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AHMEDABAD

OFFICE OF THE INSURANCE OMBUDSMAN (GUJARAT)

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Phone : 079-27546840, 27545441 Fax : 079-27546142

Awarded Dated 27-04-2009

Group Mediclaim.

The claim was lodged for Rs.99594/- while TPA paramount Health Service Pvt. Ltd. paid for Rs.62748/- deducting Rs.19674/- as per terms and condition of policy. It was observed that deductions were made are in order except for Rs.4625/- a valid receipt issued by sterling Hospital. The claim was partially paid for Rs.4625/-

Case No. 11-002-0369-09

Mr.Yogendra I.Acharya V/s. The New India Assurance Co.Ltd.

Awarded Dated 11-05-2009

LIC Group Mediclaim.

Complainant had lodged mediclaim for her husband for treatment of Jaundice.

The Respondent had repudiated the claim on ground of breach of policy condition 4.8 stating that the claim is not payable for treatment/consequences arising due to use of intoxicating drugs/Alcohol. The Respondent got investigation report of Dr.N.S.Sharda. The investigating doctor has submitted evidence of sick leave issued by Dr. Akhani certifying that the insured was suffering from alcoholic liver disease and hospitalization from 17-07-07 to 21-07-07 and again on 30-7-07 to 3-8-07.

The claim was payable as the evidence copy of leave record obtained does not mention nature of sickness but mentioned duration of leave and nature of leave. Further the diseased was admitted for viral hepatitis with encephalopathy and not of alcoholic liver disease.

Case No. 11-003-0373-09

Mr.Pankaj V. Mehta V/s. National Insurance Co.Ltd.

Case No. 14-010-0021-10

Mr.Anirudh Lidbide V/s. IFFCO TOKIO Gen. Insurance Co. Ltd.

Awarded Dated 30-07-2009

Group Mediclaim

Complainant lodged a claim for reimbursement of expenses for hospitalization was repudiated by the Respondent on the ground of Policy condition No.6, i.e. fraudulent device used by the insured. The Respondent has disputed on management of treatment given by doctors of the hospital. The Respondent has also disputed about medicines used and raised bills for medicines and injections. The forum find that admission for disease as malaria is genuine and TPA can deduct amount of medicines/injections which are in excess than prescribed but cannot penalize insured by rejecting entire claim.

Respondent is directed to pay claim for Rs.17,672/- to the complainant.

Case No.11-002-0120-10

Mr. Manish Verma Vs. The New India Assurance Co. Ltd.

Award dated 27-08-2009

Group Mediclaim Policy

The Complainant's wife (Insured) was admitted at Bavishi Hospital, Ahmedabad on 17-05-2008 and a female child was delivered by L.S.C.S. operation on 19-05-08 i.e. at the end of 35 weeks pregnancy period and discharged on 22-05-2008.

The claim was repudiated by invoking Clause No. 5.16.2 of Group Mediclaim Policy which excludes benefit to the policy holder during the waiting period of nine months from the date of enrollment of the employee in the Group Mediclaim Scheme. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.

In the Discharge Summary, the Operating Surgeon has mentioned Indication for operation as Bad Obstetric History. The Respondent had produced opinion of their Panel Doctor Ruchi Dave, MD (Gynaec) who opined that while enrolling in the Group Mediclaim Scheme, the Insured was pregnant for more than 28 weeks with bad obstetric history with previous two miscarriages and 2 pre term deliveries of dead babies which should have been declared by her in proposal form. Forum observed that Respondent's Medical Referee is convinced that the claim is fit for relaxation of waiting period in view of the bad obstetric history of the Insured. Since, under the Subject Group Mediclaim Policy, only declaration of the persons to be covered is required, question of non disclosure of pregnancy at the time of admission to the Policy does not arise.

There is no difference of opinion between the views of the operating Gynecologist and the panel doctor of the Respondent. So the decision of Respondent to repudiate the claim is arbitrary and has no justification.

Therefore, forum advised the Respondent to pay admissible amount.

Case No. 11-002-0120-10

Mr.Manish Verma Vs. The New India Assurance Co.Ltd.

Award Dated 27-08-2009

Repudiation of Group Mediclaim :

The Insured was hospitalized for delivery and a female child was delivered by LSCS operation at the end of 35 weeks pregnancy period. The complainant lodged claim for hospital expenses and bills for medicines. The insurer had repudiated the claim on the ground of clause No.5.16.2 of Group Mediclaim policy which excludes benefit to the policy holder during waiting period of nine months from the date of enrolment of the employee

In the scheme. The said clause reads as under :

> "A waiting period of nine months is applicable for payment of any claim relating to normal delivery or caesarean section of abdominal operation for extra uterine pregnancy. The waiting period may be relaxed, only in case of delivery miscarriage or abortion induced by accident or other medical emergency."

The complainant submitted that looking to the insured's condition, treating doctor decided for caesarean delivery, though the normal full confinement period was not over.

As per the certificate of the treating doctor, looking to the bad obstetric history, caesarean operation was done,

Because the operating Gynecologist had opined that because of bad obstetric history, caesarean operation was done before normal full confinement period was over which proved that there was a medical emergency.

So the decision of Respondent to repudiate the claim was set aside. In the result of complaint succeeds.

Case No. 11-005-0078-10

Mr. Gaurang R. Joshi V/s. Oriental Insurance Co. Ltd.

Award Dated 21-07-2009

Partial settlement of claim under Group Personal Accident Policy.

The Insured suffered an accidental injury causing a fracture in his right leg. Doctor Deepak Bhatia (M.S.Ortho) treated him covering his leg by POP and advised rest for 3 weeks. Subsequently the treating Orthopedist after removing POP advised rest for further one week.

The respondent submitted that they obtained opinion of their two panel doctors who opined that the complainant's temporary total disablement (TTD) was for a period of 3 weeks and accordingly compensated for 3 weeks.

The complainant submitted that though he started walking with crutches, he was confined to home for 4 weeks and not for 3 weeks, he should be paid TTD for four weeks.

Because the POP was for 3 weeks and the complainant started walking with support, fourth week was a period of temporary partial disablement which is not covered under the subject policy.

The decision of the respondent to settle the claim for 3 weeks TTD was upheld.

Case No. 11-002-0103-10

Ms. Smita B. Sheth V/s. New India Assurance Co. Ltd.

Award Dated 21-7-2009

Partial settlement of Mediclaim

The Insured was covered under Group Mediclaim policy of LIC Employees. The complainant was hospitalized at Ashish Surgical Hospital, Petlad from 17-07-08 to 19-07-08 for the treatment of P. Vivax Malaria. Claim lodged for Rs. 6676/- as against which the Respondent settled the claim for Rs. 5870/-

The Respondent submitted that while filing the claim form dated 19-8-07 through her employer LIC of India amount mentioned was Rs.5876/- which was settled in to-to rounding off to Rs.5870/-. The Respondent produced the copies of 3 bills of medicines purchased which sum total was Rs.2776/- whereas the complainant had shown as Rs.3576/- committing the mistake by showing Rs.800/- more.

Since, there was error in totaling committed by the complainant, the decision of the Respondent was upheld.

Thus the complaint failed to succeed.

Award dated 23-07-2009

Case No. 11-003-0092-10

Mr. Prag Jayantilal Shah Vs. National Insurance Co.Ltd.

Group Mediclaim Floater Policy

The claim was partially settled by invoking policy exclusion Clause 4.3 in respect of increased Sum Insured. As per clause 4.3, treatment of cataract is excluded for first two years of policy.

On analysis of materials on record it is revealed that the complainant was covered under mediclaim policy with sum insured of Rs.20, 000/-since 2006. The Sum Insured was increased from Rs.20,000/- to Rs. 50000/- with the consent of the complainant under revised mediclaim policy in 2007. The Complainant renewed the policy for the period from 12.01.2008 to 11.01.2008 for Rs. 50000/- with 15% bonus on original Sum Insured of Rs.20,000/-.
The insured underwent surgery for right eye cataract extraction by suturless Phaco-Emulsification and was discharged on 13.03.2008

As per the revised terms and conditions, treatment for cataract is excluded for two years i.e. up to 2009. Hence reimbursement of expenses incurred on treatment for cataract would not be payable as far as the increased sum insured is covered

The decision of the Respondent to consideration of payment of claim within the limit of original Sum Insured of Rs.20, 000/- along with bonus of Rs.3, 000/- is justified

The case was dismissed.

Award dated 10-06-2009

Case No. 11-004-0041-10

Mr. Kunal Hasmukhbhai Shah Vs. United India insurance Co.Ltd.

Group Mediclaim Family Floater Policy

The insured was operated for total replacement surgery of right Knee. Total expenses incurred on hospitalisation were Rs. 180676/. The complainant got reimbursement of hospitalisation expenses to the tune of Rs.

145000/ from the New India assurance company and for balance amount of Rs. 35676/- claim was lodged with the respondent under the renewed group Mediclaim family floater policy

During the course of hearing it was brought to the notice of respondent that as per clause 4.3 of floater policy treatment for Knee surgery is excluded during the first policy year only and there is no evidence on record to prove that the disease was preexisting prior to date of inception of the policy

On mediation of this forum, the Respondent offered to pay an amount of Rs.25000/- which was accepted by the complainant. Therefore, no formal award was made in this case.

Award dated 31-08-2009

Case No.11-004-0134-10

Mr. Gokuldas Nayak Vs. The United India Insurance Co. Ltd.

Group Mediclaim Policy

Complainant's wife had a severe attack of asthma and she was kept under observation at hospital following the advice of the treating doctors as precautionary measures.

The claim was repudiated invoking clause 4.1 of the policy on the grounds that hospitalisation is not justified.

Doctor's opinion produced by the Respondent does not offer any convincing reason that hospitalisation was not required. The panel doctor has not examined the case papers carefully as is evident by his remarks that as per submitted hospital documents patient was treated with oral medicines and investigation only. This is not correct as hospital document categorically state administration of IV fluids, injection giving exact quantity.

The insured was admitted at the hospital for acute bronchitis as per the advice of. Consultant physician. The treating physician is the best judge whether hospitalisation is necessary or not.

The forum observed that the decision of the Respondent to repudiate the claim on the grounds that Hospitalisation was not necessary is not supported by the material on record and is not justified.

Respondent's was directed to settle the claim.

Award dated 25-08-2009

Case No.11-005-0082-10

Mr. Devendrakumar C Doshi Vs. The Oriental Insurance Co.Ltd.

Group Mediclaim floater Policy

The insured member was hospitalized for MCA infarct, Hyper Tension, Hypothyroidism and lumbar spondylosis. Claim was lodged for expenses of hospitalization were partially settled by the Respondent on the grounds that the disease –Diabetes was pre-existing prior to inception of policy.
The respondent in their repudiation letter alleged that insured was treated for Right MCA infarct, Hypertension for which diabetes is proximate cause, as diabetes existed prior to the inception of policy and it was excluded under the policy as pre existing disease however respondent could not produced any evidence to show that diabetes was excluded under the policy or it was preexisting prior to the inception of the policy. The policy was incepted in the year 2004.
As the respondent had not produced any documentary evidence to show that the disease for which insured was hospitalized was existing prior to inception of the policy they were directed to settle balance claim amount.

Award dated 21-05-2009

Case No. 14-003-0019-10

Mr. Vasudevbhai M Patel Vs. National Insurance Co. Ltd.

Group Mediclaim Floater Policy

The claim was not settled despite lodgment of claim along with claim form and all papers for reimbursement of hospitalisation expenses of Rs. 12799/-.

The patient was admitted for treatment for treatment of severe iron deficiency Anemia. Several diagnostic tests were carried out and four units of blood (RBC) were transfused.

The respondent did not submit any written explanation for delay in settlement of claim despite repeated reminders by forum.

By not settling the claim or sending any contrary communication it gets established that respondent had shown gross negligence and callousness in following Protection of Policyholders' Interests) Regulations, 2002 of IRDA.

In absence of any reasonable explanation for the inordinate delay and considering the facts of the case, relevant papers on record the forum construed that the respondent had acted negligently and it is an apparent case of deficiency in service. The delay in settlement of the claim by the respondent is not justified.

The Respondent was directed to settle the claim.

Case No. 11-003-0092-10

Award dated 23-07-2009

Mr. Prag Jayantilal Shah Vs. National Insurance Co.Ltd.

Group Mediclaim Floater Policy

The claim was partially settled by invoking policy exclusion Clause 4.3 in respect of increased Sum Insured. As per clause 4.3, treatment of cataract is excluded for first two years of policy.

On analysis of materials on record it is revealed that the complainant was covered under mediclaim policy with sum insured of Rs.20, 000/-since 2006. The Sum Insured was increased from Rs.20, 000/- to Rs. 50000/- with the consent of the complainant under revised mediclaim policy in 2007. The Complainant renewed the policy for the period from 12.01.2008 to 11.01.2008 for Rs. 50000/- with 15% bonus on original Sum Insured of Rs.20, 000/-.
The insured underwent surgery for right eye cataract extraction by suturless Phaco-Emulsification and was discharged on 13.03.2008

As per the revised terms and conditions, treatment for cataract is excluded for two years i.e. up to 2009. Hence reimbursement of expenses incurred on treatment for cataract would not be payable as far as the increased sum insured is covered

The decision of the Respondent to consideration of payment of claim within the limit of original Sum Insured of Rs.20, 000/- along with bonus of Rs.3, 000/- is justified

The case was dismissed.

CASE NO. 11-004-0206-10

MR. D K PATEL

V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Dated: 14-09-2009

Repudiation of Mediclaim because of late submission of papers invoking clause 5.4 by the Respondent. Papers were examined and found 45 days late submitted by the complainant. It is also found that treatment was in continuing and treated as post hospitalization treatment. For which as per terms and conditions of the Mediclaim policy up to 60 days post hospitalization expenses can be reimbursed. The Respondent was directed to pay the full claim amount.

CASE NO. 11-009-0228-10

DR. HIREN PARIKH

V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Dated: 29.09.2009

Repudiation of Mediclaim. The Respondent rejected the claim because insured was admitted less than 24 hours. Complainant produce set of papers and reports, which prove that insured was admitted to the hospital for 10 days. The Respondent was directed to pay the admissible claim amount as per policy terms and conditions.

BHUBANESHWAR

Group mediclaim policy

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-003-0477

Smt Puspanjali pattnaik

Vrs

National Insurance Co. Ltd., Bhubaneswar DO-II

Award dated 02Apr 2009-07-02

Complainant's husband had taken a Tie up Health Insurance Policy with National Insurance Company Ltd for himself and his wife. He died while under treatment at Kalinga Hospital. A claim was lodged. Insurer repudiated the claim on the grounds that the disease was pre existing.

Hon'ble Ombudsman heard the case on 19.01.2009 where both sides were present. Hon'ble Ombudsman after hearing both sides and on perusing documents like clinical summery of Kalinga Hospital and other treatment papers held that there is no whisper about diabetes, as cause of death and hence set aside the repudiation decision and directed Insurance company to settle the claim within one month of receipt of consent letter.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-004-0566

Sri Prem Bihari Gupta

Vrs

United India Insurance Co. Ltd., Hyderabad DO-IV

Award dated 13Th May, 2009

Complainant had taken Andhra Bank Arogya Daan Floater Group Mediclaim Insurance Policy for self and wife with United India Insurance Company Ltd. Complainant was hospitalised for treatment of coronary artery and renal artery disorder and preferred a claim, which was rejected on the grounds that the disease was pre existing.

Hon'ble Ombudsman heard the case on 12th May 2009, where complainant remained absent even though adequate notice in advance was given. Rather sent a fax reporting, no purpose would be served in attending the hearing. Hon'ble Ombudsman dismissed the complaint for non persecution.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-012-0502

Sri Adeita Patra

Vrs

ICICI Lombard Gen Insurance Co Ltd.

Award dated 08th May 2009

Complainant had taken a Group Mediclaim Policy with ICICI Lombard Gen Insurance Co Ltd through Ragadi Co-operative Weavers' Society. Complainant has submitted all treatment papers for his hospitalization but Insurer has not settled the claim.

Hon'ble Ombudsman heard the case on 17.03.2009 where complainant was absent but Insurance Company was present, inspite of prior notice issued to both parties. Insurance company expressed that they are unable to settle the claim as the complainant has not submitted documents to them. How ever complainant has submitted some documents to this forum. There fore direction was given to the Insurance Company to settle the claim within 15 days of receipt of consent letter, as per documents submitted and that he may submit within 15 days of receipt of this order.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-004-0503

Sri Biswanath Pattnaik

Vrs

United India Insurance Co. Ltd., Rourkella DO

Award dated 12Th May, 2009

Complainant had taken Group Mediclaim Insurance Policy for self and family with United India Insurance Company Ltd. Complainant and his wife were treated as OPD patients and claimed as per the policy terms. Insurance Company delayed settlement. Hon'ble Ombudsman heard the case on 12th May 2009, where both parties were present. After hearing both sides and perusing documents produced held that the delay in settlement was not intentional rather due to follow up of laid down procedure and accordingly disposed off the complaint

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-004-0551

Sri Sudeep Satpathy

Vrs

United India Insurance Co. Ltd., Hyderabad DO IV

Award dated 16Th June, 2009

Complainant had taken Group Mediclaim Insurance Policy for self and family with United India Insurance Company Ltd. Complainant's father was operated at the LV Prasad Eye Institute Bhubaneswar for Retinal Detachment .Hon'ble Ombudsman heard the case on 17th March 2009, where both parties were present. After hearing both sides and perusing documents produced held that the repudiation of the claim as a pre-existing condition is not proper as it was a sudden development and ordered to pay the claimed amount within one month on receipt of the consent letter from the complainant

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-012-0573

Smt Archana Somani

Vrs

ICICI Lombard Gen Insurance Co Ltd. Bhubaneswar

Award dated 24th August 2009

Complainant had taken a Group Mediclaim Policy with ICICI Lombard Gen Insurance Co Ltd through Ragadi Co-operative Weavers' Society. Complainant has submitted all treatment papers for his hospitalization but Insurer has not settled the claim.

Hon'ble Ombudsman heard the case on 17.03.2009 where complainant was absent but Insurance Company was present, inspite of prior notice issued to both parties. Insurance company expressed that they are unable to settle the claim as the complainant has not submitted documents to them. However complainant has submitted some documents to this forum. Therefore direction was given to the Insurance Company to settle the claim within 15 days of receipt of consent letter, as per documents submitted and complainant was directed to submit documents to insurance company within 15 days of receipt of this order.

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B HOPAL

Category: **Group Mediclaim**

Sub Category: **Total Repudiation of Claim**

Order No.: BPL/GI/09-10/04 **Case No.: GI/UII/0109/99**

ORDER Dated 7th May, 2009.

Mr. Amarjeet Singh Chawla V/S...United India Insurance Co. Ltd., D.O.4, Hyderabad.

Brief Background

Mr. A.S. Chawla (hereinafter called Complainant) informed that he had obtained Andhra Bank-Arogyadaan Mediclaim policy no. 050400/48/06/41/00000116 for Rs. 500000/- for the period from 14.03.2007 to 13.03.2008 from United India Insurance Co. Ltd., D.O. IV, Hyderabad (hereinafter called Respondent) under which claim was lodged for his treatment with the Respondent.

As per the Complainant he had no ailments when he took the policy and suddenly had severe chest pain on 25.11.2007 and was hospitalized at Dr. Bantia Clinic Raipur from 25.11.07 to 26.11.07 thereafter he was shifted to Escorts Heart Institute & Research Center, Raipur from 26.11.2007 to 30.11.2007 and again on 10.012.2007 to 11.12.2007 where the total amount for Rs. 39373/- was incurred and all the relevant documents were submitted to Family Health Plan Ltd. Hyderabad (TPA) and all the queries raised by TPA were also complied but even after reminders the claim neither settled nor denied by the respondent. Aggrieved with the decision of the Respondent, he approached this office by providing all claim related documents for necessary settlement of his claim.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy. He was admitted in Banthia Nursing home for the complaint of chest pain on 25.11.2007 to 26.11.2007 and in Escort Heat Institute & Research Center Raipur from 26.11.2007 to 30.11.2007 and again on 10.12.2007 to 11.12.2007. The matter of dispute observed for pre-existing disease at the time of inception of Policy. At the time of hearing the Respondent explained that the claim is repudiated due to pre-existing disease. On asking about how they come to conclusion that it is a pre-existing disease, it is responded that the complainant obtained first time policy for Sum Insured of Rs. 5.00 Lakhs, and suffered from disease within 8 month from the inception of policy and also that the original discharge summary for the hospitalization of 25.11.07 to 26.11.2007 not submitted and also that the case sheet clearly establishes that his disease was diagnosed as ACS-VSA on 24.11.2007 but the connected reports dated 24.11.2007 were not submitted and also that as per CAG reports there is 100% Stenosis in various location of the vessels and recommended for CABG which shows the intensity levels of the disease of the patient which would manifest over a period of time and definitely before the commencement of the present insurance Policy. On asking about why the first time Insurance for Rs. 5.00 lakhs was given and whether any health checkup reports were obtained from the complainant and also whether the proposal form was obtained to know if there is any concealment of fact about the above disease, it was explained that she does not has such kind of information being claim pertain to their Hyderabad Office. Similarly on asking about whether they have obtained any Medical opinion from doctors other than TPA to prove the pre-existence of above disease at the time of Insurance, it was explained that no separate medical opinion available in the file but submitted the opinion of Claims manager, FHPL Hyderabad (TPA) containing almost all the points explained above by the respondent. Similarly on asking about any concrete proof in support of their assumption that the above disease was in existence prior to inception of Policy i.e.

whether they have any medical record for the treatment of heart disease for the period **prior to the commencement of Policy**, the reply was in negative. The Respondent attention was drawn about the certificate of Dr. Bantia dated 23.7.2008 where it is certified by him that the complainant was admitted for the complaint of Chest pain on 25.11.2007 and the same reported to be the first complaint, then how it can be considered as pre-existing the time of inception of insurance. Similarly, the copy of bill as submitted by complainant for the payment to Banthia Nursing home for the period from 25.11.2007 to 26.11.2007 for Rs. 6000/- was also explained to respondent and asked when the detail of treatment is available in the bill then why the discharge summary in original and other connected documents were insisted when as per the bill it reveals that the simple treatment just like first aid (i.e. I.C.U charges, Pulse Oxemeter, infusion pump, Nursing charges, consultation charges, Oxygen charges, Ambulance charges etc.) was given then the question of demanding detailed investigation report for the above kind of treatment does not arise, moreover, if any hospital documents etc. are required to respondent for the processing of claim , then the same may also be obtained/investigated at their own. I have also gone through the Discharge summary of Escorts Heart Centre, Raipur where in the column of Resume of History it is mentioned that the "complainant was presented with complaints of chest pain on and off **since 1 month**". It is also observed that the entire documents which were available with complainant specially pertaining to Escorts Heart centre where CAG was done have already been provided to Respondent.

In view of the circumstances stated above, the decision of the Respondent to repudiate the claim is unfair and unjust as the same found taken merely on the basis of assumption without any concrete evidential support, Hence, the Respondent is directed to pay the claim for Rs. 39373/- to the Complainant within 15 days from the receipt of consent letter from the Complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

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

Category: **Group Mediclaim**

Sub Category: **Total Repudiation of Claim**

Order No.: BPL/GI/09-10/19 **Case No.: GI/UII/0509/10**

Mr. Shyam Lal Agarwal V/s United India Insurance Co. Ltd.,

Brief Background

Mr. Shyam Lal Agarwal (hereinafter called Complainant) informed that he had obtained Andhra Bank-Arogyadaan Mediclaim policy no. 050400/48/07/41/0000075 for Rs. 100000/- for the period from 29.01.2008 to 28.01.2009 along with coverage to his family members from United India Insurance Co. Ltd., D.O. IV, Hyderabad. (Hereinafter called Respondent)

As per the Complainant he is continuously obtaining Mediclaim Insurance policy since 29.01.2007 and was suffering from the weakness of both upper and lower limbs, Muscle wasting of thenar muscles, Loss of sensation of toes, blackish discoloration of legs since few month before and was admitted in Arya Vaidyasala, Kottakal, Kerala and claim for total expenses incurred for Rs. 45148/- (including Traveling expenses for Rs. 5746/-)) was submitted to the TPA of respondent but the claim is repudiated by them vide their letter dated 12.01.2009 mentioning the present hospitalization relates to major associated diseases "Rt. Knee pain since 2 years" which found pre-existing Disease hence claim is not payable. The complainant further mentioned that his main problem was weakness in both limbs and loss of sensation in toes and other fingers and was not admitted for right knee problem as the ligament injury was sustained approximately one and half year back which was fully cured long back with oral medicines even before above hospitalization. The complainant further mentioned that during discussion with the treating doctor of above hospital, it was told by him as a history of his earlier health problems. Aggrieved with the non settlement of claim, the complainant approached this forum for necessary settlement of claim.

The Respondent vides its self contained note letter dated 16.5.2009 together with the other documents submitted that the claim for Rs. 38725/- was lodged which is repudiated by their TPA on the grounds that the present hospitalization and treatment under the present policy is for a Pre-existing disease as per the certificate No. K: 18219:07 dated 6.11.2008 issued by Dr. K.Muraleedharan, Dy. Chief Physician of Arya Vaidyasala, Kottakal wherein it is mentioned **" As reported by the patient, his ailments developed gradually and have a probable duration of Two years"** It is further mentioned by Respondent that since the ailment took place before the commencement of the Policy (29.01.2007), and also that based on the documents submitted the admitted disease is related to pre-existing disease which is a exclusion under the policy hence the claim is Repudiated and requested this forum to dismiss the complaint.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy. He was admitted in Kottakkal Arya Vaidyasala, Kottakkal (Kerala) for the period from 8.9.2008 to 9.10.2008 for the above mentioned 4 complaints and diagnosed as Vathavyadhi. During the course of hearing the complainant reiterated almost all the matters as mentioned in his complaint letters and stated that he was not hospitalized for the sole problem of Rt. Knee Pain because the same was already cured due to treatment taken at Raipur even much before the hospitalization. The complainant firmly explained that his main problem/disease was sensation of toes of left leg, Black

discolouraisation of legs, weakness of both upper and lower limbs etc. but the claim is denied on the ground of major associated diseases were " Rt. Knee Pain since 2 year. On the other side the Respondent also reiterated the same narration as mentioned in the self contained note and stated on asking that the claim is repudiated on the ground of discharge summary and Certificate issued by hospital wherein it is mentioned that ailments developed gradually and have a probable duration of Two years. I have personally gone through the abovementioned Discharge summary and Certificate and observed that in the column of History of present illness is mentioned as **"Gradual onset"** and in certificate the duration of ailments mentioned as **"As reported by the patient, his ailments developed gradually and have a probable duration of Two years**. In the above case the first Policy was obtained on 29.01.2007 which means prior to hospitalization the policy has run for 20 months. On asking from respondent about the nature of disease/complaint for which the complainant was admitted in the hospital it was explained that as per hospital record the complainant was admitted for loss of sensation of Toes, weakness of both upper and lower limbs, Muscle wasting of thenar muscles, Blackish discoloration of legs. Then the Respondent was asked why the claim is repudiated on the ground of Rt. Knee pain since 2 year though there was other above mentioned problems/disease were also suffering by the complainant and the treatment was also for the above complaints, the respondent replied that the claim was scrutinized and settled by their TPA. The respondent's attention was also drawn towards Discharge summary and Certificate where nothing is mentioned as RT. Knee pain since 2 year. Similarly, the respondent was also asked to submit any evidence proving that the above diseases were since last two years, it is replied that the probable duration of 2 year is mentioned in Certificate of hospital only.

In view of the circumstances stated above, the decision of the Respondent to repudiate the claim is **unfair and unjust** as the same found taken merely on the basis of **assumption** without any concrete evidential support i.e. there is no evidential confirmation that the complainant was suffering the above mentioned 4 ailments (for which he was hospitalized and treated at Kottakkal Arya Vaidya Sala) prior to inception date of first Policy i.e. 29.01.2007. Therefore, the Respondent is directed to pay the claim for Rs. 36594/- as found payable to the Complainant.

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Category: **Group Mediclaim**

Sub Category: **Total Repudiation of Claim**

Order No.: **BPL/GI/09-10/20** **Case No.: GI/UII/0609/19**

Order Dated 27th July, 2009

Mrs. Shushila Devi Agarwal V/s United India Insurance Co. Ltd.

Brief Background

Mr. Shyam Lal Agarwal (hereinafter called Complainant) informed that he had obtained Andhra Bank-Arogyadaan Mediclaim policy no. 050400/48/07/41/0000075 for Rs. 100000/- for the period from 29.01.2008 to 28.01.2009 along with coverage to his family members including his wife Shushila Devi Agarwal from United India Insurance Co. Ltd., D.O. IV, Hyderabad. (Hereinafter called Respondent)

As per the Complainant he is continuously obtaining Mediclaim Insurance policy since 29.01.2007 and his wife Shushila Devi was suffering from Pain and swelling all over the body, Pain on lower back & neck, bleeding gums, Hypothyroidism since few months before Admission in hospital at Arya Vaidyasala, Kottakal, Kerala for the period from 8.9.2008 to 09.10.2008 and incurred Rs. 37065/- (including Traveling & food exp. For Rs. 5746/-) and the claim was submitted to TPA for the settlement but the claim is repudiated on the ground of Pre-existing disease. Then the complainant approached the higher authority of respondent vide letter dated 12.2.2009 mentioning that there was health problem to his wife in the year 2003 which was well cured by oral medicine and also that the present problems was developed in few months ago only. But the higher authority of respondent upholds the decision of TPA. Aggrieved with the Repudiation of claim, the complainant approached this forum the necessary settlement of claim.

The Respondent vides its self contained note letter dated 30.06.2009 together with the other documents submitted that the claim lodged for Rs. 31319/- is repudiated by their TPA on the grounds that the present hospitalization and treatment under the present policy is for a Pre-existing disease as per the Discharge Summary dated 7.10.2008 the History of present illness is a gradual increase since 5 years while the Policy starts from 29.01.2007 which found prior to commencement of the policy and found Pre-existing disease which is excluded under exclusion No. 7.2 from the scope of Policy. The respondent further requested this forum to dismiss the complaint of the claimanant on the above ground.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy. She was admitted in abovementioned Hospital for the treatment of **Sandhigadhavatham**. During the course of hearing the complainant explained that she was suffering the Pain and swelling all over the body, Pain on lower back and neck and hypothyroidism etc. since few months back and cured after the treatment taken at above hospital. The Respondent stated that as per documents submitted by complainant the history of present illness found **Gradual onset since 5 years** though the Policy incepts from 29.01.2007 therefore, the same is found pre-existing disease which is excluded under the condition No. 7.2 hence the claim is not payable. I have personally gone through the Hospital Discharge summary dated 7.10.2008 and found that the period of present Illness is reported as “since 5 years”. The complainant was

asked whether they contacted the Hospital for the abovementioned period of disease as 5 years if the same is not since 5 years?, it is replied that they did not contact to hospital and reiterated that she was suffering from last few months only and not for last 5 years. Then she was asked to provide any documentary evidence i.e. any pathological reports etc. proving that the ailment is current and not since last five years, but nothing is produced by complainant.

In view of the circumstances stated above, the decision of the Respondent to repudiate the claim is **just & fair** as the Discharge summary of Hospital clearly speaks that the present hospitalization was for the treatment of illness which **Gradual onset since 5 years** establishing Pre-existing Disease prior to inception of Policy which is excluded under the condition No. 7.2 of the Policy. Therefore, the Complaint is dismissed without any relief.

_____----------END----------_____

Category: **Group Mediclaim**

Sub Category: **Partial Repudiation of Claim**

Order No.: BPL/GI/09-10/22 **Case No.: GI/NIA/0609/23**

Dated at Bhopal 31st July, 2009.

Smt. Sarwari Beg...V/s The New India Assurance Co. Ltd.,

Brief Background

Smt. Sarwari Beg (hereinafter called Complainant) is covered under LIC Group Mediclaim Tailor-made Insurance policy No. 120700/34/08/12/00000049 for the period 01.04.2008 to 31.03.2009 issued by The New India Assurance Co. Ltd., D.O. 120700, Mumbai (hereinafter called Respondent)

As per the Complainant a mediclaim for Rs. 25561/- for Cataract Surgery was lodged with the Respondent but claim for Surgeons Fee is settled for Rs. 1000/- as against Bill for Rs. 8500/- against the Policy condition causing partial settlement of claim. The complainant approached the higher authority of respondent but there was also no favorable response. Aggrieved with the unauthorized deduction of Rs. 7500/- from the Doctors fee, she approached this forum for necessary settlement of claim.

The Respondent in its self contained note dated 03.07.2009 submitted that the Deduction for Doctor's Fee for Rs. 7500/- is made because the same is **paid in cash** by complainant to Doctor and the fee receipt is given on Letter head and not on proper Receipt, hence only Rs. 1000/- is payable to complainant as per their H.O.circular No. PK/Health/R.K.K/2008/9/IBD/Admn/56 dated 22.9.2008. The Respondent also mentioned that as per above circular Doctor Fee should be paid by Cheque against proper Receipt issued by the Doctor and if the payment made in cash, the maximum amount is payable for Rs. 1000/-. The Respondent further mentioned that there are other deductions also made for Rs. 362/- from the claim amount being found not covered under the scope of Policy. It is also mentioned in Self contained Note that they have properly responded to Complainant vide their letters dated 4.5.2009 and 6.5.2009 whereby the reason of deduction were communicated and was asked to complainant to furnish details of Payment made by Cheque enabling them to release balance amount of Rs. 7500/-

Observations:

I have gone through all the materials on record and submissions made during hearing and my observations are summarized below.

There is no dispute that the complainant was covered under the above-mentioned policy for the period from 01.04.2008 to 31.03.2009 and was hospitalized at Suyash Hospital, Indore for Cataract Surgery which was done by Dr. Aditya Agarwal on 11.2.2009 and incurred total expenses for Rs. 25561/- including Consultants/Surgeon Fee for Rs. 8500/-. The only dispute is for **mode of payment of Fees** to consultant surgeon. During the course of hearing the respondent reiterated almost all the points as mentioned in their self contained note and emphasized that the deduction of Rs. 7500/- is made in the light of their H.O. circular No. Health/RKK/2008/9/IBD/56 dated 22.09.2008. On asking it is stated by Respondent that the above Policy is issued by their Mumbai D.O.120700 and the circular is issued by their H.O. Similarly, on asking it is also explained by Respondent that the above circular is applicable to the condition No. 2.3 of all Family Floater Mediclaim Policies and Group Mediclaim Policies. The Respondent was further asked whether the above circular is also applicable to Policy issued to L.I.C. Group Mediclaim Policy which is a Tailor-made Insurance, it is explained that it is likewise applicable to L.I.C.group mediclaim policy. Then his attention was drawn towards the aforesaid circular where no specific word for L.I.C.Group Mediclaim-Tailor-made Insurance Policy is mentioned, then, the Respondent confirmed that there is no specifically mention of applicability of above provisions to LIC Group Mediclaim Policy. The respondent was further asked to read the condition No. 2.3 of the Policy for which the above amendment/provision is to be applied. The respondent read the condition No. 2.3 of the L.I.C Group Mediclaim Policy and during his reading of above condition it is found **that the condition No. 2.3 represents the coverage for Minimum period of Hospitalization of 24 Hrs. and deletion of 24 hrs. Clause in certain diseases** etc. though the amendments/provisions in aforesaid Circular are for **Fee to consultants/Surgeon, Anesthetist etc.** Then, the respondent was asked by this forum whether the provision of payment of Consultants/Surgeon Fee through Cheque

is also applied to L.I.C.Group Mediclaim-Tailor-made Insurance Policy, He could not reply in positive.

In view of the circumstances stated above, the decision of the Respondent to Deduct the amount of Rs. **7500/**-is not **just & Fair** as it is beyond any doubt that the Fees for Rs. 8500/- established paid to Dr. Aditya Agarwal, by the complainant and the proper Receipt No. 68 dated 11.2.2009 is issued by Dr. Aditya Agarwal which was submitted to Respondent and there is no specific mention about above condition (i.e. mode of payment to Doctor) in the above Policy. As regards the provision amended in the aforesaid circular it is not established that the provisions of above Circular is also applicable on the Policy under which the claim falls i.e. L.I.C.Group Mediclaim-Tailor-made Insurance Policy because the above circular amends the provisions of condition No. 2.3 of other General Mediclaim Policy and not to the condition No. 2.3 of L.I.C. Group Mediclaim-Tailor-made Insurance Policy. Therefore, the Respondent is directed to pay difference amount of **Rs. 7500/- to the Complainant within 15 days** from the receipt of consent letter from the Complainant, **failing which it** will attract a simple interest of **9% p.a.** from the date of this order to the date of actual payment.

_____-----END------_____

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-247/2009-10

C.A.Mohammed Haneef

Vs

National Insurance Co.Ltd.

AWARD DATED 29.09.2009

The complainant is covered under Group Sampoorna Arogya Bima Policy since 01.01.2007. On 28.03.2008, he was admitted at Lisie Hospital and then at PNVM Hospital from 03.04.2008 to 17.04.2008. The treatment was for CAD. The claim was repudiated on the ground that for the first 2 years, CAD is excluded from the scope of the policy and on appealing against repudiation before the grievance cell, the claim was repudiated on the ground of pre-existing illness. It was stated by the insured that he has undergone treatment for CAD and he never had CAD before taking the policy. It was submitted by the insurer that at the time of taking the policy, the insured was hypertensive. As HTN and CAD are closely related to each other, CAD also is to be taken as pre-existing and hence, the claim is not payable.

Exclusion clause 5.1.1 excludes only pre-existing disease. Any condition arising out of pre-existing illness is not excluded. At the time of taking the policy, the LA was having only HTN and not CAD. HTN and CAD are distinct disease, though one may contribute to the other. The insurer also has no point that CAD is pre-existing. Policy excludes only pre-existing illness and any complication arising out of pre-existing illness is not excluded. Hence the repudiation is to be set aside and an award is, therefore, passed directing the insurer to pay the eligible amount of Rs.21,425/- with 8% interest p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-443/2008-09

C.Sreedharan

Vs

The New India Assurance Co.Ltd.

AWARD DATED 23.04.2009

The complainant, being a retired officer of LIC of India, is covered under the Group Mediclaim Policy. He was hospitalized from 19,.06.2008 to 05.07.2008 at Baby Memorial Hospital, Kozhikode, during which period, he had undergone a surgery. As to that, a claim was raised and the claim was settled by disallowing Rs.8,000/- from room rent. It was submitted by the insured that as no ordinary rooms were available, he was forced to occupy an AC room. They have disallowed an amount of Rs.8,000/- as the amount charged under the head 'Electricity & Water'. According to him, these facilities were there at the time of his occupation of the room and it was not provided as per his request. Also the room will not be allotted without these facilities. Hence he is eligible for the amount of Rs.8,000/- also.

The partial repudiation of claim is merely on the ground that of Clause 1.0[D][b] of policy condition which states that electricity, water charges, etc. are not covered under the policy. It is true that such additional facilities are provided not as per the request of the insured. But the fact remains that there is specific exclusion of these items as per policy conditions. If any additional facilities are enjoyed, the same has to be borne by the insured only. Hence the complaint is devoid of any merit and hence DISMISSED.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-493/2008-09

Smt.Chandramathi

Vs

United India Insurance Co.Ltd.

AWARD DATED 22.05.2009

The complainant was insured under a mediclaim policy for the period 22.11.2006 to 22.11.2007 through Win Career Guidance & Placement Cell. She had taken IP treatment from Alpha ENT hospital for CSOM. The claim was repudiated on the ground that the ailment is chronic and hence pre-existing. The disease usually reaches this stage after a period of more than 1 to 2 years. Their investigator has found that the insured had loss of hearing, ear discharge and pain for the last 10 years. Hence it is to be taken as pre-existing only.

However, it was submitted by the insured that she had the complaint only 3 months back. On feeling irritation, she rubbed her ear and then, the discharge came. In the discharge summary also, duration of illness was shown as 3 months only. As per the note submitted by the insurer, the illness can reach such a stage after 1 to 2 years. Hence even if it is a pre-existing one, the illness was set in 1 to 2 years back only. The admission was on 14.06.2007. But the policy was there since 22.11.2005. Hence even according to the argument of insurer also, it cannot be definitely said that the illness is pre-existing. Though the investigator has stated that the illness was there for 10 years, no evidence was produced. The treating doctor's certificate states that the illness was there for 3 months only. Hence it cannot be taken as a pre-existing one. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.12,520/- with 8% interest p.a. and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-430/2009-10

G.K.Prakash

Vs

United India Insurance Co.Ltd.

AWARD DATED 31.07.2009

The complainant was covered by a mediclaim policy since 01.11.2004. On 20.01.2007, he was admitted to AIMS for coronary angiogram. The claim was repudiated by invoking clause 4.1 of policy condition. It was submitted by the insurer that he was a diabetic patient since 25 years and hypertensive since 8 years, as per the discharge summary from the hospital. As he had undergone treatment for cardiac ailment, the claim falls within Cl.4.1 of exclusion clause, which excludes any claim for a pre-existing disease. The insured admitted that diabetes mellitus is pre-existing and he has disclosed the same while taking the policy and hence, he is eligible for the claim amount.

The claim was repudiated on the ground that as the life assured was having diabetes mellitus and hypertension, any claim for CAD is not admissible as hypertension and DM are risk factors as far as CAD is concerned. But Cl.4.1 excludes only pre-existing disease and not any disease arising from a pre-existing condition. Hypertension and DM are not cardiac diseases though they may be risk factor as far as CAD is concerned. But policy does not exclude such risk factors. Hence the complainant is eligible to get the claim amount. An award is, therefore, passed for the eligible amount of Rs.25,900/- with interest @ 8% p.a. and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-259/2009-10

K.S.Anilkumar

Vs

The New India Assurance Co.Ltd.

AWARD DATED 08.09.2009

The complainant being an LIC employee, was covered under a tailor made group mediclaim insurance policy including his wife. During the currency of the policy, his wife was admitted in MBMM Hospital, Kothamangalam on 18.09.2008 and was discharged on 22.09.2008 after Mcdonald's cervical encirclage. The claim was repudiated on the ground that for maternity treatment, only expenses for hospitalization during pregnancy period will be payable. Pre-natal and post-natal expenses will not be paid. It was submitted by the complainant that this particular type of surgery was done only to prevent miscarriage. Earlier his wife had undergone miscarriage 2 or 3 times.

As per policy condition, hospitalization expenses for any illness or disease will be reimbursed to the insured during the policy term. Hence the treatment was not for any illness or disease. It was only to set right a particular condition. If it was not done, premature delivery would have occurred. But for pregnancy, the condition of uterus would be insignificant and such procedure would not have been required. Hence such claim can be considered only as a maternity claim. As per policy condition, for maternity treatment, only hospitalization for confinement period in the hospital is payable. Pre-natal and post-natal expenses are not covered under the policy. Natal means pertaining to birth which occurs only on the final stage of pregnancy. Hence this treatment can be taken as a pre-natal one only which is not covered under the policy. The complaint, therefore, stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-010-543/2008-09

Smt.Lilly George

Vs

IFFCO-TOKIO General Insurance Co.Ltd.

AWARD DATED 18.05.2009

The complainant, Smt.Lilly George, is covered by a group mediclaim policy issued to Kerala State Co-operative Bank Ltd. covering 343 employees and their families. The complainant was admitted in Vasudeva Vilasam Nursing Home and undergone treatment for Sandhigathavatham from 10.04.2008 to 07.08.2008. Her claim for reimbursement of hospital expenses was repudiated on the ground that there is no justification in undergoing as IP treatment and all the treatment imparted can be taken on an OP basis. It was submitted by the insured that she was admitted in the hospital as per advice of a qualified doctor and also she was not in a position to travel due to pain in the joints and all over the body. The nursing home is 80 kms. away from her residence.

The claim was repudiated merely on the ground that there was no need for hospitalization and the treatment could be done on an OP basis. Hospital records produced show that during the course of treatment, she had undergone Abhayangam, Ooshmam, Navarakizhi, Pizhichil, etc. The symptoms given in the discharge summary shows the condition of the patient at the time of admission. She had severe pain and swelling in joints, cervical pain, weakness of legs, numbness of both legs. In such a condition, it is not possible for the patient to undertake long journey daily for getting treatment. Moreover, complete rest is also required during such treatment. Hence these medical procedures require either hospitalization or domiciliary hospitalization. Hence the claim cannot be repudiated on the ground that hospitalization is not required. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.45,717/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-491/2008-09

P.F.Varghese Babu

Vs

National Insurance Co.Ltd.

AWARD DATED 27.05.2009

The complainant is covered by a group mediclaim policy. During the 2nd year of the policy, the complainant underwent hospitalization for treatment of kidney stone. The claim was repudiated by letter dated 07.10.2008 which was confirmed by the grievance cell on 08.01.2009. The policy was taken on 09.12.2006. As per policy condition, at the time of taking policy, coverage for treatment of kidney stone will be available from 2nd year onwards only. But in the 2nd year revival, it was stated as from 3rd year onwards. The insured was admitted in the hospital during the 2nd year of policy and hence, he is eligible for claimed amount. By the time the complaint came up for hearing, the insurer settled the claim for Rs.45,160/-. But the insured is insisting for payment of cost and interest for belated payment.

It is to be noted that the claim form was submitted in September 2008. After the initial repudiation by the TPA and insurer, the claim was finally settled on 06.05.2009 for Rs.45,160/- i.e., after a lapse of 7 months. For this purpose, the insured had to approach the insurer and TPA many times. As his efforts became futile, he had to approach the Ombudsman also. The claim was settled only after approaching this authority. Hence he is eligible for interest and cost. An award is, therefore, passed directing the insurer to pay an interest @ 8% p.a. [Rs.2,107/-] and a cost of Rs.300/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-258/2009-10

T.V.Sidharthan

Vs

The Oriental Insurance Co.Ltd.

AWARD DATED 29.09.2009

The complainant and his family members were covered by a group mediclaim policy. His daughter had undergone Advanced Surface Ablation Surgery [ASAS] for correction of refractive error, at Little Flower Hospital, Angamaly. The claim was repudiated on the ground that the surgery was a cosmetic surgery which is not covered under the policy. It was argued by the insured that the surgery was not a cosmetic surgery. At that time, his daughter was studying for M.Sc [Maths] and now she is studying for B.Ed. She had had to strain her eyes much on writing and reading. Further, Dr.Tony Fernandez of Little Flower Hospital, who is a well known Ophthalmic Surgeon, has certified that she was intolerant to contact lenses. Surgery was done to avoid using contact lenses and high power glasses.

Clause 4.5 of policy excludes cosmetic or aesthetic treatment of any description. If refractive error is there, it can be corrected by using glasses or contact lenses or by ASAS. Hence ASAS is done only to avoid using contact lenses or high power glasses. Hence it is indeed a cosmetic surgery. Now the complainant would say that his daughter had a lot to write and study. But it can be done using glasses or contact lenses. Hence the surgery can be treated as a cosmetic surgery only, which is excluded as per policy condition. Also as per Cl.4.6 of policy condition, any surgery for correction of eyesight is excluded. As this is a surgery for correction of eyesight, it comes under exclusion clause and hence this is a fit case for repudiation. The complaint, therefore, stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-051/2009-10

V.Premkumar

Vs

The Oriental Insurance Co.Ltd.

AWARD DATED 18.06.2009

The complainant, being a worker of Apollo Tyres Ltd., was covered under a group mediclaim policy. He had undergone treatment from Lakeshore Hospital for 2 days from 10.11.2008. He approached the hospital with complaint of chest pain. The ailment was diagnosed to be bowel disease due to fatty liver. The claim was repudiated on the ground that there was no active line of treatment from the hospital. They had done only some investigations and after that, he was discharged. It was submitted by the insured that he had consulted Lakeshore Hospital as he could not get relief from his pain from the treatment taken from a local hospital. As further investigations were required, he was admitted in the hospital, on the advice of treating doctor only.

The discharge summary and hospital records produced states 'Functional Bowel Disease'. He was extensively investigated and OGD was done which was normal. All the other clinical examination done also showed normal result. USG of abdomen was done on 10.11.2008 which also showed normal result. After these tests, he was discharged on 11.11.2008 prescribing some tablets. No active line of treatment was given except some tablets. Out of a total bill of Rs.3,360/-, medicine bill was only Rs.580/-. Hence it looks that no active line of treatment was there from the hospital except tests and investigation. Hospitalisation merely for investigation not followed by active treatment is not covered under the policy. The complaint is, therefore, devoid of any merits and is to be **DISMISSED**.