BHUBANESWAR

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No.14-004-0776

Sri Motibas Giri

Vrs

United India Insurance Co. Ltd., Rourkella Branch

Award dated 21st March. 2011

Complainant and his spouse were covered under a Group Mediclaim Insurance Policy taken for the retired SAIL employees from United India Insurance Co. Ltd . For the OPD treatment of him self and his wife he lodged two medi claims. Even after submission of treatment papers and desired documents, the claims were not settled.

Hon'ble Ombudsman heard the case on 23.02.2011 where complainant was not present. Insurance Company openly admitted that the documents are misplaced and there fore the claims are not settled. Ombudsman directed insurance Company to trace out the papers and settle the claim within 15 days. Further he also directed the complainant to provide Xerox copies of the documents if retained to insurance company immediately. In the event neither complainant nor the insurance company are in a position to trace out the documents, the claim is to be settled for the amount as disclosed in the P-II.

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KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-066/2010-11

K.N.Rajesh Kumar
Vs
The New India Assurance Co.Ltd.

AWARD DATED 15.12.2010

The complainant, an employee of LIC of India, is covered under the Group Mediclaim policy issued by The New India Assurance Co.Ltd. His dependant mother is also covered under the said policy. He is paying a regular premium of Rs.486/-. His mother was hospitalized and treated for renal problem but the claim raised for medical reimbursement to the tune of Rs.41,113.50 towards the said hospitalization was rejected by the insurer on the ground that she is not dependant on the complainant. Hence he approached this Forum for justice.

At the time of personal hearing, the representative of the insurer submitted that the complainant is covered under the policy. But the claim has been rejected as the beneficiary viz., his mother, is earning a monthly income of more than Rs.2,550/-. As per Clause 3.5 of the policy conditions, dependant means a person who is financially dependant on the employee and not earning more than Rs.2,550/- per month. The complainant was not present at the hearing but in his notes of argument, sent with a request to be considered during hearing, clearly states that his mother is earning a monthly pension of Rs.2,696/-. However, he has contested the said clause because the insurer has been receiving the premiums being remitted by him for covering his mother too. Since the policy condition is very clear, the decision of the insurer in rejecting the claim is proper.

The complaint, therefore, stands DISMISSED.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-248/2010-11

M.P.Dharmarajan
Vs

United India Insurance Co.Ltd.

AWARD DATED 29.03.2011

The complainant's employer had taken an employees' group mediclaim policy which covered the complainant's mother also. When she was hospitalized on four occasions during 2005 and 2006, he incurred Rs. 24202/- (approx) towards treatment. The claim for the complainant's mother's hospitalization expenses was repudiated on the ground that she was treated for a pre-existing disease, which was not covered under the policy. Hence, the appeal to this Forum.

Records were perused and hearing held. It is noted that the complainant's mother was having insurance coverage from 2004 onwards. The complainant's mother was treated on four occasions during the said years. In the relevant portion dealing with the history of illness, it is noted that the patient is a known diabetic for 8 years on treatment, which means that she was suffering from the said disease at least from 1998. Though the mother of complainant was having insurance coverage from 1.1.2004, the medical evidence available would reveal that she was undergoing treatment for diabetes at least from 1998 and hence the claim is hit by clause 4.1 of the policy conditions. Hence the repudiation action of the respondent-insurer is justified.

In the result, the complaint is dismissed. There is no order as to cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-129/2010-11

P.Deepudas
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.03.2011

The complainant's employer had taken an employees' group mediclaim policy which covered the complainant's mother also. When she was hospitalized, he incurred Rs. 2550/- (approx) towards treatment. Also, the complainant himself was hospitalized and a consolidated claim was preferred. The claim for the complainant's mother's hospitalization expenses was repudiated on the ground that she was treated for a pre-existing disease, which was not covered under the policy. The respondent-insurer submitted that the claim of the complainant for Rs. 30000/- (approx) was already settled. As the complainant had not received the above two amounts, the complaint to this Forum.

Records were perused and hearing held. The discharge summary of the mother of the complainant would reveal that the lady was treated for acute exacerbation and regarding

history of illness, the doctor has mentioned it as one week only. In order to repudiate the claim on the basis of a pre-existing illness, the insurer should have enough evidence that the complainant's mother had been suffering from the ailment even prior to the date of inception of the policy, which in this case is 1.1.2005. Hence, this claim should be allowed. About the complainant's own claim, the respondent-insurer had admitted his liability to pay the expenses incurred by the complainant for his treatment. It is learnt that the respondent-insurer had effected the payment of Rs. 30000/- in the name of one, Mr. Sanilkumar, instead of in the name of the complainant.

In the result, an award is passed directing the respondent-insurer to pay Rs. 33460/- to the complainant within the period prescribed failing which he shall pay interest on the amount @ 9% from the date of filing of the complaint (7.5.2010) till payment. There is no order as to cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-148/2010-11

K.P.Jayanandan
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.03.2011

The complainant's employer had taken an employees' group mediclaim policy which covered the complainant's mother also. When she was hospitalized in Jan, 2006, he incurred Rs. 2297/- (approx) towards treatment. The claim for the complainant's mother's hospitalization expenses was repudiated on the ground that she was treated for a pre-existing disease, which was not covered under the policy. Hence, the appeal to this Forum.

Records were perused and hearing held. It is noted that the complainant and his mother were covered under the mediclaim policy for the years 2005 and 2006. The complainant's mother was treated for BPPV, systemic hypertension and COPD. In the relevant portion dealing with the history of illness, it is noted that the patient was suffering from COPD for four years, which means that she was suffering from the said disease at least from 2002. The complainant failed to produce any evidence to show that prior to 1.1.2004, the mother of the complainant was having any insurance cover. Hence the repudiation action of the respondent-insurer is perfectly justified.

In the result, the complaint is dismissed. There is no order as to cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-109/2010-11

C.Santhosh Kumar
Vs
United India Insurance Co.Ltd.

AWARD DATED 29.03.2011

The complainant, whose father was also covered in the Employees' Group Mediclaim policy taken out by his employer, preferred a claim for the expenses incurred by him on his father's hospitalization, to the tune of Rs. 4906/- approx. The respondent-insurer repudiated the claim. The complainant is entitled to get reimbursement of the amount with interest. The respondent-insurer stated that as pre-existing illnesses are not covered, the claim was repudiated.

Records were perused and hearing held. Here, neither the hospitalization nor the genuineness of the medical bills is disputed. The discharge summary does not indicate that the father of the complainant underwent treatment earlier for the same ailment. However, the medical report by the attending medical officer states that the patient was suffering from the same illness from 13.2.2001. However, the complainant has a definite case that himself and his father were having continuous insurance coverage from 2000 onwards. The fact is established from the letter issued by the New India assurance company also, from whom the employer had taken the group policy. So, for application of Clause 4.1 i.e., to repudiate a claim as pre-existing ailment, the ailment must be in existence even prior to 1.1.2000. There is no evidence that the father of the complainant was suffering from the ailment prior to 1.1.2000. So the ailment for which the father of the complainant underwent treatment cannot be termed as pre-existing. Therefore, the repudiation action of the respondent-insurer cannot be sustained.

In the result, an award is passed directing the respondent-insurer to pay Rs. 4906/- to the complainant within the period prescribed failing which the respondent-insurer shall pay interest on the amount @ 9% p.a. from the date of filing of the complaint (4.5.2010) till payment. There is no order as to cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-133/2010-11

K.Sreenivasan
Vs
United India Insurance Co.Ltd.

AWARD DATED 31.03.2011

The complainant was covered under an Employees Group Mediclaim policy taken by his employer.The complainant had made a claim of Rs 100000 in connection with a hospitalization which was repudiated by the insurer without any valid reason.The Ombudsman's forum was approached for allowing the claim with interest.

The insurer contended that the Total Sum Assured is 35000 which is the maximum liability for the relevant year 2006 .Already an amount of Rs 19124/- was settled for an earlier hospitalization on 05.04.2006.Hence the balance available is only Rs 15876/-.

Both sides were heard and the facts and submissions were perused.There is proof of disbursement of Rs 19124 in relation to the claim in 2006.So the balance amount available is 15876/-.The repudiation of the claim cannot be sustained.At the same time complainant is entitled to only Rs 15876/- as reimbursement.

The respondent insurer is directed to pay Rs 15876/-.There is no order to cost.

HYDERABAD

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.292.2010-11

Smt. K Anupa Murlidhar, Vs. New India Assurance co. Ltd.

Award No:G-112/1.10.2010

Smt. K Anupa Murlidhar preferred a claim for reimbursement in respect of ear operation of her husband under the Group Mediclaim policy issued by the insurer covering all the LIC employees and their families. Smt. K Anupa Murlidhar's husband

suffered from hardness in both ears. Because of progressive hearing loss, he underwent right Stapedectomy, as an in-patient, at Yashoda Hospital, Secunderabad. The claim was rejected by TPA under policy under exclusion 4.6. Smt. K Anupa Murlidhar made a review application. She did not get any response from the insurer. Aggrieved, she filed this complaint.

The complainant stated that her husband underwent surgery on 20.10.2009 due to excess bone growth in the ears. She stated that she submitted her claim on 26.10.2009 to the insurer. There was no reply for more than 4½ months thereafter. She received a letter from the insurer dated 11.3.2010 repudiating her claim under policy exclusion 4.6. She sent an application to the RO vide her letter dated 9.4.10 seeking review of the decision. The insurer received a letter from the RO stating they would revert on hearing from their concerned DO. Even after a lapse of 11 months thereafter, the claim was not settled by the insurer. The complainant further stated that after lodging the claim with our office, the insurer sent a letter dated 31.8.10 asking her to produce the prescription / advice of the doctor clarifying the need for surgery as an in-patient.

The insurer stated that the claim was first repudiated by their claim processing Divisional Office on the ground that the surgery was for placing

cochlear implants in the ear and so it fell under policy exclusion 4.6. The same was communicated to the Divisional Office of the complainant vide their rejection letter dated 11.3.2010.

On seeking review by the complainant, the matter was referred for medical opinion of their TPA and it was opined by their doctor that the claim fell under policy coverage but it was only an OPD procedure. The insurer stated that they sought clarification from the complainant to produce medical certificate / prescription from the treating doctor advising for surgery and need for hospitalization. They further stated that due to non-compliance for the above by the complainant, the claim was pending.

ORDER

It is stated by insurer that the claim is pending for settlement for compliance by the complainant to clarify the need for in-patient treatment. The insurer was rather late in asking for such confirmation. The TPA doctor, who appeared as the insurer's witness, confirmed that the surgery required in-patient treatment. The insurer's representative was asked if the insurer invoked the condition requiring hospitalization of 24 hours or more.

He stated that this was not raised by the insurer. The hearing conclusively established that the complainant's husband underwent a surgery which was covered under the policy.

In view of the above, it was held that the insurer delayed settlement of the claim for specious reasons. the insurer is directed to settle the claim for the processed claim amount of Rs.52,136/- [inclusive of post hospitalization expenses].

The complainant preferred the claim on 26.10.2009 and it was received by the insurer on 1.11.2009. Till 11.3.2010, there was no communication from the insurer to the complainant. Only after lodging a complaint with this office, the insurer began to act. It is clear that the insurer delayed settlement of the claim for too long. The insurer is directed to pay interest @ 8% on Rs.52136/- from 1-12-2009 till the date of payment of the amount to the complainant.

In the result, the complaint is allowed for Rs.52136/- together with interest @ 8% thereon.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.03.272.2010-11

Dr. SS Gupta Vs. National Insurance co. Ltd.

Award No:G-113/11.10.2010

Dr. S.S. Gupta proposed his family under Group Mediclaim Policy, issued by the insurer to Vijaya Bank Credit Card Holders and is being covered under the policy from 2005. The cover under the policy was renewed from 1.1.10 to 31.12.10 for floater sum insured limit of Rs.4.00 lakhs. Dr. S.S. Gupta's wife, Mrs. Usha Gupta, underwent treatment for 'Bilateral Osteoarthritis-Grade III' at BSF Health Care by Quantum Magnetic Resonance Therapy from 21.5.10 to 10.6.10 and preferred a claim on TPA / the insurer for expenditure incurred. The TPA / insurer rejected the claim quoting policy exclusion clause 4.13. Aggrieved, Dr. S.S. Gupta filed this complaint for redressal.

The complainant stated that his wife first had consultation with M/s SBH Health Care on 27.4.10 and planned for QMR therapy and sent pre-

authorization request letter to TPA on 30.4.10 for approval of treatment along with Kolkata Insurance Ombudsman award copy which allowed the treatment under Mediclaim policy. He also sent e-mails to the TPA and the insurer for authorization and confirmation for treatment but there was no response. He stated that, on his telephonic enquiries, he was told by the TPA Officials that SBH Health Care was not a network hospital and so he was advised to make a reimbursement claim. He further stated to have followed up the matter with the TPA continuously and before commencement of treatment he sent once again pre-authorization request letter as per the TPA's directions. He stated that, on 20.5.10, one of the TPA call centre officials asked him to go ahead with the treatment even without authorization and claim reimbursement. The complainant stated that as per the guidelines of the insurer on TPA services, the TPA had to send regret letter for any rejections within 7 days but he had not received any rejection letter for two pre-authorization requests sent by him. In the absence of regret letter and basing on call centre official's information, he assumed that his request was accepted by the TPA and so his wife underwent

treatment. Later on, the TPA rejected the claim under policy exclusion and appeal was also rejected by the insurer quoting the same exclusion. The complainant stated that basing on decision of the Insurance Ombudsman, Kolkata, other nationalized insurance companies settled the claims and hence National Insurance Co. Ltd. should also settle the claim.

The insurer contended that the claim of complainant was repudiated by them on the following grounds:

- The policy allowed hospitalisation expenses for treatment at a hospital as an in-patient. M/s SBF Health Care was not falling under the policy definition given for "Hospital/Nursing Home".
- Procedure / Treatment done on OPD was not payable under the policy
- Policy exclusion 4.13 excluded Magneto-Therapy treatment.
- Policy exclusion 4.23 excluded Outpatient diagnostic / medical treatment.

In their Self Contained Note, the insurer further stated that QMR therapy was not payable and pre-

authorization request was rejected by the TPA before commencement of treatment and no confirmation was given to the insured about admissibility of treatment by any person. The insurer, therefore stated that the claim was rejected by them on valid grounds and policy exclusions.

ORDER

One of the key conditions of the policy is that hospitalization for a period of more than 24 hours. On a careful consideration of the circumstances of the case and the literature available on Cytotron Therapy, Ombudsman was convinced that Cytotron Therapy treatment that the complainant's wife underwent did not require in-patient hospitalization. It was held that even if the condition of the complainant was debilitating at the time she was taken to the centre, the treatment did not require hospitalization. The treatment that the complainant's wife took, for which the claim was made, therefore, did not comply with the policy requirement of minimum 24 hours hospitalization. The complainant's plea that RFQMR treatment has to be reckoned as advancement in medical technology also cannot be accepted since hospitalization is ***sine qua non*** even in such cases. RFQMR treatment does not require hospitalization for any length of time. It was held that the insurer was justified in rejecting the claim.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD)) G -11.19.302.2010-11

Shri Manjunath Udyavar Vs Apollo Munich Health Ins.Ltd.

Award No:G-120/12.10.2010

Sri Manjunath Udyavar, an employee of M/s POS Merchant Solutions Pvt. Ltd., was covered along with his family members for CSI of Rs. 1.00 lakh under Group Mediclaim Policy taken by the employer from the insurer. Sri Manjunath Udyavar preferred a claim on the insurer for his son's treatment of adenoidectomy. The insurer rejected the claim on the ground of PED. Representation made to review the decision was also not considered. Aggrieved, Sri Manjunath Udyavar filed the complaint for redressal.

The complainant stated that his son was admitted for nasal obstruction, snoring and decreased hearing. He was treated conservatively in the hospital during a day's stay at the hospital and he underwent surgery. Sri Manjunath Udyavar preferred a claim on the complainant stated that the insurer's rejection was based on a prescription dt. 12.1.2009 which had no relevance to the present illness and the disease was not pre-existing. The complainant, therefore, stated that rejection of the claim by the insurer was unjustified.

The insurer stated that the complainant was covered under a Group Mediclaim Policy, along with his family members, through his employer and the policy specifically excluded all pre-existing diseases. The complainant's son was treated for chronic adenoid hypertrophy with bilateral secretory otitis media for which he underwent Bilateral Myringotomy with

Grommet insertion with adenoidectomy. The discharge summary suggested that the patient was under medication for treatment of Otitis Media for chronic adenoids, well before the commencement of the policy, and it was supported by prescription of the patient dated 12.1.09. The insurer further contended that on scrutiny and careful evaluation of the discharge summary and the prescriptions dated 12.1.09, 5.11.09 and 22.12.09, it transpired that the treatment and hospitalization was for a pre-existing ailment which was hit by the exclusion clause under sect. 2 [d] of the policy and so the claim was rightly denied.

ORDER

The policy issued by the insurer excluded all pre-existing diseases. The complainant's son was suffering from "Otitis Media". The medical papers produced state that the said illness was chronic. The complainant, therefore, preferred a claim for an ailment which existed before commencement of the policy and so the treatment related to a pre-existing disease.

Since the treatment related to PED, it was held that the insurer rightly rejected the claim.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.03.239.2010-11

Smt. G.S GeethaVs National Insurance Co.Ltd.

Award No:G-124/11.10.2010

Smt. G.S. Geetha along with her husband was covered under Dhanvanhri Bhima Mediclaim [Group] policy, through M/s State Bank of Mysore, issued by the insurer for the period from 1.1.10 to 31.12.10 for SI limit of Rs. one lakh per family. She stated that due to fever on and off, she consulted her doctor and underwent different investigations and tests. She also underwent ERCP procedure as day care and preferred claim on the insurer. The insurer rejected the claim on the ground of PED. Her representation seeking review of the decision was also rejected by the insurer. Aggrieved, Smt. G.S. Geetha filed this complaint seeking redressal of her grievance.

The complainant stated that her gall bladder was removed during 2005 and she did not any complaints relating to gall bladder. She suffered from fever frequently and her doctor put her through investigations. He suspected stone formation in bile duct. She was referred to the Gastroenterologist who further conducted medical tests and advised her to undergo ERCP procedure immediately. She underwent the same for removal of stones in Common Bile Duct [CBD] and preferred the claim on the insurer. The TPA rejected the claim as PED. She obtained a medical certificate from the treating doctor stating that the present ailment was not related to any PED and it was a new illness. In spite of submitting the doctor's certificate, neither the TPA nor the insurer settled the claim.

The insurer contended that the complainant was first covered under their group mediclaim policy from

1.1.09 and she preferred a claim on the second year policy with them. She preferred a claim for removal of calculus in common bile duct on OPD basis and it was rejected by the TPA. The insurer also concurred with the TPA's decision on the grounds that –

- The ailment was diagnosed as 'post cholecystectomy on & off fever' in pre-authorization request from the hospital.
- The complainant underwent cholecystectomy during 2005 and the present illness was a complication of cholecystectomy.
- The doctor certified that the retainer stones secondary to gall bladder form after 2 to 3 years.

The insurer stated that the calculus in CBD were gall bladder stones and this was a complication / related to cholecystectomy which the complainant underwent during 2005. Therefore, the ailment fell under policy exclusion clause 4.1. The insurer contended that their repudiation was on justifiable grounds as per the policy terms and conditions.

ORDER

The complainant contended that the ailment cannot be treated as PED and in support thereof she obtained the treating doctor's certificate. The insurer and the TPA

contended that their rejection of claim as PED was justified and that all PEDs are covered only after three claim free years whereas the claim was preferred by the complainant on second year policy.

The insurer relied upon policy exclusion for denying the claim. Clause 4 of the policy contains exclusions. The exclusion relevant exclusion is sub-clause 4.1. Clause 4 insofar as the same is relevant is reproduced hereunder:

> *"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:*
> *"4.1 All diseases/injuries which are pre-existing when the cover incepts for the first time. The exclusion will be deleted after three consecutive continuous claims free policy years in respect of all diseases provided there was no hospitalization for pre-existing ailment during such three years of insurance."*

The aforesaid exclusion applies in respect of all diseases/injuries which are pre-existing when the cover incepts for the first time. Therefore, the essential condition is the existence of the disease when the policy incepts.

The question is whether the stated disease existed when the insured obtained the policy on 1.1.09 when the complainant was first covered under their group mediclaim policy. The complainant underwent cholecystectomy during 2005. The insurer held that the present illness was a complication of cholecystectomy. The complainant stated that the treating doctor commented that this type of CBD calculus might form one in 10000 cases after 2 to 3 years and that the complainant's present ailment was a new formation of calculus in CBD. The TPA doctor stated that there was no definite period specified in any medical books/journals that post cholecystectomy stones in CBD would form within so many months or years. In other words, the insurer and the TPA doctor admitted that the complainant's illness was a complication of cholecystectomy but such complication has surfaced now and not within 2 to 3 years. This analysis still falls short of the requirement for denial of the claim. Clause 4.1 entitles the insurer to deny the claim only if the disease existed when the policy was taken. The insurer has no evidence in support of the assumption that the complainant suffered from the stated disease when the policy first incepted.

In view of the above, he find that the insurer incorrectly pressed exclusion clause for denying the claim of the complainant. It was held that exclusion under clause 4.1 does not apply to the case of the complainant. the insurer is directed to admit the complainant's claim and make payment to the complainant subject to deductions and

ceiling, if any, under the policy together with interest @ 8% on the amount payable from 1-5-2010 till the payment of the amount to the complainant.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.196.2010-11

Sri Patta Veerraju V/s United India Ins. Co.Ltd.

Award No:G-127/25.10.2010

Sri P. Veerraju, retired employee of M/s SAIL, covered along with his spouse under Group Health Insurance Policy taken by M/s SAIL to their retired employees with the insurer's Delhi Office. He preferred a claim on the insurer for in-patient treatment taken by him for 'Perianal Abscess with Fever' from 13.3.2009 to 20.3.2009 at H.R.K. Hospital, Visakhapatnam. The hospital being a non-net work hospital, he submitted reimbursement claim for hospitalization expenses of Rs.18068/-. The TPA rejected the claim stating that the hospital was not a recognized hospital and it did not fall under the definition of 'Hospital' and that the 'Hospital' should have minimum 15 beds for admission of claim. Sri P.Veerraju stated that in emergency situations treatment taken at un-registered hospital also was admissible as per the policy guidelines and denial of the claim by the insurer was unjustified. Aggrieved, Sri P.Veerraju filed this complaint.

The complainant stated that by complying with the instructions given in the handbook on Mediclaim [2009], he had submitted the reimbursement claim to the TPA – MD India, Chennai within 30 days along with all the required claim documents and bills. The TPA sent a letter asking him to furnish the hospital registration number and the number of in-patient beds the hospital had. This was supplied to the TPA by obtaining a certificate from the hospital to the effect

that it had 10 beds with all the facilities like operation theatre, laboratory, x-ray, etc. He further stated that there was a stipulation under clause 9A-III for admission of claims when treatment was taken at un-registered hospitals in emergency situations. He stated that he was admitted on emergency at the hospital and he underwent treatment there. He contended that he was entitled to reimbursement of the claim under the policy.

The claim of the insured person was denied by their TPA – MDIndia- invoking policy clause '6.a' which provided the definition of Hospital/Nursing Home. The insured person underwent treatment for 'perianal abscess with fever' at HRK Hospital, Visakhapatnam. The hospital confirmed that it had only 10 beds. The requirement under the policy was minimum 15 beds and so it fell out-side the scope of policy. The claim was denied by the TPA and concurred by them.

ORDER

The insurance policy between the insurer and the insured person represents a contract between the parties. The terms of the agreement have to be strictly construed to determine the extent of liability of the insurer. The insured person has to follow the terms of contract expressly set out therein in order to claim a benefit under the policy. The hospital where the insured person/complainant underwent treatment did not qualify to be a Hospital / Nursing Home as per the policy issued by insurer. The complainant also failed to comply with clause 9A-III of the policy.

In view of above, it was held that the insurer rightly rejected the claim.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.03.216.2010-11

Sri Chandresh V Davey V/s National Insurance Co. Ltd.

Award No:G-128/25.10.2010

Sri Chandresh V Davey covered his family under the insurer's Family Floater mediclaim policy through Bank of India, Vijayawada with sum insured limit of Rs.5 Lakhs. He felt uneasiness in breathing and chest pain one day before his hospitalization at Purna Heart Institute and admitted with complaints of exertional breathlessness on 4.5.2009. He underwent Coronary Artery Bypass Grafting surgery on 7.5.2009 and he was discharged on 14.5.2009. He submitted all the relevant bills and reports to the TPA for settlement of claim for Rs.1,79,174/-. The TPA asked him to submit the original discharge summary which he submitted. Subsequently, the TPA asked the insured person to submit an affidavit confirming that he had not preferred any claim with any other insurer. He submitted this as well. Yet, the TPA did not settle the claim. The Insured sent a legal notice to the insurer and the TPA. This also did not elicit any reply. Aggrieved, Sri Chandresh V Davey filed this complaint.

The complainant stated that he had mediclaim policy earlier with United India Insurance Co. Ltd. for several years. He shifted to the present insurer consequent upon his financing bank, i.e. Bank of India, becoming the corporate agent of the present insurer. He stated that he had no health problem earlier and his hospitalization was due to sudden onset of disease. He stated that he was admitted at Purna Heart Institute, Vijayawada in emergency condition. The hospital issued

certificate clearly stating 'emergency condition on admission' which was also sent to the TPA / Insurer for settlement of the claim. He claimed to have sent reports of his medical check on 14.3.2009 which did not reveal any heart problem.

The insurer contended that the claim was processed by their TPA and called for certain claim documents. The complainant did not comply. The insurer sent instructions to the TPA to pursue the matter with the complainant and to process the claim at the earliest.

O R D E R

The hospital discharge summary recorded that the complainant is a known case of Coronary Artery Disease with chronic stable angina and on medication for diabetes which is under control. The complainant shifted the policy with break in renewal. Thereby he lost the coverage / benefit for all pre-existing diseases. Due to shifting and the break, the present ailment of the complainant fell under policy definition of Pre-existing disease. As per clause 3.5, pre-existing disease is a disease which existed when the policy incepts, whether or not the policy holder is aware of the disease. Coronary artery complication would not arise in a matter of a few days. The problem must have existed for a long time even though the complainant had not noticed it. The insurer is directed that the complainant's claim related to a PED. Following this, rejection of the claim by the insurer under policy exclusion 4.1 needs no intervention.

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

COMPLAINT No. I.O.(HYD) G -11.04.283.2010-11

Sri M Mallikarjuna Rao V/s
United India Ins. Co Ltd.

Award No:G-131/25.10.2010

Sri M. Mallikarjuna Rao, an employee of Sangam Dairy, was covered under group hospitalization policy taken by their union – Guntur Dist. Milk Producers Mutually Aided Co-op. Union Ltd., Vadlamudi – with the insurer covering spouse and two dependent children, for sum insured limit of Rs.one lakh per family, on floater basis. He underwent bypass surgery at Manipal Super Specialty Hospital, Tadepally on 28.7.2008 and submitted claim for Rs.107027/-. The claim was settled by the insurer imposing restriction / limitation as per condition / clause 1.2[F] of the policy for Rs.70,000/-. He represented to the insurer against imposition of the restriction on policy coverage through the employer. The employer also took up the matter with the insurer stating that there were no restrictions while the policy was bought. Yet, the insurer rejected the claim. Aggrieved, Sri M. Mallikarjuna Rao filed this complaint.

The complainant stated that his hospitalization claim was short settled by the insurer. He stated that the policy coverage was for Rs.one lakh while the insurer settled the claim for Rs.70,000/- as against his hospitalization expenses of Rs.1,07,027/-. The claim was short settled by the insurer by Rs.30,000/- by imposing a restriction which did not find place in the policy. He, therefore, stated that the short-settlement was unjustified.

The insurer stated that the insured person / complainant was covered under the Group Mediclaim Policy issued by them. He preferred a claim on the

policy for liver disease on 5.8.2008 and it was settled by them for Rs.8600/-. He preferred another claim for heart surgery and this claim was restricted to 70% of SI as per group hospitalization policy under clause 1.2 [F] due to cap/sub-limit for each of the specified treatments and paid Rs.70,000/-. The insurer stated that for the balance amount of Rs.21,400/-, the complainant was entitled to claim during the policy period for any other ailment suffered by him. The insured was informed and appraised of the current policy coverage at the time of renewal and their settlement, as per policy terms and conditions, was in order. They requested for absolving them of any further liability.

ORDER

The complainant who was privy to the discussions which his Union had with the insurer stated that there were no restrictions under the policy. The insurer, however, stated the contrary and insisted that the policy issued contained restrictive clauses. I cannot undertake a review of the discussions which preceded issue of the policy. I also have no capacity to rewrite the policy for the policy holder. That being so, I have to confine myself to an examination of the policy issued and to state whether the terms of the policy permitted the insurer to restrict the hospitalization expenses incurred by the complainant. In other words, I can only adjudicate whether or not the claim has been settled in accordance with the policy issued.

There is no doubt that the insurer issued the policy document to the complainant's employer. The policy document clearly stipulated that the policy was subject to the attached terms and conditions. If the insurer failed to supply the said terms and

conditions, the insured had the right to ask for the same. The insurer's failure to supply the terms and conditions, however, did not imply that the policy cover was not subject to any conditions.

The terms and conditions of the health insurance policy issued restricted the liability of the insurer for major surgeries to 70% of SI. The insurer met the liability as specified in the policy while settling the claim. The contention of the complainant is that since the insurer had settled the claims of a few other employees for 100% of SI limit and that a similar dispensation should be meted out to him. This cannot be accepted for the other cases are not known to me and further a wrongful admission does not entitle admission of other wrongful claims as well.

In view of the above, it was held that the insurer settled the claim in accordance with the terms of the policy. Since there is no infirmity in the decision of the insurer, it was decline to interfere with the decision of the insurer.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.345.2010-11

Smt. C. Mani Malini V/s New India Assurance Co. Ltd.

Award No:G-146/16.11.2010

Smt. C Mani Malini, working as Assistant in LIC of India, was covered under Group Mediclaim Policy taken by her employer with the insurer. She was suffering from High Myopia in her both eyes. She preferred a claim on the insurer for reimbursement of hospital expenses incurred by her at 3 monthly intervals for administration of Avastin injection for treatment of CNVM [Choroidal Neo Vascular Membrane] in her right eye. The insurer rejected the claim. She made an application for review and it was also rejected by the insurer. Aggrieved, Smt. Mani Malini filed this complaint.

The complainant stated that for treatment of decreased vision and floaters in her right eye which

was diagnosed as Myopic CNVM, the doctor administered three Intra-Vitreal-Avastin injections to her eye at monthly intervals. The treating doctor stated it as a surgical procedure and was done in the Operation Theatre. The reimbursement claims were rejected by the insurer quoting guidelines/ circular issued by their HO. She stated that this circular did not form part of the policy. She stated that the rejection was unjust.

The insurer stated that as per guidelines / instructions given by their HO vide Circular No. HO/Health/04/2009 Dt. 9.2.2009, the reimbursement claims of the insured person were repudiated. The insurer stated that for Age Related Macular Degeneration [ARMD] drugs like Avastin or Lucentis or Macugen and other related drugs were given as intravetral injection. It was an OPD treatment though this injection was given in the Operation Theatre. In view of the nature of the treatment, it fell outside the scope of health policies. Accordingly, the reimbursement claims of insured person were denied.

ORDER

Insurance is a contract between the parties, the terms and conditions of which bind the parties equally. The group policy issued by the insurer to the employees of the LIC did not contain exclusion of Avastin injections. The insurer's representative stated

that the insurer issued a circular providing for exclusion of Avastin. Since he did not have a copy of the amended policy/ MOU, he was asked to provide a copy of the same within a week failing which it would be construed that the policy did not exclude Avastin. The time allowed has since expired and there has been no communication from the insurer on the issue so far. In the circumstances, it was presume that the insurer did not amend the policy. Following this, it was held that the policy for the period from 1.4.2009 to 31.3.2010 did not contain any exclusion of Avastin.

In view of the above, the insurer is directed to admit the claim of the insured person as per terms and conditions of MOU. The admissible claim amount was worked out by the insurer for Rs. 29364/- [Rs.2700/- was deducted for non-admissible amounts] for all the three claims put together. Further, the insurer delayed inordinately in processing the claim. The insurer is directed the insurer to pay interest @ 8% from 1.8.2009 till payment of the claim of Rs.29,364.

In the result, the complaint is allowed for Rs.29,364/- together with interest @ 8% thereon from 1.8.2009 till the date of payment.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.413.2010-11

Sri BGR Kamath V/s United India Insurance .Co Ltd.

Award No:G-147/15.11.2010

Sri B.G.R. Kamath took the insurer's Can comfort policy covering himself and his wife for SI limit of Rs.1.00 Lakh each from 1.1.2005 to 31.12.2005. The policy was continuously renewed without any break till date. He preferred a claim for reimbursement of hospitalization expenses incurred for treatment of his wife at Columbia Asia Hospital, Bengaluru from 5.6.10 to 12.6.10. She was hospitalized with the chief complaint of vomiting because of which she became very weak and drowsy. The hospital diagnosed her case as severe Hyponatremia – Thiazide + Vomiting induced with secondary diagnosis of DM, HTN. The TPA and the insurer rejected the claim as PED basing on the noting of Discharge Summary. Aggrieved, Sri B.G.R. Kamath filed this complaint.

The complainant stated that his genuine claim was rejected by TPA/Insurer as PED erroneously. He stated that they were Senior Citizens and his wife was hospitalized in an unconscious state. The diagnosis was that the sodium levels in her body had reached perilously low levels. He stated that they had insurance cover from 1999 continuously and at that time his wife was not suffering from DM or HTN and so to treat the present hospitalization as PED condition did not look right. The claim was further denied on the ground that "the adverse effect of the drug which is advised towards pre existing illness will not be paid." He stated that the drug was used as advised by a qualified MD doctor of renowned hospital – The Mallaya Hospital, Bengaluru – and also stated that a copy of the prescription was sent to TPA/Insurer for reviewing the case. He stated that the denial of the claim was unjustified.

The insurer contended that the complainant and the insured person were covered under Group Mediclaim Policy issued by them to Canara Bank Credit Card holders. The policy was issued by them from 2005 and the insured persons were covered under the policy from then onwards continuously till

date. The insured person was admitted in the hospital with complaints of vomiting and their relatives attributed this condition to the consumption of Tablet GAITY for UTI. The doctors diagnosed the cause for present illness as severe "Hyponatremia". It was stated in the Discharge Summary that the insured person was suffering from HTN & DM for the past 15 & 7 years respectively. The present illness was a complication of HTN & DM and they were pre-existing when the cover incepted for the first time with the Company and so the claim was rejected as per policy condition 4.1. correctly by the TPA and the insurer also upheld its decision. The insurer contended that their repudiation was in order as per the policy terms and conditions.

O R D E R

The insurer rejected the claim of the complainant on the ground that the present illness was a complication of PED. The complainant proved that he had continuous coverage under the Can Bank mediclaim policy continuously from 1999. The Bank changed the insurer from previous 'New India Assurance Co. Ltd.' to the present insurer 'United India Ins. Co. Ltd.' from 2005. The insurer / TPA rejected the claim quoting policy exclusion 4.1 which read as under:

> *All illness/disease/defect/injuries which are pre-existing, when the cover incepts for the first time. For this purpose the policy commencing from a date after a break in earlier policy, either with this company or any other insurance company in India, will be treated as a fresh policy and illness/disease/defect/injury contracted during earlier policy period or break period will be treated as pre-existing and will be excluded from scope of cover.*

The insurer / TPA rejected the claim without calling for the details of the previous insurance from the complainant though he had declared that he had insurance cover from 1999. Exclusion under 4.1 of the policy applies only to pre-existing disease, illness or defect or injury. The insured person did not get treated for any pre-existing disease, illness or defect or injury. The insured person was admitted in the hospital for dehydration and loss of salts. This problem had no antecedents and it cannot be equated with a known disease or illness. Also, since the insured person was covered continuously since 1999, the present insurer cannot cite PED for exclusion.

In view of above, it was held that the insurer erroneously repudiated the claim. The insurer is directed the insurer to allow the claim after deducting inadmissible and non-medical expenses billed / claimed, if any, as per the policy. The complainant claimed compensation for mental agony which is not allowed.

In the result, the complaint is allowed in part.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.004.411.2010-11

Shri D. Raja Reddy V/s United India Insurance .Co Ltd.

Award No:G-148/16.11.2010

Sri D. Raja Reddy along with his wife and children was covered under AB Arogyadan Group Mediclaim Policy issued by the insurer for Andhra Bank Account holders for a sum insured limit of Rs.2.50 Lakhs for the period from 6.3.2010 to 5.3.2011. It was a second year policy with the insurer. He was hospitalized at Yasoda Hospital, Hyderabad from 27.3.2010 to 1.4.2010 with complaints of chest pain on and off for two days before admission in the hospital. On investigations, he was diagnosed as "CAD: Acute Coronary Syndrome, CAG: Two Vessel Disease [OM & OLV]". He was treated for the same. He preferred a claim on the insurer for the expenses incurred. The claim was rejected by the TPA citing PED as the reason. Sri D. Raja Reddy submitted a detailed explanatory letter to the insurer seeking review of the decision of TPA. Still the insurer upheld the decision of the TPA. Aggrieved, Sri D. Raja Reddy filed this complaint.

The complainant stated that he was admitted in Yasoda Hospital, Hyderabad on 27.3.2010 when had chest pain. Pre-authorization request sent by the hospital was denied by TPA. On enquiring for the reasons for denial of cashless facility, the TPA stated that the treating doctor stated in pre-authorization request and in the case sheets that the complainant was suffering from HTN for the past 2 years. He stated that he was asked to submit reimbursement claim. He stated he was in good health without any BP or DM. He stated that his claim for Cataract Operation, which he underwent on 14.3.2010, was paid by the TPA. The complainant stated that on taking up the matter with the treating doctor, he corrected the mistake by giving a certificate that the complainant was not having any HTN. Even after submission of the certificate, the claim was denied by the insurer. He pleaded that for the mistake committed by the doctor, he should not be penalized by the insurer.

The insurer stated in their Self Contained Note that the insured person preferred a claim for heart disease on second year policy and the medical team of TPA denied the claim on the ground that the present hospitalization was for a PED. The insured person was

suffering from HTN since 2 years as per the noting of treating doctor. It was also specified in the Indoor Case Sheets of the hospital that the patient was a k/c/o HTN for 2 years. The insured person submitted a certificate from the doctor which stated "insured person was not his regular patient and no previous medical history was available". This certificate did not say that the insured person had no HTN. The insurer stated that the case records also showed high BP readings and with such history of high BP only the ailment would have developed gradually. The present hospitalization was for an ailment which was primarily due to Hypertensive condition, which had existed before the commencement of policy. The treatment undertaken, therefore, was for a PED. The claim was rejected as per policy exclusion 4.1. The insurer stated that the claim of the insured person / complainant was rejected as per the terms and conditions of the policy and prayed for absolving them of any liability.

ORDER

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. The hospital record repeatedly states that the complainant was k/c/o HTN for two years. In hospital progress sheet also noted HTN +ve against history of present illness. It also

records that he was taking Aten 50 mg for HTN. The complainant stated that the record was untrue. This cannot be accepted. The hospital cannot be accused of noting down the medical history of the patient incorrectly. The doctors cannot be accused of having any vested interest. Further, the certificate obtained by the complainant from the treating doctor does not help the complainant. It only states that the treating doctor had not treated him earlier. Further, the notings in the case sheets of the complainant have to be read together. It cannot be that some notings were correct while the rest were not. When read in totality, the veracity of the hospital record cannot be questioned. Moreover, the complainant was diagnosed to have been suffering from CAD: Acute Coronary Syndrome. This is associated with HTN only. The CAD of such magnitude could not have arisen in a matter of a few months.

In view of the above, it was held that the insurer rightly relied upon the medical record in concluding that the complainant was HTN + ve even while he obtained the policy. Thus, the insurer had valid reasons for repudiating the claim of the complainant. Following this, I uphold the decision of the insurer.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.004.258.2010-11

Smt. Y Krishna Kumari V/s United India Insurance Co. Ltd.

Award No:G-150/16.11.2010

Smt. Y. Krishna Kumari was covered under AB Arogyadan Group Mediclaim Policy from 28.11.2007 and it was continuously renewed without any break till date. She was hospitalized at Care Hospital, Hyderabad on 27.1.2010 with the complaint of chest discomfort and palpitations since one hour and history of breathlessness. Her illness was diagnosed as CAD – ACS Unstable Angina, Trop T-Positive – BKGD Hypertension, DM, and CAD-USA [2005] Cervical Spondylosis during the hospitalization period from 27.1.2010 to 29.1.2010. Pre-authorization request was denied by the TPA. On seeking reimbursement claim, the TPA asked for past history of HTN & DM with previous treatment records. She furnished the details. The TPA rejected the claim as PED. She

filed an appeal to the insurer and it was also turned down. Aggrieved, Smt. Y. Krishna Kumari filed this complaint.

The complainant stated that her claim was denied by the insurer stating that she was suffering from HTN & DM prior to the first policy taken with them. She claimed that she was not suffering from HTN and it was detected during February 2009 only. The hospital records of Swathi Diabetic Clinic were sent to TPA which showed first detection of HTN & DM by Dr. Madan Gopal Kotla for reviewing her case and admission of claim. She stated that the TPA/Insurer rejected her claim erroneously and requested for passing favourable orders.

The insurer in their Self Contained Note stated that the insured person / complainant preferred a claim for heart disease on 3rd year policy with them. The pre-authorization was denied by TPA on noting of the doctor that she was a k/c/o DM – 2 years, HTN – 5 years & Heart Disease – since 2005. The discharge summary of the hospital stated her final diagnosis as – CAD – ACS unstable Angina, Trop-T Positive and Better Known General Diagnosis [BKGD] as – HTN+, DM+, CAD-USA [2005], Cervical Spondylosis. The insurer stated that the complainant / insured person

was a known case of CAD & HTN before the commencement date of first policy with them and so the claim was rejected as PED as per clause 4.1 of the policy.

O R D E R

The complainant contended that the ailment cannot be treated as PED and in support thereof she submitted her medical records of Swathi Diabetic Clinic headed by Dr. Madan Gopal Kotla. The insurer and the TPA contended that their rejection of claim as PED was justified and that all PEDs are covered only after three claim free years whereas the claim was preferred by the complainant on third year policy.

The insurer relied upon policy exclusion for denying the claim. Clause 4 of the policy contains exclusions. The relevant exclusion is sub-clause 4.1. Clause 4 insofar as the same is relevant is reproduced hereunder:

> *"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:*
> *"4.1 All diseases/injuries which are pre-existing when the cover incepts for the first time. The exclusion will be deleted after three consecutive continuous claims free policy years in respect of all diseases provided there was no hospitalization for pre-existing ailment during such three years of insurance."*

The aforesaid exclusion applies in respect of all diseases/injuries which are pre-existing when the cover incepts for the first time. Therefore, the essential condition is the existence of the disease when the policy incepts.

The question is whether the stated disease existed when the insured obtained the policy on 28.11.2007 when the complainant was first covered under the group mediclaim policy. The complainant underwent treatment for CAD during 2005. The insurer held that the present illness was a complication of / associated to CAD. Clause 4.1 entitles the insurer to deny the claim only if the disease existed when the policy was taken. The insurer relied on the evidence of the hospital record for existence of CAD prior to inception of the first policy with them in support of PED.

In view of the above, it was held that the insurer rightly repudiated the claim under Exclusion 4.1 of the policy. The insurer is directed uphold the decision of the insurer.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.002.230.2010-11

Smt. P. Lakshmi V/s New India Ass.Co.Ltd.

Award No:G-152/18.11.2010

Smt. P. Lakshmi is covered under the group Mediclaim policy obtained by her employer, the LIC of India, from New India Assurance Company Ltd. She preferred a claim for reimbursement towards an emergency surgery performed on her for termination of pregnancy on 7.2.2010 as she was diagnosed with ectopic pregnancy. The claim under the Mediclaim group policy was rejected by the TPA under policy exclusion clause 5.16.3 treating the same as maternity related surgery. Aggrieved, Mrs. P .Lakshmi filed this complaint.

The complainant stated that she has two living children and she underwent tubectomy in the year 2004. Yet, she developed ectopic pregnancy. Ectopic pregnancy was a rare phenomenon under which pregnancy gets formed in fallopian tube. It could be life threatening if surgery was not performed on priority basis to avoid rupture of the tube. In order to save her life, the doctors performed emergency surgery for termination of unwanted pregnancy. The insurer rejected her claim on the ground that the said surgery related to maternity and since she has two surviving children, she was not entitled to expenses relating to

third pregnancy. She contended that the insurer erred in treating the surgery as one of maternity.

The insurer contended that the complainant was covered under group Mediclaim policy under which pregnancy related claims were admissible for the first two children only. The insured person had two living children and since the surgery underwent by the complaint fell under pregnancy clause, they had to reject the claim as per clause 5.16.3 of the policy. The insurer stated that the claim was repudiated as per the policy/MOU.

ORDER

The insurer contended that repudiation of the claim was justified in terms of clause 5.16.3 of policy. Sub-clause 5.16 relates to "Special conditions applicable to maternity expenses". Item 3 of sub-clause 5.16 of the policy is reproduced hereunder:

> *"claims in respect of delivery for only first two living children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any renewal thereof. Those insured persons who are already having two or more living children will not be eligible for this benefit ,even if they have not claimed for their earlier confinements.''*

Exclusion under sub-clause 5.16 could be pressed into service in cases of maternity expenses. If the expenses relate to maternity, then item 3 under sub-clause 5.16 can be invoked. Therefore, in the impugned case, it is necessary to first examine if the expenses incurred by the complainant related to maternity and if the answer to this is in the affirmative, then examine whether the said expenses are excluded under item 3 of the said sub-clause.

Maternity presupposes a condition whereby the woman prepares herself to become a mother. If a woman has undergone tubectomy, medically she is free from conception. So, the question of a woman claiming maternity expenses in such a case does

not arise. In freak cases, however, if the woman still conceives, it is known as ectopic pregnancy which is a result of failure of tubectomy. Such pregnancy does not lead to maternity. Instead, it calls for surgical intervention failing which the fallopian tube where the pregnancy occurred could burst and endanger the woman's life.

The complainant had ectopic pregnancy. The doctors performed emergency surgery for termination of unwanted pregnancy. This surgery was performed in order to save her life and not for the purpose of delivery of a child. It also was not a case of abortion. Since this was not a case of maternity, sub-clause 5.16 of the policy cannot be invoked against the complainant. Further, item 3 of the said sub-clause also cannot be invoked against the complainant since the expenses did not relate to delivery of a child or operations associated therewith.

In view of above, it was held that the policy did not exclude the expenses claimed by the complainant. The insurer is directed to pay the claim, subject to deductions, if any, applicable under the policy/MOU.

In result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.289.2010-11

Sri Kurian George V/s New India Assurance Co.Ltd

Award No:G-161/21.11.2010

Sri Kurian George and his wife were covered under the Group Mediclaim Policy taken by the LIC for their retired employees. He was covered under the policy for SI limit of Rs.80,000/- basing on his cadre at the time of retirement on 31.3.2003. He opted for enhancement of SI limit from Rs80,000 to Rs.2.00 lacs in February 2009 for the policy period from 1.4.2009 to 31.3.2010. His wife developed some problem of menopausal bleeding in August 2009 and she underwent POP smear test on 31.8.2009. Subsequently, after a series of blood tests, she was advised to undergo DNC. The problem persisted and

she underwent TAH on 8.12.2009. On HPE, it was diagnosed that she was suffering from "Carcinoma Endometrium" and thereafter she took further treatment of radiation. The total expenses incurred amounted to Rs.2,11,651/- but the insurer settled the claim for Rs.80,000/- only, i.e. original cadre eligibility sum insured limit. Aggrieved, Sri Kurian George filed this complaint.

The complainant stated that due to advancing age, he exercised his option for enhancement of SI in February 2009. The problem of his wife started during August 2009. He totally denied the contentions of the insurer that he was aware of the disease and his exercising of option was pre-planned for the treatment of his wife's disease. He stated that the insurer was wrong. He further contended that on examining the medical reports it can be known that the beginning of problem was from August 2009 only.

The insurer contended that the insured person / complainant did not exercise his option given to all the retired employees at the time of their retirement for enhancement of sum insured and continued from 2003 to 2009 with same SI limit. He exercised the option for the policy period from 1.4.2009 to 31.3.2010. The insurer further stated that at the time of enhancement, a declaration from the retired employee was obtained about the terms and conditions

for optional enhanced SI limit. The policy stipulated the following condition 2.A. for optional increase in SI:

> *"However, if it is found that the sum insured has been optionally increased to take care of a disease or for a planned surgery, the claim will be settled only up to the basic sum insured during the policy period. The decision of the Company will be final and binding."*

The insurer stated that the claim of the insured person was repudiated for optional enhanced SI limit basing on policy condition 2.A. rightly basing on the noting in the hospital records. The Insurer also relied upon the decision in Award No. I.O.(Hyd) G.23/2010-11 dt. 13.5.2010 where a similar complaint was dismissed by the Ombudsman.

O R D E R

In view of the above, I hold that the insurer has no evidence to disprove the claim The sum insured under the policy was Rs.80,000/- up to 2007-08 as per the retired employee's cadre eligibility. On renewal, he got it enhanced to Rs 2,00,000/- for the period 2009-10. The total cost incurred towards hospitalization on three different occasions during the policy period was Rs.2,11,651/-. The insurer settled the claim for Rs 80,000/- only on the ground that the enhancement was planned.

The insurer's reliance on Award No.G-23 dt 13.5.2010 is misplaced in that the facts were distinguishable. In any case, the decisions of the Insurance Ombudsman cannot be cited as precedents.

The insured person enhanced SI to Rs.2,00,000/- in February 2009. The complainant stated that his wife's problem was diagnosed in August 2009. The

question is whether the complainant could have anticipated the problem and enhanced SI limit to meet the medical expenses of his wife. None would wait for treatment of cancer until August if it was detected in February. Thus, I do not find any substance in the insurer's allegation that the enhancement was planned. Condition 2.A of the policy envisages the insurer to establish that the sum insured has been optionally increased to take care of a disease or for a planned surgery. The insurer has not produced any evidence to demonstrate that the insured person knew the existence of the disease or that he had planned a surgery when the enhancement was proposed. Merely stating that the insured person is affected by condition 2.A. would not be sufficient.

Of the complainant that his wife's medical problem was detected much after enhancement of SI limit. Following this, I uphold the contentions of the complainant. The insurer is directed to process the claim and pay as per revised sum insured limit under the policy.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G.11.03.311.2010-11

Shri. Anand Ramaswamy V/s National Insurance Co. Ltd.

Award No:G-163/22.11.2010

Shri Anand Ramaswamy was covered under Group Mediclaim Policy obtained by his employer, Bank of America. He was a known case of High Grade Myopia in his left eye with – 10 power. He underwent refractive surgery for the purpose of correction of eye sight and claimed expenses from the insurer. The insurer repudiated the claim citing clause 4.6 of the policy conditions. Aggrieved, Sri Anand Ramaswamy filed this compliant.

The complainant stated that in the absence of proper eyesight in his eye, he was partially blind and he managed to lead his life with great difficulty. He contended that as he was in dire need of the surgery, he had to undergo refractive surgery. He stated that the surgery he underwent could not be classified as cosmetic surgery.

The insurer submitted that in terms of clause 4.6 of the policy conditions, the claim under the policy was rightly repudiated.

O R D E R

The complainant had high myopia. He could not manage the problem with spectacles or contact lens. He had to go for refractive surgery. On perusal of the policy, I find that the surgery underwent by the complainant finds a place in the list of exclusions under item 4.6. There is no ambiguity in this behalf. Insurance policy is a contract, the terms of which bind the parties equally. Further, the terms of the policy have to be construed strictly.

In view of the above, it was held that the insurer's decision to repudiate claim under the policy is justified.

In result, the complaint dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 09. 446. 2010-11

Sri B. Srinivasa Rao **V/s** Reliance General Insurance Co. Ltd.

Award No:G-171/16.12.2010

Sri. B. Srinivasa Rao, along with his dependent family members, was covered under the Group Mediclaim Policy issued by the Insurer taken by his employer M/s Electro Optical Instruments Research Academy [ELOIRA]. He preferred a claim for reimbursement of hospitalization expenses in respect of hospitalization of his mother at Kamineni Hospital from 19.4.2010 to 22.4.2010. The TPA rejected the claim stating that the present hospitalization was for investigation and evaluation of the ailment. He made a representation to the insurer / TPA along with treating doctor's certificate for reconsideration of the decision. In spite of several reminders, the representation was not considered. Aggrieved, Sri B. Srinivas Rao field complaint with this complaint for redressal.

The complainant stated that his mother was suffering from recurrent episodes of loss of consciousness and she was admitted in Kamineni Hospital on the advice of her treating doctor. Her condition was very serious and to save her life, hospitalization was necessary and to this effect her treating doctor also issued a

certificate. The reimbursement claim was rejected by the TPA stating that hospitalization was for evaluation of the problem. He requested that the issue be resolved.

In the self contained note, the insurer stated that during the course of hospitalization only evaluation of ailment was done by conducting various investigations and only oral medication was given with normal saline. This could have been taken as an out-patient basis without the necessary of admission. The insurer stated that the claim of the insured person was rejected under policy exclusion clause 4.9.

O R D E R

The treating doctor issued a certificate stating that the patient was admitted for evaluation and that admission was as per the standard of care. Clause 4.9 of the insurer's policy excludes diagnostic tests or other tests not consistent with or incidental to the diagnosis or trearment of the positive existence or presence of any ailment for which confinement is required. Neither the discharge summary nor the medicalcertificate obtained by the insured speaks of any specific ailment. Hospitalisation expenses claimed are hit by clause 4.9 of the policy.

In view of the above, it was held that the insurer rightly repudiated the claim of the insured.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.466.2010-11

Award No:G-179/7.2.2011

Sri R.G. Shenoy **V/s** United India Insurance Co.Ltd

Shri R.G. Shenoy along with his wife Smt. Susheela G Shenoy was covered under Canara Bank Group Mediclaim Policy 'Can comfort' issued by the insurer. He preferred a claim on the insurer for reimbursement of RFQMR treatment expenses in respect of treatment of his wife for Osteo Arthritis at SBF Health Care centre, Bangalore. The claim was rejected by the insurer invoking policy clauses. Appeal made to review the decision was also rejected. Aggrieved, Shri R.G. Shenoy filed this complaint.

The complainant stated that he and his wife were continuously covered under the policy for the past 9 years. He stated that the doctor while issuing discharge certificate recorded that his wife was suffering from O/A of both knees for the past 15 years and the TPA rejected the claim as PED. He further stated that his wife suffered from knee pain, for a short while, 15 years ago and probably she might have informed the same to the doctor. He stated that denial of the claim by the insurer on that ground was unfair and unreasonable. He referred to Kolkata Ombudsman's Award wherein the insurer was directed to admit the claim for similar treatment. He also referred to the settlement of the claim by Bajaj Allianz for the same treatment at the same centre.

The insurer in their self contained note stated that the insured person was covered under their group mediclaim policy issued to Canara Bank credit card holders from 2005 only. They stated that as per the claim documents submitted, the insured person had been suffering from knee pain since 15 years. As per 'Can comfort' Policy conditions, pre-existing illness is excluded under the scope of the policy. the Insured person underwent RFQMR treatment and preferred a claim on the policy and it was not payable under the policy for the following grounds:

1. SBF health care was not registered as a Hospital and it did not meet the definition of Hospital

2. The treatment did not require hospitalization and the duration of treatment was less than an hour. It could be taken on OPD basis.
3. It did not fall under day care procedure.
4. It was still an experimental and unproven system of treatment as evidenced in their website where they claim that the procedure was 'gaining acceptance' amongst doctors.

The Insurer stated that based on the above grounds and condition No. 4.1 of the policy, the claim was rejected.

O R D E R

The claim of the insured person is basically hit by the 'PED' clause of the policy. It was clearly stated in the discharge summary that the insured person had pain in both knees for the past 15 years. The insured person also stated in the claim form that she was suffering from pain in both the knees for the past 15 years. The condition pre-existed before commencement of the first policy with the insurer, i.e. from 2005. The claim, therefore, was rightly rejected by the insurer citing clause 4.1 of the policy.

The mediclaim policy issued to the complainant covers hospitalization expenses for medical treatment in a hospital/ nursing home as an in-patient. The pre-requisites for admissibility of a claim under the policy are (i) hospitalization (ii) treatment in a hospital and (iii) treatment as in-patient. Further, 'hospitalization' is defined to mean admission in a hospital/ nursing home for a minimum period of 24 hours. The time limit of 24 hours is waived in respect of any procedure agreed by the TPA/ Company which requires less than 24 hours hospitalization due to advancement in medical technology. The policy also excludes experimental and unproven treatment.

A careful examination of the record shows that the complainant was not hospitalized at all. She was not an in-patient in the centre where she underwent QMR therapy. The centre has no in-patient facilities. The policy envisages that the requirement of hospitalization for 24 hours can be reduced in some circumstances. But hospitalization for some length of time is *sine qua non* for admission of any claim under the policy. When the patient is treated on OPD basis, the key condition of hospitalization is not fulfilled. The policy that governs the contract between the insurer and the complainant is such that the claim is not admissible.

The complainant referred to the decision of Kolkata Ombudsman in support of his claim urging that it constituted a precedent. This is not acceptable. The decisions of Ombudsmen do not constitute precedents. They, therefore, have no binding effect. Further, I notice that the decision of Kolkata Ombudsman was rendered in the context of the policy that was issued to the complainant in that case. It has to be recognized that mediclaim policies are not identical. They are often tailor-made to suit the requirement of the specific person/group. Likewise, the settlement made by private insurer Bajaj Allianz also cannot persuade me to accept similar claims.

A policy of insurance is a contract between the parties thereto and the terms of the contract bind either party in equal measure. The terms also have to be strictly construed. Insurance Ombudsman cannot modify or re-write the terms of the policy for the benefit of either party.

In view of the above, it was held that the terms and conditions of the policy issued by the insurer to the complainant do not admit claim of expenses for QMR treatment. Consequently, I do not find any reason to interfere with the decision of the insurer. It was held that the insurer rightly rejected the claim as per the terms of the policy.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.19.349.2010-11

Mr. Muneerahmed Tahashildar **V/s** Apollo Munich Health Insurance Co.Ltd.

Award No:G-182/15.2.2011

Mr. Muneer Ahmed Tahashildar, an employee of M/s SAIC India Pvt. Ltd., along with his family members is covered under Group Mediclaim policy taken by his employer. His wife Smt. Raina Tahasildar was admitted to Bangalore Baptist Hospital, Bangalore for maternity on 28.1.2010 and LSCS was done on the same day. She subsequently developed breathlessness on 30.1.2010 and it was diagnosed as Pnemonitis and she was treated for it and discharged on 4.2.2010. Out of total bill of Rs.62,540/- the insurer settled the claim for Rs.50,000/- stating it as the maximum limit for maternity. After discharge from this hospital she was immediately admitted at Wockhardt Hospital,

Bangalore and she was treated for the same from 4.2.2010 to 6.2.2010 and the insurer settled the claim of hospital in full for Rs.22,090/-. Again she was admitted at Wockhardt Hospital, Bangalore on 22.2.2010 for complaints of breathlessness and she was diagnosed and treated as a case of Hyperventilation syndrome. The claim of the insured for Rs.10,041/- was denied by the insurer on the ground that there was no active line of treatment. Appeal made for reconsideration of the claim was not considered. Aggrieved, Mr. Muneer Ahmed Tahashildar filed this compliant seeking relief in regard to the short settlement of Rs.12,540/- and rejection of claim for Rs.10,041/-.

The complainant contended that though his wife was admitted for maternity, she developed breathlessness after delivery which did not relate to her pregnancy. The treating gynaecologist also certified that her ailment was not a complication of pregnancy and so he was entitled for full claim amount and restricting the claim for Rs.50,000/- was not in order. He further stated that as the treatment at Bangalore Baptist Hospital was not satisfactory, he got his wife discharged from the hospital and on the same day she was admitted at Worckhardt Hospital and continued treatment. The insurer settled the claim in full. He questioned how the claim was settled by the insurer in full if it was a complication of maternity. He stated that the insurer wrongly restricted the claim for Rs.50,000/- and he was entitled for the balance amount of Rs.12,540/- in the first hospitalization claim. He stated that his wife was again hospitalized

from 22.2.2010 for similar complications and the claim for Rs.10,041/- was rejected by the insurer stating the reason as below:

> *"As per insurance company policy terms and condition expenses towards evaluation and diagnosis purpose without followed by any active line of treatment is excluded from the policy itself, hence this claim stands repudiated"*

He stated that his wife was diagnosed and treated as a case of Hyperventilation Syndrome with nebulization, oxygen, IV fluids and other supportive treatment. He wondered how the patient could become well and get discharged if no treatment was given. He stated that the insurer wrongly rejected the claim and he was also entitled for reimbursement of hospitalization expenses of Rs.10,041/-.

The insurer contended that both the admissions were related to maternity and the usual complications associated with it and hence the claims were subject to maternity sub-limits only. The total limit under the maternity clause had been paid to the complainant. The complainant's wife was admitted at Wockhardt Hospitals primarily to investigate the cause of breathlessness which was later diagnosed as

Hyperventilation syndrome. The Insurer stated that hyperventilation syndrome might be related to psychiatry or post maternity. The policy excluded treatment relating to psychiatry and restricted all expenses relating to maternity within the maternity sub-limits. The insured person was investigated and treated with nebulization which did not require admission in a hospital. The prescription dated 20.3.2010 submitted by the complainant clearly showed that she was taking the same treatment, i.e. nebulization with supporting treatment on OPD basis without any admission / hospitalization. The insurer stated that they had relied upon the medical literature of Harrison's Principles of Internal Medicine [16th edition page Nos. 1561-1565]. The insured person was admitted on 22.2.2010 with complaints of acute onset of breathlessness for one hour while she was sleeping. She was investigated and diagnosed as a case of hyperventilation syndrome with hypothyroidism and hypertension. The treatment given during one day admission included nebulization and supporting treatment. The discharge summary indicated that IV fluids were given but the pharmacy bills did not show any IV fluids. The Insurer stated that hyperventilation

is a normal feature of pregnancy. The insurer stated that the claim was rejected relying upon the medical literature of Harrison's Principles of Internal Medicine [16th Edition page nos. 1571-1573] and on the ground that there was no active line of treatment and the problem was one of post maternity complications.

O R D E R

In the first claim, the insurer provided cashless benefit and paid the claim for treatment even after shifting to another hospital but restricted the claim to the sub-limit of maternity of Rs.50,000/-. The hospital record says that she had been treated for pneumonitis. The treating doctor also has affirmed that this was not a complication of maternity. In view of this, the complainant is entitled to the benefit of the doubt. It was held that this is a fit case for payment of *ex gratia*. Accordingly, the insurer is directed to pay the balance of the claim amount in the first claim to the claimant as *ex gratia*.

Insofar as admission of the complainant's wife in the hospital on 22.2.2010 is concerned, the extensive medical literature supplied supports the case of the insurer. Since the complainant appeared to disagree with the insurer's representative as also the medical literature that the insurer relied upon, it was consulted an independent medical expert. He examined the medical papers of the complainant's wife and concurred in the view that hyperventilation syndrome in this case was a complication of maternity.

In view of the foregoing, it was held that the insurer rightly held that hospitalisation expenses from 22-2-10 are not payable under the policy.

In the result, the complaint is allowed in part as an *ex gratia*.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.573. 2010-11

Shri Damodar G. Kerur **V/s** United India Ins. Co. Ltd.

Award No:G-240/28.2.2011

Shri Damodar G. Kerur, an ex-employee of Syndicate Bank, was covered under a Group Mediclaim Policy for superannuated employees of the bank. He was treated for hypoglycemic episode relating to Diabetes at TR Hospital, Bangalore and he preferred a claim for reimbursement but the TPA M/s Medi Assist rejected the claim stating that it was a pre-existing disease and was not covered under the policy. Aggrieved, Shri Damodar G Kerur filed this complaint.

Sri Damodar G. Kerur stated that he was admitted at TR Hospital, Bangalore on 14.4.2010 and was treated for hypoglycemic episode and he was discharged on16.4.2010. When a claim was made for reimbursement of expenses, the same was rejected by the TPA, M/s Medi Assist India Pvt.Ltd. on 18.5.2010 by citing clause No.4.1 of the policy. The Bank vide its Circular dt.9.12.2009 informed that the insurance policy covered hospitalization expenses in respect of treatment for all diseases including pre-existing diseases except pre-existing cancer.

The insurer contended that they issued a tailor made policy on 1.3.2010 to the Bank. Shri Damodar G. Kerur was covered under the policy but the illness he suffered from and got treated pertained to the pre-existing disease and clause No.4.1 of the policy condition clearly excluded the same. Hence, the TPA rejected the claim correctly. The discharge summary of the hospital also stated that Shri Damodar G. Kerur had history of diabetes and hypertension for the past 17 years. The Bank circular supplied to them by Shri Damodar G. Kerur contained erroneous information and the bank issued Circular No.ref:3974/SWD//Mediclaim 2011-12 dt.6.12.2010 correcting the error while communicating renewal of the policy for the year 2011-12.

ORDER

The contentions of both the parties were heard perused the reports/documents submitted.

It is observed that there is no dispute on the illness suffered as pre-existing one. Shri Damodar G. Kerur was admitted in TR Hospital and got treated for diabetes related hypoglycemic episode from 14.4.2010 to 16.4.2010. it is noticed that the Group Health Insurance Policy issued by the insurer to the Syndicate Bank, which is a tailor-made policy, restricts cover to all diseases/injuries which are pre-existing when the cover incepts for the first time. The Circular ref:3778/SWD/Mediclaim 2010-11 dt.9.12.2009 issued by the Syndicate Bank Head Office, Manipal clearly states that the policy covers the hospitalization expenses in respect of treatment for injury due to accident and all diseases including pre-existing disease except for pre-existing cancer. That the bank issued the circular erroneously appears true. Such a circular which is not in consonance with the policy cannot bind the insurer.

In view of the above, it was held that the insurer has rightly repudiated the claim invoking exclusion under 4.1 of the terms and conditions of the policy.

Notwithstanding the foregoing, it was held that this is a case where the complainant was misled into believing that he was covered under the policy. Although it is the bank and not the insurer which is responsible for allowing such a misunderstanding, it was deemed it fit to allow ex gratia of Rs.2000 (Rs.two thousand) only to the complainant. The insurer is directed accordingly.

In the course of the hearing, the complainant raised the issue of further remedy. It was held that the insurer has not committed any folly in repudiating the claim. But it was must inform the complainant that this award in no would prejudice his claim with any party. In particular, it was clarify that this award would not militate against his complaint, if any, against the bank.

In the result, the complaint is partly allowed for ex gratia of Rs.2000.

Award No:G-254/31.3.2011

Smt. S. Kalpana **V/s** United India Insurance Co. Ltd.

Smt. S. Kalpana w/o Sri P.N. Srinath, a retired employee of M/s Bharath Electronics Ltd., covered under group mediclaim policy issued by insurer for retired employees of M/s B.E.Ltd. She preferred a claim for reimbursement of expenses incurred for aurvedic treatment at M/s Sukrutham Aurveda, Bangalore as an inpatient for 6 days followed by 8 days out patient treatment. The claim preferred for Rs.11,899.50 was rejected by the insurer on the ground that treatment was taken at a 'Clinic' which did not fall under policy definition of 'Hospital/Nursing Home'. She made a representation for reconsideration which also was rejected. Aggrieved, Smt. S. Kalpana, filed this complaint.

O R D E R

The insured person underwent treatment at a *'clinic'* which did not qualify to be treated as a 'Hospital/Nursing Home' for admission of the claim, as per the terms and conditions of policy issued. Insurance is a contract between the parties whose terms and conditions bind both the parties equally. I find that the insurer rightly repudiated the claim.

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

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.477.2010-11

Sri Vinu Koruth Zacharaiah **V/s** United India Insurance Co.Ltd.

Award No:G-261/31.3.2011

Sri Vinu K Zachariah covered under his employer's corporate group mediclaim policy issued by the insurer from 1.10.09 to 30.9.10 approached CMC Vellore during the first week of May 2010, for a shoulder injury and related pain. On initial check up, his sugar levels were found to be high. He was advised immediate admission for lowering of sugar levels and he got admitted from 12.5.10 to 17.5.10. He preferred a claim on the insurer for the reimbursement of hospitalization expenses. The TPA of the insurer stated that there was no active line of in-patient treatment during the hospital stay and only routine blood investigations were carried out and so the TPA rejected the claim under exclusion clause 4.10 of the policy. He made a representation for review of the decision to the insurer but without a result. Aggrieved, Sri Vinu Koruth Zachariah filed this complaint.

O R D E R

The insurer rejected the claim of the complainant on the ground that there was no active line of treatment. The insured person was admitted for management of high sugar levels which were detected when he underwent preliminary check-up for his right shoulder injury. Management of blood sugar levels being a greater priority than the shoulder injury he was advised first to undergo its management. Following the advice of his doctor, he got admitted and underwent treatment. The hospital discharge summary clearly stated the necessity of admission and the nature of treatment given to control high blood sugar levels of the insured person. The insured person submitted internal case sheets of the hospital which show the details of treatment during the hospital stay. The insurer mistakenly assumed that the complainant claimed expenses for investigation. This is not so. He claimed expenses relating to management of sugar levels.

In view of above, it was held that the insurer erroneously repudiated the claim. The insurer is directed to allow the claim after deducting inadmissible and non-medical expenses billed / claimed, if any, as per the policy.

In the result, the complaint is allowed.

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.

MUMBAI

31.01.2011

Varistha Mediclaim Policy

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI-711/2010-2011
Award No. IO/MUM/A/ 473/2010-11 dt. 31.01.2011
Complainant: Shri Ghansham Bathija
Respondent: National Insurance Co. Ltd.

Shri Ghansham Bathija was covered under Varistha Mediclaim Policy for Senior Citizens bearing No.270200/48/09/8500000604 for the period 18.06.2009 to 17.06.2010 for Sum Insured of Rs.1,00,000/- with additional cover of Rs.2,00,000/- for Critical illness, issued by National Insurance Co. Ltd. Shri Bathija underwent CABG on 18.01.2010 at N.M. Wadia Institute of Cardiology, Pune. The claim lodged for reimbursement under Section I of the policy was settled for Rs.92,430/- after deducting Co-pay of 10% However against the claim for Rs.2,00,000/- under Section II of the policy– Critical illness cover, the Company sent him a settlement voucher for Rs.40,000/- The insured however demanded settlement for the full S.I. of Rs.2,00,000/- for Critical Illness. The Company however reiterated their stand of settlement for Rs.40,000/-. Aggrieved by the same, Shri Bathija approached this Forum seeking relief in the matter.

A joint hearing was held with the parties to the dispute. Smt. Komal Sukhija, daughter of the complainant submitted that the claim under critical illness cover has not arisen during the waiting period prescribed under the policy and has been made after due observance of survival period as narrated under the policy as has also been supported with the requisite hospital papers. She also submitted that the terms and conditions were shown to her when the she visited the Office. The Company official confirmed that the policy was issued to Shri Bathija with duly attached printed policy bond specifying the terms, conditions, provisions and exclusion under the policy. Under Section II i.e. Critical Illness cover, the SI is Rs.2,00,000/- and under provision no.3, compensation for Coronary Artery Surgery is limited to 20% of SI. Accordingly they had offered to pay Rs.40,000/- in addition to Rs.92,430/- already paid under Section I. The complainant was advised to take the payment of Rs.40,000/- offered by the Company without prejudice to his right to claim for the balance amount.

A perusal of the copy of the Prospectus as produced by the complainant revealed that in the event of the insured contracting any of the listed critical illnesses, the policy provided for payment of compensation of the SI mentioned under this section for critical illness without any sub-limit, subject to compliance of all conditions stipulated thereunder. On the other hand, from the copy of the policy clauses as exhibited by the Company, it was seen that as per provision no. 3 to this Section, the compensation for Coronary Artery Surgery is limited to 20% of the S.I. under this section.

A Prospectus also known as an “offer document” is a formal legal document that provides details about a product offered for sale to the public. It should contain all the facts that a buyer needs to know to make an informed decision about the product. The material included in the Prospectus is the basic information which influences the proposer’s decision whether to go in for the product or not and should highlight all the

salient features of the product which include not only the benefits offered but also more specifically the restrictions, if any with regard to such benefits. No doubt, it is not expected to reproduce the entire terms and conditions of the policy. Also, the insured has a right to cancel the policy if the terms and conditions of the same are not acceptable to him by serving a notice on the Company. In the event of any dispute arising in this regard, this Forum will rely on the policy terms and conditions, which forms the basis of the contract, while arriving at any decision in the matter. And as per the said conditions, the Company's decision to settle the claim for Rs.40,000/- could not be faulted with, being based on policy terms and conditions.

But in the instant case, there was no evidence to show that the policy clauses were, in fact, dispatched to and received by the complainant. In view of the same and the apparent discrepancies/inconsistencies in the two documents issued by the Company for the same product causing unnecessary hardship to the complainant, it was thought fit to give some benefit to the complainant by allowing an additional amount of Rs.60,000/- as lumpsum compensation on ex-gratia basis, to resolve the dispute.

17.03.2011

Group Mediclaim Insurance Policy

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI-277/2010-2011
Award No. IO/MUM/A/551/2010-11 dt. 17.03.2011
Complainant: Shri Chetan Kumar Hemani
Respondent: The National Insurance Company Ltd

Shri. Chetan Kishore Hemani along with his wife, daughter and mother was covered under the Tailormade Group Mediclaim Insurance Policy No. 154400/46/09/ 8500002914 for the period 28.02.2010 to 27.02.2011 for Sum Insured of Rs.5,00,000/- on floater basis issued for the customers of Karvy Stock Broking Ltd. by National Insurance Co. Ltd.. His mother Smt. Hansa Kishore Hemani was admitted to Asian Heart Institute from 18.02.2010 to 03.03.2010 where she was diagnosed of Ischaemic Heart Disease and underwent CABG. The claim lodged for Rs.7,75,000/- approx. was rejected by M/s. Family Health Plan (TPA) Ltd. on the ground that the date of admission in the hospital was falling prior to the policy inception date. Shri Chetan represented to the TPA as well as to the intermediaries M/s KARVY Stock Broking Ltd. and the Insurance Company requesting reconsideration of the claim as the premium cheque was issued on 27.01.2010 prior to the date of hospitalization and even the operation was conducted on 22.02.2010 i.e. after the date of issue of premium receipt dt. 19.02.2010. Both the agencies however reiterated their stand of rejection of the claim. The Insurance Company did not respond to his representation. Being aggrieved he approached this Forum for intervention in the matter for settlement of the claim.

A joint hearing was scheduled to be held with the parties to the dispute. However as the Insurance Company's office is based in Kolkata, no official appeared for the hearing but forwarded their written statement along with the relevant documents which were taken on record. Shri Chetan Hemani deposed stating that he is an employee of Infosys India Ltd. at Pune. He met a Karvy executive in their Pune office who gave him to understand that 'Karvy' is one of the distributors of policies issued by National Insurance Co. Ltd. On 27.01.2010 one Mr. Ravi, Regional Sales Manager of Karvy gave him a power-point presentation explaining the benefits of the family floater policy of 'National'. It was also told to him that he would get an additional bonus coverage of Rs.75,000/- without paying any additional premium, over and above the regular floater SI of Rs.5,00,000/- opted by him. He decided to buy the policy over the counter, covering himself and his family members and issued a cheque dt. 27.01.2010 along with duly filled in proposal form and other necessary documents. He did not get any acknowledgement for the same but was given to understand that the policy will be issued by National's Kolkata office effective from the last date of the same month i.e. January 2010 itself. Despite repeated follow-up he was not given the policy copy but only received a receipt dt. 19.02.2010 issued by 'National' for the premium paid which mentioned the date of cheque as 27.01.2010. He was not aware that the policy was issued effective from 28.02.2010.

The Insurance Company in their written statement stated that the subject Group Medical Policy was issued to M/s. KARVY STOCK BROKING LTD. for their 284 customers and their dependents. As per MOU with M/s. Karvy, all proposals received from them during the month were to be underwritten at the end of the month on good faith and a Master Policy would be effective from the last date of the month the cheque is deposited to Karvy Kolkata Office. In the subject case, the premium was received by them on 12.02.2010 from Karvy's Kolkata office and risk was covered from 28.02.2010, the last date of the month and receipt issued on 19.02.2010.

On an analysis of the entire case, it was firstly observed that though the Group Tailor-made policy was designed to cover the existing customers of KSBL, Shri Chetan Hemani being a non-member of KSBL was covered under the said policy in violation of the provisions of the MOU. The Company should have taken adequate care by verification of necessary documents to ensure that the proposers included in the list forwarded by KSBL are, if fact, members of KSBL. Further, as per the MOU, the premium cheques collected in favour of NATIONAL INSURANCE CO. Ltd. by the local KARVY representaitves were to be deposited in the local AXIS Bank Branch and all proposals collected during the month would be underwritten and a group policy would be issued on the last day of that month covering the members whose proposals have been received. In the instant case, the Company has not disputed the date of receipt of proposal and premium cheque i.e. 27.01.2010 by Karvy representative at Pune. Hence going by the provisions of the MOU, proposals with premium cheque collected in the month of January should be underwritten and included in the Group policy issued from 31.01.2010. The Company has only stated that the premium was received by them on 12.02.2010 from Karvy Kolkata office, however the fact remains that the complainant has paid the premium in the month of January. There is no specific provision in the MOU with respect to cut-off date for premium cheques received towards the end of the month which cannot be included in the policy to be issued on the last date of that month and to

be included in the policy for the subsequent month. Also the Insurance Company could not throw light on this issue after being asked by this Forum. As regards the query on CD Account they only confirmed that no balance is maintained in the CD Account either to take care of such situations. In the absence of any laid down provisions in the MOU to take care of such possibilities, the Company cannot now take a plea that the premium has reached their office in the month of February 2010 over which the proposer has no control after having paid the premium to the authorized representative of KSBL in the month of January nor is he informed about the same. Also, as confirmed by the Insurance Company, they have received the premium on 12.02.2010 which is prior to the date of hospitalization. Under the circumstances, the benefit of doubt was given in favour of the complainant and the Insurance Company was directed to settle the claim for the admissible expenses upto the limit of the Sum Insured under the policy including Additional Critical illness cover, after ascertaining the details of claim/s received under any other policy in force at the relevant time.