opinion Rs 9,500/- was in excess and unreasonable and disallowed it.

The case came up for hearing on 22/01/2009.

After hearing the parties, documents such as Hospital bills, Discharge Summary, policy terms and conditions etc were perused. It was seen that in the case of the present hospitalization, the TPA of the insurer had opined that similar treatment in other premium hospitals would only cost between Rs.45,000/- and Rs.50,000/- and not as charged .It is seen that no amount has been fixed as the cost of the surgery but only a range has been given. A perusal of the terms and conditions of the policy reveals there is no mention made regarding the hospitals in which a patient can avail treatment for a particular ailment. In the absence of any mention, the insured is free to choose any hospital, where he thinks that his ailment could be cured completely and also based on the previous experiences of similar treatment taken by his relatives/friends. Comparing with the similar hospitalization claims may provide us a fair idea about the charges for a particular surgery/condition but cannot be taken as the right amount in the absence of such standards fixed in the policy clause which alone would be of a binding nature.

Held that decision to reduce rs 9,500/- was unjustified and an Exgratia amount of Rs 5,000/- was awarded under Rule 18 of Redressal of Public Grievance Rules, 1998.

The complaint was partly allowed as Ex-Gratia.

Chennai Ombudsman Centre
Complaint No.IO(CHN) 11.02.1419 / 2008-09
Mr.B.N. Raghothaman
Vs
The New India Assurance Co. Ltd
AWARD No 100 dated 26/02/2009

The Complainant, Shri B N Raghothaman and his wife are covered under LIC Staff Group Mediclaim Insurance policy with M/s New India Assurance Co. Ltd. The complainant's wife was hospitalized for

Bilateral total knee replacement during the policy period. The complainant lodged the claim with the insurer for Rs.2,32,184/-. The insurer settled the claim for Rs.2,28,153/- and disallowed an amount of Rs.3,831/-.

The insurer stated the non admissible amount was Rs.3,831/- with breakup being Rs.1,701/- towards non medical expenses, Rs.500/- towards drape and Rs.1540/- where proper bills were not provided and that the above reductions have been done as per the policy conditions.

The case thus came up for hearing on 22/01/2009 at Coimbatore.

The Complainant could not be present for the hearing. After hearing the insurer and the representative of the TPA documents such as Discharge, bills, hospital records, etc were perused.

It is confirmed that an amount of Rs.1,701/- has been disallowed as non medical expenses which includes cost of rubber sheet, oxygen mask, workadine solution, betadine scrubs, water, Rs.590/- towards expenses on drapes and Rs.1000/- for blood charges, where proper bills were not submitted by the insured. Although a doctor has certified that blood transfusion took place, the insured had not submitted the proper bills. If bills were submitted, the TPA would have considered the same. In respect of other items, though they were required in the treatment, certain consumables were disallowed as per the terms of the policy.

Held that the amounts disallowed had been done as per the terms of the policy.

The complaint was dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1528 / 2008-09

Dr. Rajalakshmi Radhakrishnan

Vs

United India Insurance Co. Ltd

Award No.123/2008-09 dated 31/03/09

The Complainant was covered under the mediclaim policy issued by the insurer M/s Indian Overseas Bank. During the policy period, the insured was hospitalized for treatment of "High Grade partial tear of anterior cruciate ligament of the left knee." She submitted bills for reimbursement of hospitalization expenses. Her claim was not settled and there was no communication from the insurer. The point to be considered is whether the action of the insurer rejecting the claim under condition 4.10 of the policy is in order.

Although the claimant had stated that she had suffered a fall, no mention of the fall has been made either in the pre authorization form or the discharge summary. No mention of trauma or admission as emergency is reflected in the Discharge summary. The certificate of the treating doctor also states that the patient was admitted for "both knee pain increased on getting up from squatting position". As such, no evidence has come to light which required hospitalization of the complainant. The MRI Scan was taken outside the hospital. But the complainant has not undergone the prescribed treatment. In fact, the only treatment taken by the patient seems to have been physiotherapy and analgesics, which do not require inpatient stay. The diagnostic tests indicate that the condition of the patient required surgical treatment, which was however not taken by the insured. Since no active line of treatment was taken pursuant to the diagnosis, the entire admission in the hospital is for diagnostic tests only. Hence, the decision of the insurer to reject the claim in the absence of any active line of treatment cannot be faulted and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1454 / 2008-09
Mr. R. Radhakrishnan
Vs
The New India Assurance Co. Ltd
Award No.126/2008-09 dated 31/03/09

The Complainant has been covered under LIC's group Mediclaim Policy with the insurer . He enhanced the sum insured from Rs.80,000/- to Rss.2,00,000/-. His hospitalization subsequent to the sum insured increase and claim amount exceeding the pre enhanced level was not allowed on the grounds that increase in sum insured is not applicable for a pre existing disease.

The point to be considered is whether the action of the insurer rejecting part of the claim on the grounds that, sum insured increase was effected for availing the additional expenses for an existing ailment during the policy period, under the policy exclusion is in order.

Even though the complainant has contended that he had not deliberately increased the sum insured to take care of an impending surgery/medical treatment, the fact that the complainant was still on medication and had been hospitalized for the same stomach pain also cannot be ignored. The policy condition which states that "if it is found that the sum insured has been optionally increased to take care of a particular disease or for a planned surgery, the claim will be settled only upto the basic sum insured during the policy period"; has been correctly interpreted by the insurer. The rationale behind the condition is that the insured can not opt for a sum insured increase after being aware of the disease to take care of additional expenditure involved.

Even though the policy provides for coverage of pre existing ailments, the condition as mentioned above applies a bar when sum insured increases are sought to be made with the knowledge that the same can be utilized for an already prevailing ailment. In view of the same, the decision of the insurer to restrict the claim amount to the original sum insured of the policy can not be faulted and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1574 / 2008-09
Mr. S. Radhakrishnan
Vs
The New India Assurance Co. Ltd
Award No.130/2008-09 dated 31/03/09

The Complainant and his wife are covered under Senior Citizen's Unit Plan of Unit Trust of India through the insurer. He was hospitalized for removal of impacted tooth and the claim was rejected by the insurer on the grounds that dental treatment is not payable under the policy.

The point to be decided was whether the rejection of the claim for dental treatment, by the insurer was justified as per the terms and conditions of the policy.

It is found that the insured was hospitalized for removal of impacted tooth.. Subsequent to the fixing of the hearing, the insurer in consultation with their Regional office have decided to settle the claim as provided in the annexure to the MOU terms entered into with UTI. The insurer had informed that they have settled the claim. They further informed that the claim payment has to be made to UTI as per the MOU terms. In view of the settlement of claim as per the MOU between the insurer and Unit Trust of India, no further relief is required and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1581 / 2008-09
Mr. R. Ramanathan
Vs
The New India Assurance Co. Ltd
Award No.131/2008-09 dated 31/03/09

The Complainant and his wife are covered under group policy issued by the insurer to Credit Card holders of Citibank, called Good Health Policy. During the policy period , the complainant underwent 'laproscopic 'Cholecystectomy'. The insurer had disallowed an amount of Rs.8,120/- on the grounds that the expenses were incurred outside the time limit prescribed for pre-hospitalization time limit fixed under the policy.

The point to be considered is whether the action of the insurer limiting the expenses to 30 days prior to the hospitalisation is in order, as per the terms and conditions of the relevant policy.

It is found that TPA has processed the claim as per the policy condition relating to pre hospitalisation expenses. It is also observed that the complainant seems to have referred to brochures pertaining to some other year other than the relevant years. It appears that the insured has depended on the prospectus rather than the actual contract which is the policy.

In the present case, it is observed that the claim has been processed as per the terms and conditions of the contract and the decision of the insurer to disallow expenses which do not qualify as pre hospitalisation expenses cannot be faulted and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1583 / 2008-09
Mr. K. Ramanujam
Vs
United India Insurance Co. Ltd
Award No.132/2008-09 dated 31/03/09

The Complainant was covered under IOB Health Care Plus Policy, a Group Mediclaim policy issued by the insurer for account holders of Indian Overseas Bank. He was diagnosed to have

jaundice with problem in liver and bile duct while he was in Tanzania. He underwent hospitalization at Chennai & Vellore . Though he submitted the bills for reimbursement to the TPA, there was no response from either the TPA or the insurer. The point to be considered is whether the action of the insurer rejecting the claim on the grounds of pre existing disease is in order.

The disease was first diagnosed in Tanzania as 'cirrhosis of liver'. The word "Chronic" was used to denote that "continual problem in Liver". This would mean that it was of long standing duration and not of recent origin, although the symptoms may have become acute lately. In the present case, the complainant was not in India when the policy was incepted. That he had no medical insurance while the complainant was employed abroad, especially in the continent of Africa is unlikely. The complainant has also not cooperated with the insurer in providing the records called for. Also the complainant has not produced clinching evidence to establish that the ailment had not commenced when the policy was incepted about two months earlier. On the other hand, the severity of the disease and the treatment taken points out that the disease might have been present well before taking the policy. In view of the failure of the insured in substantiating with evidence that he was not having the said disease at the time of taking the policy for the first time the complaint is dismissed.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-010-0087/08-09

Smt. Chandrawati Devi
- Vs -
The IFFCO Tokio General Insurance Co. Ltd.

Award dated : 29.12.2008

Mrs. Chandrawati Devi was an insured under "Group Medishield Policy" of the IFFCO Tokio General Insurance Co. Ltd. with the Sum Insured of Rs.45,000/- for the period 15.08.2006 to 14.08.2007. The Insured was hospitalized on 09.06.2006 wherein an operation "Cholecystectomy with (Rt) Pyclolithotomy" was done under general anesthesia on 09.06.2006. Subsequently, again she was admitted in the hospitalized on 25.12.2006 for treatment "Symtomatic (Lt) renal pelvic calculus (3 x 2 cm) and treatment like "(Lt) PCNL + DJS under general anaesthesia was done on 28.12.2006". Her claim was rejected on the ground of non submission of required documents. Being aggrieved, the Complainant approached this Authority for redressal.

It appears that the claim form was submitted by the Insured before the TPA – Golden Multi Services Club Ltd. and it was received by them on 07.03.2007. According to the Complainant, she had submitted the supporting documents alongwith her claim before the TPA and the TPA – Paramount Health Services Pvt. Ltd. vide letter dated 22.06.2007 has also admitted about receipt of such documents pertaining to the claim lodged by Mrs. Chandrawati Devi. However, vide the aforesaid letter, the claim under account "Chandrawati Devi" was treated as closed due to non submission of required documents. It is however not known what documents were required by the TPA / Insurer and in the absence of any "Self Contained Note" it has also not been clear to us. There is a copy of letter dated 20.03.2007 written by the TPA – Golden Multi Services Club Ltd. issued to one of the Insureds under the policy asking him to produce certain documents mentioned therein in order to settle the said claim under account Chandrawati Devi and the endorsement made on the body of the aforesaid letter shows that the TPA - Golden Multi Services Club Ltd. has received the required documents on 30.05.2007 and according to the Complainant, she had also submitted all such documents on that day. Thus the repudiation of claim appears to be based on a vague circumstances. If however, any further documents are required, she may be informed about it and arrange to settle the claim on receipt of such documents. Accordingly direction was made.

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-296/2008-09

Shri Abraham Eapen
Vs
The New India Assurance Co.Ltd.

AWARD DATED 09.01.2009

The complainant is a retired LIC employee who is covered under a group mediclaim policy. Following sudden onset of giddiness and discomfort, he consulted Ananthapuri Hospital on 15.03.2008. He was admitted there on 17.03.2008 and got discharged on 18.03.2008. The claim was repudiated on the ground that the hospitalization was only for diagnostic purpose and no active line of treatment was taken from the hospital. From the records produced and from the submissions made by the insured and insurer at the time of hearing, it looks that the complainant was admitted for one day on 17.03.2008. At the time of admission, he took only medicines which he was taking earlier. No medicines were prescribed and given. ECG and TMT were taken and he was discharged on 18.032008 and prescribed some medicines which he was taking earlier. It looks that admission was only for taking TMT and ECG. The medicines prescribed at the time of discharge were the same used by the insured earlier. It was submitted by the insured that while he consulted the doctor on 15.03.2008, the doctor might have advised some investigation or tests. He was admitted on 17.03.2008 only for claiming insurance benefit. He could have continued out-patient treatment, instead he got admitted in the hospital for one day and bought medicines for 2 months worth Rs.6,035/-. Also, in his letter addressed to the insurance company, he has stated that he was advised by the doctor to get admitted for investigation. As the insurer was able to prove with clinching evidence that the hospitalization is only for investigation, the complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-185/2008-09

Shri V.Aravindakshan
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 31.10.2008

The complainant is covered by a group mediclaim policy, being an employee of Apollo Tyres Ltd., covering himself and his family members. His daughter, Anitha, had undergone ophthalmic surgery on 12.01.2008 and the claim was repudiated on the ground that the treatment was in the nature of cosmetic treatment which was not covered under Cl.4.5 of policy.

In the discharge summary, the diagnosis was shown as compound myopic astigmatism. The type of surgery conducted was zyoptic aspheric. The ailment astigmatism is an abnormal condition of eye in which the light rays cannot be focused in retina of eye. Usually, this is corrected by contact lense or wearing glasses. The insured was using glasses continuously for the last 5 years. Now she had undergone a surgery only to avoid usage of glasses. Surgery was done only for correction of a deficiency. It is to be treated as only a cosmetic surgery. As cosmetic surgery is specifically excluded from the scope of policy, there is no reason to interfere with the decision of the insurer. The complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-373/2008-09

Shri C.Sukumaran
Vs
The New India Assurance Co.Ltd.

AWARD DATED 25.02.2009

The complainant has been covered by a mediclaim policy. He was admitted from 20.06.2007 to 21.07.2007 for treatment of Santhigathavatham. The claim raised was repudiated as if treatment was for a pre-existing ailment. It was submitted by the insurer that in the case sheet produced from the hospital and in the claim form, the insured himself had stated that he was suffering from Santhigathavatham for the last 15 years. As the policy commenced in 2001, it is a pre-existing disease which is not covered under the policy. The complainant had admitted that the statement was given by him, but it is a wrong statement. The disease was set in only in 2003 and hence, it is not pre-existing. But it is to be noted that at the time of consulting a doctor, one will give only correct history of the illness to get correct treatment. Hence the statement given by the insured before the doctor only is to be believed. As per that statement, the illness was there for the last 15 years and hence a pre-existing one. As pre-existing illness is not covered, the complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/14-002-342/2008-09

Krishnan Chandroth
Vs
The New India Assurance Co.Ltd.

AWARD DATED 25.02.2009

The complainant, being a DM's Club Member LIC Agent of Kannur Branch Office, was issued with a group mediclaim policy. He was hospitalized from 30.04.2005 to 01.05.2006 and from 23.11.2006 to 28.11.2006 at Pariyaram Medical College Hospital. As the claim was repudiated, he approached the forum for justice. It was submitted by the insurer that there was inordinate delay in submitting the claim. The 1st claim was submitted after 333 days of disease and the 2nd claim after 127 days of discharge. As there is inordinate delay in submitting the claim, they are not in a position to honour the claim.

As per policy condition 5.4, all claims must be submitted within 30 days of discharge. Only in extreme case, when the insured or his relatives are not in a position to submit the claim within the stipulated time, the condition can be waived. In the present case, no reason was given for condoning the delay. In the 1st case, the admission was only for 1 day and he was advised to consult the doctor after 4 days. If he was in a disabled condition, he wouldn't have been discharged after 1 day of admission. It looks that there is absolutely no reason to waive the delay and hence, the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-292/2008-09

Smt.Kunjamma George
Vs
United India Insurance Co.Ltd.

AWARD DATED 14.01.2009

The complainant and her family members are covered under Individual Mediclaim Policy. She has undergone continuous hospitalisation at 4 different hospitals since 29.08.2007 to 11.09.2008. 5 claims for treatment at 4 different hospitals within a span of 15 days were submitted at a time, but only 2 claims were admitted and the other 3 claims were repudiated. The reasons for repudiation was shown as pre-existing disease in the case of one claim, no active treatment requiring hospitalisation was there in respect of the other claims.

There is no dispute to the fact that treatment was done at 4 different hospitals in 5 different stretches continuously for one and the same disease. The disease was finally diagnosed only during the 5th admission, as Systemic hypertension and migraine. It was submitted by the insurer that as per hospital records, she was on symptomatic treatment for migraine for 27 years. But it was submitted by the complainant that it was a mistake committed by the junior doctors. On enquiry, the complainant told about occasional headache but the junior doctors mistook it as migraine which was later clarified by Dr.Rema Pai, Head of Department of Internal Medicines. On going through the hospital report, it looks that at first, the doctors were in a confusion, whether the illness was vasculitis or migraine. Only after various tests, it was confirmed to be migraine. Had she been suffering from migraine for 27 years, she would have definitely informed the same to the doctors and it would have been reported in the hospital records. But except in the noting of junior doctors, no where it is mentioned that she had taken treatment for migraine. Also, it is very difficult to believe that the Head of Department of Medicines of such a reputed hospital like AIMS will give a false certificate regarding treatment. Hence it cannot be said that the disease is pre-existing. Another ground of repudiation is that there is no active line of treatment requiring hospitalization. Hospital bills produced show that she has been given IV injection 3 times a day, which cannot be done without hospitalization.

5 claims for 5 admissions within a span of 15 days were submitted at a time, out of which 2 claims were admitted. As pre-hospitalisation and post-hospitalisation expenses are also covered under the policy, insurer cannot repudiate the other 3 claims, as all the hospitalization were within a period of 15 days.

From the above discussion, it can be seen that the repudiation cannot be justified and has to be revoked. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.14,918.61 with 8% interest p.a. and a cost of Rs.1,500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002/152/2008-09

Smt.Mercy P.Thomas
Vs
The New India Assurance Co.ltd.

AWARD DATED 25.09.2008

The complainant, being a LIC employee, is covered under group mediclaim policy of The New India Assurance Co.Ltd. On 18.03.2005, she underwent a minor dental surgery and the claim was repudiated on the ground that such treatment was not covered by the policy. It was submitted by the insurer that they addressed a letter to the treating doctor to confirm whether hospitalization was actually required and

also reason for operation. Inspite of the reminders, they didn't receive any reply from the doctor. The surgery was for removal of apex of the tooth and for removing remnants of pulp. The treatment was for wear and tear of teeth which was excluded as per Cl.4.7 of policy conditions. The complainant deliberately got admitted to get insurance benefit that too, for wear and tear rectification. The complainant had stated that as she had a previous history of bleeding, the attending doctor advised admission, and that is why she got admitted in the hospital. The attending doctor has given a certificate that "as the patient gave previous history of bleeding, I admitted her for surgery". It looks that but for the previous history of bleeding, she could not have been admitted for the minor surgery, which in the normal course does not require hospitalization. It looks that person susceptible to bleeding requires hospitalization. As per Cl.4.7 dental treatment covers hospital expenses and excludes any treatment of surgery which is of corrective nature, cosmetic or aesthetic procedure including wear and tear, RCT. As the hospital expenses are covered under the policy, an award is passed directing the insurer to pay the eligible amount of Rs.2,175/- with 8% interest till date of payment.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-483/2008-09

Shri N.R.Chandrasekharan
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 13.03.2009

The complainant, who is a worker in Apollo Tyres Ltd., has taken a group mediclaim policy from Oriental Insurance Co.Ltd. His daughter had undergone an Advanced Surface Ablation Surgery in both eyes from Little Flower Hospital, Angamaly. The claim was repudiated as if the surgery is of a cosmetic nature. According to the insurer, this surgery was done only to avoid usage of contact lenses and hence it comes under the category of cosmetic surgery, which is excluded as per Cl.4.5 of policy condition. The complainant has produced a certificate from the surgeon who conducted the surgery certifying that the surgery was conducted as the insured was intolerant to contact lenses. However, it was argued on behalf of the insurer that it was the usual practice of the doctors to use the term 'intolerance' whenever such a surgery is done.

It is relevant to note that in order to constitute a cosmetic treatment, there must be some other procedure which can rectify the mistake. As far as refractive error is concerned, the mistake can be rectified only by wearing lenses. But the surgeon has stated that the insured is intolerant to lenses. Then the only other way is surgery. Hence it is not proper to say that this is a cosmetic surgery. However, there is another exclusion clause viz., Cl.4.6

which excludes surgery for correction of eyesight. Here the surgery is done for correction of eyesight only. In the certificate of doctor, it is specifically stated that the surgery was done for correction of eyesight. If it is so, it will fall under exclusion clause 4.6. The complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-301/2008-09

Shri P.A.Chandy
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 04.12.2008

The complainant, employed in Apollo Tyres Ltd., Perambra, is covered under a Group mediclaim policy. His dependant son had undergone 'Advanced Surface Ablation Surgery' for correcting myopic astigmatism at Little Flower Hospital, Angamaly. The claim was repudiated on the ground that the treatment was of a cosmetic nature, which is excluded as per Cl.4.5 of policy conditions. Cl.4.5 of policy conditions excludes all claims for change of life style and cosmetic or aesthetic treatment. It was submitted by the insurer that the treatment comes under definition of cosmetic treatment and this defect of eye can very well be corrected by using appropriate glass. The insured sought for surgery only to avoid using glasses and hence this is a fit case for repudiation. It was submitted by the complainant that the surgery was done on the advise of treating doctor as being a welder, he had to wear google glasses. Hence in his case, advance surface ablation surgery cannot be said as cosmetic nature, as this was required for pursuing his job.

The only dispute is relating to the nature of surgery, whether cosmetic or not. The word cosmetic or aesthetic has to be interpreted as a relative term. The complainant's son is working as a welder, for which, he has to use google glasses. A person who is using lenses cannot use google glasses. Also the treating doctor has certified that he is in tolerant to contact lenses and spectacles. Hence it cannot be said that this surgery is a cosmetic nature, as far as the patient is concerned. Hence he is eligible for claim amount. An award is, therefore, passed directing the insurer to pay an amount of Rs.23,548/- with interest @ 8% p.a.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-406/2008-09

V.K.Bhaskaran
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 17.02.2009

The complainant's wife was covered by group mediclaim policy of Oriental Insurance Co.Ltd. In March 2008, she was taken to the hospital for dental treatment for 2 days. The claim was repudiated invoking Cl.4.7 of policy condition. It was submitted by the insurer that the patient was admitted for treatment of generalized gingivitis and root stumps. All infected root stumps were extracted. Procedure undergone in the hospital was only normal outdoor procedure. Hospitalisation was not justified. As per Cl.4.7 of policy condition, such treatments are not covered, unless arising from a disease or accident.

The policy guarantees indemnification for hospital treatment, which requires hospitalization only. The hospital records produced show that extraction of effected root stumps only was done at the hospital. She was discharged with advice to maintain routine hygienic habits and to replace missing teeth after proper wound healing. No other steps were done. Records produced do not show any other complications or any treatment other than extraction. No special condition requiring admission is disclosed. The repudiation is, therefore, upheld and the complaint is **DISMISSED**.

KOLKATA

Group Mediclaim Policy

Kolkata Ombudsman Centre
Case No. 372/11/002/NL/08/2008-09
Shri Ratan Kumar Rana
Vs.
The New India Assurance Co. Ltd.

Order Dated : 06.02.2009

Facts & Submissions :

This complaint was filed against repudiation of a claim on the ground that the expenses incurred for the birth of third child was not covered under Group Mediclaim Insurance Policy.

The petitioner, Shri Ratan Kumar Rana stated that he was having a Group Mediclaim Insurance Policy with the New India Assurance Co. Ltd. for the period 1.4.2007 to 31.3.2008 covering self, spouse and two living children. He further stated that his wife was admitted on 18.10.2007 at Charu Chandra Seva Sadan for child birth and stayed there upto 19.10.2007. After his wife got discharged from Nursing Home, he submitted a claim for Rs. 2224.64 through his employer, LICI on 07.11.2007 to the insurance company for getting reimbursement of expenses. The insurance company repudiated the claim on 23.11.2007 on the ground that third child birth was not covered under the provisions of Maternity Expenses Benefit Point No.3 of Group Mediclaim policy. He represented against the decision of the insurance company on 04.12.2007 stating that he was having only two living children i.e. one daughter aged about 6 years and one son born on 19.10.2007. He again contended that he did not even claim for reimbursement for his daughter's birth expenses. To substantiate this fact, he also cited a certificate to this effect issued by Marishda Gram Panchayet, Purba Medinipur on 12.10.2008. In the P-II form he categorically clarified that the insurance company was wrong in repudiating the claim on 23.11.2007 because the event of miscarriage pointed out by the insurance company had occurred in between his 1st living child and 2nd living child.

The insurance company stated that the complainant had lodged a hospitalization claim for Rs.2224/- towards the expenses incurred for childbirth of his wife. On scrutiny of claim papers, it had been observed from the Discharge Summary dt. 19.10.07 issued by the Nursing Home that Smt. Bandana Rana had conceived the 3rd Gravida which meant the third child.

They repudiated the claim by invoking policy condition No.5.16/3.

Decision :

It was absolutely clear from the policy condition that the claim in respect of delivery for only first two living children and/or operations associated therewith will be considered in respect of any insured person which means that the expenses incurred with regard to two living children inspite of many abortions that took place in between two living children were reimbursable. Therefore, Hon'ble Ombudsman agreed with the arguments of the complainant and the expenses incurred for second delivery were reimbursable and therefore, he directed the insurance company to pay the claim within the frame work of the terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 305/14/010/NL/07/2008-09
Shri Parikshit Kumar Sachan
Vs.
Iffco Tokio General Insurance Co. Ltd..

Order Dated : 30.01.2009

Facts & Submissions :

This petition was against delay in settlement of claim under Group Medishield Policy issued to Golden Multi Services Club Ltd. by Iffco Tokio General Insurance Company Limited.

The petitioner, Shri Parikshit Kr. Sachan stated that he had taken a Mediclaim policy of Iffco Tokio General Insurance Company Ltd. through GMSCL, Kanpur Nagar on 19.06.2006. He was admitted in P.B. N Hospital, Barra Viswa Bank, Kanpur Nagar from 03.05.2007 to 20.05.2007 for his treatment and he had incurred total expenditure of Rs.31,504/- towards medicine bills, medical test and hospitalization charges. He submitted all original bills of hospitalization, medical test and medicines on 23.05.2007 with Medishield Claim Form through GMSCL, Kanpur Nagar to the insurance company. On 17.07.2007 he got a letter from M/s Paramount Health Services Pvt. Ltd., the TPA of the insurance company that his mediclaim was treated as "No Claim" due to non submission of the required documents though he had submitted all the requisite original papers to GMSCL, Kanpur

Iffco Tokio General Insurance Company Ltd. stated that the complainant was insured with them for the period 15.07.2006 to 14.07.207 under Group Medishield Policy No. 52026173 with sum insured of Rs.75,000/-. The discharge slip of P.B.N Hospital revealed that the insured was suffering from upper abdominal pain, vomiting, weakness & high fever and he was treated in the hospital from 03.05.2007 to 20.05.2007. M/s Paramount Health Services Pvt. Ltd, their TPA on receipt of the claim intimation requested the insured to submit the medical paper in order to process the claim but in spite of repeated requests the insured had failed to provide them the same.

Under these circumstances the TPA had no option but to close the claim.

DECISION:

As the complainant did not attend the hearing, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis. The insurance company had been directed to send a copy of the letter dated 25.06.2008 to the insured directing him to send all the required original documents immediately, so that they could re-open the file and deal with the matter de novo. The complainant was requested to comply with the letter dated 26.05.2008. The insurance company was directed to re-open the file on receipt of the original document and settle the claim as per terms and conditions of the policy.

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Kolkata Ombudsman Centre
Case No. 430/14/005/NL/09/2008-09
Smt. Mina Batabyal
Vs.
The Oriental Insurance Company Ltd

Order Dated : 16.03.2009
Facts & Submissions :

This petition was in respect of delay in settlement of a claim under Group Mediclaim Insurance Policy issued to Chowrangi Healthcare Club by The Oriental Insurance Company Ltd.

The petitioner Smt. Mina Batabyal stated that she was covered under a Group Mediclaim Insurance Policy No. 311600/27/535/ MISC/ 2060/ 1201 for the period 15.09.2005 to 11.09.2006 through Chowrangi Healthcare Club (with maternity benefit) for a sum insured of Rs.65,000/-. She submitted a maternity claim of Rs.13,210/- on 14.11.2005 to the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. but surprisingly the said claim had not been settled and/ or payment had been made to her without showing any rhyme or reason for the same nor the insurance company replied the same. She represented to the insurance company on 11.09.2007 but her appeal was not considered. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.13,210.75.

The insurance company did not send the self-contained note.

DECISION:

Since it had been proved that there was continuity of the Group Mediclaim Policy i.e., mediclaim policy taken by Chowrangi Healthcare Club on behalf of their member Smt. Mina Batabyal and Shri Subhas Batabyal which was existed with National Insurance Company Ltd. and later continued with the Oriental Insurance Company Ltd. Therefore, Hon'ble Ombudsman was of the firm opinion that maternity benefits were reimbursable in the second year as there would not be any waiting period if the claim was made in the second year policy under Group Insurance Scheme.

Therefore, he held that the claim was exigible and directed the insurance company to pay the claim as per terms and conditions of the policy.

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Kolkata Ombudsman Centre
Case No. 469/11/002/NL/09/2008-09
Smt. Sikha Bose
Vs.
The New India Assurance Co. Ltd.

Order Dated : 13.03.2009
Facts & Submissions :

This petition was against partial repudiation of claim under Group Mediclaim Policy issued by the New India Assurance Company Ltd.

The petitioner Smt. Sikha Bose stated that she along with her husband was covered under Group Mediclaim Policy. Her husband Shri Sankar Prasad Bose was suffering from acute pain in liver and as per advice of Dr. Surajit Kar he was hospitalized at Nightingale Diagnostic & Medicare Centre Pvt. Ltd., Kolkata on 24.05.2006 and released on 26.05.2006. She submitted a claim for Rs.36,740/- to the insurance company on 02.08.2006, but the insurance company paid Rs.23,440/- deducting Rs.13,800/- wanting detailed break-up of medicine receipt of Rs.13,800/- although original money receipt was already submitted with the claim form. She represented to the insurance company on 16.05.2007 along with detailed break-up of medicine bill and requested them to pay the balance amount of Rs.13,800/-. Further she represented to the insurance company through L.I.C.I on 12.02.2008. She even represented her case to the Chairman of N.I.A on 28.04.2008 but she had not received any reply from the Divisional office of the insurance company or Head Office of the insurance company.

The insurance company did not provide the self-contained note.

DECISION:

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The complainant had given evidence to show that the bills have been submitted to her employer i.e., L.I.C.I on 16.05.2007 who forwarded the same to the N.I.A on 18.05.2007 and N.I.A received it on 25.05.2007. The insurance company did not take any decision with regard to the payment of bills submitted for Rs.13,800/-. Therefore, he directed the insurance to review the bill and make payment as per terms and conditions of the policy.

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LUCKNOW

Lucknow Ombudsman Centre
Case No.G-27/11/02/08-09
Shri.Diwakar Sarkar
Vs
The New India Assurance Co. Ltd..

Award Dated : 16.12.2008
Complaint filed against New India Assurance Co. Ltd. by Shri.Diwakar Sarkar in respect of rejecting his claim for treatment of his wife for "Septum rejection".

Facts : Shri.Diwakar Sarkar, is covered under a group mediclaim policy for LIC employees. His wife underwent an operation for "Septum rejection" at AIIMS Hospital. His claim was repudiated on the ground that the said treatment was taken for "infertility" which is an exception under clause 4.8 of the policy. Aggrieved with the decision of the insurer the claimant approached this forum giving rise to the complaint.

Findings : On careful examination of all the documents the forum found that the discharge summary at the AIIMS, Delhi clearly shows the history and condition on admission as "Primary infertility and Bicornuate uterus". The opinion passed by Dr.Kavita Bhatnagar also confirms the condition to be connected with infertility. Medical journal also clearly elucidates that "Septum rejection" is a malformation of the uterus and is definitely responsible for infertility. It is also noted that the insured's previous claim where the treatment was taken in the same hospital has also been rejected under the same exclusion. However the insured had submitted that the claim is payable as per the provision contained in Para 1.0 of the policy read with Para 2.2 of the policy. On going through above condition it is abundantly clear that the coverage under 1.0 is subject to exclusions as available in the policy.

Decision: Held that the scope for squeezing the claim under 1.0 is not possible without the exclusion clause under 4.8. As a result the insured cannot get the benefit of this claim which clearly falls under exception 4.8. As such the claim is not tenable. The repudiation of the claim under the policy was therefore, held to be in order.

KOLKATA

GROUP MEDICLAIM POLICY

Kolkata Ombudsman Centre
Case No. 105/14/002/NL/05/2008-09
Shri Debasis Bala
Vs.
The New India Assurance Company Ltd.

Order Dated : 31.10.2008
Facts & Submissions :

This petition was against partial settlement of claim under Group Mediclaim Policy issued by The New India Assurance Company Ltd.

The petitioner Shri Debasis Bala stated that he was covered under Group Mediclaim Policy. He was hospitalized in Bhadreswar Municipal Hospital "Ankur', Hooghly for the period 14.10.2007 to 18.10.2007 for his treatment (the disease was not properly mentioned in the Discharge Certificate). He lodged a claim for Rs.14,880.65 with the insurance company but the claim was sanctioned for Rs.10,271/-. He requested the insurance company to pay the balance amount which was not considered favourably. Hence he approached this forum for redressal of his grievance seeking relief of balance amount of Rs.4,609.65.

The insurance company in their self-contained note dated 03.07.2008 mentioned that initially they paid Rs.10,271/- and after review they paid an amount of Rs.397/-. They submitted a statement giving the reasons for not allowing Rs.3,023/-.

Decision:

On going through the evidence available, it was found that Pavlov bills given by Pavlov Institute & Hospitals for Rs.534/- and Rs.623/- were not in order because both of them did not have the advice of a doctor nor they correspond to the period of hospitalization. There was no supporting bill for those expenditures. Similarly, we find that money receipt No. 417 for Rs.480/- had already been included in the hospital bill. Therefore, ignoring these three items the insurance company was directed to pay the remaining items viz. Rs.48/-, Rs.12.50, Rs.425/-, Rs.95/- and Rs.715/- = Rs.1,295.50 (Rupees One thousand two hundred ninety five and paise fifty) only as these expenses were incurred by the patient during the course of hospitalization. Hon'ble Ombudsman held that no separate doctor's advice was required if the tests and investigations were done during the course of his stay in the hospital. Therefore, he directed the insurance company to pay the amount as mentioned.

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