AHMEDABAD

Case No. 11-009-0540-10

Mr. Suresh K Trivedi

V/s.

Reliance General Insurance Co. Ltd.

Award dated 29-04-2010

Mediclaim

Complainant admitted at Shlok Hospital on 18-06-2009 for treatment of infective Hepatitis.

Claim lodged for treatment expenses was repudiated by the Respondent on the ground that fraudulent claim by referring treatment papers which are not in line of treatment of Hepatitis. Further receipts issued by hospital are also not in order and creates doubts as to its correctness or validity. The claim has been repudiated on the basis of fraud and proving a fraud requires an elaborate legal procedure calling for examination of documents, calling for vitness under oath etc. which is beyond jurisdiction of this forum.

In order to decide the issue, it would be necessary to have application of legal process (like Admission/Denial of documents etc.) a task which is beyond the scope of this Forum. It falls outside the ambit of this Forum. Hence without going into the merits of the case and passing any quantitative award for the same, the Complainant is deemed beyond the jurisdiction of this Forum leaving it for the Complainant to pursue other means to resolve the grievance either with in the framework of Government

Rules under reference or taking recourse to any other forum as may be considered appropriate.

Case No.11-002-0099-11

Mr. Jagdish M Patel

V/s.

The New India Assurance Co. Ltd.

Award dated 18-05-2010

Repudiation of Floater Group Mediclaim Policy:

Claim for reimbursement of expenses for cataract surgery of complainant's father was repudiated by the Respondent invoking policy clause 4.3 which stipulates that expenses incurred on treatment for cataract has a waiting period of two years from the date of inception of policy. It is observed that the waiting period for cataract surgery can be overruled if the policy has been renewed in continuation without any break for 3 years in succession, but the claim has arisen in the first policy year.

The insured had a Mediclaim policy with Oriental Insurance Co. Ltd. since 2005-06 and thereafter he switched to the New India Assurance Co. Ltd. from 12-04-2007 to 11-04-2008 and renewed up to 11-04-2009. Thereafter the said policy was not renewed by the Complainant, but he took a fresh policy covering himself and his family members from the Oriental Insurance Co. Ltd. for the period from 21-04-2009 20-04-2010 and a fresh policy from the New India Assurance Company for the period from 29-04-2009 to 28-04-2010.

The subject complaint relates for the claim under the policy with the New India Assurance Co. Ltd. which is a fresh policy and as per the terms and conditions of the policy, surgery for cataract has waiting period of two years. The Respondent is justified in rejecting the claim in terms of Clause 4.3.

In the result complaint fails to succeed.

Case No.11-005-0072-11

Mr. Bhupendra R. Shah

V/s.

Oriental Insurance Co. Ltd.

Award dated 24-05-2010

Partial settlement of Mediclaim:

Claim lodged for treatment of Road Traffic Accident by the complainant was settled by the Respondent disallowing an amount of Rs.20,030/- as per the opinion of Respondent's panel doctor.

Complainant submitted that the Respondent has not given any reason for deductions made and also did not quote the terms and conditions of policy under which the deductions were made.

This forum observed that the treating doctor's opinion for the treatment given and expenses incurred by the Complainant carry more weitage than the opinion given by a Doctor based on papers.

In the present case the deduction made at the instance of Panel Doctor's opinion are arbitrary and no justification was given except for an amount of Rs.800/- towards bed charges where actual entitlement is Rs.4000/- while the hospital has charged Rs.4800/- and directed to pay an amount of Rs.19,230/- to the Complainant.

In the result complaint partially succeeds.

Case No.11-002-0104-11

Mr. Chandrakant J Shelat

V/s.

The New India Assurance Co. Ltd.

Award dated 31-05-2010

Repudiation of Mediclaim under Group Medclaim Policy:

The Respondent had repudiated the claim invoking clause 4.13 of Group Mediclaim Policy which interalia states that the company is not liable to make any payment under the policy in respect of cataract for first year from the inception of the policy.

The Respondent submitted that cataract surgery was undergone in the first year from the date of inception of the policy hence it was treated as pre-existing disease and claim was repudiated. Date of inception of the policy being 09-09-2008 and date of admission at Hospital being 18-08-2009. Since cataract has a waiting period of one year from the date of inception of the policy, the claim is not admissible under policy clause 4.13.

In the result complaint fails to succeed.

Award dated 31.5.2010

Case No. 11-004-0080-11

Mr. Rohitbahi Chotabhai Patel

Vs.

United India Insurance Co. Ltd.

Group Mediclaim Policy

The Respondent in their written submission and the TPA in their repudiation letter stated that the Complainant had not given intimation regarding date of hospitalization to the TPA/Insurer's office hence invoking clause 11(a) the claim has been rejected.

The Complainant produced copy of intimation letter as also copy of proof of FAX made on FAX No. 022 40581266 of Alankit Healthcare TPA Limited dated 23-09-2009 as an evidence that intimation was received by the TPA-Alankit Health Care Ltd., on 23-09-2009 i.e. within 72 hours as envisaged under policy condition.

The respondent was directed to settle the claim.

Award dated 31.5.2010

Case No. 11-004-0030-11

Mr. Mahendrabhai Ishwarbhai Maisuriya

Vs.

United India Insurance Co. Ltd.

Group Mediclaim Policy

He claim was not admitted due to exclusion No.4.10 of the policy issued which state that conversion of out patient dispensary to hospitalization is excluded from the provision of the policy.

There was on record a copy of Discharge Summary from Parth Hospital, Bardoli which shows that insured was admitted on 18-09-2009 and was discharged on 20-09-2009. The Diagnosis was Bronchitis and URTI.

There were also on record copies of various prescriptions and laboratory test reports confirming the active line of treatment given to the insured.

The Respondent have on their own taken decision without obtaining any opinion from a Medical man that the subject claim is a conversion of OPD into hospitalization

Since the insured underwent treatment in a hospital on the advice by specialist physician and the intimation of hospitalization was also sent in time, Respondent's decision to repudiate the claim was not justified.

Award dated 31.5.2010

Case No. 11-004-0045-11

Mr. Jagdish N Chaudhari

Vs.

United India Insurance Co. Ltd.

Group Mediclaim Policy

The claim has been rejected by Respondent on the ground of non receipt of intimation regarding date of hospitalization either to TPA or to Insurer.

As per clause 11(a), members are required to intimate about hospitalisation to TPA/insurer within 72 hours from the date of Hospitalization or else the claim can be repudiated.

The insured was admitted to hospital on 14-07-2009 while intimation was sent to TPA on 18-07-2009.

The letter dated 01-02-2009 of the Complainant shows that intimation was given to TPA Alankit at Mumbai and it seems that letter was sent by courier on 18.7.2009. There was delay of 4 days which is beyond 72 hours as stipulated as per terms and conditions of the policy.

Respondent was justified in repudiation of claim invoking clause 11(a) of the policy.

Award dated 31.5.2010

Case No. 11-004-0090-11

Mr. Shantilal B Patel

Vs.

United India Insurance Co. Ltd.

Group Mediclaim Policy

The claim has been rejected by Respondent on the ground of non receipt of intimation hospitalization either to TPA or to Insurer

The Respondent submitted that intimation regarding Hospitalization was not given to the TPA/Insurer's within 72 hours of Hospitalisation which is breach of clause No.11 (a) of the MOU for policy.

As per clause 11(a), members are required to intimate about hospitalisation to TPA/insurer within 72 hours from the date of Hospitalization or else the claim can be repudiated.

The insured was admitted to hospital on 26-04-2009 while intimation was sent to TPA on 02-05-2009 a delay of 6 days.

Respondent was justified in repudiation of claim invoking clause 11(a) of the policy

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Award dated 31.5.2010

Case No. 11-004-0095-11

Mr. Millind M Shah

Vs.

United India Insurance Co. Ltd.

Group Mediclaim Policy

It was observed that the insured aged 69 years was hospitalised at Dr. Jivraj Mehta Smarak Health Foundation, Mumbai from 27.5.2009 to 30.5.2009 for treatment of vertigo and mild hyper tension. Policy was in force during the period of hospitalisation.

The TPA of the Respondent Vipul MedCorp Pvt. Ltd. scrutinized the claim file, and called for the several requirements and subsequently referred the matter to the respondent on 6.1.2010 for their final decision with recommendation for repudiation of claim.

The respondent had not taken any decision under the claim till date. There was no evidence on record of any communication from respondent after receipt of reference from TPA vide their letter dated 06.1.2010.

As per IRDA (Protection of Policyholders' Interests) Regulations, 2002.

1. Every insurer shall inform and keep informed periodically the insured on the requirements to be fulfilled by the insured regarding lodging of a claim arising in terms of the policy and the procedures to be followed by him to enable the insures to settle a claim early.
2. On receipt of all the requirements or the additional requirements, as the case may be, an insurer shall decide about the claim within a period of 30 days. If the insurer, for any reasons to be recorded in writing and communicated to the insured, decides to reject a claim under the policy, it shall do so within a period of 30 days from the date of receipt of the requirements or additional requirements, as the case may be.

The absence of any reasonable explanation for the inordinate delay and considering the facts of the case, delay in settlement of the claim by the respondent was not justified

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Award dated 22-06-2010

Case No.11-002-0220-11

Mr. Prahlad N

V/s

New India Ass. Co.Ltd.

Group Mediclaim Policy

The claim was settled partially for an amount of Rs.80,000/- out of Sun Insured of Rs. 2 lac. by invoking policy Clause 2A.

Clause 2a states that "If it is found that the sum insured has been 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. The decision of the Company will be final and binding."

The claim was occurred in the policy period 09-10, when insured underwent replacement of heart Valve in the month of October 2009 i.e. after more than one and half year from the increase in Sum Insured.

As the policy period defined in the policy schedule as 1st April of the year to 31st March of next year (Both days inclusive) Clause 2a is applicable to increased Sum Insured during the currency of policy period in which Sum Insured is increased optionally. The complainant increased the Sum Insured for the policy period from 1.4.2008 to 31.3.2009 where as the claim was preferred during the policy period from 1.4.2009 to 31.3.2010 hence the clause is not valid. Since the claim falls during the policy period 1.4.2009 to 31.3.2010 after completion of one year for increase in optional SI.

Respondent's decision to settle the claim partially was not justified and they directed to pay claim for increased SI.

Award dated 30-8-2010

Case No. 11-002-0240-11

Mr.Hetalkumar R Sevak

Vs.

New India Ass. Co. Ltd.

Group Mediclaim Policy

The complaint was for two claims. First claim was related to repudiation of claim for Pregnancy Expenses.

The Respondent repudiated the claim invoking Clause 4.4.13 of the Floater Group Mediclaim Policy which states that any medical expenses incurred for or arising from or traceable to pregnancy, child birth, miscarriage, abortion or complications of any of these including caesarean section is permanently excluded from the benefit of the policy.

Since the complainant had not paid premium for optional cover for Maternity expenses benefit and subject claim is preferred for expenses incurred on child birth by normal delivery the Respondent's decision to repudiate the claim invoking clause 4.4.13 was justified..

Claim II

The respondent had by invoking condition 5.7 of the policy issued a notice on 13.11.2009 and 19.11.2009 to the Master Policy holder and the complainant respectively for cancellation of policy with effect from. 12.12.2009 which interalia states that on account of heavy claim ratio the company has decided to cancel the policy with effect from 12.12.2009 however the company shall remain liable for any claim which arise till 12.12.2009 further the company shall refund pro-rata premium for unexpired period of insurance for the insured person who have not lodged the claims prior to the date of cancellation of policy.

The complainant had lodged claim on 25.12.2009, 25.1.2010 and 29.1.2010 for chemotherapy on 16 & 23 December 2009 and for expenses incurred for further treatment consisting of diagnostics test etc. as post hospitalisation expenses.

Since the policy was cancelled with effect from 13.12.2009 invoking condition 5.7 of the policy after giving notice one month in advance on 12.12.2009 to the master policy holder. The complainant was also informed by the respondent vide letter dated 19.11.2009 hence the Respondent is not liable for claims as post hospitalisation expenses.

Claim for reimbursement of expenses incurred prior to the date of cancellation of the policy was justified.

Award dated 30-8-2010

Case No. 11-002-0390-11

Mr.Ravi B Shah

Vs.

New India Ass. Co. Ltd.

Group Mediclaim Policy

A claim was repudiatedt by invoking Clause 4.1 of the medical policy which relates to pre-existing condition specially Diabetes which is not covered if additional premium for its coverage is not paid.
Record shows that the policy was incepted on 20.6.2000. The policy was renewed in chain continuously. From policy year 2008-09 the policy was renewed with revised terms and condition as per Mediclaim policy 2007 for which the respondent obtained fresh proposal from the complainant dated 30.6.2008. As per Mediclaim policy 2007 specific pre-existing conditions like Diabetes and Hypertension are covered only on payment of additional premium. Since the complainant had not disclosed preexisting diseases Diabetes and Hypertension respondent did not charge any additional premium for Diabetes and Hypertension.

Since the insured was aged nearer to 60 years and policy was continuously run continuously for 10 years and there were no claim history under the policy since last four years and the revised Mediclaim Policy 2007 was in the first year. The respondent was directed to follow the common practice prevalent in the insurance industry to recover

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BHUBANESWAR

Group Mediclaim Insurance

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No.11-004-0679

Sri Ranjit Kumar Mishra

Vrs

United India Insurance Co. Ltd., DO-II, Kolkata

Award dated 20th Aug. 2010

Complainant had taken a Group Mediclaim Insurance Policy from United India Insurance Co. Ltd for self and family. For the treatment of ailment of his wife, he reported a claim with the insurance company. But the claim was repudiated on the ground that the treatment was taken for the disease excluded in first 2 years of the policy. On the other hand complainant informed that he is covered under the said group policy continuously and hence the claim should not fall under the exclusion.

Hon'ble Ombudsman heard the case on 18.08.2010 and 20.08.2010, where both parties were present. After hearing both sides and perusing the policy with detail terms and conditions, held that the complainant relied on wrong document as the policy terms has under gone change, when he left his previous employer and joined the present one. More over there was a gap in insurance, resulting in discontinuity of policy. The decision of Insurance company was there fore up held.

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Group Medi Claim

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0695

Sri P K Mishra

Vrs

New India Assurance Co Ltd.

Bhubaneswar

Award dated 23rd September 2010

The complainant and his family are covered under LIC Group Medi Claim Policy of New India Assurance Co Ltd from 1.4.2009 to 31.3.2010. His son met with an accident and was admitted to a hospital. Sri Mishra claimed Rs 1,02,460/- on insurer. The insurer settled the claim for Rs 87,367/-. Subsequently Sri Mishra submitted bill for Rs 12,178/-. Insurer has not settled the supplementary claim.

Hon'ble Ombudsman heard the case on 22.09.2010 where both parties were present. On perusal of records, and hearing both sides, held that the complainant signed the discharge voucher as full and final settlement of his claim, without any objection what so ever. The contract there fore, stood discharged by preference. In the result the complaint is dismissed without relief.

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Group Mediclaim sep 10

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0706

Sri Sankar Parida

Vrs

New India Assurance Co Ltd.,

Cuttack DO-II

Award dated 23rd September 2010

Complainant was an employee of LIC and was covered under a Group Mediclaim Policy with New India Assurance Company Ltd for himself and his family. His wife was treated for incomplete abortion and a claim was lodged with the insurer. The insurer rejected the claim relying on the policy exclusion that maternity benefit extension is not payable if the insured has two or more living children.

Hon'ble Ombudsman held that repudiation of the claim is in order and the complaint was dismissed.

Senior Citizen Mediclaim Policy

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0720

Sri Biswanath Mohanty

Vrs

New India Assurance Co Ltd.

Bhubaneswar DO-II

Award dated 23rd September 2010

Complainant took a Senior Citizen Mediclaim Policy with New India Assurance Company Ltd for himself and his wife. He was treated for " Obstruction of Superior Temporal Br of the retinal vein at L V Prasad Eye institute, Bhubaneswar and lodged a claim. Insurance Company repudiated the claim on the pretext that the treatment taken was experimental and unproven one , falling under the policy exclusions.

Hon'ble Ombudsman heard the case on 22.09.2010 where both sides were present.

Complainant pleaded that his treatment was done by the Director of LV Prasad eye institute and being a doctor him self is aware of the treatment taken. It is the accepted mode world over.

Insurance company expressed that they relied on the version of their TPA, who happens to be technically competent to opine on the treatment.

Ombudsman held that insurer arrived at the conclusion that the treatment was experimental and unproven was without much evidence. He was of the opinion that the treatment taken is widely accepted these days. Hence directed insurer to pay Rs 14,984/- to complainant, which he has claimed.

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CHENNAI

Complaint No.IO (CHN) 11.02.1047 / 2010-11

Award no-IO(CHN)/G/17/2010 dated 30thJune2010.

(Mediclaim)

Mr.V.Joseph vs New India Assurance Co Ltd.

The complainant and his family were covered under the group mediclaim policy for LIC employees for a sum insured of rs 2,00,000/-.During the policy period from 01/04/2008 to 31/03/2009 the complainant's son was hospitalized from 26.12.2008 to 02.01.2009 for treatment of an extensive anterior wall Myo Cardial Infarction and submitted the claim for Rs 80,000/-.to the insurer.The claim was rejected by the insurer on the ground that the insured's son was not dependent on him since he was 23 years old and as per clause 3.5 of the policy it states that male children of the employee are covered if they are under 22 years old and if they are to be treated as dependent beyond 22 years and upto 25 years they have to pursue full time course in a

recognized institution.In the present case the insured's son was studying a computer course for a period of three months and hence the insurer had written a letter to LIC to confirm that the course was a full time course and the son who had undergone operation was a dependent son for which the insurer has not received any reply.In view of this the insurer had given a final notice to the insured ie;LIC stating that since they have not received any reply they are treating the claim as no claim and closed the file.

The insured had mentioned that the premium for self,his wife and son were deducted by LIC based on his declaration and the payment is still continued.He was not aware of the maximum age limit under the policy for dependent male children.The insurer had stated that the claim was not admissible on two issues (a)consumption of alcohol by the patient which is one of the major risk factors of coronary ailment and (b) dependent male children upto the age of 21 years are only covered under the policy;upto 25 years of age if pursuing whole time studies.In the present case the age of the son is 23 years and he is not pursuing whole time course.and hence the claim is not payable.Hoe ever on taking up the matter with their higher office they have agreed to consider the claim provided the Dependency is proved.It has been observed that the insurer has sought clarification regarding dependency from LIC for which no reply seems to have been received.As per condition 3.5 Male children upto the age of 21 years ;upto 25 years of age if pursuing whole time studies in a recognized educational institution .Correspondence course is not considered as whole time studies for this purpose.The complainant has not submitted any proof to the insurer to the effect that the course was a whole time one and the institution was a recognized one satisfying the definition for dependent mentioned in the policy.The complainant's employer also did not send any reply to the insurer clarifying the position.Taking all the factors into account the decision of the insurer in repudiating the claim is in order.

The complaint is dismissed.

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-035/2010-11

Dr.Kuruvilla Thomas

Vs

Oriental Insurance Co.Ltd.

AWARD DATED 15.06.2010

The complainant's wife was covered by the group mediclaim policy of IMA as a dependent of the complainant. She was hospitalized for 48 days in 2007 for treatment of back pain. The claim for Rs.12,679/- was repudiated stating that there was no active line of treatment [Cl.4.10].

The repudiation is made only on the ground that there was no active line of treatment. In the discharge summary, it was stated that conservative treatment was given. But, if hospitalization is required for treatment other than surgical intervention, the insured will be entitled to get reimbursement. Clause 4.10 excludes expenses incurred at hospital primarily for evaluation and diagnostic purposes not followed by active line of treatment during the hospitalised period. Conservative treatment can also be an active line of treatment. In the self contained note, it is stated that the treatment included rest, hot packs, traction, etc. For traction, hospitalization is required. Hence the treatment was one requiring hospitalization. So the repudiation made is not proper. An award is passed directing the insurer to pay the sum of Rs.12,679/- with interest @ 8% p.a. since the date of claim till payment and cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-009-059/2010-11

P.K.Kannan

Vs

Reliance General Insurance Co.Ltd.

AWARD DATED 23.06.2010

The complainant's wife was covered by group mediclaim policy. During the currency of the policy, she was hospitalized for delivery. Claim for hospital expenses was repudiated by the insurer invoking the clause as to waiting period.

The point to be considered here is whether claim occurred during the waiting period. As per policy conditions, a waiting period of 9 months is applicable for payment of any claim of maternity benefits. Here the policy commenced on 20.12.2008. Hence waiting period will extend upto 19.09.2009. But

hospitalization was from 23.09.2009 to 25.09.2009. Hence hospitalization was after 9 months of commencement of policy. So the complainant is entitled to the hospitalization expenses. Hence an award is passed directing the insurer to pay a sum of Rs.12,133/- together with interest @ 8% p.a. since the date of claim till payment and cost of Rs.500/-.

HYDERABAD

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 012.374. 2009-10

Sri N S Ravishankar V/**s** ICICI Lombard Gen. Ins. Co. Ltd.

Award No:G-007/07.04.2010

Sri N Subbanna, father of Sri N S Ravishankar, was insured under a group insurance policy of AXIS Bank. He was admitted to Kasturba Hospital on 1.1.2009 on complaints of chest pain. He was treated for Unstable Angina. He submitted his claim with the insurers for Rs.8,459 which was approved by the insurer for Rs.8,234. However, the insurer did not make any payment in spite of reminding them several times. The insurer did not respond to the e-mails sent by the complainant. As the insurer did not respond, Sri N S Ravishankar approached this office with a complaint.

The complainant stated that his father was hospitalized on 1.1.2009 in Kasturba Hospital, Manipal and got discharged on 2.1.2009. The hospital charged him Rs.8,459 towards treatment which he claimed for reimbursement. He also asked the TPA for cash-less facility which the TPA had rejected for non receipt of information. He settled the bill with the hospital and preferred a claim on the insurer. The insurer sent an e-mail stating that the claim

was approved for Rs.8,234 only but the amount was not paid so far. Hence, he sought relief along with interest @ 12% and costs amounting to Rs.1,000.

The insurer vide its note dated 26.3.2010 submitted that the insured had asked for cash-less facility for hospitalization of his father. The TPA had sought additional information from the hospital. On receipt of the information, the facility was denied by the TPA on the premise that the admission was only for evaluation purpose which was not covered under the policy.

O R D E R

The complainant has accused the insurer of defaulting after informing of the approval of his claim. It, however, appears that the complainant overlooked to submit the claim form. The insurer has offered to settle the claim on receipt of the claim form. The complainant is directed to comply with this requirement for expeditious settlement of the claim.

In the result, the complaint is treated as allowed for statistical purposes.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 004. 0409. 2009-10

Smt. L Bharathi **V/s** United India Insurance Co. Ltd.

Award No:G-018/06.05.2010

The complainant was admitted in Tilaknagar Hospital with complaints of pain in anal region. She was treated for Excision of Sentinal Pile. She preferred a claim with the insurer which was rejected under clause 4.1 by the TPA stating that the treatment was for management of an existing disease. The complainant is aggrieved and hence this complaint.

The complainant contended that the exclusion clause did not apply in her case because she was suffering from the said problem only for six months prior to her hospitalization. She referred to the certificate issued by the treating doctor.

The TPA rejected the claim under clause 4.1 as the treatment related to management of a pre-existing ailment. However, the Grievance Department of the insurer while reconsidering the case found that the decision of the TPA was wrong and sought time to settle the claim.

O R D E R

Since the insurer has agreed to admit and settle the claim, the complaint does not require to be deliberated at length.

In the result, the complaint is treated as allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 004. 0381. 2009-10

Sri. SSVSRSS Subba Rao **V/s** United India Insurance Co. Ltd.

Award No:G-019/06.05.2010

Sri Subba Rao's wife was admitted in KIMS hospital with complaints of fibroids in the uterus. Lapartomy was done and discharged after six days of hospitalization. The TPA reportedly sanctioned cash-less facility for Rs.30000 and at the time of discharge the amount was reduced to Rs.20000. Sri Subba Rao sought settlement of the bill amount of Rs.70,000 whereas the claim was settled at Rs.20,000 as per the cap applicable for hysterectomy. Aggrieved, Sri Subba Rao filed this complaint.

The complainant contended that the procedure underwent by his wife was Myomectomy which is categorized as a major surgery and the claim should be settled @ 80% of the total bill. He submitted a certificate from a gynecologist of Osmania General Hospital stating that the procedure involved was a major surgery.

The insurer in their note clarified that the surgical procedure underwent by the patient was an alternative to Hysterectomy particularly done in cases of women in their child bearing age. The policy prescribes sub-limits and for treatments such as Hysterectomy, the ceiling is 20% of the sum insured or Rs.50000 whichever is less. Hence, the claim was settled for Rs.20000.

O R D E R

The documents submitted show that the patient developed growth over her uterus and she was advised by the doctor to get it removed. The growth or myoma was non-malignant and not life threatening. Further, the patient was also in her late twenties and without issues, and, therefore, hysterectomy was not the solution and instead the myoma was removed.

Hysterectomy is a surgical procedure involving removal of uterus. Myomectomy does not involve removal of uterus. It involves removal of the growth in uterus. The two cannot be the same even though the procedure might overlap.

The insurer's representative as also the doctor from the TPA vehemently contended that hysterectomy and myomectomy relate to the same procedure with different outcomes in that the first procedure results in removal of uterus while the latter results in saving the uterus. This contention has no legal basis. The policy has a ceiling only for hysterectomy. Such a ceiling, by analogy, cannot be extended to myomectomy.

In view of the above, it held that the insurer has erred in applying a ceiling of expenses towards hospitalization. The treatment that the complainant's wife underwent fell neither under the category of major operations as listed in the policy nor under the category of treatments with 20% cap. In other words, the expenditure incurred by the complainant's wife has to be settled without any ceiling, subject, however, to any other restrictions contained in the policy.

The insurer is directed to process and settle the claim as per the terms of the policy as per my decision above.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 002. 011. 2010-11

Sri. N. R. Sugavanam V/s New India Assurance Co. Ltd.

Award No:G-023/13.05.2010

Sri Sugavanam and his wife are insured under Group Mediclaim Policy issued to Employees of LIC. He increased the sum insured from Rs.1,20,000 to Rs.3,00,000 at the time of his retirement in 2008. His wife underwent knee operation on 10-8-1009. The surgery costed Rs.2,42,000. Yet, Sri Sugavanam's claim was settled by the insurer only for Rs.1,20,000. Aggrieved, Sri Sugavanam filed this complaint.

The complainant submitted that the insurer had collected premium for Rs.3,00,000 and settled only Rs.1,20,000 without giving reasons for short settlement. He pleaded that the treatment cost him Rs.2,42,000 and it was unfair to deny him the balance amount.

The insurer vide their note contended that the complainant's wife was earlier operated for Ring Avulsion about five years ago and still undergoing treatment for Lateral Meniseves Tear. The treating doctor had advised her to undergo Arthroscopic Surgery on her right knee and hence the surgery had been planned for 22.5.08. He once again examined her and suggested knee joint replacement to be performed on 10.8.2009. The Sum Insured was increased to Rs.3,00,000 from the original sum of Rs1,20,000 but the

enhanced sum assured did not apply to planned surgery. The complainant had increased the sum assured keeping in view the likely expenditure on knee replacement. The insurer stated that as per condition No.2 (A) of the policy the claim for Rs.2,36,214 had been settled by them for Rs.1,20,000 because of the stipulation that if the Sum Insured is optionally increased to take care of a planned surgery, the claim will be settled only up to the basic sum insured during the policy period. The insurer, therefore, justified its action.

O R D E R

The sum insured for the complainant was Rs.1,20,000 for the policy period from 1-4-08 to 31-3-09. On renewal, the sum insured was enhanced to Rs.3,00,000 for the period 1-4-09 to 31-3-10. The consultant orthopaedic surgeon issued a note in which he stated that the complainant's wife was under his treatment for the past 8 months and that she was advised left knee replacement surgery tentatively on 10-8-2009. This note suggests that the complainant's wife had a serious problem when the sum insured was enhanced. Clause 2(A) of the policy stipulates that if a sum insured had been optionally increased to take care of a particular disease or a planned surgery, the claim would be settled only up to the basic sum insured. It is obvious that the claim related to a particular disease for which surgery was in sight and, therefore, the restriction in clause 2(A) of the policy applied.

The complainant vehemently opposed application of the restriction in clause 2(A) of the policy to the surgery that his wife underwent on the premise that he was unaware of the conditions in the policy, as the policy document was not supplied to him. This argument has no merit. The complainant obtained cover under a group policy issued to the employees of the LIC. The LIC would have circulated the terms of the policy and asked its employees to subscribe to the policy. The LIC would have collected premium from the employees only

thereafter. As a former employee of the LIC, it does not behove the complainant to state that he paid the premium without knowing the terms of the policy and that the said terms should not be applied to him.

In view of the above, it was held that condition No.2 (A) of the policy applied to the claim and that settlement of the claim at Rs.1,20,000 by the insurer was in order.

In the result, the complaint is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 003. 0385. 2009-10

Sri S Niranjan Kumar V/s New India Assurance Co. Ltd.

Award No:G-031/27.05.2010

Sri Niranjan Kumar and his wife, Smt. Prasanna Kumari, are covered under a Group Mediclaim Policy issued to LIC employees. Smt.Prasanna Kumari delivered a child on 22.8.08 and he preferred a claim for Rs.24,913 for reimbursement. The insurer rejected the claim on the ground that Sri Niranjan Kumar joined the group Mediclaim Scheme on 9.2.08 and that the scheme is subject to condition 5.6 (2) by which a waiting period of nine months is applicable for payment of claim relating to normal delivery or caesarean section of abdominal operation for extra uterine pregnancy. The insurer rejected the claim on the

ground that the complainant's wife delivered the child within this period and, therefore, the claim was not exigible. Aggrieved, Sri Niranjan Kumar filed this complaint.

The complainant contended that he joined as Development Officer in LIC of India at Rajam in November 2006 and was confirmed on 9.2.08. His employer started deducting premium since then. While so, on 22-8-08 his wife gave birth to a male child by caesarean operation. He preferred a claim with the insurance company. However, his claim was rejected under one or the other condition of the policy which he was not aware of. He further submitted that they were not aware that his wife was pregnant at the time of entry into the scheme and, therefore, it was not proper to exclude his claim citing the threshold of 9 months.

The insurer submitted that Sri Niranjan Kumar preferred a claim on 16.9.08 for hospitalization expenses for delivery of his son. The complainant and his wife joined the scheme on 9.2.08. As per condition number 5.16(2) of the policy issued to LIC of India, a waiting period of nine months is applicable for payment of claim relating to normal delivery or caesarean section of abdominal operation for extra uterine pregnancy. In the present case, the delivery occurred on 20.8.08 by which time only 6 months and 12 days were completed. Hence, the claim was not payable and the same was informed to the complainant. His appeal for reconsideration on humanitarian grounds could not be entertained due to operation of the said exclusion.

O R D E R

It is observed that the complainant on his appointment as a Development Officer in LIC of India was on probation for some period and was confirmed only from 9-2-08. It is noted that the mediclaim policy is applicable to only those employees who are confirmed in the employment of LIC of India. The complainant could be enrolled in the scheme only on his confirmation in the cadre by which time his wife had conceived. The delivery also occurred within six months from his joining the scheme. His claim clearly falls outside the scope of the policy by virtue condition number 5.16(2) which specifies that the waiting period of nine months is applicable for payment of claims relating to delivery. Hence, the repudiation of the claim by insurer is found to be in order

The complainant stated that he was not aware of the conditions of the policy and had he been aware that his claim would not be allowed due to exclusions in the policy, he would have gone to another hospital where expenses towards hospitalisation would have been less. He requested me to consider his complaint in the light of this and allow the claim. This cannot be accepted. The policy is clear in this behalf and the exclusion has been stated in clear terms.

The complainant stated that the LIC should publicise the scheme and make the employees be aware of the exclusions. Ombudsman concurred with the complainant on this. The LIC should take steps to ensure that its employees are aware of the scheme.

In the result, the complainant is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.002.049.2010-11

Sri Gampala Prakasa Rao V/s New India Assurance Co. Ltd.

Award No:G-045/21.06.2010

Sri G. Prakasa Rao, a retired employee of LIC, covered under Group Mediclaim Policy taken by the Corporation, preferred hospitalization claim for treatment taken by him at Asian Institute of Gastroenterology, Hyderabad for "*painless bleeding after stools*". He took treatment as an in-patient from 15.7.10 to 16.7.10. He submitted bills for reimbursement of expenses for a sum of Rs. 9582 through LIC to the insurer. The claim was repudiated by insurer on the ground that there was no hospitalization for 24 hours. He filed an appeal to the Grievance Dept of Regional Office of the insurer. There was no reply to this. Aggrieved, Sri G. Prakasa Rao filed this complaint.

The complainant submitted that his stay at hospital was more than 24 hours and the insurer calculated the time mentioned in the final bill which fell 18 minutes short of 24 hours. After making the bill, he waited for the doctor's discharge advice and it took more than 2 hours for him to leave the hospital from the time mentioned in the final bill. He also contended that as per the terms and conditions of Mediclaim policy issued, for undergoing piles operation, 24 hours hospitalization was not stipulated. He took treatment in the hospital and underwent colonoscopic banding for arresting bleeding. He is entitled for reimbursement of medical expenses incurred for this purpose.

The insurer contended that the period of hospitalization was less than 24 hours and thereby the claim was repudiated as per para 2.3 of the clause attached to the policy. The insurer also contended that as per para 1.0 [a] of the clause, hospitalization expenses for medical/surgical/treatment at any Nursing Home/hospital as in-patient are only covered. The complainant has not furnished any discharge summary showing the details of treatment given to him, if any. The insurer also submitted a copy of the policy issued to the LIC. This did not contain any waiver of 24 hours hospitalization period for the treatment underwent by the complainant.

O R D E R

The contentions of both the parties were heard and all the reports/documents submitted were perused. Sri G. Prakasa Rao, a retired employee of LIC, is covered continuously under Group Mediclaim Policy taken by the LIC. As per the case sheet furnished by the complainant, he reached the hospital on 15-7-09 with the complaint of bleeding. He underwent sygmoidoscopy, which revealed a sigmoid polyp and internal haemorriods. He was advised colonoscopic banding. This was carried out the next day.

The complainant entered the hospital, got a few tests conducted and went through colonoscopic banding. The time that the complainant spent in the hospital was more than 24 hours. As per the billing done by the hospital, the duration in the hospital was a few minutes short of 24 hours. Reckoning the period of hospitalization as per the bills excluded the time spent in the hospital before payment of the first bill and after payment of the last bill. Even

otherwise, when rounded off, a difference of a few minutes would not matter. Thus, it was held that the complainant was hospitalized for the stipulated period of 24 hours.

The insurer's representative stated that the complainant underwent a procedure and not a treatment. He stated that colonoscopic banding is a procedure while only a treatment is covered under the policy. He was requested to explain the difference and how the difference impacted the claim. He explained that condition 1.0 of the policy envisaged cover of only hospitalization expenses for medical/surgical treatment whereas colonoscopic banding is a procedure for which no hospitalization is required. This contention is not convincing. The complainant went to the hospital with complaint of bleeding. The hospital, which is highly reputed, made him go through some tests and suggested colonoscopic banding procedure. Colonoscopic banding also could be known as a treatment rather than a procedure. The difference is inexplicable. Moreover, the difference, if any, is not discernable in the policy. Another contention is that colonoscopic banding could have been gone through as out-patient. The hospital admitted him and subjected him to colonoscopic banding as in-patient. It is difficult to assume existence of a choice for the complainant in this behalf. The insurer's representative's contentions, therefore, are devoid of merit.

In parting, it was mentioned that the claim in this case was repudiated on the ground that the complainant was not hospitalized for 24 hours or more. It was dealt with that ground in an earlier paragraph and held that the requirement of hospitalization for 24 hours or more was satisfied in this case. Discussion of the other contentions as in the preceding paragraph is, therefore, academic in nature.

In view of the above, the insurer is directed to admit the claim and pay the claim amount of Rs.9582.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.150.2010-11

Sri S. Kesavan V/s United India Insurance Co. Ltd.
Award No:G-066/26.07.2010

Sri S.Kesavan was covered under Andhra Bank's AB Arogyadan Policy from 28.7.2008 to 27.7.2009. He preferred a claim for reimbursement of hospitalization expenses for accidental inhalation of chemical fumes which caused breathlessness. Even after certification by the treating doctor, the insurer & the TPA rejected his claim. The insurer stated that onset of breathlessness was due to his pre-existing ailments of Cardio-Myopathy, Prostatomegaly and Orthopnea. Aggrieved, Sri S.Kesavan filed this complaint for redressal.

The complainant stated that, on 5.4.2009, accidental inhaling of chemical fumes by the detergent "ALA" while washing the floor tiles in his house, caused him breathlessness and he was hospitalized for easing out the difficulty in breathing. He was put in ICCU and was administered oxygen & nebulization and discharged on 9.4.10 after the respiratory system became stable. He submitted the claim and it was rejected by the TPA stating that hospitalization was for a pre-existing disease. He further stated that he had submitted a certificate from Dr.Raghotham Reddy D, the treating doctor, clarifying that his treatment was for breathlessness and not related to any PED.

The insurer stated that the complainant was hospitalized for sudden onset of breathlessness and as per the hospital records he was a known case of Dilated Cardio-Myopathy, Prostatomegaly, Cervical Spondylosis and history of Orthopnea. As per the discharge summary, the treatment given to the complainant was for the above diseases only. The insured took first insurance policy during

2004 and it was renewed with a gap of 9 days during 2005. It was renewed on time during 2006. There was a gap of 40 days in renewal in the year 2007 and hence it was treated as a fresh policy. There was no gap in the renewal period for 2008-09. The complainant was a k/c of Dilated Cardiomyopathy since 15 years and was under medication. It was further stated by them that acids at domestic level would not lead to severe respiratory problem. The condition of breathlessness was due to his pre-existing diseases only. All PED were covered only after three continuous renewals of AB Arogyadan policy. Due to the break in renewal, the present ailment was outside the scope of cover. It was further stated by them that Dr. Meeraji Rao, one of the treating doctors, certified that the complainant was a known case of Dilated Cardiomyopathy since last 15 years and he was under his follow up since 2008. He further stated that he was presently admitted to ICCU with acute respiratory problem. He also had slow heart rate and ventricular ectopics. The insurer further contended that in any of the hospital records it was not specified that the present hospitalization was due to accidental inhaling of chemical fumes.

O R D E R

Perusal of complainant's hospital record case sheets show that the treating doctors mentioned in their own hand-writing that the complainant was a known case of Dilated Cardiomyopathy and his present condition of breathlessness was related to his existing disease only. He was treated at the hospital by Dr. Raghotham Reddy and Dr. Meeraji Rao. Both of them opined differently in their certificates. The certificate issued by the former is undated and is not in tune with the hospital record maintained contemporaneously.

In the circumstances, Ombudsman relied upon the noting on the hospital case records and the discharge summary and hold that there is no merit in the complaint. It was held that the insurer correctly repudiated the claim of the complainant.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.088.2010-11

Sri P. Sreedhar Reddy V/s United India Insurance Co. Ltd.

Award No:G-067/26.07.2010

Sri P. Sreedhar Reddy covered his family members under Andhra Bank's AB Arogyadan Policy from 17.10.2009 to 16.10.2010. He preferred a claim on insurer for his son's skin disease diagnosed as *"Pityriasis Lichen ides Chronica"* from 18.11.2009 to 23.2.2010. The treatment taken at the hospital on OPD basis was "*Phototherapy"*. The TPA and the insurer rejected the claim stating that the nature of treatment was not covered under the Policy terms and conditions and rejected the claim. Aggrieved, Sri P. Sreedhar Reddy filed this complaint for redressal.

The complainant stated that he had submitted all the documents for reimbursement of treatment expenses stating that his son underwent "Phototherapy" which was similar to Radiotherapy. Although radiotherapy and phototherapy were different names, they were the same in the basic nature, application methodology and by medical definition. The intention of such treatment in both was to penetrate the "Rays" with *radiation effect* into the body wherever required. The intensity of the rays used and the source of radiation might be different based on the requirement of particular disease. The complainant stated that the insurer wrongly repudiated the claim.

The insurer stated that the complainant's family was covered under AB Arogyadan Group Mediclaim policy and his claim was repudiated by the TPA stating that the treatment of Phototherapy of whole body in OPD was not covered as per the terms, conditions & exceptions of the policy. The complainant sought review of the decision of TPA. The Grievance Dept stated that they had obtained expert medical opinion from Dr. T.D. Singh, Cosmetologist & Skin Specialist who opined that Radiotherapy and Phototherapy were two different modes of treatment and they were not similar. The difference as stated by him was:

Phototherapy: Exposure of skin to specific wave lengths of light using lasers, light Emitting diodes, fluorescent lamps, diachronic lamps. Also known as Light therapy.

Radiotherapy: Treatment with ionizing radiation. It deposits energy which injures Or destroys cells in the area being treated [the target tissue].

He further opined that OPD treatment was sufficient for the disease of the insured person. They upheld the decision of the TPA.

O R D E R

The complainant agreed that his son underwent phototherapy treatment on OPD basis. As per the policy, 24 hours hospitalization is not necessary for Radiotherapy treatment. Such exception is not extended to phototherapy treatment. There is no merit in the complainant's contention that both the treatments were similar or identical. They are different and are used for different purposes.

The further contention of complainant is that his claim is covered under clause 2[a] & 2[b] of the policy since skin diseases do not require 24 hrs. hospitalization. This contention also has no merit because hospitalization is *sine qua non* under clause 2[a] & 2[b] of the policy. The difference is that hospitalization could be less than 24 hours. It does not envisage cases of no hospitalization.

In view of the above, merit was found in the complaint. It was held that the insurer correctly repudiated the claim of the complainant.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.120.2010-11

Sri P.V. Naik V/s The New India Assurance Co. Ltd.
Award No:G-071/2.08.2010

Sri P.V. Naik, retired employee of the insurer, along with his dependent family members

was covered under Group Mediclaim policy for retired employees by the insurer. He preferred a claim for Root Canal Treatment of his wife and claimed a sum of Rs.5161/-. The claim was repudiated by the insurer as it was excluded from scope of cover of mediclaim policy. Aggrieved, Sri P.V. Naik filed this complaint for redressal.

The complainant stated that he had submitted claim documents for reimbursement of dental RCT expenses of his wife and the insurer rejected the claim stating that it was excluded from the scope of the policy coverage. The complainant stated that he was paid earlier two claims. He contended that there was no justification for denial of the claim.

The insurer stated that dental treatment / surgery of any kind unless requiring hospitalization was excluded under Staff Mediclaim and General Mediclaim policies. Hence, the claim was rightly rejected.

O R D E R

There is no doubt that mediclaim policy excludes dental treatment / surgery unless requiring hospitalization. The insurer admittedly paid the claims of dental treatment / surgery earlier overlooking the exclusions in the policy. Such transgression by the insurer did not bestow a right on the complainant to a similar treatment. Insurance is a contract the terms of which have to be construed strictly. There is no ambiguity in exclusion of dental treatment/ surgery from coverage of the policy. The policy clearly and explicitly excludes OP treatment of dental treatment / surgery.

In view of the above, it was held that the insurer correctly repudiated the claim. Consequently, merit was found in the complaint.

In the result, the complaint is dismissed without any relief.

Sri P.V. Naik V/s The New India Assurance Co. Ltd.

Award No:G-072/2.08.2010

Sri P.V. Naik, retired employee of the insurer, along with his dependent family members was covered under Group Mediclaim policy for retired employees by the insurer. He preferred a claim for ayurvedic treatment that he underwent for Rs.46678/-. The claim was short settled by the insurer by Rs.1310/- disallowing hospital registration and diet charges. Aggrieved, Sri Naik filed this complaint for redressal.

The complainant stated that his claim was delayed by the insurer and after a lot of persuasion, they settled the claim disallowing diet charges. He further stated that he had submitted a certificate from the hospital stating that the in-patient was not allowed to take outside food and the diet was supplied by hospital depending upon the ailments and medicines administered in treatment. Diet formed a part of the treatment and hence it was liable to be reimbursed.

The insurer stated that the claim was for ayurvedic treatment in an ayurvedic hospital. The insurer's investigator was denied access to the records of the hospital under the instructions of complainant and that was the main cause for delay. Somehow, they got the information from the hospital and settled the claim. The diet and hospital registration charges, being non-medical expenses, were not paid.

O R D E R

It is noted that Mediclaim policies reimburse the insured person against hospitalization expenses incurred for in-patient treatment. Its coverage does not extend to 'diet' charges. The insurer settled the claim of the complainant after disallowing diet charges and registration expenses as they constitute non-medical expenses. Hospitalisation expenses cannot include within their amplitude diet charges even if the hospital prohibits outside food and insists on consumption of food supplied by the hospital.

In view of the above, it was found that the insurer correctly restricted the claim. Consequently, merit was found in the complaint.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.122.2010-11

Sri P.V. Naik V/s The New India Assurance Co. Ltd.
Award No:G-077/4.08.2010

Sri P.V. Naik, retired employee of the insurer, along with his dependent family members was covered under Group Mediclaim policy for retired employees by the insurer. He preferred a claim for bone marrow transplantation to her daughter which she underwent at BGS Hospital, Bangalore on package deal for Rs.3,00,000/-. Sri P.V. Naik paid the amount by two DDs to the hospital and submitted reimbursement claim to the insurer. The insurer asked the complainant to obtain bifurcated bill from the hospital separately for the patient and the donor and also cash receipts for the amount paid to the hospital. The complainant took up the matter with the hospital and the hospital replied that, being a package deal, split bill could not be issued. The hospital also stated that it has issued a bill with serial number confirming receipt of the amount from the complainant and they would not issue any other kind of bill. The insurer was not satisfied with the reply of the hospital and entrusted the claim for investigation, the report of which was still awaited. Sri P.V. Naik reported the delay in settlement of the claim to the Grievances Dept. but no reply was received by him. Aggrieved, Sri Naik filed this complaint for redressal.

The complainant stated that his claim was yet to be settled by the insurer and after a lot of persuasion, it was stated to him that bifurcation of bill was required to ascertain the actual amount of claim to be reimbursed under the policy. He pleaded that why he was being penalized if hospital was not giving it.

The insurer stated that for admission of claim, they needed bifurcated details to apply the limits and they asked the complainant to provide the details of date-wise and head-wise description bill supporting main bill and also separate bifurcated bill for the patient and the donor. These were essential for them to process the claim. They had deputed an investigator to obtain the details and were awaiting his report.

O R D E R

Mediclaim policies reimburse hospitalization expenses incurred for in-patient treatment including 30 days pre and 60 days post hospitalization only. There is no doubt that the insurer had genuine difficulties in settling the claim.

The complainant incurred expenses towards hospitalisation of his daughter. It is not correct to state that the present hospitalization was not necessitated by medical emergency and it was volunteered by the complainant. Bone marrow transplant has to be planned. Yet, it is considered life saving. Expenditure incurred by the complainant towards bone marrow transplant for his daughter is covered under the policy. The complainant's son was the donor of bone marrow. He had to undergo many tests before accepting him as donor. The hospital stated that donor expenses were not charged in the bill. The insurer stated that in view of non-co-operation of the hospital, this claim was unverifiable. Notwithstanding this, it was held that expenditure on such tests conducted on the donor cannot be disallowed because they were necessary for transplant.

It is obvious that the package deal included follow up treatment for one year. Expenditure ascribable to such follow up is inadmissible under the policy. The total expenditure incurred by the complainant as package amounted to Rs.3,00,000. Out of this, it was held that a sum of Rs.1,00,000 related to follow up expenses. Consequently, it was estimate expenses towards hospitalisation at Rs.2,00,000. The policy has a cap for major surgeries @ 75%. Accordingly, applying the ceiling, the claim is restricted to 75% of Rs.2 lakhs. This works out to Rs.1,50,000.

In view of the above, the insurer is directed to settle the claim at Rs.1,50,000. Interest claimed by the complainant is not allowed since the insurer faced genuine difficulties in settling the claim and the delay was not deliberate.

In the result, the complaint is allowed partly.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.05.183.2010-11

Sri Dhiraj Saxena V/s Oriental Insurance Co. Ltd.
Award No:G-082/9.08.2010

Sri Dhiraj Saxena, an employee of Jet Airways, along with his dependent parents, was covered under the Oriental Insurance Co. Ltd.'s Group Mediclaim policy. His mother underwent operation of 'dual incisional hernia and Sleeve Gastroplasty'. He stated that before hospitalization, he contacted the TPA about admissibility of claim and stated that the staff on duty at Chennai office of TPA informed him that both surgeries were payable and the hospital where they were planning operation was not a network hospital. Therefore, he had to prefer reimbursement claim. On submission of claim, the TPA admitted claim only for 'Hernia' and rejected it for Sleeve Gastroplasty. He further stated that on enquiring with the TPA, he was informed that Sleeve Gastroplasty, being a cosmetic surgery, was not covered under the policy. Referring to the decision of our centre in Award No. 131/2009-10, the complainant made this complaint for redressal.

The complainant submitted that before hospitalization, he spoke to the TPA staff on duty about admissibility of claim and duty staff reconfirmed, in consultation with their doctor, that dual operation expenses of incisonal hernia and sleeve Gastroplasty were payable under the policy and he had to prefer reimbursement claim. Basing on the tele-conversation assurance, he pooled up money for the hospitalization expenses and submitted the claim for

reimbursement. The claim was admitted only for hernia and it was disallowed for Sleeve Gastroplasty on the ground it was a cosmetic surgery. He stated to have submitted certificate from treating doctor that ***"multiple metabolic factors are not allowing her to lead normal life and she would benefit greatly from 'Gastroplastry' [Sleeve Gastrectomy] for her weight loss and it is not a cosmetic procedure".*** He further stated that it was a life saving surgery and it was very much essential for her mother to lead a normal life. He represented for reconsideration of decision of the TPA to the insurer's regional office and yet there was no revision in the decision.

The insurer contended that the insured person, Smt. Hemalata Saxena, was a known case of DM, HTN, Hypothyroidism and Morbid Obesity with incisional Hernia. She was hospitalized at Kirloskar Hospital, Hyderabad for Gastroplasty [Sleeve Gastrectomy] and Incisional Hernia [Hernioraphy]. The TPA settled the claim for hospitalization expenses of Hernia and expenditure towards Gatroplasty was denied. Gastroplasty [Sleeve Gastrectomy] expenditure was for Morbid Obesity and it was not payable as per Policy Exclusion No. 4.19 – which states *"the company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of: treatment of obesity or condition arising therefrom [including morbid obesity] and any other weight control programme, services or supplies etc."* Accordingly, the claim of the complainant was denied for sleeve gastrectomy.

O R D E R

The insurer's policy specifically excluded the treatment expenses for Morbid Obesity under policy exclusion clause No. 4.19. Gastroplasty is a procedure for management of morbid obesity. The complainant's mother had to undergo this procedure for control of her weight and management of obesity. Thus, the policy exclusion applied to this procedure. The decision in award No. 131/2009-10 relied upon by the complainant related to the claim of the insurer that Gastroplasty was cosmetic surgery. Further, the insurer had not claimed policy exclusion for morbid obesity. Thus, the complainant's reliance on decision in award No. 131/2009-10 is misplaced.

Since the policy provided for specific exclusion for treatment of obesity or condition arising therefrom including morbid obesity and Gastroplasty doubtless related to treatment of obesity, the insurer's denial of expenses towards hospitalisation for Gastroplasty is in accordance with the policy terms and conditions. In the circumstances, there is no infirmity in the decision of the insurer. Following this, it was upheld the decision of the insurer.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 02 226 2010-11

Sri Vijaya Babu V/s New India Assurance Co. Ltd.

Award No:G-093/31.08.2010

The Board of Trustees of erstwhile Unit Trust of India [UTI] formulated a Scheme titled "The Senior Citizen's Unit Scheme / Plan" [SCUP] with the principal objective of helping members of the scheme/plan to build up savings in order to avail medical and hospitalization benefits for the member and the spouse when they attain the stipulated age as per the scheme and plan provisions. The UTI and New India Assurance Co. Ltd. entered into an MOU for implementing the provisions of the scheme for the purpose of making payment to the hospitals in respect of medical treatment given to the member of the scheme and the plan as per terms, conditions and stipulations made under the scheme/plan and arrangement agreed to from time to time for smooth operation of the scheme. The SCUP had been terminated w.e.f. 18.2.2008 and only those members of the said Scheme/Plan, who attained the age of 58 years as on 18.2.2008 shall

continue to be eligible for the medical and hospitalization benefits as per the said Scheme/Plan provisions, and the members / unit holders of the scheme have been intimated as appropriate. The MOU was latest renewed by the insurer w.e.f. 1.3.2010.

Sri G. Vijaya Babu, an investor in the Scheme/Plan, was covered under the Group Mediclaim Policy issued by the insurer and its terms and conditions are as per the MOU entered into by the three parties. He preferred a claim for his hospitalization expenses at Care Banjara Hospital where he incurred hospitalization expenses of Rs.2,21,458/-. The claim was settled by the insurer for Rs.1,50,000/- whereas he claimed that he was entitled to the benefit of Rs.2,50,000/- + Cumulative Bonus of Rs.12,500/- under the scheme. He submitted claim to the insurer for payment of short settlement amount of Rs.71,458/- which was rejected by the insurer, referring to MOU. Aggrieved by the rejection of insurer, Sri G. Vijaya Babu made a complaint for redressal.

The complainant stated that as per the log book given under the scheme, he was eligible for compensation of Rs.2,62,500/-. He further stated that the limit of Rs.1,50,000/- applied only to the spouse as per condition No.4 of scheme, the details of which were given to him. He stated that the member was entitled to the total amount without any limit. The rejection of the claim by insurer referring to a clause under the MOU was not justified as he was not a party to the MOU and the clauses were not in agreement with the policy terms and conditions given to him.

The insurer contended that the Identity Cards and Log Books are being prepared, maintained and provided to its members by M/s UTI / UTI AMC only. Since the complainant was a member by virtue of his membership with UTI, he could not disassociate himself from the MOU. By virtue of MOU only, he took treatment in Care Hospital. The complainant was not eligible for any amount over and above Rs.1.50 Lakhs. The MOU was entered into by them with UTI AMC and Quality Care India Limited for providing exclusive hospitalization benefit to eligible individual members under the Senior Citizens Unit Scheme – 1993 and the plan 1993 and as per MOU the hospital shall not bill more than Rs.1.50 lakhs, per illness per patient, during the period of hospitalization. They had already paid an amount of Rs.1.50 Lakhs to the hospital and the complainant was not entitled to any further amount under the scheme.

O R D E R

The complainant is entitled for payment of hospitalization expenses as per Scheme. The insurer is governed by their agreement / MOU with the UTIAMC and Quality Care India for providing exclusive hospitalization benefits to the eligible members. The agreement is being renewed from time to time stipulating limitation for each hospitalization expenses per illness and per person. The said limitation is fixed at Rs.1.50 lakhs. The entitled member does not have any right to claim benefit over and above the terms of the agreement. It is by virtue of agreement only that the complainant became entitled to the benefit. As submitted by the insurer, the insured, being a member through UTI-SCUP, is governed by the terms and conditions of the MOU. He cannot disassociate himself from the MOU. The terms and conditions of MOU bind all the parties and its beneficiaries equally. The complainant cannot take advantage of a clerical error committed in mentioning the limit of Rs.1,50,000 as applicable to the spouse in the instructions. The insurer did not issue the instructions. It was the UTI which issued the instructions. The insurer is not bound by the erroneous instructions issued by the UTI. The insurer is only bound by the terms of the MOU.

In view of the above, it was found that the insurer correctly restricted the claim. Consequently merit was found in the complaint.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.14.214.2010-11

Sri Loksundar K V/s Cholamandalam MS General Ins. Co. Ltd

Award No:G-096/14.09.2010

Sri Loksundar K, being an employee of M/s Global Payments Asia Pacific [India] Pvt. Ltd., was covered under employer's Group Mediclaim Policy issued by the insurer covering all employees together with their family members. He preferred a reimbursement claim for maternity hospitalization expenses belatedly and it was rejected by the insurer invoking policy conditions. Aggrieved, Sri Loksundar K filed the complaint requesting redressal of his grievance.

The complainant stated that he was not aware of coverage under Group Mediclaim Policy and on knowing it he preferred a claim. He made a representation to Head Office for condoning the delay of 140 days and to pay the claim. They have not reviewed their decision.

The insurer stated that complainant preferred the claim after unreasonable delay and as per their Group Policy terms and conditions the claim had to be submitted within 30 days from the date of discharge from the hospital. The terms and conditions of contract are binding on both parties. The complainant took his own time to submit claim documents even after he had knowledge of coverage under the policy. The insurer further stated that it was the responsibility of the employer to provide policy coverage details and to enlighten the claim procedure to all their employees and they are not responsible for educating all the employees of the employer. They quoted the decisions of Apex court in support of their rejection for non-compliance of policy terms and conditions.

O R D E R

The complainant filed the claim belatedly. The insurer followed the letter of the contract and repudiated the claim. This is a case of maternity hospitalization expenses. The claim is admitted to be genuine but for the delay. The complainant's statement that he did not know the admissibility of the claim since he was covered under a group policy is accepted. The delay occurred due to plausible reasons.

In view of the above, the insurer is directed to settle the claim on an ex gratia basis at Rs.10,000 (Rs.ten thousand only).

In the result, the complaint is allowed as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.002.215.2010-11

Sri T. Sampath Iyengar V/s New India Assurance Co. Ltd.
Award No:G-098/14.09.2010

Sri T. Sampath Iyengar, a retired employee of LIC of India, was covered under LIC Group Mediclaim Policy issued by New India Assurance Co. Ltd.'s Mumbai Divisional Office. He preferred a reimbursement claim for hospitalization expenses incurred by him for the symptoms of recurrent giddiness, imbalance and fear of falling. He stated that he was suffering from 75% permanent physical disability right from his childhood due to polio. He further stated that he was suffering from vascular disease, DM and HTN. Due to drop in sugar levels and for treatment of the existing ailments and to exclude an evolving stroke, he was advised admission in the hospital for treatment and so he was admitted on 21.9.2009. He preferred a reimbursement claim and it was rejected by insurer stating that there was no active line of treatment. There was no reconsideration by the insurer on appeal made by Sri T. Sampath Iyengar. Aggrieved, he filed this complaint for redressal.

The complainant stated that the insurer rejected his claim quoting policy exclusion 4.10, i.e. hospitalization not followed by active line of treatment. He stated that he clarified the position that diagnosis and treatment in his case were very much incidental to the positive existence of ailments. He further stated that as per policy clause 2, he was entitled for reimbursement of total hospitalization expenses since there was 24 hrs. hospitalization. On rejection of claim, he stated that he obtained a certificate from his treating doctor confirming

the necessity of his admission and treatment taken during the course of his hospitalization and these documents were forwarded for review by the insurer. He also stated that under clause 5.17, the claim in respect of expenses incurred for CT Scan and Doppler Carotid Test were to be admitted as out-patient expenses also. The insurer denied the same. He stated that his post hospitalization claim was also rejected by the insurer.

The insurer contended that the complainant was a known case of HTN, DM and Vertebro bacillary insufficiency and there was no history of any major symptoms necessitating present hospitalization. As per hospital records, the condition of the complainant at the time of admission was 'Normal'. He was admitted for evaluation of his complaint of giddiness, imbalance, etc. During the course of one day hospitalization, he was treated with only one Tablet of Ecospirin. The hospital carried out various investigations for evaluation and they were not followed by any active line of treatment. The hospital authorities stated that the present symptoms of the complainant were due to age related changes only. They admitted Pelvic Scan charges of Rs.680/- as per clause 5.17 and the rest of the claim was rejected. They further stated that post hospitalization expenses were payable only for admitted in-patient claim.

O R D E R

The policy issued by the insurer stipulates certain conditions for admission of claims. Complying with one of such conditions does not validate the claim of the complainant when other provisos/clauses do not permit the claim. Clause 4.10 of the policy stipulates admission of in-patient hospitalization claim followed by active line of treatment. On perusal of documents submitted, it is noticed that there was no active line of treatment following admission in the hospital. The policy does not provide for reimbursement of claims on expenses incurred towards evaluation and diagnostic purposes without active line of treatment. Therefore, the insurer's contention that the present hospitalization did not involve active line of treatment is correct and is accepted.

Clause 5.17 of the policy allows expenses for CT Scan and Doppler Carotid. The insurer has wrongly rejected the claim of complainant in this behalf. The complainant is entitled to

reimbursement of Rs. 3740/- for CT Scan and Rs.1320/- for the balance amount payable for Sonography.

In view of above, the insurer is directed to pay Rs.5060 (Rs. Five thousand sixty only) to the complainant.

In the result, the complaint is partly allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 02. 278 2010-11

Sri V. Venudhara Sastry V/s New India Assurance Co. Ltd.

Award No:G-103/14.09.2010

Sri V. Venudhara Sastry was covered under Group Mediclaim Policy for SI of Rs.1,00,000 issued by the insurer covering all credit card holders of Andhra Bank who opted for coverage under the policy. Sri V. Venudhara Sastry stated that he was a Sr. Citizen covered under the GMP from 1.4.2003 without any break. He underwent surgery at Indo American Cancer Institute on 5.6.2009 and submitted claim for reimbursement of hospital expenses of Rs.81,476/- as his cashless benefit request was denied by the TPA. He stated that he made several requests to the TPA and also to the insurer for settlement of the claim but in vain. He further stated that on personal visit to the insurer's office, he was informed that the claim was denied at it was a PED and recurrent in nature. Aggrieved, Sri Sastry filed this complaint for redressal.

The complainant stated that he was continuously covered under the policy of insurer from 1.4.2003. He preferred earlier a claim for similar surgery which he underwent during 2007.

On denial of his claim by the insurer, he made a complaint under the RPG Rules and the Ombudsman allowed him ex gratia of Rs.50,000/-. He further stated that as per the Senior Citizens Mediclaim Prospectus of the insurer, all PEDs were covered after 18 months of continuous coverage with the insurer. Since he had insurance cover from 1.4.2003, denial of his claim by the insurer was unjustified.

The insurer contended that as per their records the insured was covered under their Group Mediclaim Policy from 1.4.2004. As per terms and conditions of the policy issued to Andhra Bank Group Mediclaim Policy covering Credit Card holders, the claim preferred by the complainant fell under PED clause of the policy and so it was rightly denied by them.

O R D E R

PED is not covered as per exclusion under clause 4.1 of the policy. The said exclusion, however, would be deleted after four consecutive claim free policy years provided there is no hospitalization within those four years in respect of the PED. There is no dispute that the complainant was afflicted with Carcinoma Parotid in 2002, i.e. prior to the commencement of the first policy with the insurer. The complainant underwent treatment in 2007 for recurrence of carcinoma. Therefore, the period of 4 years had not elapsed by 2007 from the first policy. Therefore, the question of deletion of PED exclusion did not arise in the case of the complainant.

There is no evidence in support of the complainant's contention that he was covered under Group Mediclaim Policy issued to Singareni Collieries Employees prior to his coverage under the Andhra Bank CC holders Group Meidclaim Policy. His further contention that the senior citizens have to be afforded favourable treatment is not borne by the insurance contract in question. His lamentation that denial of claim by the insurer amounted to betrayal of faith the policy holders had with the insurance companies is of no consequence when the issue involved is the terms of a contract. His further contention that the insurer has to honour the claim because the insurer accepted the renewal premium without any express condition use of the complainant is not valid since the policy document issued specifically contains exclusion of PED.

In view of the above, nothing was found any infirmity in the decision of the insurer. Following this, it was upheld the decision of the insurer.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.11.213.2010-11

Sri Mahendra Kumar **V/s** Bajaj Allianz General Ins. Co. Ltd.

Award No:G-107/14.09.2010

Sri Mahendra Kumar, proprietor of a readymade garments business firm, M/s M.S. Fabrics, insured his stock-in-trade and furniture, fixtures and fittings under the insurer's Shop Keepers Policy for Rs.66,00,000/-. Due to short circuit, on 9-3-2009, the stocks in the shop were completely gutted along with F/F/F. Sri Mahendra Kumar preferred a claim under the policy. The insurer deputed a surveyor for assessment of the loss and he submitted a report confirming that the loss occurred due to insured peril and there was no breach of policy terms and conditions. Sri Mahendra Kumar declared that all his books of account, purchase bills, sales invoices, etc. were destroyed in the fire accident. He stated that basing on tax returns and obtaining information from his buyers, he arrived at the loss he claimed from the insurer. Since the surveyor could not verify the books of account, another Chartered Accountant surveyor was asked to do the job. The second surveyor obtained consent of Sri Mahendra Kumar for settlement of the claim and accordingly the insurer settled the claim.

Sri Mahendra Kumar stated that his consent was obtained under the threat of complete denial of the claim. He stated that he accepted the settlement under protest due to financial problems. He further stated that the copy of the survey report was not made available to him and the insurer short settled the claim which he was forced to accept under duress and coercion. He claimed that the insurer fraudulently reduced his legitimate claim and in spite of repeated requests and legal notice sent, the short settled claim amount was not paid to him. Aggrieved by the short settlement of claim, Sri Mahendra Kumar filed this complaint for redressal.

The complainant stated that he insured his stocks in the shop for Rs.50 lakhs and the furniture for Rs.16 lakhs. The first surveyor assessed the loss for Rs.50,74,466/- and by appointing the second survey, the insurer fraudulently reduced his legitimate claim amount and paid only Rs.35,00,244/- obtaining consent forcibly by threatening to deny the total claim if not accepted. He further stated that due to financial problems and with a view to restart his business, he accepted the settlement under protest and duress.

The insurer stated that the first surveyor submitted the assessment report without proper verification of the books of account submitted by the complainant. They appointed a Chartered Accountant as the surveyor to verify the books of account. The second surveyor pointed out various lapses in the books of account and noted that the purchases shown in the accounts were not supported by payment details. The complainant submitted income tax returns for the years 2007-08 and 2008-09 together after the fire accident. He also pointed out that huge purchases were shown during March 2009 as against average purchases for preceding months which did not exceeded Rs.2.50 lakhs. The insurer stated that because of the above lapses, the assessment of stocks was re-assessed. Thereafter, the consent of the complainant was obtained for settlement. The consent was obtained in the presence of the complainant's own witness. The consent given by the complainant was of his free volition. The complainant voluntarily agreed for 'full and final' settlement of the claim for the loss sustained in the fire accident. The insurer stated that this complaint was an after thought. The insurer stated that the contract of insurance was a contract of indemnity and the complainant was duly indemnified under consent and so no further liability arose.

O R D E R

There are no grounds for me to believe that the consent was obtained by the insurer as alleged by the complainant. The complainant failed to establish that the consent was given by him under duress/coercion. Hence, it was viewed that the complaint is not entertainable. Even on merits, it was held that there is no infirmity in the settlement arrived at by the insurer.

In the result, the complaint is dismissed without any relief.

LUCKNOW

GROUP MEDICLAIM

Case no.G-14/11/02/2009-10

Mrs. Sunita Singh Vs. The New India Assurance Co.Ltd.

The complainant was covered under LIC employees group mediclaim policy issued by The New India Assurance Co. Ltd.. The insured on complaint of some abdominal and related problems got admitted at Pushpanjali Hospital Agra on 14.06.2008 and remained there till 18.07.2008/ After discharge from the hospital she preferred a claim with the insurer. The respondent company repudiated her claim on the following grounds :-

1. There has been a delay of two months in submitting the claim.
2. Consumption of medicines has been shown on higher side.

Regarding the first objection Hon'ble Ombudsman the delay keeping in view that she was recouping from a severe operation and she might not be aware of the fact that claim papers should be submitted within fifteen days of discharge from the hospital.

On going through the papers it was found that there was a bunch of cash memos given by M/s Garg Medical Hall totaling to Rs.2,29,922/. There were 34 receipts from pathologist but there were no prescriptions and reports on the file nor there was any daily progress report prepared by the attending doctor or nursing staff. Bills were found exaggerated and concocted. In the result the repudiation made by the respondent company was upheld.